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## Submissions for this publication

Articles, news, views, announcements and items of interest to the therapeutic community are always welcome. Submissions can be sent via e-mail, on a standard floppy disk or typed on one side of an A4 sheet. Files should preferably be submitted in MS Word format, although a wide range of file formats can be opened. If in doubt send it in.

All correspondence for the Editor should be addressed care of the NCP mailing address.

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### **Disclaimer**

**The views and opinions expressed in *Fidelity* are those of the authors. Similarly, any advertising that appears in this publication is not necessarily endorsed by the NCP.**

## **EDITORIAL**

Welcome to the winter edition of Fidelity, the journal of the National Council of Psychotherapists. As you are all aware, we have recently moved into the wilds of Derbyshire for a better quality of life. We all preach happiness to our clients so we thought that it was time that we listened to ourselves.

Along with the move to such a picturesque part of the country, we decided that now would be a good time to rebrand the NCP.

We already had to change so many things, that we thought a total rebrand would also be good, so you will notice over the coming weeks and months that the NCP paperwork has changed, along with the email address and the fax number. What hasn't changed is the telephone number (0845 230 6072) and our commitment to great service to all of our members.

Within the pages of this great new look magazine (isn't that a wonderful picture on the front cover?) you will find a number of advertisements that we believe offer excellent value for money.

We ourselves have used the specialist card service for our Christmas cards and also our moving house cards. Our new printer is offering all members a terrific deal on printing, even if you only have small quantities, as most of us do.

There is an excellent offer for discounted training in the centre pages and lots of interesting articles inside.

Talking of articles; where are yours? We are always asking for items for the Journal and yet few people seem to think that what they could write would be good enough. Well it would be. We have all kinds of members, some like really academic articles and others prefer the real case studies and "down to earth" stuff that everyone can understand

Inside is a reminder concerning insurance and how important it is today. One ex member failed to take out insurance yet told us they had done so; needless to say, they are no longer members and will be unable to access insurance at any price. **So Be Warned.**

Also inside is the latest on the saga of regulation for our profession. As has happened so many times before, the two organisations that began the process fell out over who would be in charge and began to "do their own thing". The DoH has now taken the process in house and we will be hearing more in due course. All members will be kept up to date as needed so keep an eye on the website notice board.

As we are almost at that time of year again, may I take this opportunity, on behalf of everyone at HQ, to wish you all the happiness of the season and a healthy, happy and prosperous New Year.

The Editor

## Addictions Part 2: By Peter O'Loughlin.

First, my apologies, I promised to have this ready for the last issue of our magazine, unfortunately I missed the deadline.

In this article we will be looking at the American Psychiatric Association's (APA) criteria for establishing the abuse of, or addiction to cannabis. It should be noted that both the APA, and the World Health Organisation (WHO) consider substance abuse, or addiction to be a mental disorder, or disease, In this context a mental disorder is defined by the APA as: *A clinically important collection of symptoms (these can be behavioural or psychological) that causes an individual distress, disability, or the increased risk of suffering pain, disability, death, or the loss of freedom.* (1)

Occasional, or recreational use, defined as once or twice a month, of cannabis, or for that matter any other psycho-active drug, whilst not recommended, is not considered to be hazardous, however, if users decide that the altered state of consciousness induced by such use is something they would prefer to experience more frequently, or is more comfortable than their normal condition, there is a probability that more frequent use will occur; given that sooner, or later, larger quantities will be required in order to achieve the same affect, we are now looking at what is termed as substance abuse, or as the more politically correct would phrase it, substance misuse, at this stage users are vulnerable to developing addiction.

Cannabis, or marijuana, as it is also known is the most widely used illicit drug within the UK. Advocated by many, including some members of the medical profession as a relatively harmless drug, a perception strengthened by successive Home Secretary's downgrading it from a class B substance to class C, it is in fact, a very insidious drug, the regular use of which has many undesirable affects including, but not limited to anxiety and depression, in a seemingly contradiction of this , the initial effects of cannabis induce feelings of mild euphoria, relaxation, and an altered state of consciousness, that permits users to view their personal world in a manner that bears little or no relation to reality. This altered state of consciousness is brought about by the principle ingredient known as THC, in addition there is some 400 plus other chemicals in the cannabis plant; a much overlooked fact is that the vast majority of cannabis peddled on our streets is around 10 times stronger than that which was available in the late 1960's and early 70's.

Cannabis normally starts to take effect within 10-15 minutes of lighting up, first time users may experience nausea, and/or dizziness. As the THC in cannabis, enters the brain, the initial feelings of euphoria start to kick in via the brain's reward systems, stimulating brain cells to release dopamine. Users may experience pleasant sensations and colours. Music and other sounds, appear to become more intense, and time seems to slow down, however after the euphoric feelings start to fade, normally 1-3 hours after ingestion, these are frequently replaced by feelings of tiredness, anxiety, depression, and lethargy, in addition there is the possibility of paranoia in the form of fear and distrust. Since most users initially fail to realise that their down mood is a composite of withdrawal symptoms, the 'natural' reaction is to use the drug again in order to attain the euphoric state, as that process continues, so the habit is established. Sooner or later, although not in every case, users find that 'more of the same' is needed in order to get the desired effect.

Further long term ill effects include, but again are not limited to, illusions, hallucinations, auditory and/or visual, impairment of the ability to form memories, an inability to recall

events, and short attention span, the latter is not infrequently mistakenly diagnosed as Attention Deficit Disorder, (ADD) especially among younger users.

Given the widespread and increasing use of cannabis, and the increasing incidence of presentations for anxiety, depression and so called stress, therapists may wish to consider the wisdom of screening for its use, since interventions for any of those conditions, where regular or persistent use of cannabis is taking place, are unlikely to have positive outcomes, until, and unless the cannabis use is addressed. There is no need to be intrusive in one's approach, my own is a seemingly innocent question, phrased with a smile as "*in addition to alcohol, what other recreational drugs do you use*"? There are of course implied assumptions in my question, the first being that the client does drink, and since most people do, my question is unlikely to cause offence, the second implication is more general, and indicates that the use of recreational drugs is fairly common, therefore my client need have no fear in confiding in me. If I get a denial of use, I smile more broadly and say "what? Not even wacky baccy"? Once again the implication is, that its use is common, and any reservations my client might have had about confiding in me can be brought to light.

If you as therapist employ similar tactics, you will be armed, in a remarkably short time, with more information than 65 percent of GPs and 90 per cent of therapists rarely, if ever obtain until its too late, thus giving you far more insight into the presenting problems.

If there is confirmation of use, you have a wonderful opportunity to establish empathy with your client, by discussing with him/her, the perceived 'benefits' listed above, thus you demonstrate your understanding of why it is being used. Having done that, you need to establish the following:

Has the recent use of cannabis caused any of the following?

Red eyes: Increased appetite: Dry mouth: Rapid Heart rate: clients sometimes mistake the latter for a panic attack. Assuming there is no pre cannabis use medical history causing any or all of these; the client is experiencing, or has experienced 'cannabis intoxication'. That being the case, further investigation is now necessary.

Have there been any perceptual disturbances such as auditory, tactile, or visual illusions? If so, is the client aware that these are caused by cannabis use? If the client is unaware that they are, and therefore that the symptoms are unreal, you are now facing a case of cannabis addiction, or as psychiatrists might describe it, cannabis psychosis. Unless you are qualified and experienced, in dealing with such a condition, common sense dictates that you should not get further involved, please, do not as others before you have done, assume that what works for helping people to stop

smoking will work in such circumstances. Be honest with your client and inform him/her that you are not qualified to deal with their condition, and that they should seek professional help from a registered addictions counsellor, or their local community Drug Action Team. (DAT) A list of private practitioners can be obtained from [www.fdap.org.uk](http://www.fdap.org.uk), whilst the latter can be found in either yellow pages or the telephone directory, or if none are listed, the local Community Mental Health team, will be able to provide contact details, as will the clients GP. Further help can be obtained by the client attending meetings of Narcotics Anonymous

If the symptoms are confined to cannabis intoxication, you now have sufficient information to advise your client of the potential dangers of continued use, and how such use is affecting their presenting condition. It is my opinion that unless the client is willing to consider relinquishing cannabis use, normal interventions will have only a minor impact on the

presenting problem, further providing this is adequately explained to the client, he/she can decide if they want to proceed on that basis. Assuming your client is willing to proceed, you will find it helpful in assisting them, to familiarise yourself with the at the ‘Gold Standard’ framework that those who are qualified in addictive behaviours work within when addressing abuse or addiction, this is known as ‘The Process of Change’. (2)

Based on research and huge populations (never less than 30,000) surveys, the authors and creators of the transtheoretical model of the above, established the actual stages that people went through, when major changes in their lifestyle became desirable or necessary. Further, the creators detected that these stages occurred regardless of whether the change came about through self motivation, or as the result of therapeutic intervention; here again, the particular model of therapy employed seemed to be less important, than the therapist being acutely aware of which stage the client was at. Further research brought to light that although each model of therapy involved had its own sphere of excellence, some therapies were more effective at the individual stages than others, therefore those who aspire to become skilled at working within the framework of ‘The Process of Change’, need to acquire a working knowledge of those most favoured; however, the authors, much to the chagrin of the supporters of specific therapies, concluded that it was not essential to be ‘formally qualified’ in each one.

‘The Process of Change’, or as it is sometimes referred to, ‘The Cycle of Change, is divided into six stages; in this instalment we will be looking at the first three.

### **Pre-contemplation:**

Individuals at this stage are unable or unwilling to recognise that it is their habit, and/or behaviour that are either the cause of their difficulties or problems, or are aggravating them. Addicts, or alcoholics, for example may insist that their habit has arisen from their problems. Whilst the truth may be a fusion of either, until and unless the individual is prepared to accept responsibility for their condition, and are willing to contemplate changing their habit or behaviour, progress is difficult. It is common practice for both therapists and those in the medical profession to classify such individuals as ‘not ready’. Speaking for myself, I find this conclusion to be judgmental, and since, as a therapist, I’m supposed to be non judgemental, I find this attitude a curious contradiction of my ‘duty of care’.

At this stage, I use a therapy known as ‘Motivational Interviewing’. (MI) This is a fairly simple process that avoids confrontation, but together with what is known as Raising Conscious Awareness, (RCA) facilitates moving the client forward to the next stage: If readers are not familiar with MI, there is a wealth of information freely available on the web. RCA is rooted in psycho-analytical therapy; in this context it is used simply to ask relevant questions of the client, with a view to getting him/her to ‘analysis’ with their answers both the benefits and ‘costs’ of their use. In doing so it may produce some emotional arousal as the client recalls incidents when cannabis has had adverse affects on him, or his loved ones. Do not, at this stage, confront your client with what emerges; my favoured approach at this stage is simply to keep asking how that makes them feel, when they tell me, I ask them to describe what that means to them, I then ask them how they would like to feel. Thus in a *seemingly* non intrusive way, I’m leading the client to confront the reality of his/her situation, without any judgement from me by either word or attitude.

### **Contemplation:**

At this stage individuals are ‘contemplating’ change; however they may still be classified as ‘not ready’. In my experience people at this stage are experiencing considerable reservations

about their ability to change, not the least of which is anxiety and fear that they will be able to cope without their drug(s) of choice. Unfortunately, their fear is such that they find it difficult to express, instead they will offer ostensible reasons for not making a commitment, which may be expressed as a change in their partners, home, job, etc., claiming that when any of those change, they will find it easier to quit. Their fear may also be rooted in previous attempts to quit and failing. A further and quite common barrier that may need to be overcome before the client can be moved forward to the next stage is that of 'wishful thinking'. Wishful thinkers like to have it both ways, to continue using their drug(s) of choice, without the adverse consequences. Such people love to talk about change, which can lead unsuspecting, or inexperienced, therapists to conclude that they are ready to move on to the next stage, this has I have discovered through bitter experience, is not the case; I have also discovered that people can stay in this stage for extended periods of time. I hang my head in shame when I say that I have one client who remained at this stage for some five years. I had failed to find the key to arouse his emotions to the point where he felt able to move onto the next stage of 'preparation', until one day, he mentioned something about his relationship with his daughter; after much gentle probing, it became clear that he was beginning to see how his habit was having considerable negative impact on the relationship. Not unnaturally, he became very emotional.

Emotional arousal is the most effective process at this stage; there are a variety of techniques that can be employed, such as visualisation. Get the client to make their own internal movie, concentrating on the consequences they have actually experienced arising from their habit, rather than confront them, get them to confront themselves, their defences, seek to have them within the confines of their mind, create distressing, but realistic, scenarios of where their drug abuse is leading them to. Help them to picture in their minds eye the further sequential consequences, *specifically* related to their own circumstances that could arise. I have found hypnosis to be valuable in this process, however, since the central nervous system is unable to differentiate between a real or imagined experience, and given that our bodies react in a similar manner to both, be prepared for some severe abreactions. If you are not confident about your ability to handle the latter, you have a 'duty of care', to refer your client to an appropriate source.

It may now be apparent that he forgoing requires applied skills, persistence and patience; there are no shortcuts for moving people on from this stage; instant overwhelming emotional arousal is rare, but if as a therapist, you are more interested in *lasting* change in your clients, as opposed to a 'quick fix', which of course is what those who use drugs are always seeking, you will have prepared yourself for this demanding process, thus enabling your client to move on to the next stage.

### **Preparation:**

Once the contemplation stage has been successfully negotiated, there is a natural urge on both the therapist's part and the client to leap straight into action, after all the client is now willing to do something about his habit, so let's get on with it. The creators of this model discovered during their research that those who leap from contemplation to the action stage are vulnerable to relapse; that without adequate preparation to modify or change, what may well be a deeply entrenched behaviour, affecting body mind and spirit, lasting success is elusive; therefore those who skip this stage do so at their own risk.

The main objects of this stage is to enable the client to continue evaluate and re-evaluate both themselves and their habit, during this process clients will become increasingly confident of their decision to bring about change. However instead of looking at the past,

and the consequences of the habit as in contemplation, we need to help the client to switch their focus onto the most suitable and personally acceptable action(s). Here again it is not for the therapist to suggest what action(s) might be suitable but to help clients formulate such action(s) that are compatible with their personal circumstances, values, and beliefs. It may well be that our client needs a network of support, from those who have been where he/she is at, if so they could do considerably worse than attend meetings of either Narcotics Anonymous, (NA) or Marijuana Anonymous, (MA) both have excellent web sites, with contact details, and hold regular meetings throughout the UK. There are no dues, or fees payable, and the *only* requirement for membership is a desire to quit.

If clients attend such meetings, they will benefit from meeting others who understand their fears and their feelings about quitting, no one will force them to quit, members who have managed to do so will be happy to share their experiences of how they managed to become free, whilst offering their voluntary support and encouragement to those who also wish to be free. If clients attending these meetings listen to the similarities of what they hear, rather than looking for any differences, they will quickly realise that they are not alone, that others who might be regarded as being far worse than them have managed to set themselves free, thus enhancing their confidence that they too can beat their habit.

Notwithstanding the client's apparent willingness to change, they are likely to experience increased feelings of anxiety as they prepare for action. Change or even thoughts of change can appear to be threatening, bringing thoughts of 'what happens if I fail'? The fact is that that there are no guarantees that change will be successful, which is why attempts at change require courage, courage is not the absence of fear, courage is when we experience fear, and still proceed with making commitments, anxiety is the natural outcome of such situations, help your clients to understand that although they may not feel they can conquer their anxiety, that you can help them to understand it, and counter it with commitment, there are a number of things that you can help your client to commit to.

1. Is he/she willing to make a commitment check out the websites of NA and MA, with a view to examining the wealth of information on both?
2. If so are they willing to commit themselves to identifying where there are geographically convenient meetings and the days they are held?
3. Are they willing to make a commitment of the date they to attend their first meeting?

There is no need to get all of these commitments in one go, the first one is a step forward, a small change in outlook and attitude, boost their egos on the basis that informed opinion and information, helps us to make informed decisions, whereas, anxiety leads to avoidance, and delay, a temptation to make excuses, to wait until 'next week', or some other 'better time'. Anxiety can make people hide their actions, so that no one will know if they fail. It is our job as therapists to alleviate anxiety, to help the client to feel stronger, more confident, but he or she has to take the necessary steps in this stage. If it becomes apparent that he/she is unwilling or feels unable to do so, we need to help them recognise that they are still in the contemplation stage, thus we have to work with where they are, rather than where we would like them to be.

In the next instalment we will be looking at cocaine and the next three stages.

© Peter O'Loughlin, Eden Lodge Practice. Beckenham BR3.3AT. October 2006.

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## **The delicate boy with breathing problems**

Jim made an appointment to come and see me in April 2002 for his debilitating panic attacks. He discussed a past fear of heights which he had partially resolved with a previous hypnotherapist during July 2000. Early on in our consultation he discussed his current fears of being trapped in traffic jams as well as anxiety whilst driving on motorways. This problem was currently negatively affecting his work. He manages a small team of marketing personnel. The need to travel is of utmost importance to him in his work. As he talked he reported many other triggers to his anxiety.

More in depth details of his personal history and current problems were as follows:-

When he was four he said his Mum had died and from that day to this - thirty four years later - he has been living with his Grandma, in Birmingham, West Midlands, U.K. His Grandma always told him that he was a delicate boy and that he was prone to breathing problems.

When I asked for the symptoms he experienced during his anxiety attacks he said the main problem was breathlessness.

Jim said he had decided to come to me for hypnotherapy help in coping with the following situations which regularly triggered his panic attacks.

- 1) Motorway driving and traffic congestion
- 2) Wide open spaces (parts of his open plan workplace were an example)
- 3) Fear of flying

During his case history taking Jim became breathless and very anxious. As soon as this happened I asked that he followed me in rubbing the sore spot as well as the emergency stop procedure, these points are under eye (UE) Collarbone (CB) and under arm (UA).

We both rubbed the sore spot at the same time and the above points whilst he continued to tell me his story. *I always aim to empower my clients to do the work on themselves whenever possible.*

Jim had consulted me for hypnotherapy following the recommendation from his doctor. As he wanted and expected to receive hypnosis I thought it was appropriate to gently introduced

EFT as a simple stress release technique to relax him during his story telling. He continued to tell me his story and remarked on the fact that he was surprised not to have needed his nebuliser during this time.

This comment about the need to use a nebuliser was the first time that he had introduced me to his fear of an asthma attack. Apparently he had always been told that his Mother died when he was four years old following an asthma attack.

At this part of the session I suggested that he may find that intentionally using EFT to help with his fears and distressing memories during this session would be helpful for him. He volunteered the idea that he could use EFT as he would normally have used his nebuliser, it could be done simply and surreptitiously so that no one would need know he had a problem.

I asked him to recall a moderately distressing memory, a time when he had had some difficulty breathing. The reason I asked for a moderately distressing memory was to creep up upon his problem with the least possibility of re-traumatising him. Working in this way, we could take the edge off the problem and give him practise doing the basic recipe for real.

Jim remembered a specific incident some 2/3 years ago when he was stuck in a motorway queue while returning home from friends. This experience was still clear in his mind and had a reasonable remaining emotional charge.

SUDS            7 out of 10

Sore spot        Even though I have this cold sick feeling in the pit of my stomach, I completely accept and respect myself. (This was done three times).

Face Points     This cold sick feeling

Collarbone     This feeling affects my breathing

Underarm       I hate this feeling

Hand and        Stuck in this traffic

Karate chop    A cold sick feeling

Points           I feel I can't breath

Gamut Spot     This point was tapped upon whilst thinking of the whole gamut of problems

SUDS            4 out of 10

After rescaling the problem I asked Jim to tell me what he had been thinking of whilst doing the EFT. He said his mind had been wondering to other past events and some future fears of his current work situation. As he discussed these past fears and future worries I wrote the phrases of these down for use in a later session to do a more in depth shortcut method when appropriate.

However, I wanted Jim to become more familiar with using the basic recipe himself before moving on and confusing him with a new process. We did a further full two more rounds much the same as above, and then we ended on the third round and incorporated a positive choice formulated by him in this session. The positive choice he used was "Even though I

experience breathing difficulties when stressed - I choose to enjoy calm more naturally efficient breathing, whatever is going on around me”.

During the second part of Jim’s first appointment with me I asked him to tell me what he imagined his SUDS level would be if he were to think of his worst ever breathing difficulty. Asking for Jim to guess at the SUDS level without asking him to actually imagine or visualise it was intentional. This is a useful method of distancing clients from their problem. This process avoids Jim getting to a high intensity level too quickly at the beginning of the session. Guessing at rather than actually reliving or re-experiencing is helpful in severe cases of anxiety. No benefit could be derived by facing Jim with his fear full on at this stage of therapy.

Jim said he imagined his SUDS level would be a six if he guessed at it but that it would be extremely high if he got into really thinking about it. We immediately began another set of the basic recipe on this event as follows:-

- |                             |   |
|-----------------------------|---|
| SUDS                        | 6 out of 10 (when guessing at his intensity level)  |
| Sore Spot                   | Even though I have some emotional intensity when I guess at this memory, I deeply and completely accept and respect myself. (This set up phrase was used three times) |
| Face points                 | This intensity whilst guessing  |
| Collarbone                  | This intensity without even thinking  |
| Under arm                   | This memory I don’t want to think about   |
| Hand and Karate Chop Points | A memory I’d just rather forget   |
| Gamut point                 | Whilst doing the 9 gamut I asked Jim to let his mind wander around the problem memory.  |
| SUDS                        | 2 out of 10 (when guessing at intensity level)  |

The positive results of this one session of tapping encouraged me to instruct Jim to allow himself to think of this experience but to let me know immediately if he noticed any increased intensity. After a while of thinking of this bad experience and discussing it further with me Jim reported that he was still only a two on the intensity scale.

To test the work we had already accomplished on this intense memory I asked Jim to do the same thing again but this time with his eyes closed really trying to imagine he was there in the frightening experience again. He laughed and said, “It doesn’t seem to bother me anymore it’s not a problem”.

Jim’s first appointment concluded with a relaxing session of hypnosis, to strengthen his choices together with post hypnotic suggestions of easily using EFT whenever he noticed the need to release any tension. These positive suggestions were recorded so that Jim could listen to them and practise self hypnosis.

On Jim's follow up appointment three weeks later I found him to be much calmer and more confident and enjoying the freedom of using EFT to relieve day to day stressors.

A further appointment was made to work specifically on reducing his fear of flying and his remaining fear of heights. We also spent half an hour exploring some of the beliefs surrounding his breathing, the loss of his Mother when he was four, and finally his fear of dying during an asthma attack. However, we found on this appointment that most of the fear had already been neutralised by the work he had done on his own between sessions as well as during therapy together.

In April 2004, some two years later, I received an updated report from Jim regarding his calm confidence at work and his ability to enjoy travelling by car as well as by air. He has already flown to Spain and Italy and is in the process of arranging to visit New Zealand in December 2004 and is really looking forward to it.

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## **Book Reviews**

### **From Trauma to Transformation** Muriel Prince Warren, DSW, ACSW

This book, written in response to the increased need for Critical Incident and Post Traumatic Stress Disorder treatment following 9/11, is a comprehensive guide for therapists who either wish to specialize in this field, or need to know a variety of techniques to use in the event that they may come across a client suffering from a related disorder.

Not only does the author provide treatment plans for the many and varied related disorders stemming from PTSD or Critical Incidents, she also categorizes the treatment of children and adolescents, in both the short and the long term as well as short and long term treatment for adult sufferers. Not only can being involved in a traumatic incident cause emotional disorders, it can also exacerbate those which already existed prior to the incident and these are also addressed in detail.

Using a variety of interventions, including hypnosis, guided imagery etc. this book should serve as a very useful guide to the treatment of what has become an increasingly more common complaint in recent years. The book also includes a large bibliography for those who wish to read further on the subject.

*From Trauma to Transformation is available from:* The Anglo American Book Company Ltd., Crown Buildings, Bancyfelin, Carmarthen, Wales. SA33 5ND. E-mail: [\*\*books@anglo-american.co.uk\*\*](mailto:books@anglo-american.co.uk) [\*\*www.anglo-american.co.uk\*\*](http://www.anglo-american.co.uk)

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## **We Need to talk about the Funeral** Jane Morrell and Simon Smith

This beautifully illustrated soft-back book is bursting with practical advice for those suffering bereavement and needing to know exactly what to do when organising a funeral. For therapists, it is an excellent resource you can recommend in the event of a client asking your advice on these matters, for instance, someone caring for a loved one with a terminal illness who knows it is only a matter of time before they must face this ordeal. I don't think anything has been omitted from this book – it even tells you how to go about arranging a green funeral should the deceased have expressed a wish for one. There is also a section on laying out a body, just in case there is anyone who would rather do this for their loved one instead of allowing the funeral directors or the hospital to perform the task. All in all, this book is a valuable source of information, dealt with in a sensitive manner and should be all a bereaved person needs to guide them through the myriad of necessary arrangements at a stressful time.

*We Need to Talk about the Funeral* can be obtained from most bookstores (it can be ordered if not in stock) and Amazon, in the usual way. Alternatively it can be bought from [www.greenfuse.co.uk](http://www.greenfuse.co.uk)  
[www.funeraladvisers.org.uk](http://www.funeraladvisers.org.uk)  
[www.weneedtotalkaboutthefuneral.com](http://www.weneedtotalkaboutthefuneral.com)

Pat Doohan. MNCP

Jane Morrell and Simon Smith both hold diplomas in Psychosynthesis Counselling. They both completed the four years of the Psychotherapy course but decided not to practice as psychotherapists

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### **Review of Workshop ‘Bringing Your Shadows to Light’ 13/08/06** **With Asaf Rolef Ben-Shahar**

I attended the workshop ‘Bringing you Shadows to Light’ – exploring negative aspects of ourselves, in London on 13<sup>th</sup> August this year, after seeing the advert in the Fidelity magazine.

The day started unusually: ten strangers sitting on cushions in a large, light-filled room, openly telling each other what we wanted each other to know about ourselves, but also what we didn't want each other to know. This was such a beautiful introduction to the group and it set the tone for honesty and trust during the workshop. We then took part in a physical exercise of jumping onto a pile of mats (approximately 7 feet high!) from a springboard. This made us all giggle and express our playful nature that we sometimes hold within. We then split into partners and played the ‘yes’/‘no’ game, where we could only use one of those words each, in a vulnerable, fierce or playful way. This eliminated any barriers we had and we found that the words no longer had meaning; instead, we relied on body language, voice pitch, facial expressions etc.

The objective of the day was to admit that we all have ‘shadows’. Asaf describes these as the negative aspects that we reject and push away from ourselves, that then become alienated and move into our unconscious. When we reject them in this way, the shadows find ways of manifesting in our lives, such as depression, anxiety, phobias, destructiveness, physical or mental symptoms. We also build defence mechanisms against our shadows, such as denial, repression, rationalisation and these create a lack of self acceptance and a conflict with our need for integrity.

As individuals, we can recognise that we all have these qualities and accept that we are not as good as we think, but not as bad as we fear. As therapists, this can support our non-judgment of others and help our clients to recognise who they really are, in all elements. It also helps to build empathy and to know as a therapist that we have all been through similar negative emotions and experiences and that the therapist is not 'superior', we are all human. We were given tips for shadow-work, therapeutic shadow rituals, plenty of hands-on practical work and a live demonstration of Asaf working with a volunteer from the group. This was a profound experience; watching the 'client' work through his shadow and seeing the way Asaf used his Integrative Mind Body Therapy in a real situation.

Since the workshop, I have looked at my reflective journal, as well as the hand-out produced by Asaf and I believe the workshop was very rewarding. At the workshop, I looked at the assumed need for a Coach/Therapist to regard themselves as being 'perfect', or they will not be able to successfully help others. I believe that we can never reach that, however much we strive for perfection, but we can love ourselves completely, knowing and accepting our shadows as part of ourselves.

I recommend this workshop to other Coaches and Therapists, to look at their own shadows in a positive and 'safe' environment and to then be able to complete shadow-work with clients. It is important to understand that we all have shadows and to welcome them back from 'exile' and accept them, can be an empowering and uplifting experience. I look forward to my next workshop with Asaf.

*Ruth O'Neil is a partner in Aquarius Coaching and works as a Holistic Life Coach in the Midlands. She works with corporate clients and individuals who are searching for more direction or a deeper understanding of who they really are. She uses coaching techniques combined with sound and energy work to aid self healing and build empowerment. She recommends wellness supplements to her clients, from over six years experience as a Wellness Coach and offers Coach Supervision to qualified Coaches and Therapists. Ruth can be contacted on 01332 853303.*

By Ruth O'Neil LNCP [www.aquariuscoaching.co.uk](http://www.aquariuscoaching.co.uk)

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## **Important – please read carefully!**

**When you receive your invitation to renew your membership of the NCP, you are asked to sign and return an undertaking that you will abide by the rules and ethics of the NCP and also that you will have adequate insurance cover in place if you are practising. The NCP trusts that all members will be sensible enough to recognise that having insurance safeguards all parties – the therapist, the public and your organisation.**

**Unfortunately, we have recently had to remove one therapist from the membership as it came to our attention that, although this person had signed to verify that insurance was in place, this was not, in fact, the case.**

**If any member is found not to have complied with any of the rules and ethics, including neglecting to have insurance, the NCP has no alternative**

other than to remove that member from the organisation and ask for all reference to the NCP to be removed from that therapist's literature.

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Unlocking the mysteries using  
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You are invited to train with Open Mind to gain insight into ME/CFS & learn to treat clients with this mystery condition. Applicants must have a basic knowledge of hypnotherapy. Attending will qualify you to be on the register of therapists who have been trained in treating CFS with Open Mind, accessible through the GHR & NCP. The course is professionally validated by the GHR & qualifies as CPD.

Your trainer: Jenny Lynn, speaker, trainer and teacher known in the field of ME/CFS.

**Venue:** Chancellors Hotel, Manchester

**Dates:** 16th, 17th 18th February 2007

**Times:** 9:30 till 5pm Friday & Saturday, 10 till 4pm Sunday.

**Cost:** £355. £40 early bird discount on bookings before 22nd December 2006

For a prospectus: Telephone 01371 820 600

Website: [www.openmindtherapy.co.uk](http://www.openmindtherapy.co.uk)

Or email: [info@openmindtherapy.co.uk](mailto:info@openmindtherapy.co.uk)

## Coping with Cancer

Recently, we have been approached by the families of two women who have just been diagnosed with cancer. My husband sees a lot of cancer sufferers because he is himself a survivor and his story is a remarkable one. Telling it to others often gives them the impetus they need to decide to become a survivor too. He also helps by teaching them mind body healing, guided imagery and recommending the hypnosis tapes and CDs which played a huge part in his recovery. However, the old saying "You can lead a horse to water but you can't make it drink" all too often applies in many cancer cases.

Everyone has their own method of coping. For instance, my husband was convinced that he would walk under a bus if he ever had cancer but he didn't and he's still around thank goodness! Over the years, we've told many cancer sufferers about self-healing tapes, changing attitudes, changing lifestyles but, while some choose to implement the advice, others see it as too much like mumbo jumbo and do their own thing. Of these, some have survived. Some of those who took the advice and ran with it have died but many have survived and are still living happy, productive lives.

Of the two most recent cases, one of them has taken all the advice on board and is following it wholeheartedly, while the other saw her case as hopeless and was contemplating suicide. As it turned out, she didn't, after all, have cancer and is now on the road to recovery.

Some people tell all and sundry they've got cancer while others are terrified even to speak the word and keep it a secret from all but their nearest and dearest. Some radically change their diet in the hope that this will stop the cancer in its tracks while others eat exactly what their body tells them they need. Either way, the belief that they will recover goes a long way towards achieving their aim.

In the main, I suppose I believe that, more than anything else, changing attitudes is the key to survival. It isn't any use just having a positive outlook if, in the subconscious, you're still harbouring anger and resentment. These need to be dealt with at a subconscious level and then perhaps the cancer can be reversed. Using everything at the patient's disposal, including visualisation, self-help CDs, healthy eating and even - yes, medical intervention, if necessary, I believe cancer need no longer be the death sentence it once was.

Pat Doohan. MNCP

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### **Useful Website**

**Just in case anyone has not yet discovered it, Self Help Magazine has a very useful website with many articles, forums, discussion groups etc. which may be helpful to our members. Their web address is: [selfhelpmagazine.com](http://selfhelpmagazine.com)**

**We need your articles! Please submit anything you think may be of interest to our readers. We can't promise to print everything but we do appreciate your input. Many thanks.**

# NOTICE BOARD

## EMOTIONAL FREEDOM TECHNIQUE - APPROVED LEVEL ONE AND TWO COURSES

Tam & Mair Llewellyn are both EFT Masters and run Gary Craig approved EFT Courses.

LEVEL ONE EFT - 26th January 2007. This is an accredited one day level one course.

LEVEL TWO EFT - 27th & 28th January 2007. This is an accredited two day level two practitioner training course. Level one is a prerequisite to this approved course.

On successful completion of these courses you are entitled to become a member of The Association for the Advancement of Meridian Techniques (AAMET) [www.AAMET.org](http://www.AAMET.org)

This course is held within the Tickhill Clinic in South Yorkshire [www.TickhillClinic.com](http://www.TickhillClinic.com)

For more details of this course ring 01302 743113 or email

[Training@TickhillClinic.com](mailto:Training@TickhillClinic.com)

For more information about Tam & Mair's EFT work visit

[www.Tam-Mair-](http://www.Tam-Mair-EFT.co.uk)

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*Please note: The NCP Notice Board is free to members so, if you have something you'd like to let others know about, please either email or post your copy to headquarters by the deadline for the issue in which you'd like it to appear (15 Feb. 15 May, 15 Aug. 15 Nov.)*

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**This is a copy, dated 14 September, of the reply to a member of the GHR when he wrote asking the DoH for information regarding the regulation of Hypnotherapy.**

Quarry House  
Quarry Hill  
Leeds LS2 7UE  
Tel: 0113 254 5000

Thank you for your letter of 19 August.

The Government has no plans to introduce statutory regulation of hypnotherapy. Instead the Government's intention is that hypnotherapy should be subject to voluntary regulation and it is encouraging that progress is being made towards this.

What we are working towards is the statutory regulation of psychological therapies including psychology, psychotherapy and counselling.

Those psychotherapists who use hypnotherapy as part of their professional practice as psychotherapists are intended to be included for regulation as psychotherapists along with other psychotherapists.

It appears that you may have been misinformed by a communication from the UK Council for Psychotherapy's Chair of their Hypno-Psychotherapy section, in which the UKCP makes several inaccurate claims.

I should like to set the record straight on these as follows:

The UKCP has not negotiated with the Department of Health to have separate registered titles for distinct modalities. The Department of Health has made attempts over the last five years to get **broad** agreement from psychotherapy organisations on the roles within psychotherapy: the roles undertaken, the competences necessary for safe and effective practice within those roles and the training to deliver competent practitioners. UKCP has been invited to help in this role identification but has been unable or unwilling to do so in such a way as to command credibility and participation from others in the psychotherapy field. Until such roles, competences and training are agreed, there is no basis for statutory regulation. This will eventually provide for the legal protection of titles, which only those who are registered by the regulator may lawfully use. We are still some way from being in a position to negotiate on protected titles, which we will do through public consultation, not with UKCP or any other professional body alone.

UKCP has however suggested a number of psychotherapy modalities, including hypno-psychotherapy. However none of the Health Departments of the UK has asked for this to be researched as a basic competence set for psychotherapy. Only therapies found to be widely in use or required as part of mainstream psychological therapy are likely to be included in the competence framework for regulation.

The Department of Health does not require UKCP to define the competences distinctive to psychotherapy modalities. In 2005 UKCP was invited jointly with the British Association of Counselling and Psychotherapy (BACP) to map training and training standards as a way of identifying roles and competences. The outcome of this project did not provide sufficient detail to be of any use in this identification.

As a result, **the Department of Health commissioned Skills for Health to co-ordinate production of a competence framework**. This will be circulated to all professional bodies in the field of psychotherapy and counselling in October and their comments invited in a consultation period probably extending to January 2007. Those who provide and use psychological therapy services will also inform the final decision on which roles, competences and training will form the basis of statutory regulation.

There is therefore no requirement for comments on competences drawn up by UKCP to be submitted to this Department by any deadline.

The expectation is that Skills for Health will produce the competence framework for psychological therapists of various kinds and practising at various levels, based on the consultation mentioned above (October 2006-January 2007). This will then be used to inform training providers of the likely future basic training requirements, and will give professional bodies a basis for setting up a voluntary regulatory system. When these preparations are ready we will publish a consultation document including draft legislation. This will cover issues such as standards of practice and

conduct, protected titles linked to specific training and competences, and the timescale for introducing the statutory system including grandparenting arrangements so that current practitioners and trainees are not disadvantaged.

I have asked the UKCP not to send out inaccurate material about this process which we and Skills for Health are keen to make as inclusive as possible.

Yours sincerely

Miss R Mead  
New Regulation Projects Manager  
Tel 0113 2546129  
Fax 0113 254 5286

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## **The Myth of Willpower**

The concept of "willpower" pits the conscious mind against the subconscious mind. In any conflict the subconscious will always triumph, therefore the concept of willpower is largely meaningless. Any notion of overcoming subconscious resistance with conscious will is a myth. Bicameral resonance is a much more accurate and useful concept.

The notion of "willpower" has caused a lot of anguish in modern times. We would all like to think that our conscious will is the master of our destiny but it takes only a brief introduction to the facts of life to realize that the truth is otherwise. No one who has ever eaten something they had already made up their mind ("willed") they would not eat—said something they had made up their mind not to say—smoked again after quitting for the umpteenth time—or experienced any of the thousands of other failures of will could possibly say they are in total, conscious control of their lives. Not seriously.

Even if we put common experience aside, the findings from modern genetics and psychology research leave no doubt that it is time to trash this outmoded concept. It should be consigned to the semantic rubbish heap along with concepts like a flat earth, spiritual possession, ghosts, and the Easter Bunny. None of these things, including willpower, exists. (Well, okay, the Easter Bunny is a possible exception.)

Let's think about what we generally mean by the term "willpower." First of all, for such a commonly used word (compound term) it is hard to find in most English dictionaries. When you do find it in the big ones, like the unabridged Webster's, what you usually see is, "see will." Then if you actually do look up will you are really in for it! Uses and meanings vary all over the map and if you thought you knew what the word meant before you looked it up, you might change your mind. If you really want to bury yourself in semantic esoterica, look up the word in the Oxford English Dictionary where you will find page after page devoted to "will".

None of which will help you actually develop anything resembling better willpower. If you are really tenacious you might head for the psychology literature. And if you thought the dictionaries were confusing, you ain't seen nothin' yet. You would discover that different schools of psychology have different notions of what will is, and that for the most part none of them agree with one another. If you were really astute in your reading you would

probably come to the conclusion that much of psychology doesn't really have a clue about what will really is.

The truth is, we could spend a lot of boring time and space trying to grapple with the concept of "will" with all its complexities and perplexities. But that would not move us forward on the practical side of things, and that is where we want to be.

However, having said that, I hasten to add that just a teensy bit of theory is helpful. You need at least some basic knowledge about how your subconscious mind works relative to this concept we are calling "willpower." Otherwise you might end up willing yourself to do something your subconscious is unwilling to do and you will fail.

**The *Cogito* and Willpower.** Just to put this into a brief historical perspective, the ancient Greeks, especially Socrates (circa 500 BC, give or take), had something to say about "will." (Didn't they have something to say about everything?) But as far as I can ascertain, they stuck pretty much to the concept of wilful intent without getting into the thornier issues of what we now think of as will power. Almost a millennium later St. Augustine (Catholic guy, 354-430 AD) sort of warmed up to the concept of inner conflict with the will. But it was René Descartes (1596-1650) who really got the ball rolling with his *Cogito, ergo sum* ("I think, therefore I am").

It is Descartes who generally gets the blame/credit for starting the whole idea of the separation of mind and body. What Descartes really did was convert what had until then been a dichotomy—body and soul—into a trichotomy of soul, body and mind. That had immense appeal to the 17th century Western intellect because of the Christian trichotomy of Father, Son and Holy Ghost. But it led to a division within the concept of self that has been troublesome ever since.

One of the troubles was the eventual development of the concept, willpower. What had been a schism between body and soul ("The spirit is willing, but the flesh is weak," for example) became a somewhat confused conflict between body and mind. That in itself was unacceptable to 19th and 20th century scientific thinking but attempts to clarify concepts like will, body, and mind (and get rid of soul) served only to make an even bigger muddle of it all.

When we try to apply this concept to practical situations it becomes obvious just how muddled is our ordinary concept of willpower. A good one to start with is weight control because approximately 70 percent of the American population is overweight. Most people who are overweight know they weigh too much—or, more accurately, there is too much fat on their bodies—and they know the solution to their problem would be to simply eat less and exercise more. So why don't they do that?

Why is there such a conflict, a fight between a conviction to do (or not do) something and the compulsion that dooms the conviction to failure? Let's distil this down to a concrete situation and let donuts stand in for whatever is a person's weakness. Imagine that just yesterday John bought a dozen donuts and ate every one of them. He was so disgusted with himself he pledged never again to eat donuts. Yet someone left a donut on the table today and he is wrestling with himself over whether or not to eat it. Part of him wants the donut; another part of him wants not to eat it. Which is which? Whence comes the desire? The resistance?

The usual argument is that his body wants the donut and his mind wants to resist it. (Roll over, Descartes!) But if we have separated mind from body, how does the body "want" anything? Is it the kind of need that comes from, say, addictions? If so, how do we know what the body needs? All knowledge is mental, right? So how did we come up with something mental from the non-mental body? As you can see we are already having trouble

with the distinction between mind and body. Some have tried to overcome this difficulty by saying that we think with our bodies. That is nonsense. We don't think with our bodies, we think with our minds.

So there are two "thinkings" going on here: One for the donut, one against the donut. And if we posit both ideas, these conflicting ideas, as residing in the same part of the same mind, then we destroy all semblance of mental stability. Thus we need either two minds or two distinct divisions within the same mind. By this argument we arrive at the conscious-subconscious dichotomy of the mind. More about this later.

**Practical Myths of Willpower** Of course the most common concept of willpower is that it is a force with which we get difficult things done. We use the term to refer to a certain strength of will which we interpret as self control. If a person has good willpower, we say, he can control himself and what he does. The major problem here is that willpower is posited as a generalized quality of mind that ranges from zero or none to some kind of super human self control. If it were that, then one's willpower would be applicable across every area of one's life. It would be like muscle. If you can lift 10 pounds of wood, you can also lift 10 pounds of steel or dirt or whatever.

So if a person had a given amount of willpower she would find it just as easy or difficult to quit smoking (or resist starting) as it would be to lose weight (or never gain it) or avoid bad habits like chewing nails or hitting her husband, and so on. Everything would be equally easy or difficult, depending upon the amount of willpower in that person's possession. She would be able to use that same willpower to never yield to pressure from friends to do something she did not want to do. She would have an equal amount of control across all areas, unvarying. Does this sound like anyone you know? Probably only in the negative; we all know at least one person who does not seem to have the slightest shred of willpower about anything. But the absence of anything that looks like willpower in one person is not evidence for its existence in others.

More often we hear about willpower from someone who has, say, quit smoking without much effort. "I just quit," he says. "Just used a little willpower and didn't smoke any more." What he fails to mention is that all that so-called willpower of which he is so proud was nowhere to be found when it came to eating. He gained a ton of weight when he quit smoking and now he cannot get rid of it. Where is all that willpower? If it really were willpower he used to quit smoking, it would also be available to control his eating behavior and anything else he consciously wanted to achieve.

So willpower is a mythical conception. It is a quality of mind or personality that just does not exist. It is a phantasm. It is a cruel hoax because it makes those of us who don't seem to have it feel inadequate. Yet adequacy and inadequacy have nothing to do with it.

**Bicameral Resonance as Willpower** On the other hand we do need a concept to explain those times when we struggle and win, times when it is not easy for us to do something but we do it anyway. For this it is better to go back to the relatively ancient concept of "will." This is the original term from which the contaminated term "willpower" came. Let's take a gander at the formal statement of the position I advocate, then I will elaborate on it. I think you will find it very useful.

**Theorem: "Will" is bicameral resonance.**

"Bicameral" simply means there are two governing parts of the mind. In other words, the conscious part and the unconscious, or subconscious, part. Mind is implicitly understood

here. We want to keep the statement of the theorem as simple as possible so I am not going to launch into a semantic investigation of what we mean by "mind."

"Resonance" is a much richer concept than mere agreement, but that is close to its meaning. We would not be far off to say "bicameral agreement," but that would be a gross oversimplification of how the two parts of the mind work together. As an analogy, imagine yourself pushing a child in a playground swing. Your actions must be in concert with the movements of the swing. Otherwise everything gets messed up. If your efforts are not finely coordinated to place your hands on the child at just the right moment and push with just the right amount of force, it does not work. When you are doing it right you could say that you and the swing+child are resonating together.

To tap into more of the richness of the concept of resonance, and to go further into the complexities of how the two parts of the mind work together, think of two musical instruments, say a horn and a guitar. If a note is played on the horn it will make the guitar strings vibrate the same note and some of its harmonics. That is resonance. The closer the horn's note is to the "key" of the string, the stronger the vibration.

Now consider two related qualities of resonance, consonance and dissonance.

Consonance is a good thing. It sounds good when two notes that are consonant are played simultaneously, and in the same way it is easy for us to do something when there is consonance between the conscious and subconscious parts of the mind. The more consonant they are, the easier it is.

Dissonance is not such a good thing. Two notes that don't go together jangle our nerves; they are not harmonious. Same goes for ideas. If there is conscious-subconscious dissonance about something, it is the subconscious "note" that will come through. In other words, without conscious-subconscious agreement, the only thing that will happen will be what the subconscious wants.

What this theorem says, then, is that will is the product of agreement about a particular idea between the subconscious and conscious parts of the mind. Everything we do, we do with agreement from the subconscious mind. To suggest that we will consciously override the subconscious is ridiculous. The subconscious mind is far and away the dominant force and must be reckoned with for any achievement to occur. Conversely, without subconscious concurrence, you will not be able to do it. Not for very long, anyway.

This position has immense ramifications at every level of human study. It challenges conventional wisdom which is seemingly set in stone. It attracts a lot of controversy.

But evidence for the validity of the theorem resides in every one of us. None of us beyond the age of puberty considers ourselves perfect. We all do things we wish we did not do, and don't do things we wish we would. Our unfulfilled wishes and desires are clearly conscious. What we really do tells us our subconscious position on things.

Self hypnosis and suggestion are the way we go about bringing the subconscious mind into agreement with our conscious plans. It is the way we tune our intrapsychic or bicameral resonance.

To achieve your ends it is in fact essential that you cease thinking in adversarial terms and move toward the concept of harmony, coordination and resonance.

Dr. Charles E. Henderson PhD. Website: <http://bcx.net/hypnosis>

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**Copy deadlines: 15 February, 15 May, 15 August, 15 November.**

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## An Argument Against Regulation?

I didn't know I was going to write so much when I started this but I think I'll send it anyway 'cos it brings up some deep issues of how we want to live in our world!

Another EFT practitioner said: 'I am afraid that a lot of certification tends (at least that is what it has done so very often in the past), to stop creativity and further development.' I agree with this...there is a danger that the real innovators come up against the 'We've always done it like this' syndrome, and people can tend to try to preserve something that's good but then it gets frozen in time and the creative innovators are thrown out of the movement.

I am in favour of less regulation... even in very highly regulated professions people get bad treatments....and may be frowned upon for questioning it. It's a wild world, impossible to make anything completely 'safe' and we all have to take responsibility for our own place in it....are you having a reaction to that statement? Try tapping!!

I observe that a high degree of professional protectionism, and control, is our 'paradigm' that we have all grown up with. It created the edifice of the Allopathic based health service we now find sometimes ineffectual, clumsy, expensive, and damaging. This paradigm also includes a huge amount of tolerance within the population for huge amounts of nasty painful and difficult treatment effects. It could be worth noticing that this paradigm may be something we jump to just because it's always been there in our conditioning. I think it's worth really deeply questioning. When we look at the incredible amount of damage that people suffer in unsuccessful treatments and side effects within our highly regulated health service, and how hard it is to effect change to that system, there's lots to think about there...especially about issues of 'safety' and also our passivity and acceptance.

When we get into a big negative judgement about what someone else is doing, we can look at what it is in ourselves that is getting all fearful or self righteous and judgemental about it!

The fear issues have helped to stop opposition to recently created laws in Europe that prevent many people from now obtaining food supplements that they have found to be very effective in treating themselves and which are very seldom harmful, certainly compared to many drug-based treatments regularly in use.

EFT is a fantastic treatment but its greatest and best aspect for me is that it is so self empowering for people to heal themselves. I believe that that is the core of Gary's dream of his work, to make it free and available to many. This means it sometimes gets used badly and diluted - but in spite of that it is overwhelmingly beneficial and is spreading so much because it is so freely available and still effective even when used by the unregulated masses.....can we trust them? I say yes, yes to freedom.

Lets keep it that way.

Ruth Fox EFT Practitioner, Hypnotherapist, Energy Healer. Sheffield

PS I'm all for mentoring, training and supervision-definitely continuous learning and exchange of knowledge. Let's all do as much as we can!

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## **NLP: Beyond Consciousness**

Neuro Linguistic Programming began as a study into how talented psychotherapists were able to achieve the results that they did. It now forms the foundation for a popular and powerful cognitive based approach to change work.

NLP is a model of understanding the phenomenological subjective experiences of a person's reality and that gives rise to thinking patterns, which guide behaviour. The basis of its methodology lies in the understanding of how we process sensory information, the language we use to make sense of and to conceptualize these neurological experiences, and the way in which we filter and encode information. This is the process by which people construct their subjective represented perceptions of reality, known as their 'map of the world', and is the key to their conscious perceptions. Consequently, such understanding offers an ability to utilise and alter behaviour by an applied approach to the neurological processes of filtering and encoding the visual, auditory, kinaesthetic, gustatory and olfactory information to our 'representational systems' and that form a persons map of reality.

Many might hold with the fact that the phenomenological raw experiences of reality are processed and construct consciously, as are the subjective insights we gain of them from a persons 'representational leakage', that materialize through discourse and observable behaviour. However, to what extent do we process information and construct our perception of reality at an entirely conscious level? Evidence of a phenomenon known as 'Emotional Vision' offers the likelihood that part of our neurological processing occurs subconsciously by emotional mediation. It advocates that our emotions are capable of mediating our perceptions, guiding what we attend to and how we process and filter the information we experience, without any conscious awareness.

The brain can be divided in to several key areas, one of which is the forebrain, which has further sub-regions such as the thalamus, amygdala and primary sensor cortex that are involved in processing information. The thalamus can be thought of as a relay system, which sends readable information to the primary sensory cortex. Another area of the forebrain contains a system called the amygdala, which is responsible for the formation and storage of memories associated with emotional events. These produce emotional responses that project

directly to what are known as *association areas*, (these include the parietal, temporal and occipital lobes) which are responsible for producing our perceptions of reality from what our senses detect. The information from the amygdala is integrated with information in the primary cortex and together produces a conscious emotional behavioural response.

Cells within the visual cortex are sensitive to the influence of emotion and it is claimed that these can directly modulate the perceptual processing of visual information. This was explored using patients with and without damage to the amygdala, due to temporal sclerosis caused by extreme epilepsy. The results demonstrated that those with damage to the amygdala resulted in no emotional modulation (filtering) of perceptual processing. The use of functional magnetic resonance imaging (fMRI) revealed that there is greater activity in the visual cortex of those with damage to the amygdala, which is unable to modulate processing in the visual cortex. Further studies support this by revealing that there are also direct connections between the amygdala and the visual cortex, as neurons project to and directly synapse at various levels with it.

The extent to which emotions modulate and influence how we perceive information is extended further by people who suffer from what is known as ‘blindsight’, who despite the destruction of their visual cortex, are still able to discriminate between emotional expressions. They report no conscious experience of having seen something (due to the visual cortex having been destroyed) and yet respond to it emotionally as though they. For example they will report no conscious recollection of having seen an extended hand and yet they will emotionally respond by extending their own hand to shake it.

Modulation of perception by ‘Emotional Vision’ suggests two things. Firstly that previously stored emotions of past emotional events are capable of directly modulating how we perceive reality, and the construction of our subjective ‘map of the world’ that guides our behaviour. Secondly, this occurs beyond conscious awareness.

Reflecting on the possibility that our perceptions of the world are mediated below conscious awareness, how appropriate are the consciously constructed representations that we detect and utilise in gaining a subjective insight in to a person’s abstract experience of reality. How useful are applied NLP techniques, such as ‘eye accessing cues’ and hypnotic language, if a person’s thinking patterns and behavioural strategies are represented by nameless sensory represented emotions.

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## **CASE STUDY by Alayne Corney LNCP**

Kay was introduced to me by the older of her two sisters whom I had previously treated for weight gain and depression. An attractive 19 year old, Kay wanted help with depression and anxiety which had begun one and a half years ago, and three weeks prior to joining the Armed Forces when she had a termination of pregnancy. Her doctors having told her that her symptoms were exogenous, had prescribed Prozac which she had been taking for 13 months. Recently she had been trembling and vomiting after meals. Her boyfriend and baby's father was a colleague who was abroad on active service for four months, which exacerbated Kay's symptoms and produced suicidal thoughts. She was frightened of herself as much as others and said she needed space. She felt inadequate due to her dyslexia for which tests had proved her to have the literacy ability of a ten year old. She had been having nightmares of a baby trying to grab hold of her hand but being pulled away. She said the only time she was free from symptoms was when she sought solace in alcohol.

It had been her parents' decision that she joined the Forces and at first she had been excited at the prospect. She believed her symptoms to be due to something else and needed to know exactly what lay at the root of her problems. Her older sister had become a replacement mother since she wanted to be close to her mother who avoided conversation and had been involved in her own business during the sisters' childhood leaving them in the care of nannies. As she talked Kay relaxed increasingly and wept intermittently, self apologetic and anxious to please, and expressing anger at herself for not coping better. This reversal was compounded by her body language which spoke of anger whenever she mentioned her parents and her upbringing. She admitted to opting out in order to cope with the social demands placed upon her which she confessed were a strain and from which she would withdraw and become a loner whenever possible.

Before commencing therapy I advised Kay to visit her doctor and ascertain whether the Prozac was inducing her physical symptoms. Her doctor subsequently discontinued the medication and sanctioned her continuing to see me. I explained my work as a hypnotherapist and psychotherapist and the ways which could be employed to access the cause of her problems, but said I felt it necessary to gather further information and then to concentrate on building a trusting rapport followed by teaching her ways to relax in order to cope with stressful situations. To this end I taught her self hypnosis, calming techniques and ideo motor signalling. I induced a deep trance having located a safe place of her choice and gave her a long ego boost using embedded metaphors for change such as life being a play with scenes which were necessary to enact and interpreted in a positive way. I also utilised numerous plays on words such as role, scent and scene. This is something which has always come quite naturally to me. Kay responded very well and wanted to continue the therapy. She was bright, articulate and forthright with a sense of loyalty, commitment and justice. Whilst she accused herself of not coping as well as she should and over indulging in smoking and drinking, as well as having suicidal thoughts, this young girl presented a picture of rationality and thoughtfulness. Moreover she demonstrated an ability to associate with her feelings.

The following week we talked about her hobbies. She enjoyed problem solving and would love to have been a car mechanic. Her parents were disapproving of her pursuing any of these due to her dyslexia and dyspraxia. They felt she needed a structured life. Free association, the Affect Bridge and modalities induced her to express the resentment and hatred she felt for her mother who helped her to have the termination and to join the Forces. The Gestalt empty chair technique proved to be a useful tool too - utilising Pseudo

Orientation in Time in the form of Erickson's Crystal Ball technique. I hoped to reinforce the future positive expectations which she was more likely to realize in time to come. Following the session and a general discussion about her needs and wishes Kay said a blockage had been removed and she drew me a diagram to illustrate her past, present and future.

It was a month before Kay could return to me. She had been admitted to the station Hospital where her symptoms were not diagnosed by them and characterized by irrational behaviour. She was now on sick leave for six months and disliked being on the prescribed medication which when reduced to half the dosage had left her shaky. She had also been provided with a specialist whom she accused of giving insufficient time and showing it. I asked her why she had returned to me when she was being given psychiatric help. She claimed to have been helped more by her visits to me than by her orthodox treatment and needed now to absolve herself of her ongoing guilt and torment about allowing her mother to insist that she had the abortion. "It is all because I have to get on with life", she said. Freely associating, she recaptured a recent time in the hospital and her mother's insistence to the doctors that Kay would be fine once she was back in the Forces. "They weren't my feelings", she said; "I didn't know what J wanted and was scared." She recounted her fears about school attendance and her mother shouting "go and get on with it". She said she wanted her mother to go away and to tell her what she wanted without "her speaking over me". She recalled an otherwise happy family Christmas when her mother nagged her to tidy the living room because everything had to be "proper". Kay had just wanted to go to her bedroom and read a book,

I felt I had reached an impasse and was frustrated at being unable to help further. I was delighted when, at Kay's behest and with her mother's willing consent, they came together for Kay's next appointment for the purpose of mitigating any misunderstandings between them. Seated directly opposite her mother at a table, Kay accused her of being too hard, telling her to get on with it and not discussing things, as it were, not getting round the table. Defensive at first, mother claimed not to understand. "Its grandma isn't it?" Kay pronounced. After a long shocked silence, mother admitted that her mother had always been involved with her younger brother who had become mentally ill and she had just had to get on with it. "Well you do don't you?" Tears ensued on the part of both women who demonstrated and vocalised much affection for each other. Misguidedly, mother had thought schizophrenia to be totally hereditary and that had she had a boy he might have developed it. This accounted for her fear of her daughter producing a son should the pregnancy have been allowed to come to term. The mother declared she had felt rejected by her mother and felt the need to be in control of everybody and everything. Kay had demonstrated deep insight and understanding as she comforted her mother and promised to support her. In effect, this appeared to be role reversal. At this point, in answer to my question, Kay admitted vehemently she wanted to discontinue her life in the Forces. "My health comes first", she proclaimed, although she had to return in the hope of being granted an official medical discharge.

Kay continued to visit me on a regular weekly basis for several months during which time we worked on her positive belief system, resources and her future opportunities, all the while focusing on relaxation exercises and her self esteem. Due to her fragile emotional state the sessions were conducted on a counselling basis rather than involving trance work. Her spiritual beliefs were discussed in great depth which led her to believe that her baby's soul would always be part of her Despite the former cathartic episode, pressures for Kay to find a job continued in view of her impending medical discharge and her mother's worry about Kay's income and career structure. Despite this their communicating was improving, though tenuous, and subject to unexpected outbursts on the part of the mother whom Kay declared had always created tension and induced her to seek the relative sanctuary of friends' homes where she would indulge in smoking and drinking. Remaining at home was becoming

untenably stressful for Kay. Due partly perhaps to a combination of her medication and her state of mind, Kay's appearance was becoming increasingly neglected. She had gained considerable weight and her face appeared puffy, transference and counter transference mounted as the sessions continued and I was compelled to remind her that I was not the person she sought to punish. Her behaviour was now becoming inappropriate, unpredictable and psychotic.

Once again Kay and her mother joined forces for a session with me. This time Kay thumb sucked, hugged a blanket, she said she couldn't bear to witness her mother's tears and blamed others for all her behaviours, admitting to being bemused by her own behaviour and traumatised by the thought of the Forces. A few weeks later Kay was admitted to a private hospital and the initial diagnosis of depression was revoked by the psychiatrist who feels that Kay's problems have an emotional basis. I am currently treating Kay's mother at her own request and Kay is stabilised and off all medication. She will not be returning to the Armed Forces and is to be granted the long breathing space she craves.

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