Summer 2009

Student and Alumni Guild E-Journal

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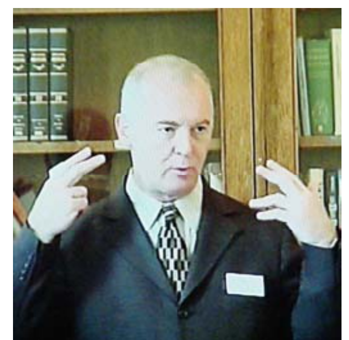
The Conference—The First of Many And A Weekend To Remember

The first NCHP Annual Conference—one of the best ideas since the introduction of squeezy Marmite, was a weekend packed with flavorsome ideas, lively discussion, debate, demonstrations and for the Saturday night partygoers of dancing.

Friday brought an informative and entertaining masterclass lead by **Shaun Brookhouse** and **Tom Nicoli.**

The formal weekend proceedings were opened by **Fiona Biddle**, MD of the National College and Chair of SAG, who emphasised the International aspects of the conference— attended by delegates from the Republic of Ireland (Terry Thorp, Elizabeth Caird, Sylvia Schoch), Denmark (Tonny Christensen, Lisbeth Lausen) Spain (Teresa Garcia Sanchez) and the USA (Tom Nicoli). The scene was thus set for an opportunity to examine and explore some of the many facets of the world of hypno-psychotherapy. The first "shhh" from **Shaun Brookhouse** signaled the start of the first presentation and the ever popular **Tom Nicoli** (USA) began the formal presentations with a reminder of the "magical" potential which comes from enabling clients to engage with their feelings.


Tom Nicoli

Tom's presentation emphasised how many clients may initially enter our therapy rooms after many years of avoiding their feelings and with a simple post-hypnotic suggestion (or was it? more of that later) of *"Don't Think, Feel"* demonstrated

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Introducing the E-journal

Welcome to the very first edition of the E-Journal for members of the Student and Alumni Guild.

As a special bonus, this edition is being sent to everyone who is eligible to join the guild, so you will be able to see what you could be missing—
or perhaps more importantly, gaining!

This is the first of many quarterly issues, and I'd like to know what you would like to see in your journal.

I'd also welcome articles, book reviews, research synopses as well as any letters, comments or questions about what's happening in the world of hypno-psychotherapy.

Like all good things, the E-Journal will develop and change over time; I hope you enjoy and engage in the experience along with me.

Happy reading *Su*

Next E-Journal Submission Deadline 15th September 2009

BUILDING LIFE AND SKILLS TRAINING

A Psycho-Educational Group Programme for People with Mild to Moderate Anxiety and Depression: Evaluation of Third Sector Provision—EE Taylor, M Med Sci, UKCP

Abstract

The Governments 'Improving Access to Psychological Therapies' aims to implement stepped-care psychological support following the National Institute of Clinical Excellence (NICE) guidelines. The purpose of this study was to assess the feasibility of a psycho-educational group programme based on cognitive-behavioural therapy and provided by a third sector organisation. A session-by-session instruction manual was compiled and the protocol tested in seven groups by three facilitators. Thirty people took part in the eight-session programme. Attrition was low and significant improvements in both anxiety and depression were observed following the intervention. A post-programme participant evaluation indicated a high degree of satisfaction with the service. The findings suggest that quality controlled third sector provision could help to reduce the burden on existing mental health services.

INTRODUCTION

Mental health has been described as the greatest social problem in our society (Layard, 2004), with depression and anxiety being the most commonly reported disorders (c.f. Shiels et al, 2004). In addition to the substantial suffering caused by these debilitating conditions, to both patients and families, the wider economic costs in terms of lost employment and NHS time are considerable. Anxiety and depression account for 40% of Incapacity Benefit claims and utilise approximately one third of GP's time (Ford et al, 2000). Traditionally, treatment in primary care has mostly been pharmacological with only a tiny minority referred for the more costly evidence-based psychological interventions (Hodgetts, 2007). Since the recommendations for a stepped model of care (DOH, 2004, 2007), however, there have been calls to increase

the provision of psychological therapies for this vulnerable group (DOH, 2008). Recommended short-term treatments include psycho-educational and cognitive-behavioural approaches.

This study assessed the short-term effectiveness of an 8-session psycho-educational programme based on cognitive-behavioural therapy (CBT). In order to circumvent the effects of personality and style of the individual group facilitator, the protocol was prepared in the standard format of a training manual and applied to 7 groups by 3 facilitators. The aim of the study was to assess the feasibility of service provision by non-NHS health professionals, in line with government requirements for changes in healthcare commissioning i.e. that 15% of all procurement should be placed in social enterprise, voluntary, community and faith groups (DOH, 2006, 2007).

MATERIALS AND METHODS

Development of the training manual

The training manual entitled Building Life and Skills Training described a standardized group intervention organised in 8 x two-hourly sessions. It included (1) an educational programme that explained the psychological, sociological and physical aspects of distressing life events on health; (2) a graded programme of CBT aimed at the identification of environmental triggers and the modification of self-defeating patterns of thought and behaviour underlying the symptoms; and (3) progressive muscle relaxation/visualisation in order to ameliorate autonomic hyperactivity, reduce pain and promote relaxation.

Setting

East Lancashire Integrated Health Care (ELIHC) is a not-for-profit social enterprise which aims to provide adjuvant psychological support in the community. A service level agreement (SLA) is in place with East Lancashire Teaching Primary Care Trust (ELPCT) and Blackburn with Darwen Primary Care Trust (BwDPCT) to provide psychological therapies for functional gastrointestinal disorders in east Lancashire. There is an additional SLA with BwDPCT to provide the Help for Health group programme (Lancashire wide) for the Jobcentre Plus funded Condition Management Programme. Social Prescribing (signposting to non-medical services to meet local need) is currently co-ordinated by the centre. Funding is otherwise dependent on private patients and grants. During the last year ELIHC has been fortunate to be granted funding from Rossendale Borough Council, a Spearhead Authority, to provide individual and group therapy to residents in super output wards with mild to moderate mental health issues and from ELPCT for the BLAST programme.

Inclusion criteria

Inclusion criteria were: people over the age of 16 with mild to moderate anxiety and/or depression; those with work or unemployment stress and those needing to increase their confidence and self-esteem. Exclusion criteria were: psychotic illness, those abusing alcohol or drugs or those who's GP felt the programme would be inappropriate for their needs. Where suitability was in doubt, the relevant GP was informed with the client's permission.

Recruitment procedures

Clients were recruited from Primary Mental Health, East

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Lancashire General Practitioners, Voluntary, Faith and Community groups. Recruitment was conducted by post, e-mail, and explanatory posters. Presentations were given to interested groups. Clients were referred/self-referred by telephone. The programme was briefly explained and any concerns were addressed. Written information (course content, choice of venue and invitation to enrol) was posted to those interested in attending.

Ethical issues

Confidentiality was maintained in relation to referral details, client records and data collection. Participants were given coded identification to ensure anonymity and nominated personnel at ELIHC stored data securely.

Programme facilitators

All facilitators were appropriately qualified Psychotherapists. All were registered, insured and experienced in facilitating groups. Facilitators followed good practice guidance, were engaged in continued professional development and attended supervision for a minimum of 2-hours per month.

Enrolment procedure

Each participant had a one-to-one enrolment session with the Group Facilitator, one week prior to commencing the programme. In this 10-minute session the necessary administration was completed, and participants were encouraged to ask questions or share concerns. All participants were issued with a written programme overview.

Clients and venue

From 74 telephone enquiries, 45 potential clients attended the enrolment session. Of these 37 clients commenced the BLAST programme. Seven clients withdrew early. Thirty clients, 11 males and 19 females aged between 18 and 65 (mean age range 26-45) completed the programme in 7 groups. All, except 2 people from Southern Asia, were white and of European origin. The average number of participants attending session one was 5 (range 4-9) and the average number of completers was 4 per group (range 2-6).

Seven groups were conducted in areas governed by ELRPCT. Five programmes were delivered in the evening and two during the day to accommodate client preference. Three programmes ran on a weekly basis and 4 ran twice weekly. Table 1 illustrates the programme schedule.

Table 1

BLAST programme schedule

Intervention

The intervention consisted of an 8-session self-help group programme, each session lasting two hours. Explanation of the relationship between thoughts, feelings and symptoms was supplemented with seminars on learning life skills such as: cognitive restructuring, anxiety/stress management and confidence building, overcoming low mood/depression, assertiveness, problem solving, anger management, pain management and hyperventilation. An action plan was completed at the 5th session for the purposes of self-assessment and future goal setting. Throughout the programme participants were encouraged to take responsibility for managing their condition themselves. After each session, participants were encouraged to practise cognitive-restructuring and relaxation on a daily basis. Behavioural assignments were also practised according to individual need. Standardised compact discs for relaxation were supplied to each participant and diaries were provided for recording symptoms, thoughts and life events. All participants received a handbook containing supportive literature on each aspect of the programme.

Table 1 Venue	Number of programmes
Rossendale	2
Burnley	3
Accrington	2
Clitheroe	Changed to Burnley

Table 1 illustrates that most groups were held in Burnley. This is because there was no uptake in Clitheroe and most interest came from Burnley.

Outcome Measures

Participants were asked to complete the Hospital Anxiety and Depression scale (HADS: Zigmond and Snaith, 1983) before and after the intervention.

This scale was specifically designed to detect anxiety and depression in medically ill patients and has demonstrated a high degree of reliability and validity with a variety of disorders (c.f. Grassi et al, 1993). Additionally, many studies have confirmed the validity of this scale when used in community and primary care settings (Snaith, 2003). The advantage of the scale is that it excludes somatic symptoms that indicate physical rather than psychological problems. Scores can range from 0-28 on each subscale and each question is rated on a 4-point scale. Past studies have established that scores greater than 8 on the depression subscale and greater than 10 on the anxiety subscale are indicative of clinical cases (Carrol et al, 1993).

Programme evaluation (participants)

Following the intervention, participants were asked to complete an anonymous, postal evaluation form to obtain their overall views and satisfaction. Respondents were invited to indicate on a Likert scale (1=very poor, 2=poor, 3=satisfactory, 4=excellent) their opinion on the ability and professional

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knowledge of the facilitator, tailoring treatment to need, personal practice assignments and relaxation. Participants were also asked to rate the degree of helpfulness of the techniques taught. These included relaxation, pain management, anxiety management, overcoming depression, helplessness, anger, guilt, insomnia, increasing confidence, working towards personal goals, improving quality of life and returning to meaningful activities.

Participants also rated the Group Members' Handbook and the programme venue. Space was available for written comments about hopes and concerns, the most useful aspect of the programme, any changes required and how respondents thought the techniques they had learnt could help them in the future.

Programme evaluation (facilitators)

On completion of the course, the three tutors were asked to complete an anonymous evaluation form to elicit their views. Tutors were invited to indicate on a Likert scale their opinion of the Facilitators' Manual, Group Members' Handbook, the venue and facilities. Again, space was provided for written comments regarding the most rewarding aspects of the programme and any changes recommended.

Analysis

Of the 30 participants who completed the programme, 23 returned completed data sets. Reasons for incomplete quantitative data were therapist inexperience in collecting data for analysis and administrative errors. The analysis therefore is based on 23 participants (7 males and 16 females).

Statistics were calculated for pre and post data using the Statistical Package for Social Sciences (SPSS) version 14. The mean pre and post-intervention scores and the mean change scores were computed.

RESULTS

Attendance was high. Fifteen clients attended all eight sessions, 9 attended seven times, three attended 6, 5 and 4 sessions respectively. Attrition was low, approximately one per group. Reasons for withdrawal included: childcare, other commitments, illness, poor motivation for self-help, personal problems, inability to attend without a Support Worker and reasons unknown.

Changes in symptom scores

Raw data was obtained from questionnaire scores before and after the programme. Participants' scores were combined to give a mean pre and post intervention score for each questionnaire construct. The mean change scores were also calculated to indicate both the degree of change and the direction (positive or negative which gives a general increase or decrease in scores). The higher the score indicates higher levels of anxiety and depression on the HADS. Scores are presented in tables two and three.

Table 2 demonstrates a reduction in clinically significant anxiety and clinically significant depression following the intervention. More participants moved into the normal category after treatment, and a similar increase is observed in borderline scores for anxiety.

Pre and post data were subjected to a two-tailed, paired samples t-test and the results are presented in table 3.

Table 3 shows significant improvement in anxiety and depression following the intervention.

Participant feedback

Fifteen participants returned the postal satisfaction survey. Findings indicated a high satisfaction rate with the programme. Except for one satisfactory rating, all participants said the Group Handbook was excellent. The venue, accessibility and facilities were rated as excellent or satisfactory by all, but a small minority reported that more comfortable chairs would be an improvement. Respondents were asked to list what they hoped to gain from the programme. Responses included: relaxation, more confidence, assertiveness, anxiety management, anger management, self-awareness and increased coping skills. These hopes were met completely for 36% of participants and mostly for 64%. Surprisingly, only 4 participants had concerns about joining the pro-

Table 2	Anxiety				Depression			
	Before	(%)	After	(%)	Before	(%)	After	(%)
Normal (0-7)	5	(22%)	8	(35%)	10	(43%)	16	(69%)
Borderline (8-10)	5	(22%)	12	(52%)	5	(22%)	5	(22%)
Abnormal (>11)	13	(56%)	3	(13%)	8	(35%)	2	(9%)

HADS change scores before and after the intervention

Table 3	Pre-treat		Post treat			
	Mean	SD	Mean	SD	t-value	p-value
Anxiety	11.26	3.54	8.08	3.57	3.61	< 0.05
Depression	9.13	3.92	4.95	3.56	4.73	< 0.001

The effect of the intervention on psychosocial functioning

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gramme, which were meeting strangers and talking in a group, or coping with the emotional content. All said that they had had the opportunity to discuss these concerns and said that it helped.

All respondents appreciated the tutor, not just in terms of knowledge and ability but also valued the tutor him/herself. For example: “The tutor actually wanted to listen to my personal needs”. Participants were asked to rate how helpful the techniques were to relieve certain symptoms. All rated techniques to help them relax, manage anxiety, anger and pain as excellent, satisfactory or not applicable. Similar ratings were noted for overcoming low mood, depression, helplessness and guilt. The majority for whom returning to work/ seeking employment was applicable returned excellent or satisfactory ratings. With the exception of one participant, who gave a poor rating, all said the goal setting procedures were excellent or satisfactory.

The most useful aspects of the programme were learning how to relax, managing anxiety, anger and depression, cognitive restructuring and a resultant increase in self-awareness and confidence. Belonging to a supportive group, and the tutors' knowledge and patience were greatly appreciated. When asked if there was anything that should be changed most responses were no. The few changes recommended included more time for discussion, the programme to have lasted longer and request for a follow-up session at a later date. With the exception of one, all participants felt that the programme had made a difference to their overall quality of life. The main ways in which it had made a difference were: improved physical and psychological health, increased confidence, the ability to change unhelpful thinking patterns, self-awareness, acceptance of self and reduction in avoidant behaviour. All participants said the programme would help them in the future in terms of managing stress and improved relationships.

Participants were asked if there was anything they would have wanted more of and again, the responses given were for more time for discussion and the course overall to have lasted longer. Final comments included:

I found this course not just useful but a life-saver, helping me to get things/ situations into perspective.

I was anxious when the course finished, about coping on my own, but I'm OK and managing my anxiety.

Fantastic course, accessible to everyone. Thank you.

Would just like to say thanks. I feel much better.

Tutor feedback

All tutors said they were adequately prepared to facilitate the programme and that the aims and objectives were met for those participants who completed the course. All agreed that the most rewarding aspect was observing positive change in participants. Problems identified included: unsuitable mix of participants for group cohesiveness and disruptive clients. One tutor had 2 clients who failed to attend enrolment, turn up at session one. The subsequent mix was unsuitable to meet need and the group needed to be split into 2 smaller groups. All tutors said the Facilitator's Manual, Group Handbook, venue and facilities were either excellent or satisfactory. General comments included:

I feel it is essential for the Group Facilitator to meet all prospective group members before they are accepted into the group.

Everything about the course worked well.

Please get more funding for more courses so more people can benefit.

DISCUSSION

This study indicates that the BLAST programme was effective in helping participants to improve their mental health. A significant improvement in anxiety and a highly significant improvement in depression were observed on completion of the intervention. However, due to the relatively small sample size (n=23), these results should be treated with caution. Lack of attrition and high attendance rates suggest the general acceptability of the intervention and feedback for the most part was positive and favourable. Not only was the programme highly appreciated, but participants valued the facilitators. Given that the latter is recognised as an important variable in intervention outcome (Beck et al, 1987, Ellis, 1994), it was noteworthy to discover that participants considered the facilitator as skilful and important in their adaptation to their various situations.

The most obvious limitation of this report is the small number of participants taking advantage of the programme. BLAST was intended to accommodate up to 20 participants per group in line with recommendations to reduce the gap between service demand and availability (Hodgetts, 2007). This recommendation, however, mostly refers to NHS Psychology departments which, inundated with demand, are in a position to deliver large psychoeducational groups to reduce stigma and maximise funding. This approach was perhaps ambitious for a third sector body when previous experience has shown that small groups are more achievable and successful (Taylor et al, 2004a; Taylor et al, 2005; Taylor 2007). In reality, out of 74 telephone enquires, 45 potential participants enrolled and 37 commenced the programme. The gap between enquiry and commitment is likely to reflect a common reported fear about discussing emo-

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tional problems with a group of strangers (c.f. Taylor et al, 2004a). Indeed, of the 37 attendees, only four included this concern on the evaluation form. Tutors, however, reported discussion of these issues during enrolment which did much to allay fear and prevent the high attrition rate associated with group therapy (Yalom et al, 1995). Ten minutes, however, was considered insufficient time for a pre-group one-to-one assessment, which may have contributed to client failure to attend the enrolment session in the first place. Facilitators usually agree that face-to-face recruitment and selection of participants for group therapy is an important determinant of effective group dynamics and success, which is congruent with the present findings. Two participants who had not met the facilitator beforehand caused disruption in the group dynamic, necessitating the provision of 2 smaller groups. This obviously has implications for cost. Conversely, as BLAST did not purport to provide group therapy, a short enrolment session was considered sufficient for a psycho-educational programme with a moderate number of delegates. This did not happen and the subsequent small groups provided an opportunity for more personal disclosure. As such group cohesiveness was important.

On the other hand, the low numbers might also reflect a reluctance to recommend a third sector organisation. Apart from a small minority of clients referred by health professionals, the vast majority heard about the programme from voluntary, community and faith groups or from former participants. Presentations to health professionals produced a mixed reaction; some expressed enthusiastic support whilst others felt they already had sufficient resources since the introduction of Primary Graduate Mental Health Workers. This problem is not a new one. Reluctance to refer to non-NHS personnel has been found in former studies with a different patient population (Taylor and Ingleton, 2003; Taylor et al, 2004b). Similarly, problems with referral have arisen in another service run alongside BLAST, which provides small-group and individual therapy for mild to moderate anxiety and depression. If the government recommendation of 15% procurement being awarded within the 3rd sector is to be achieved, ways to overcome NHS professionals' resistance to referral need to be found. The greatest complaint from people with, theoretically mild to moderate anxiety and depression but in reality sometimes severe anxiety and depression, is the non-availability of psychological therapies . Most receive a prescription for antidepressant or anxiolytic/hypnotic medication after a 5 or 10 minute consultation with their GP. Very few (9%) are referred for psychological therapies for which there unacceptable waiting times (Hodgetts, 2007), and in some mental health services, evidence-based therapy is not available at all (Layard, 2004).

A number of participants suggested the programme was too short. Whilst some preferred the shorter commitment of twice weekly (Taylor, 2007), there was insufficient time to practise the skills learnt, in relation to their own lives, whilst the support of the group was still available. There were also problems with illness. If, for example, a participant was unable to attend for a week due to ill health, S/he missed two sessions making it difficult to catch up, which in some cases led to attrition. It is therefore recommended that future programmes run on a weekly basis. A follow-up session after 3-months would also be useful for small groups to see if improvement has been maintained and to reduce the 'cold turkey' effect.

A further concern was the number of missing/ inaccurate data sets. Recommendations include a training session for group facilitators and administrative staff to give them ownership of inputting data, with the aim of highlighting the importance of accuracy.

Nevertheless the study supports the feasibility of providing a CBT based educational programme using a standardised manual. Participants demonstrated advanced skills in managing and preventing emotional problems which is congruent with NICE guidance (2004, 2007). Despite the small referral numbers in this study, word of mouth recommendation has led to a demand for the service from both individuals and organisations. Service provision by a 3rd sector body has the advantage of avoiding the stigma associated with both primary and secondary mental health. For example: "I was desperate for help but afraid that if I saw a Psychologist, people would think I was mad". The programme has additionally demonstrated potential as a generic platform for bespoke courses, especially for young excluded people, which supports former work (Collishaw et al, 2004). See appendix one for service development since cessation of Primary Care Trust funding.

The promised government cash injection for the expansion of psychological therapies (DOH, 2008) is welcome news but much of this money will be spent on the lengthy process of training and supervising NHS Personnel. Layard (2004) suggests that the location of service provision is unimportant providing there is good control of quality and cost. Quality controlled, third sector provision is available currently and procurement should go some way to ease the pressure on mental health services which, as Hodgetts (2007) suggests, are "in danger of being swamped by demand". It is not the intention of this report to imply criticism of the hard work, care and commitment of mental health professionals but rather to inform over-

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burdened services of additional support. It is hoped that this type of report will increase NHS confidence in recommending and funding appropriate charitable organisations.

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APPENDIX ONE

Requests for the BLAST Programme

Since funding cessation, North Lancs Training Group (training provider for young people) has funded 2 BLAST programmes. Young Peoples' Services (formerly Connexions) have funded 4 x 2-hourly taster sessions in Rossendale, Accrington and Preston with further sessions arranged for Accrington and Clitheroe. Social and emotional aspects of learning (SEAL) is now part of the schools curriculum and the BLAST programme is in the process of adjustment, by request, for delivery in schools and young peoples' services. Alder Grange School in Rossendale has provided funding for development and provision; talks are ongoing with Lancashire County Council and a training programme for facilitators is in preparation for SEAL.

In addition to a waiting list for individuals requesting the BLAST programme, organisational requests for the scheme if further funding becomes available include:

ELPCT Mental Health Team Accrington

Mental Health Day Services Burnley

Lancashire Care Services Accrington

BPR Substance Misuse Services Burnley

Haslingden Health Centre Rossendale

Shelter for the Homeless Accrington

Calico Enterprises Housing Association Burnley

Youth Community Project Burnley

Castle Supported Living Clitheroe

Lancashire County Council

Conference Review Continued—Saturday

Simon Duff

(Continued from page 1)

how people can rapidly become aware of the "emotional lava" which may be bubbling and boiling away beneath the surface; the "why" as opposed to the "what" which clients may present at their initial consultation.

Demonstration volunteer **Dr. Obaidullah Saeed,** who will henceforth be known to all as *"Dr O"* shared with us with an example of how feelings can physically manifest within body tension and with some beautifully formulated bodywork, regression and physical anchoring, Tom rapidly demonstrated how it was possible for a subject to move from a perceived need to feel prepared and protected to feeling "happy and relieved".

Dan Nightingale

Tom's second volunteer **Celia Stevenson-Bird**, took us on a journey to "blame city" which, with some bodywork and a smattering of empty chair (just as well Tom moved before he encouraged her to hit it!) was erased from the map, and then given back to those who had put it there in the first place.

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In the second session of the day, Doctors **Dan Nightingale** and **Simon Duff** gave us an overview of their research on the potential for using hypnotherapy to enhance the quality of life for sufferers of dementia.

Josephine Teague

Simon began by noting that in many care homes, patients are potentially at risk of harm through the prescription of anti-psychotic drugs and lack of real life stimulation. He then drew our attention to the fact that this is in direct conflict with the 2001 National Service Framework for Older People which emphasised the benefits of patient centred care in enabling an individual to fulfill their potential and remain a social being despite declining capabilities. Simon provided a timely reminder of the potential benefits of hypnosis in the management of pain, the reduction of stress, production of positive behavioural change and reduced need for medication in many instances.

Dan then took us through the research project itself, noting the initial challenge of addressing the advisability of working with clients who are already living in an altered state of awareness.

Selecting a group of active participants, a control group who experienced additional interaction but not hypnosis and a control group who underwent treatment as usual, Dan tested the impact of using the NCHP six stage protocol on the active participants quality of life.

The results showed significant improvements in the indicators used to calculate scores for the overall quality of life for those within the active participants group in comparison to their baseline measurements and also the degree of change experienced by the two control groups.

Concluding that there is much still to be done in understanding the potential for hypnotic intervention in the care of those suffering from dementia, Dan gave us an insight into his hopes for the future, which include the development of the Faculty of Dementia, promotion of the developed training course, further research and convincing of Primary Care Trusts that hypnotherapy is a valuable psycho-social intervention – in line with The National Dementia Strategy.

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It was a trip back to basics with **JosephineTeague** after lunch when she stated that she really hoped she would be teaching us to "suck eggs" with the Egan's Three Stage Model of Counselling.

This session was equally helpful as a reminder for those in the room able to whip up an impressive soufflé as it was an introduction for those still working through the Delia chapter on how to boil an egg.

Remembering the power of

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Conference Review Continued—Saturday

(Continued from page 8)

being present in the room with clients and creating the core conditions became more and more apparent as Jo took us through exploring and focusing on client issues , understanding whilst also challenging and empathising and then of course, engaging the client in action to move forward.

Noting that some clients issues may require us to hop backwards, or forwards and take the steps out of synch emphasised the importance of dealing with clients as individuals rather than a set of symptoms which are simply manipulated through a process.

A professional trainer to the core, Jo naturally spoke about open and closed questioning, the power of silence, paraphrasing and listening, and she also included one of my favorite pointers to aid effective listening in the statement that *"Everything before the BUT is bull****"* - naturally I would not normally include this sort of statement in an article, and Jo apologised for any offence it might cause in advance; however as it turned out, this proved an interesting observation in that very shortly after Jo's presentation I heard some unofficial feedback from a delegate who shall remain nameless which went along the lines of "...well of course there was nothing I didn't already know and do, BUT it's a good model to work with..."

———

For those who have bemoaned having to study the history of hypnotherapy **Peter Blythe** took to the floor and exploded many of the myths, distortions and outright lies which are still held by many to be the truth about hypnosis.

Introducing us to Hypnos and his more dubious brother Thanatos, Peter took us on a journey of understanding of how many of the misconceptions surrounding the use of hypnotherapy came to be accepted as the truth and indeed still survive today.

He told us that he too had initially described hypnosis as "healing sleep" and admitted "falling into the trap" of believing some of the lies and distortions which have emerged throughout our history.

He told us the story about his father Henry, a stage hypnotist, who stood for election as a councilor in 1964 using the motto "Look into my eyes and vote for me, Henry Blythe" before enlightening us on his views and experiences of depth testing, suggestibility testing, client regression and ideo-motor responses.

Peter told us that even John Hartland, author Medical and Dental Hypnosis fell into the trap of perpetuating some of these distortions.

Time flew by (were we in trance? more of that later) and Peter finished by emphasizing the importance of understanding the mistakes of the past to enable present and future success which of course brought it all together in one massive "aha moment".

At the end of the session, my husband Steve who was attending his first hypnopsychotherapy conference, leapt to his feet (I've never seen him move that fast) and went straight over to Peter, and told him that had he been taught history either at school or on his Foundation Course in this way, writing his portfolio would have been an absolute pleasure— In response to this very specific piece of feedback, Fiona has asked me to let you all know that all students will receive a DVD of Peters presentation to help ignite this spark of enthusiasm for the history of our profession!

———

The final presentation of the day was **Emmy van Deurzen** on Psychotherapy and the Quest for Happiness.

This was a whistle stop tour of existentialism which some would have gladly given over much more than an hour to experience in

(Continued on page 10)

Peter Blythe—Founder of the NCHP and Honorary Fellow of SAG

"Look into my eyes and vote for me, Henry Blythe"

Emmy van Deurzen

Conference Review Continued—Saturday & Saturday Night

Michael Pollitt—Founders Award

Cliff Garraway—A Shining Light
and immaculately well groomed as ever!

Teresa Garcia Sanchez Receiving her Honorary Fellowship

(Continued from page 9)

greater depth.

Emmy whisked us through the concepts of hedonism v eudaimonia, Frankl's way to meaning and the four dimensions of existence; physical, social, personal and spiritual.

We revisited the 10 commandments and observed the changes in attitude which had produced a new set of "rules" for the 21st Century which bears little resemblance to what some might now consider the initial draft or rough guide to leading a good life.

We then explored whether we could really make ourselves (and Slough) happy by following a formulaic manifesto or routine set of tasks—the answer was of course blindingly obvious; that whereas we can all appreciate the benefits of taking action to facilitate change, the action in isolation is highly unlikely to be sufficient.

I'll swear that I could almost hear the thought processes of those in the room with questions and feel the energy that wanted to be channeled into a long and lively debate about the concept of accepting the whole life experience, whether awareness runs the risk of translating into wallowing, whether our role as therapist can ever make a real difference and indeed whether it should—and then time ran out!

I suppose for me, that was as good a message as any, however I was left with the image of one of Emmy's slides in my mind— the one filled with questions. I took the liberty of putting these to Shaun and Fiona who have agreed to ask Emmy to come back next year, or even better perhaps arrange a cpd workshop / event—she has a very busy schedule, but you never know, we might be lucky!

Saturday Night—time to wine, dine, boogie and recognise those who have achieved something even more special in the months preceding the conference;

As an aside I must mention that Fiona looked resplendent in her somewhat wicked little black dress and strumpet shoes (this is a compliment), especially when she was whisked into the arms of the youngest and most handsome conference attendee Greg. Unfortunately, I suppose I have to also mention that Greg is indeed Fiona's son, although it would have made a much better gossipy story had this second piece of information been left unsaid.

The award ceremony began with Shaun asking Peter Blythe to join him on stage to present the Founders Award which was presented to Michael Pollitt in recognition of achieving the highest mark of 90.4% in his completion of the Certificate in Hypno-Psychotherapy.

The J.P Noble Award was awarded to Adam Prince for his dissertation entitled "A review of the theory and applications of hypnodrama, psychodrama and monodrama and how these and related therapeutic techniques can inform an integrative hypnotherapy practice." Unfortunately he was unable to receive it in person. However this excellent piece of work is available via the college and provides an excellent example for all who are working on their dissertation now and in the future.

Likewise an award from the Academic Board in appreciation of devoted service was announced for Nigel Sprent in the year of his retirement following many years of teaching for the NCHP.

Honorary Fellowships of the Students and Alumni Guild were awarded to Peter Blythe, Jon Beilby, Teresa Garcia Sanchez, and Josephine Teague.

The final award "A Shining Light In The World Of Hypnotherapy" was presented to Clifford Garraway in recognition of the tireless efforts and positive support provided by Cliff to his fellow professionals over many years.

The party went on long after I had left, however the ultimate prize for endurance this year goes to Richard Nicholls and Sharon Mustard - maybe next year, we'll consider a "Last One

(Continued on page 11)

Conference Review Continued—Sunday

(Continued from page 10)

Standing" award ☺

Sunday morning found us in the company of Bill Hard reinforcing the benefits of using hypnosis techniques to build assertiveness and improve the quality of communication.

Starting at the beginning Bill guided us through the differences between assertiveness and aggression, the irrational beliefs that many have about the characteristics of assertive people.

Together we explored the rights and duties which support the over-riding concept of respect for ones self and others and facilitates assertiveness and the ability to co-exist with others on an equal footing.

Understanding that simply adopting assertiveness techniques by themselves is insufficient to create the actual experience, Bill gave us a wonderful illustration of how the delivery of a four point message might go horribly wrong, without the support of a firm foundation, normalizing the feeling.

Bill would obviously have liked more room as he engaged several volunteers in experiential activities, and clearly would have involved everyone if he could—never the less, he was able to demonstrate the concepts of "I exist : You exist", learning to feel comfortable with feeling uncomfortable, being specific rather than general and focusing on addressing a behaviour rather than labeling the person.

Kat Jenkins assisted in a demonstration on how a shift in focus to the lower parts of the body could help the individual stand firm and Hilary Norris-Evans became even more aware of her inner strength (as if it were ever in doubt) and ability to sustain her position and resist manipulation without actively trying.

Jon Beilby provided a fascinating insight into his work with groups of people suffering from long term illness and dealing with unemployment.

He began by outlining the social and human costs of high levels of illness and unemployment and the difficulties with breaking the illness / unemployment cycle.

Jon then outlined the Help for Health© Programme which utilises eight, three hour, weekly sessions incorporating CBT, Stress Management and Hypnosis (termed "relaxation" so as not to scare the horses), for groups of up to 12 people in the Lancashire area.

The aims for the programme are to teach the participants to manage their conditions, support each other and return to realistic functioning whilst encouraging, motivating and empowering them to return to meaningful social activity and ultimately to employment.

Jon walked us through the programme sessions in detail and highlighted the changes observed in individuals who had previously perceived themselves to be alone, unable to let go of self limiting belief and feelings becoming able to decide what they want from life and find a way to achieve it.

Jon concluded with an outline of what he would most like for the future, which is to encourage the expansion of the Help for Health© Programme across the UK via local UKCP registered therapists in conjunction with REAL (Rossendale Enterprise Anchor Limited), a charitable organization focused on winning contracts for the delivery of the the programme in local health authority areas throughout the UK.

Jon offered his email address for anyone interested in promoting the scheme in their local areas; jon.beilby@tiscali.co.uk

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Bill Hard

"Assertive people are those who are able to feel comfortable with feeling uncomfortable"

Jon Beilby—Honorary Fellowship

Conference Review Continued—Sunday

John Rowan

(Continued from page 11)

The next session was lead by **John Rowan** who's subject matter of Hypnotherapy and the Humanistic sparked a lively debate into the definition and nature of what constitutes a hypnotic trance—hence the uncertainty of earlier remarks.

John described his work on Sub Personalities (described also as parts work) and noted that many concepts originating from the hypnotherapeutic modality have simply been absorbed into humanistic theories and concepts without acknowledgement of their source.

He described the traditional concept of induced trance whereby the subject is guided into the altered state and then emerged and observed that this may be irrelevant and unnecessary when considered in the context of modern therapy.

He then proceeded to demonstrate the use of guided fantasies with the assistance of **Rae Jenson.** Although there was certainly no formal induction method used, several observers voiced their belief that some level of hypnoidal state had nevertheless been achieved, even if subtly or even unknowingly induced!

John proceeded to demonstrate some classic empty chair work with Rae, until once again time took control once more and the session was brought to a close.

The discussions though, continued on throughout lunch and beyond—providing an excellent example of just how stimulating the opportunity of coming together can be for all of us!

Geoff Ibbotson began the afternoon session with an enlightening and moving account of his use of hypno-psychotherapy techniques with sufferers of post traumatic stress syndrome and Complex Trauma and Disorders of Extreme Stress (DESNOS).

"After living in hell, you can't expect people to be angels"

He touched upon many of the symptoms experienced by survivors of trauma who go on to develop these conditions including depression, anxiety disorders, alcohol & substance abuse, somatisation disorder and violence or criminal behavior—the poignant comment made here, being that "After living in hell you can't expect people to be angels".

Geoff brought our attention to the proportion of people in society likely to experience PTSD or DESNOS in their lifetime, which can be as high as 15% of those employed in the emergency services, rising to 30% of those who have experienced service within a war zone. These figures are perhaps to be expected, however he also noted that 5% of men and 10% of women in society as a whole, will experience PTSD at some time in their life.

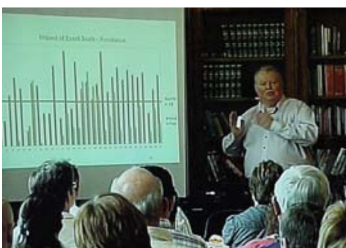
Geoff went on to explain that current NICE regulations actively discourage the use of non trauma focused interventions such as relaxation or non directive therapies such as hypnopsychotherapy on the grounds "that there is as yet no convincing evidence for a clinically important effect of these treatments on PTSD".

From this point on, it was clear that this is exactly the sort of proof that Geoff is looking to produce from his work as he went on to discuss his approach, illustrated with case studies and data which is to be published in the public domain shortly.

Needless to say, the information provided a compelling argument in favor of supporting a review of the current guidelines; a quest in which I'm sure many will wish Geoff the maximum success in achieving.

And then, as if we had all been in some sort of trance, experiencing time distortion (yes, the debate about the possibility of this in the absence of a formal induction was still going on

(Continued on page 13)



Geoff Ibbotson

Conference Review Continued—Sunday

(Continued from page 12)

☺), it was time for the omnipresent Principal of the college **Shaun Brookhouse**, (resplendent in his Ericksonian purple) to engage the entire room on the subject of the power of Milton Erickson.

Challenging some of the popular pre-conceptions, Shaun reminded us that Erickson the man had none of the super-human qualities purported by many of his followers; arguably one of the best known practitioners of hypnotherapy, the question posed was in what ways, if any should Erickson's approach be considered psychotherapeutic?

Shaun outlined the findings of Jay Hayley's initial and then repeated reviews of the nature of Erickson's work, noting how it developed over time, and then added even more observations made by Beahrs.

At the same time, he drew out observations about the nature of the therapeutic relationships, the fluidity of Erickson's approach and the parallels which can be drawn with the various humanistic psychotherapeutic modalities with which we are (or are becoming) familiar.

The conclusion then, blindingly obvious! Erickson is in every way able to claim a place at the side of those who expound the virtues of the therapeutic alliance, resolution to change and the instigation of intervention to bring about coordination between conscious and unconscious functioning.

Reflecting on Shaun's presentation whilst writing this piece brought a smile to my face as once again I realised how much content had been seamlessly incorporated into what had felt like a bit of a chat; on so many occasions, and this session being no exception, I have heard people comment that whilst listening and talking with Shaun they had been completely engaged and yet unaware of just how much was "going in" until much later. So on that note, I guess it's a big "thanks" to Milton and of course to Shaun who succeeded in bringing him back to life in yet another light.

And then it was all over! I had a flash of recollection of a point made by **Bill Hards** at the beginning of the day "no one manages time, everyone gets the same amount—what you manage is what you do with it".

Well I certainly enjoyed what I chose to do with my time over this weekend; so many exciting and interesting ideas, so many excellent, professional and friendly people—and that's just the beginning.

Next years conference will be held in the Midlands on the **12th / 13th June 2010** with another **Masterclass** preceding it on **Friday 11th.**

We have many of the speakers already lined up, and will be offering some tasty discounts for early booking—so keep an eye open for these and we'll see you all next year. *Su*

Shaun Brookhouse

REMEMBER!

The benefits of membership of the Students & Alumni Guild include;

- *A listing on the online directory of qualified hypno-psychotherapists at **www.hypno-psychotherapy.net***
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The Therapy of Outcome Measures – A Short Case Study

By Debbie Featherstone 9th May 2009

No – it isn't a typo!

Using Outcome Measures really is therapy in itself – it has a tremendous powerful effect – more powerful than any encouraging words. They are an "absolute" for patients. They show them the change is for real and not just "in their head".

I use measures all the time – whether I am measuring tinnitus distress through the THI or other instruments; measuring levels of anxiety and depression using the HAD Scale, the BDI (Beck Depression Inventory) or BAI (Beck Anxiety Inventory), effects of hyperacusis using the HSQ (Hearing Sensitivity Questionnaire), effects of dizziness using the DHI (Dizziness Handicap Inventory) and of course measuring changes through using a 0 – 10 scale in goal setting and goal achievements.

Outcome measures show clients the change is real, not just "in their head"

Bear with me while I tell you a story about a man that I've been working with over the past couple of months.

Jack

This man – let's call him "Jack" for the sake of his anonymity – has been an audiology patient for a long time. He was an angry man and took his temper out on anyone and everyone it seemed; he'd upset every audiologist who had tried to help him, and had been "blacklisted" in so far as a note had been put on his audiology record that he was only to be seen by the Head of Service – never by any of the core audiology staff.

Jack has a mild-moderate hearing loss and tinnitus – the tinnitus was "driving him mad" and he wanted it fixed! The audiologists were "useless" according to him and he was insisting a few months ago that full details about his hearing and his tinnitus should be sent to his GP. He was threatening to go to the papers and to his MP to complain about the audiology department because they did nothing to help him. At least this was his take on the situation and he'd growled down the phone to a number of people in the department demanding that he was given "proper help"!

The only reason he ended up on my books was because the Chief Audiologist thought he was complaining about me – I never did get to the bottom of why that assumption had been made but can only think it was because for the past couple of years all patients with troublesome tinnitus should be referred to Hearing Therapy, and Jack had in fact attended one of my Tinnitus Screen Groups two years ago.

Back then, his tinnitus hadn't been quite so bad and he hadn't been ready to have hearing aids. He had chosen not to go ahead with a full programme of tinnitus management at that time, and was content with the information about tinnitus that he'd received through attending the one-off two hour group session.

Anyway, as a result of this "complaint" I telephoned the patient, and he explained that he had no complaint about me whatsoever – in fact, he said, I had been the only person he'd managed to get any sense out of! And would I please arrange for a report including an audiogram and details of his tinnitus to be sent to his GP. I agreed to do that immediately and I offered him an appointment to come in to see me which he agreed to do.

I spent a couple of sessions with Jack, listening to how useless the hearing aids were so he saw no point in using them, and how awful his tinnitus was. I arranged for him to be seen by our Head of Service for a re-evaluation of his hearing aids and talked to him about committing to attending therapy sessions with me. Once his hearing aids had been adjusted – and they did require re-programming – he found them to be an improvement and agreed to use them. We worked on goals that he wanted to achieve, and discussed how we would go about achieving them. We completed measures for his

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"Jack's self esteem was on the floor"

The Therapy of Outcome Measures - continued

(Continued from page 14)

tinnitus (I use the THI and another questionnaire I call the TQ10) and for anxiety and depression using the HAD Scale. The THI score was 72% (reduced from 94% before using hearing aids); TQ10 was 37/50 and the HAD measured 18/21 for depression and 16/21 for anxiety.

Jack began attending weekly therapy sessions, and each time more and more information was revealed. He had four failed marriages behind him, and two failed relationships with men. Jack had only been able to admit to himself 10 years ago that he was gay. He had been treated very badly by both of his male partners – especially the more recent of the two. He was afraid of getting involved in another relationship but he was so lonely. Jack lives on his own, his mobility isn't good and uses a wheelchair other than when he is pottering around at home. He is visited regularly by his daughter but hasn't been out socially since his last relationship came to an end about eighteen months ago. He whiles away his time – especially in the evenings – on internet chat lines in the hope of meeting "Mister Right" but had found so many people on there to be untrustworthy and even abusive on occasions.

Jack's self esteem was on the floor, he'd had suicidal thoughts regularly as well as thoughts of cutting himself, though he hadn't actually gone through with any of these.

He described what must have amounted to tens and tens of hours of "counselling" over the years that he unceremoniously describes as a complete waste of time! The words he uses are unrepeatable in this medium! He was having nightmares most nights that tended always to be a similar story – he was on a bus supposedly going to his home but always the bus would drop him off and his home was nowhere to be seen, or he would get to his home only to find he didn't live there at all.

There's lots more I could tell you about Jack, but there's enough here I think for you to grasp the general scenario surrounding Jack's life.

I have been working with Jack on a weekly basis now since February. I have used a huge amount of validation, explanation, dialogue and challenging plus hypnotherapy.

I have done some cognitive work with Jack throughout our sessions, but CBT per se wasn't wholly appropriate in Jack's case – mainly because he'd supposedly had it before (from what he described to me it was no such thing and if it was, it had been done very inadequately!) and I didn't need to make more work for Jack trying to undo that particular belief when really, it would only have been for the sake of it. There were other very effective ways of helping Jack and I am happy to say – as you will see in the next few paragraphs – they have been extremely effective.

Last week, I went to the waiting room to fetch Jack for his appointment. There he was, sat in his wheelchair – sure enough it was him, but my goodness he looked different! He was sat up straight in his chair and smiled at me! He radiated a completely different persona to that which I'd been used to seeing in that waiting room over the past weeks. Though admittedly, there had been some smiles during our 1-1 sessions of late. We had our therapy session and Jack returned yesterday for his next appointment. Once again, there he was in the waiting room, sat erect and smiling. He zoomed into the clinic room (remember he is in a chair!) and parked up – unusually close to my chair I noticed.

He was full of it – even though he'd had a bad migraine the day before. That was the first migraine he'd had for six weeks whereas prior to our therapy he was having them two or three times a week. He said it must have been because he'd been lying awkwardly in bed during the night – he's sleeping so much better now. Regularly gets 7 hours a night of uninterrupted sleep. He's not had any nightmares for about 4 weeks and tinnitus? Hardly notices it now!

> ***"You'll see a difference with this one"***

I said to him it was time to revisit the measures. "Oh if you must!" he said. I explained to him why I used them – that it was so that my patients could see for themselves, on paper, the changes that they'd made. So he happily agreed.

As he worked his way through the first one (TQ10) he was ticking all the boxes down the left hand side of the questionnaire (i.e. little or no problem) and when he got about halfway down the paper, he said to me "You'll see a difference with this one".

He finished that one, and I gave him the THI – same thing – lots of "No" boxes ticked with the occasional "Sometimes". Then I gave

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The Therapy of Outcome Measures - continued

(Continued from page 15)

him the HAD Scale – tick tick he drew in the boxes.

I scored each of the questionnaires as he completed them, and coupled them

		Before	After	Minimum Possible	Maximum Possible
HAD	Depression	18	4	0	21
HAD	Anxiety	16	3	0	21
THI		72	18	0	100
TQ10		37	11	10	50

with the previous questionnaires he'd done some 6 weeks before.

Then it was time to show Jack the comparisons:

Jack's response when he saw these for himself? "Wow!!!!!" He beamed all over his face. And so he should – he's done brilliantly!

"He beamed all over his face. And so he should—he's done brilliantly"

Then he said – as is often the case – "but now I'm worried that I won't be able to stay like this. I'm scared that I'll go backwards." Jack and I talked about this. I told him it was absolutely normal to think that – nearly everyone does. Look at all the work you've done to get here, I said to him. How can you go back to where you were before? With everything that you understand now? You just didn't understand it all before but now you do. And I saw the light go on again in Jack's eyes. Yes, he said, it can't happen can it? And indeed no – it can't. Things will happen in his life that will cause him upset no doubt, but he has a completely different way of understanding things now. In fact, yesterday it was Jack who volunteered those words to me!

In conclusion

When Jack saw those outcome measures, they did him more good than any words I could have used to reinforce what changes he has made.

The reason I have sat here today and written this article is to – hopefully – encourage any of you who don't already use Outcome Measures to use them in future. I hope I have given you good reason to use them. Jack is one of many

hundreds of patients I have worked with over the years but also probably one of the more complex too. All patients – whatever problems they come to us with – are seeking change, and how better can they see the changes they have made than by comparing their own answers?

My work with Jack isn't quite finished yet. It's so often the case that at this stage something happens that challenges the new found beliefs and understanding, and it's really important in my experience that this is embraced as being part of the therapy process. In fact, once something has happened that does challenge those new found beliefs and understandings, and the person can have their hand held

through it, then they really have made permanent changes that they know they can trust to be there in the future. I use final outcome measures at the very end of therapy – after we've covered relapse prevention in theory and very often in practice - and more often than not, the measures are even better.

If anyone doesn't have the measures to use, just drop me an email and I'll send them to you.

Happy measuring ☺

Practice Building Tip— provided by Richard Nicholls

"If you're happy and you know it, tell a friend"
Richard Nicholls

Remember the best means of promoting your services comes about through clients talking to their friends and family about how therapy has helped them.

Of course you would not overtly encourage clients to discuss their therapy with others, especially if they have been dealing with a sensitive, personal issue—however some will do it anyway.

It is human nature to want to help others, and if your client feels you have helped them, why wouldn't they recommend you to a friend or loved one?

If you feel uncomfortable asking for referrals, you might consider a poster or sign which is visible from the therapy chair — remember humor is a good bridge builder and the client can choose to act upon it or not as they feel appropriate.

If you have a practice building tip to share—email it to me at su.ricks@nchp.org.uk

Obsessive Compulsive Disorder and Brain Patterns
Research synopsis provided by Jo Goss

The cause of OCD is not known although there are a number of hypotheses, one of which is that there is a genetic link, and that OCD may be the result of certain inherited genes that affect the development of the brain. Indeed although no specific genes have so far been identified it has been apparent for some time that the condition does run in families, and research indicates that a person with OCD is four times more likely to have another family member with the condition than somebody who does not.

Researchers at Cambridge University may be a little closer to a breakthrough in this respect. It appears that although the specific genes responsible have still not so far been isolated certain genes do indeed increase the risk of OCD by affecting the amount and location of grey matter in the brain, and this in turn affects an individual's ability to perform mental tasks. It further appears individuals with OCD and their families all show such distinctive patterns in their brain structures, even though not all those sharing these same brain structures go on to develop the disorder.

The researchers used cognitive and brain measures to determine whether or not there might be biological markers of genetic risk for developing OCD. Initially they used magnetic resonance imaging (MRI) to obtain pictures of the brains of OCD patients, and also of healthy close relatives such as parents, siblings or children. They also used MRI to obtain pictures of the brains of a control group made up of healthy people who had no relatives suffering from the condition. These pictures showed marked differences in the amount of grey matter in the brain.

To test the hypothesis further both the OCD group and the control group were asked to complete a computerised test designed to measure the ability to stop repetitive behaviours. This test involved pressing a left or right button as quickly as possible whenever an arrow appeared. As soon as they heard a beep they were to attempt to stop their responses. The OCD patients and their families fared considerably worse than those in the control group, taking much longer to respond to the beep. The researchers associated this to the decreases in grey matter in those regions in the brain responsible for suppressing responses and habits.

The researchers concluded therefore that, 'Impaired brain function in the areas of the brain associated with stopping motor responses may contribute to the repetitive behaviours that are characteristic of OCD'. They further confirmed that such brain changes run in families, and that this suggests strongly that there is indeed a genetic link to the condition.

However, the researchers stress that their findings are not conclusive and that further research in this area is needed. Additionally they stress that there is also a need to investigate and identify other contributing factors for OCD.

Source: www.medicalnewstoday.com/articles/89876.php

accessed 24/05/2009

Jo Goss, Elgin, Scotland

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An ad consisting of up to 50 words including your contact details will cost £5 per edition.

Remember to include prices and postage / packaging where appropriate as well as your contact information including a telephone number and email address if possible.

Remember many of the old books collecting dust on your shelves could help new and future students on their journey into the world of therapy and could also help fund your investment in new publications.

Perhaps you have a consulting room which is not fully utilized; offering a room share could help out a fellow therapist and spread your costs.

If you are a supervisor, or run peer support groups in your area, remember to tell other members of SAG about it here—In fact if there is anything you would like to advertise which would be of interest to other members, can be added here for just a small administration fee.

Message From The Chair—Fiona Biddle

It is a great pleasure for me to introduce this inaugural edition of the NCSAG E-Journal. I hope that you will find it of use. Communication is the key to an organisation's success, and since Shaun and I have taken over operational control of the National College, I hope you will agree that we have kept you all in the loop as to what is happening in the greater Hypno-Psychotherapy world.

This journal is a place for you to expand your knowledge of Hypno-Psychotherapy as well as a place for you to share what you are doing to take the modality further. We aim to have articles, news and views, and other features which you will find really useful.

Since we have had approval from the UKCP to change our status from that of a Training Member Organisation, to a Training and Accrediting Member Organisation, the need to provide you with the best possible service, whether you are a student or alumnus is clear. This journal is one of many services we are rolling out over the next few months. We hope you will like them.

If you are interested, we have recently launched a new website just for the NCSAG, you can find it at www.hypno-psychotherapy.net

Enjoy the journal

Fiona Biddle—Chair, NCHP Students & Alumni Guild