

The Australian Hypnotherapists' Association

Australia's Peak Body for
Hypnotherapists since 1949



Is your hypnotherapist accredited?

For more than half a century, the Australian Hypnotherapists' Association has set the standard for professional hypnotherapy in Australia. The acknowledged leader in it's field, the AHA is recognised as Australia's Peak Body and offers accredited clinical hypnotherapists in every state and territory.

To find an accredited hypnotherapist, visit the National Hypnotherapists of Australia Register:

www.national-hypnotherapists-register-australia.com

or call the AHA free information line:

1800 067 557

Hypnotherapy has been proven effective for:

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Pain control
Weight loss
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Improve memory
Increase confidence
Improve motivation
Enhance learning abilities
and much more

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www.ahahypnotherapy.org.au

SMOKING IT'S MOSTLY IN THE MIND

World No Tobacco Day is marked throughout the world on May 31st each year. Since its inception in 1987, the World Health Organisation's goal has been to increase awareness of the dangers of smoking by lobbying governments to make health promoting changes to legislation.

In recent times, Australia has become a world leader by showing what can be achieved when government and the community work together to reduce smoking in the general population. Since the 1960's, the number of smokers has dropped year by year and now less than 20% of Australians smoke.

Since 1949, the Australian Hypnotherapists' Association and its members have helped thousands of Australians permanently stop smoking. With hundreds of qualified and accredited hypnotherapists in every state and territory, the AHA, as Australia's Peak Body for hypnotherapists, has been instrumental in promoting the message that quitting smoking is not only desirable but achievable.

SMOKERS WANT TO QUIT

Research shows that over 92% of smokers would like to quit but don't believe they can succeed in doing so easily. When a smoker does decide to quit they can be confused by the many options available to them. Should they go "cold turkey" or perhaps use acupuncture, there is also drug therapy, laser therapy, nicotine replacement therapy or of course.... hypnotherapy.

WHY USE HYPNOTHERAPY?

Hypnotherapy uses the ability of the mind to bring about permanent change. It differs from other therapies because of its proven multi-level

approach which addresses all three dependencies associated with smoking, the physical, habitual and psychological.

There is now broad agreement that smoking is more than a physical addiction. The habitual patterns a smoker develops, as well as the psychology behind that habit, also plays a major part in a person's smoking behaviour.

For example; a smoker may habitually smoke when drinking coffee or alcohol or perhaps when using the phone or to get a break from work. They may also smoke when stressed, anxious, unhappy or to change their mood.

To successfully and permanently quit smoking, it's important that all three issues be addressed; that is the physical, habitual and psychological. Hypnotherapy does this by working at a subconscious level which is where habits and psychological patterns reside. This is necessary because habits are automatic and subconscious.

When a person experiences hypnotherapy, their body is very relaxed and at the same time their mind is highly focused. This is a state of mind not unlike daydreaming and in this altered state, the logical, critical faculties of the mind are distracted, allowing the subconscious mind to be open to suggestions that can help to change habits and realign psychological patterns.

In this highly suggestible state of mind, a person can also be helped to alter their beliefs about their inability to quit smoking. Any potential physical withdrawal symptoms are addressed at the same time by using proven hypnotic techniques.

According to the New Scientist Magazine, (Vol. 136), the largest scientific comparison of ways of breaking the smoking habit, revealed

hypnotherapy to be the most effective. Frank Schmidt and research student Chockalingam Viswesvaran of the University of Iowa carried out a meta-analysis, statistically combining the results from more than 600 studies covering almost 72 000 people from America, Scandinavia and elsewhere in Europe.

By combining the results from so many separate studies, the meta-analysis enabled the real effectiveness of each technique to be picked out from the statistical "noise" that often blights studies involving smaller numbers of subjects. For most smokers, the most effective technique was hypnotherapy.

THE PAY-OFF FOR BUSINESS

Studies show that smokers take more sick days and are less productive than their non-smoking colleagues, so it is in the interest of employers that employees quit smoking. In addition to these obvious benefits, smokers who quit using hypnotherapy have few if any withdrawal symptoms, taking advantage of a safe, natural, cost effective and drug free method of breaking their habit, at the same time as learning techniques that help them reduce any feelings of stress and anxiety.

THE AUSTRALIAN HYPNOTHERAPISTS' ASSOCIATION

The AHA was founded in 1949 and is the oldest and most respected professional hypnotherapy association in Australia, recognised by government and industry as the Peak Body for the profession. All clinical AHA members are accredited by the National Hypnotherapists of Australia (NHRA).

Antoine Matarasso
National President, Australian Hypnotherapists' Association



The health dangers of active smoking had long been known, but it was not until the mid 1980s that smoking became an urgent issue for the corporate world. In 1986 the first successful case of litigation against a corporation in Australia occurred when an employer was sued and compensation awarded to an employee for failure of the workplace to provide a safe working environment free from passive smoke. The corporate world had been shaken with the knowledge that responsibility had to be taken into banning smoking in the workplace.

What is passive smoke?

Passive smoke consists of second hand smoke (the smoke exhaled by the smoker) and side stream smoke (the smoke which exudes from the burning end of cigarette). Side stream smoke is particularly dangerous because it contains particulate matter including carbon monoxide and nicotine which because of their tiny particle size can be breathed deeply into the lungs by non-smokers. Research began to link chronic exposure to passive smoke in the workplace with oral cancers, lung cancer, heart and blood vessel disease and emphysema.

The first policies banning smoking indoors in workplaces were driven due to the risk of litigation. Employers had a workplace occupational health and safety (OH&S) duty of care to provide a safe working environment for all employees. The mid 1980s saw the first workplace smoke free policies become law where smoking was first banned indoors in some government workplaces. The choking haziness of a designated smoking room provided a compromise in other workplaces. Soggy cigarette butts began choking drains immediately outside building entrances. The private sector soon followed suit. During the 1990s and the 2000s, smoke free policies were further refined. In government workplaces, smoking is banned in all work areas including outdoors.

Research in Australia clearly revealed that smoke free workplace policies contributed to reducing the rates

of smoking during working hours and influenced many smokers to attempt "quitting". Some workplaces even provided workplace smoking cessation programs to prepare employees for total smoking bans.

But has this really been enough?

Results of workplace stopping smoking programs have varied with employees attending them with mixed motivations.

There were those who attended because they:

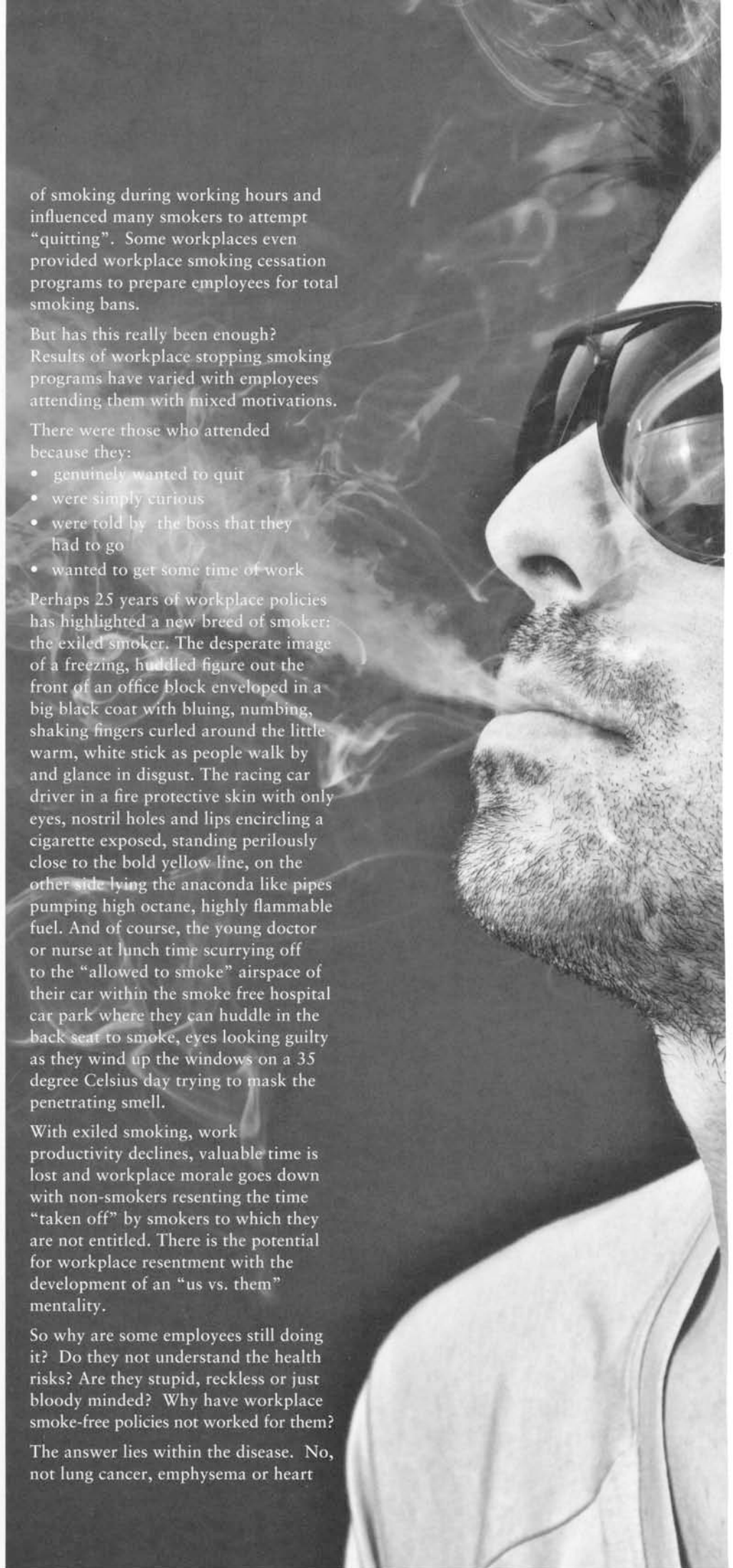
- genuinely wanted to quit
- were simply curious
- were told by the boss that they had to go
- wanted to get some time of work

Perhaps 25 years of workplace policies has highlighted a new breed of smoker: the exiled smoker. The desperate image of a freezing, huddled figure out the front of an office block enveloped in a big black coat with bluing, numbing, shaking fingers curled around the little warm, white stick as people walk by and glance in disgust. The racing car driver in a fire protective skin with only eyes, nostril holes and lips encircling a cigarette exposed, standing perilously close to the bold yellow line, on the other side lying the anaconda like pipes pumping high octane, highly flammable fuel. And of course, the young doctor or nurse at lunch time scurrying off to the "allowed to smoke" airspace of their car within the smoke free hospital car park where they can huddle in the back seat to smoke, eyes looking guilty as they wind up the windows on a 35 degree Celsius day trying to mask the penetrating smell.

With exiled smoking, work productivity declines, valuable time is lost and workplace morale goes down with non-smokers resenting the time "taken off" by smokers to which they are not entitled. There is the potential for workplace resentment with the development of an "us vs. them" mentality.

So why are some employees still doing it? Do they not understand the health risks? Are they stupid, reckless or just bloody minded? Why have workplace smoke-free policies not worked for them?

The answer lies within the disease. No, not lung cancer, emphysema or heart



and blood vessel disease but the disease of tobacco smoking.

The International Classification of Diseases (ICD) has categorised three types of the disease of tobacco smoking.

1. Tobacco Use – Young people first experimenting with tobacco.
2. Harmful Use – (not addicted). People who smoke tobacco to achieve the positive and pleasurable brain effects from nicotine.
3. Tobacco Dependence – People who are physically and psychologically addicted to nicotine.

Nicotine is a drug, a very powerful drug. When someone smokes a cigarette nicotine enters the blood stream via the lungs. This creates a peak shot effect in the blood stream within just four seconds. Within just seven seconds nicotine has crossed directly into the brain and it is here that it has its major and immediate effects.

A feel good, reward like substance which naturally occurs in the brain called dopamine is released. This is responsible for the sense of pleasure that a cigarette provides. However, it is much more complex than that. A whole series of chain like chemical, brain reactions occur which typically vary from smoker to smoker. Another important brain chemical which is released is serotonin which has a very important function in modulating mood, the sense of feeling happy or sad. Nicotine directly causes the release of endorphins which provide a sense of calming and relaxation and also the release of adrenaline which provides a more stimulatory and “pick me up” effect. Most of this activity occurs in the mid section of the brain known as the limbic system. However, there are other important brain areas involved including the Pre Frontal Cortex. It is here that nicotine has the amazing ability to directly stimulate intellectual functioning including memory, concentration and decision making.

So nicotine has the power to effect performance at work. However, for the smoker who has tobacco dependence, it is the lack of nicotine that can negatively affect work productivity.

Nicotine is the most addictive drug known to humankind. One in three tobacco users will develop tobacco

(nicotine) dependence (addiction). This is more than those who become addicted to alcohol (1 in 20) and more than those who become addicted to heroin (1 in 5).

The Diagnostic and Statistical Manual IV of Psychiatric Disorders lists the following four criteria for tobacco dependence:

Use of nicotine is:

1. A primary behaviour – the need to smoke (self administer nicotine) is like the need to eat, sleep and drink water.
2. To maintain a blood level to which tolerance develops – with time, more of the drug is required to achieve the same effect of wellbeing.
3. To avoid withdrawals which cause relapse – because within only 40 minutes to two hours of smoking only a very tiny amount of nicotine is left in the blood stream and the smoker experiences acute nicotine withdrawal. The cigarette becomes an efficient nicotine delivery device to instantly relieve nicotine withdrawal.

There are four categories of nicotine withdrawal symptoms including those which are:

- Physical – headaches, constipation, mouth ulcers.
 - Cognitive – lack of concentration, memory loss.
 - Emotional – aggression, irritability, anxiety.
 - Behavioural – being fidgety, the sense of “needing to do something with my hands”.
4. In the face of known medical and social detriment – we’ve all seen the graphic ads on TV. Smokers have too. It tells you on the box that it is going to kill you. We now have explicit pictures on cigarette packets showing grotesque images of smoking related disease. Yet they still do it.

Smokers who have tobacco dependence have special brain cells which are highly sensitive to nicotine. In fact, these cells called receptors need nicotine to function properly. Take nicotine away, and you have a brain which cannot communicate its messages properly. The smoker experiences nicotine withdrawal and can therefore not function at work properly.

smoking

So the issue is that not all smokers are the same. Some have high sensitivity to nicotine (high dependence) while others only have a little bit of sensitivity (low dependence). Some smokers have no sensitivity to nicotine (tobacco users). Whether a smoker has high or low sensitivity to nicotine or none at all has nothing to do with a weakness of character, lack of will power or being slack. It is inherited, determined by a series of genes.

Workplace policies have been extremely effective in helping to reduce the total number of cigarettes smoked during workplace hours and have enabled many tobacco users, misusers and smokers with low levels of nicotine dependence to either quit or to smoke less. But smoking less does not necessarily equate with reduced harm to the employee. Smokers with severe tobacco dependence in the face of workplace bans will simply change the way they smoke the cigarette to extract exactly the same amount of nicotine. To do this, typically they will drag harder and consequently inhale greater amounts of carbon monoxide and tar.

The World Health Organisation classifies tobacco dependence as a chronic disease which involves periods of remission (not smoking) and relapse (back to smoking). During prolonged remission, brain receptors are able to desensitise (down regulate) to nicotine. However with relapse, re-sensitisation (up regulation) of brain receptors occurs very quickly. Workplace smoking bans are extremely important as the inhalation of nicotine via passive smoke exposure can also cause receptors to re-sensitise to nicotine and cause relapse to smoking, even years after quitting.

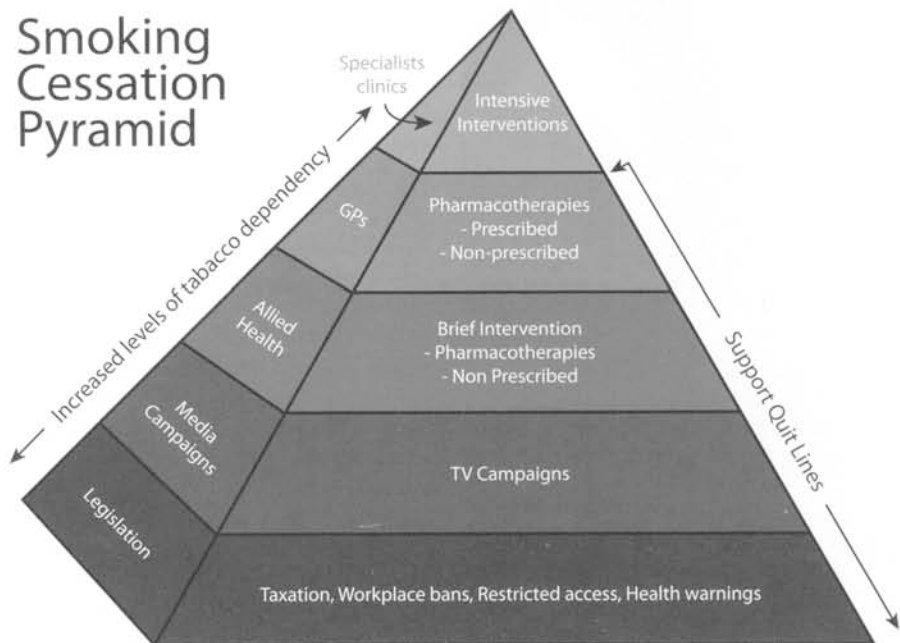
Relapse can also occur in the long term due to cue conditioning. Because inhaled nicotine is so short acting and smokers need to re-dose frequently during the day, smoking becomes easily associated with various daily tasks, behaviours and environmental settings. If the workplace is an environment where smoking is banned, it means that smokers learn to disassociate the need for a cigarette with their working environment.

So the remaining employees are doing

it not because they are defiant, senseless or stupid. They consist of a more “hard core” group for whom workplace policies have not adequately addressed the disease of tobacco dependence. The problem is that there is a lot of misinformation with regard to tobacco smoking. Even amongst some health professionals there is a lack of awareness between the different types of tobacco smoking and levels of nicotine addiction. Many doctors in hospitals typically prescribe from a “one nicotine patch fits all” perspective for inpatients who are not allowed to smoke. There is little concept of assessing nicotine dependence levels and tailoring medications to manage nicotine dependence to the individual’s level of addiction.

Similarly, in the workplace, if some employees were able to stop smoking when workplace bans were implemented, the expectation is that their still smoking colleagues should have been able to stop smoking just like they did. What both these examples highlight is that for remaining smokers, a higher level of clinical intervention rather than policy driven intervention is required.

This is summed up comprehensively in the following model of smoking cessation devised by Professor Renee Bittoun which highlights the change in interventions required with remaining higher dependent smokers:



The pyramid shows a hierarchy of smoking cessation. At the bottom of the pyramid are the broader strategies that may help smokers quit spontaneously while at the top are the more intensive approaches that may be required for the more heavily dependent smoker. (Bittoun, 2004)

Higher intensity interventions involve the use of combinations of evidence based medications to treat tobacco dependence. Evidence based medications are those which have been shown in clinical trials to provide the best clinical outcomes (biologically verified abstinence) at three, six and 12 months. These medications include:

1. Combination Nicotine Replacement Therapy (NRT) – such as nicotine skin patches, gum, lozenges, under the tongue tablets and inhalers. Unfortunately, there are many myths about NRT including:
 - “Aren’t I just replacing nicotine with nicotine and keeping the addiction going?”Wrong! NRT delivers nicotine very slowly unlike cigarettes which deliver it very quickly. It is the rapid delivery which causes the addiction. At the same time there is no carbon monoxide, tar or any of the other 4000 or so chemicals which have



been identified in cigarette smoke being consumed.

- “Doesn’t NRT contain dangerous levels of nicotine which can poison you such as 21mg in the patch when my cigarettes only contain only 0.8 mg?”

Wrong! NRT delivers a much lower blood concentration of nicotine. Typically smokers are under dosed which is why some will smoke at the same time. Others will refrain from smoking but will experience unpleasant “side effects” which have been misdiagnosed and are usually nicotine withdrawal symptoms which can be relieved by increasing the total amount of NRT being used.

2. Zyban and NRT

Zyban is a prescription medication. It works by inhibiting the release of dopamine (pleasure, rewarding brain chemical) in the midbrain on smoking. Smokers just lose interest in smoking. Zyban does not work for every one because different smokers use nicotine in different brain pathways and in different receptor subunits. Therefore in some individuals, Zyban may not be targeting the correct brain areas and so they will just keep smoking.

3. Champix and NRT

Champix is also a prescription medication. It works by targeting nicotine receptor subunits called alpha 4 beta2 so that no or at least less nicotine from smoking is required.

Similarly, Champix may not work for everyone because there are other nicotine receptor subunits involved in nicotine dependence.

So what roles do corporate managers play in the management of those employees who “continue to do it”?

The corporate manager’s role is extremely important. It involves implementing a series of measures which are instrumental in either helping those who continue to smoke to control their smoking at work, a concept known as harm minimisation or to quit smoking completely. These measures include the implementation of:

- Evidence based education programmes for smoking employees that explain tobacco smoking as a disease, the different types of tobacco smoking and the many differences between smokers.
- Evidence based education programmes for employees who don’t smoke to explain the reasons for exiled smoking behaviour and that it is not simply a time for “slacking off work”.
- Evidence based education for OH&S staff on recommending the use of NRT in the work place to assist smokers to control their smoking while at work without suffering the negative consequences of nicotine withdrawal which have the potential to affect their personal wellbeing and work productivity.
- A program conducted by an

accredited tobacco treatment specialist to help smokers minimise their smoking while at work or to quit completely.

- A service which provides subsidised NRT.
- A referral system through OH&S staff to more intensive evidence based treatment clinics.
- Designated time to attend more intensive tobacco dependence treatment clinics.
- Strategies to create a work environment which demonstrates a philosophy of encouragement and empathy towards continuing smokers in the workplace attempting to minimise or quit smoking during working hours.

The consequences of such measures can only be advantageous to the workplace. The key is a supportive and empathetic environment rather than a purely policy driven and punitive one. The overall effect can only be a positive one which safeguards the health of all employees, improves work morale and increases productivity.

One of the most effective ways to empower any workplace.

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CLINICAL HYPNOSIS

a long term solution to smoking

Many programs have been implemented to enable people to stop smoking, but so few achieve long term success. One of the major issues with some existing stop smoking campaigns is that they see smoking as a behaviour in isolation and fail to take into account the broader context and psychological issues that drive smoking.

Smoking is a central and important aspect of a smoker's life, so to quit is a major life change and far more complex than just stopping the smoking behaviour. Treatment requires all the attention and resources usually put into any other life changing event.

Psychological support for quitting smoking is rarely used, but can be essential in achieving long term success. This approach includes an understanding of the emotional role smoking has on a smoker's life, and the psychological impact of what it means

to stop smoking. While the logical understanding that smoking is killing them is evident, the fears associated with not smoking may be even greater. Seeking psychological help to stop smoking provides a safety net that softens the uncertainties associated with stopping smoking.

Clinical Hypnosis is a specialised and highly ethical form of hypnosis only available to medical and psychological professionals. This is a very powerful tool when used by a specialist psychologist who has an understanding of what drives smoking. This can enable the powerful change from smoker to non smoker in a way that is emotionally safe, gradual, and sustainable. Each smoker has their own unique reasons to both continue, and to stop, smoking. Understanding these reasons, and the psychological attachment to smoking, enables each Clinical Hypnosis session to be tailored to meet each person's individual needs.

Clinical Hypnosis has been extremely well researched, with studies showing definitive changes in brain waves patterns during hypnosis that are different compared to the waking or sleeping states. During hypnosis a person is in a trance state where they are sensitive to suggestion in both the conscious and subconscious mind. When a smoker is in a hypnotic trance, they relax and gently and safely allow themselves to no longer smoke.

At the Centre for Human Potential Dr. Stephanie Stephens uses Clinical Hypnosis and specialises in smoking cessation. She coaches individuals in an Employee Assistance Program and runs 'Group Coaching for Smokers' workshops in organisations, where people are able to gain understanding and insights into their smoking. Dr. Stephens also uses the same powerful tools for weight loss, sleep difficulties, stress, and confidence building.



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