



The Australian Hypnotherapy Journal

The official journal of the AHA & its member associations ASTA & ASOCHA

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Letters to the Editor should be clearly marked as such and be a maximum of 200 words.

Editor: Chereyl Jackman

Proof reader: Bruni Brewin

Front Cover: Sunset at North Lakes, Queensland

President's Report

Mailin Colman

Greetings, AHA members,

State AGM's

As of the 12th of June all state AGM's are complete. As my first "solo" tour as president around the states, I am delighted to report that it was a wonderful experience for me in that I was able to put so many faces to names. Having covered Amanda's maternity leave over the last 6 months or so, I have spoken to many, many members both long term and new and this also has been such a worthwhile experience giving me insight into what is working and what is not working within the AHA. Attending the AGM's just capped that experience by being able to meet so many of the members I've spent time with over the phone.



I'd really love to take this opportunity to thank all of the state committees for looking after me so well and the members for giving me such a lovely welcome in WA, NSW, Victoria and QLD.

There are several new committee members in each state and the AHA website will be updated very soon. The new committee members are listed in the directory towards the end of this journal so please familiarise yourself with the new volunteers and make them welcome.

National AGM – 30th June, 2016

The national AGM will be held somewhere different this year – Adelaide! This will be held on the 30th of June and information will be sent out to all members in the next few days. Once again, I look forward to spending productive time with the national committee, the state SEO's and meeting as many of the South Australian members as possible.

AHA Renewals

The renewal period has passed and I am so pleased to say that it was a far easier process this year than last. I wish to sincerely thank the AHA members for embracing the AHA members' database and allowing this experience to be so much more pleasant for us all this year. For those members who may still be struggling with aspects of the database, please do not hesitate to contact our national administrator, Amanda Healy or myself – we are always more than happy to assist.

NHRA

The AHA has discussed this register on numerous occasions and it has been minuted several times that changes are required to this register accessed by the general public. I'm very happy to announce that this is now in progress. Our database designer is working on processes whereby the NHRA will be linked directly to the AHA members' database so that once information is updated in the database, this will be updated in real time to the register. This is taking some time as the new system has to be written very carefully to link information relevant to the public without compromising member privacy so please bear with us and join the national committee in celebrating the fact that this positive change is underway. I'm sure Antoine will be delighted with the reduction in his workload and the AHA members will be relieved once the new system is up and running.

Wishing you all a pleasant and prosperous winter ahead – stay warm and busy!

Warmest regards,

Mailin Colman

AHA President

AHA website: <http://www.ahahypnotherapy.org.au>
National Hypnotherapists Register Australia: <http://www.national-hypnotherapists-register-australia.com/>
http://www.national-hypnotherapists-register-australia.com/listing_changes.htm
AHA guidelines & policies: http://www.ahahypnotherapy.org.au/aha_members_area/
AHA Submissions to Government: <http://ahahypnotherapy.org.au/submissions-to-government/>

Keeping in touch ...



<http://www.hypnotherapycouncilofaustralia.com>



http://www.psh.org.au/about_psh.htm



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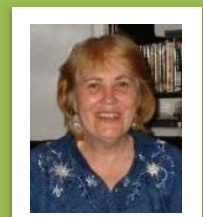
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Book Review 'The Feeling of What Happens'

Author: Antonio Damasio
Distributor: Houghton Mifflin Harcourt (1999)
ISBN: 978-0-15-100369-3
Reviewed by: Michael Masani



If you are looking for the latest ideas and research into the nature of feelings and consciousness, told by one of the world's leading neuro scientists who also happens to be a great storyteller, then I recommend this, Damasio's latest offering.

Among his many case studies is David, a patient of Damasio's for over 20 years, who had extensive brain damage and was unable to learn any new fact at all. His was one of the most severe defects in learning and memory ever recorded. David was engaged in an experiment to assess what parts of his memory were still functioning. He was asked to perform tasks by three different people on separate occasions. The first person was warm and friendly, (the 'good guy') the second was neutral and the third (the 'bad guy') was brusque and refused any request from David.

When questioned later David had no memory of these events. He was shown photos of the three people and asked what he knew about them. Nothing came to mind. When asked, 'whom would you go to if you needed help?' and 'Who do you think is your friend in this group?' David chose the 'good guy' 80% of the time and the 'bad guy' was almost never chosen - clearly not a random selection. He had no recollection of any instance when he had interacted with these people, but when he was asked who, among the three was his friend, he consistently chose the 'good guy'.

According to Damasio there was nothing in David's conscious mind that gave him a reason to choose the 'good guy'. His non-conscious preference related to the *emotions* induced in him during the experiment. His emotional brain was recording memory even though he had no episodic memory. Damasio goes on to say the 'bad guy' was actually a young, pleasant and beautiful woman, but no amount of natural beauty could have compensated for the negative emotion induced by the 'bad guy' manner. (This idea that emotional memories can exist independently of episodic memory may have great significance for therapy – particularly in regard to generalised anxiety disorder.)

Damasio describes how emotions originate within the subconscious and can be induced in a non-conscious manner. He describes how emotions are induced both by direct experiences and by memories that re-present experiences in thought processes.

He gives examples of indirect inducers of emotion, such as the blocking of an anticipated pleasure and the sudden suspension of pain or fear. He illustrates the latter by reference to Alfred Hitchcock and claims, 'whether we like it or not, we feel very comfortable after Janet Leigh stops screaming in the shower and lies quietly on the bathtub floor.'

Damasio talks of 'feelings that are not conscious' and how 'background emotions' can be detected from posture, speed of movement and contracted facial muscles. There are fascinating chapters on core consciousness and extended consciousness. He poses the question 'how does consciousness come into being?' The answer, according to Damasio, is through emotions, or proto-emotions in the first instance.

This is a truly well informed, multi-layered approach into what makes us who we are. I must admit there were times when my eyes glazed over trying to comprehend the detail of brain anatomy. However his refreshing embrace of the phenomenon of consciousness makes for a readily accessible read - even if you do not know your homunculus from your prefrontal cortex!



Alternative Solutions

Bruni Brewin

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Australian Institute for Health and Welfare (AIHW)

About 1 in 200 people in Australia sought treatment for alcohol and other drug use in 2014-2015, with just over half of those (54%) reporting more than one drug of concern, according to a report released by the Australian Institute for Health and Welfare (AIHW).

New data in the report *Alcohol and other drugs treatment service in Australia, 2014-15*, show that about 115,000 clients received more than 170,000 treatment episodes over the year from 843 agencies across Australia. While alcohol (38%) continued to be the main drug clients sought treatment for, amphetamine treatment doubled from 9% to 20% between 2010-11 and 2014-15.

Over the last decade, alcohol, cannabis, amphetamines and heroin continued to be the most common principal drugs of concern in Australia.

Alternative Solution?

If you suffer from any of the above symptoms, contact a trained Hypnotherapist in your area who may be able to help you release these addictions.

Contact the Hypnotherapy Register of
Australia (HRA):

<http://www.national-hypnotherapy-register-australia.com/>

FOR AHA MEMBERS ONLY ...

HAVE YOU JOINED THE AHA DISCUSSION GROUP?

Nothing could be simpler

By joining the AHA discussion group forum you gain access to the largest membership of any hypnotherapy association in Australia, a huge resource of sharing ideas to benefit our practices. It helps all members, no matter which State you are in, whether you live in a CBD or Rural District – each of us are able to communicate and share ideas and knowledge with every other member.

It's as simple as writing an email, just like you do when writing an email to a friend.

Your forum email address is:

aha-Discussion@gogglegroups.com.

When you are a member of the forum, you receive posting from other members, as well as being able to post yourself. You can decide whether to respond to an email to be helpful, or watch other responses, or just delete the email if you have no interest in the topic of discussion. These postings can include requests for help with clients, interesting articles, and other discussion topics of interest to your hypnotherapy practice.

The one rule we have is that you do not post advertising (your own or links that have advertising of their own or someone else's business, workshops, etc).

Advertising can be placed in the Journal. Refer Australian Hypnotherapy Journal Advertising Guidelines in 'Contents' page for details of fees and page number.

We would like to see all members being involved, so if you haven't joined us yet, send an email to my personal email address:



AHA Discussion Group

Jeremy Barbouttis

02 9518 9912

jeremy@exemail.com.au

... and I will verify that you are an AHA member and add you on. (You are required to do this before you can receive or post any messages.

Why isn't therapy always successful for my clients?

Karen Bartle

We've all had clients who leave our sessions with the best of intentions and the necessary conditions to succeed, only to become frustrated because they have re/lapsed sometime later. Once they leave, it becomes their responsibility to implement the agreed changework right? Well, for decades, the notion of who is responsible for the client's changework has been a hot topic for debate. However, whilst debating whether it's the therapist's role, or the client's responsibility, what is often ignored are other factors beyond the therapy room which the therapist or client are unable to control and which can impact the efficacy of therapy.

The debate is usually driven by a genuine desire to see clients progress. But also, it is sometimes due to insecurity in therapists who either feel they are a personal failure when clients do not progress, or the choice of therapy/intervention perhaps wasn't the right one, or it's to do with the clients 'resistance', 'secondary gain', 'defence mechanisms', 'lack of motivation', and a host of other psychological reasons that absolve the therapist from the responsibility that they feel they should be taking.

Because of all the contradictions, we sometimes get ourselves into a bit of a trap. When a client does not obtain a result, we sometimes take responsibility, embarking on a reflective journey to assess what we could have done better. When a client succeeds and thanks us we tell them it was *their* hard work that brought about change, and that we only gave them the suggestions we felt they had already asked for. We minimise ourselves in an attempt to leave them feeling empowered. And yet really we want to celebrate, and we often do, of course, once they have left.

While we get caught up in the either/or bind of who is responsible, client or therapist, we miss two things. One, the therapeutic relationship is a partnership – a dynamic 'both/and' rather than 'either/or'. And two – our main focus here – the debate excludes a whole range of other factors that are important in therapy. These are collectively known as 'extra-therapeutic factors'. Although some factors are under the control of either client or therapist, many are not.

According to Miller, Duncan and Hubble (1997), in their book *Escape from Babel: Toward a Unifying Language for Psychotherapy Practice*, extratherapeutic factors are actually largely responsible for the success or failure of therapy. According to Lambert (1992) extra-therapeutic factors account for 40% of therapeutic outcome, the therapeutic relationship accounts for 30%, therapeutic technique 15%, and expectancy and placebo 15%. Even such cherished notions as the importance of the length of a therapist's professional training, or the style of therapy employed, are, it seems, relatively unimportant compared to these factors.

According to Howard, Kopta, Krause and Orlinsky (1986) research has estimated that 15% of clients show measurable change prior to their first appointment. Weiner-Davis, de Shazer and Gingerich (1987) reported 66% in a study of 30 clients. The latter study was replicated by Lawson (1994) who reported 60% over 82 clients. Clients who experience pre-treatment change are four times more likely to complete their treatment in psychotherapy (Beyerbach, Morejon, Palenzuela and Rodriguez-Aris, 1996).

Where change is of a client's making, it is important they are able to take credit for this. Research shows that those who take credit for their own successes will maintain their gains. Where people are given a placebo substance, those who attribute success to their own efforts are more likely to maintain success, while those who attribute success to the placebo substance are less likely to maintain their gains (Frank, 1976; Liberman, 1978).

Statisticians amongst you will be familiar with the term 'regression effect' or 'regression towards the mean'. Exceptional and extreme results on one measurement have a tendency to move towards the norm on the next. So, a client with severe anxiety on one session may find this less severe on a later session. Both client and therapist may celebrate their excellent work and yet this may well have occurred anyway, without intervention. A hypnotherapist might celebrate their wonderful healing powers when helping a client to heal after an operation. However, the body regresses back from abnormal states (cuts) to its normal state with or without the hypnotherapist's help. According to Miller, Duncan and Hubble (op. cit.) 40% of people on waiting lists for psychotherapy improve.

Miller, Duncan and Hubble (op. cit.) provide another interesting example of the influence of extra-therapeutic factors. A man was attending therapy, without success. He and his partner had not spoken to one another about anything other than business matters for two years after an enormous argument. They

slept in separate rooms. Family came to visit and they lost track of time. It was too late for family to drive home or book a hotel room so the couple had to sleep together to free up a bedroom for them to stay the night. They talked about things other than business and even made love that night. They both turned up to the next therapy session to say things had moved on swiftly. A few sessions later therapy was complete.

In another example they cite a client who was self-described as 'desperately neurotic'. She had heard about Milton Erickson's great achievements as a therapist and wanted to see him. However, she couldn't bring herself to talk to him about her problems face to face. So she asked him if he would allow her to drive up to his house and park in the driveway and just imagine he was in the car talking about the best way to solve the issue. He agreed and she solved her problem after a couple of visits without his direct input.

Here are some more extra-therapeutic factors:

Client History	Client Identity	Social & Environmental factors	Fortuitous Events	Support Structures	Client Psychology & Biology
Achievements	Age	Family relations	Deaths	Family	Comorbidity
Failures	Sexuality	Romantic partners	Injuries	Friends	Nutrition
Divorce	Sex/gender	School experiences	Accidents	Caring professionals	Hygiene
Abuse	Religion and spirituality	Friends	Illnesses	Partner	
Neglect	Culture	Sexual partners	Financial gains	Colleagues	
Racism	Social status	Employment experiences	Financial loss	Managers	
Prejudice	Ethnicity	Hobbies/interests		Mentors	
Poverty	Dis/ability	Exercise/recreation			
Childhood		Mentors & role models			
Drug use					

Many of these factors also need to be thought about along a time axis, in terms of the past, present and future.

Most of the extra-therapeutic factors are quite straightforward and obvious in their impact. Support structures, however, are often taken-for-granted as unproblematically useful in the talking therapies. Let's therefore offer a critique.

Having family, friends, colleagues, a partner, a manager, a parent, or a mentor supporting the client can bring many benefits. It can help them to stay focused and engaged with therapy and change. Support can mean that therapy is not an isolated island visited once a week, but rather, an ongoing effort, as the supporter can help a client through difficult patches between sessions, and help them to value and attend therapy and recognise changes they may not have noticed by themselves. And a supporter provides the client with someone to celebrate and share their successes with.

On the other hand, support can be a real disadvantage. Support can be withdrawn, for example, when a friendship ends, when the supporter can no longer cope or has troubles of their own that need prioritising, or when they withdraw support out of spite or ignorance. This leaves your client with a sudden demand for finding another supporter or going it alone. Support can also be dramatically lost when a supporter dies. As well, support can encourage dependency either because the client, the supporter, or both, benefit from this.

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Karen Bartle

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Gestalt and Existential Work

Georgina Mitchell

On the 5th of June 2016 I had the great pleasure of attending the AHA Workshop entitled “Gestalt and Existential Work.” The workshop was delivered by Peter Harris. Peter is a Psychotherapist, Counsellor, Clinical Supervisor and Counsellor Trainer with a Master’s Degree in Gestalt Therapies. Peter works in inner city Sydney applying his skills to assist clients in holistic change; many of his clients have comorbidities in homelessness and various mental health conditions.

Peter’s presentation was both engaging and informative, beginning with the premise that “Through awareness comes choice”. Some of the “take-aways” I got from Peter’s workshop were as follows:

In delivering Gestalt Therapy, the therapist is there to support, not drive, the client’s experience. The client goes through a process of measuring via a cost/benefit analysis e.g. measuring the cost of maintaining a behaviour or course of action against its benefit and using this exploratory process to help with their subsequent choices. The therapist holds in their own awareness that context influences experience and with this in mind is careful about the influence their presence and responses may have upon the clients experience and outcome in therapy.

According to Gestalt Theory there are three zones or levels of awareness. The Outer Zone which is the world we experience around us via our senses (sight, smell, hearing, taste and feelings), the Inner Zone where things such as hunger, tiredness, pain and thirst reside, and finally the Middle Zone which is described as the land of thoughts and feelings. The Therapist may choose to draw the client’s awareness to the different zones during the session, often beginning any experiential part of the session by grounding the client in their inner zone through focus on deep relaxing breath.

In Gestalt therapy the therapist is slow to label and allows instead the client to come up with their own interpretation as they organise their understanding of their experience. The therapist strives to create a safe and non-judgemental space in which the client feels able to present their full self rather than an edited version; the therapist is there to ensure that where the client may have previously felt shamed i.e. un-met and unsupported, that in the therapeutic setting they experience the opposite. A client often enters therapy wondering “what can I ‘be’ here” so the therapist through building their relationship strives to let them know that they can be exactly who they are i.e. the sum total of all their component parts. Gestalt is a concept of completion whereby all the elements of self are enabled to work together in harmony.

Gestalt promotes more equality in the relationship between therapist and client than some other more directional therapies e.g. CBT. That said in Gestalt it is the client that does most of the work, “if you’re working more than the client, stop!” Sometimes therapy may therefore include long silences; these can create more space for awareness.

During the workshop Peter demonstrated two techniques, first the cushion technique and then a two chair technique. In the cushion technique the client selected a cushion to represent themselves and placed it on the floor, they then selected more cushions, each of which represented a component part of the issue they wanted to focus on. They then placed them on the floor as they deemed appropriate; in the example demonstrated the cushions were named e.g. safe, boring, scared. In this process the client was encouraged to move around and interact from the point of view of the cushion they chose with other cushions of their choice. The therapist gently witnessed this process, occasionally asking exploratory questions e.g. “How would it feel if...?” or making gentle suggestions. When the client appeared satisfied they were asked if “anything felt undone?” The 2nd demonstration involved the client sitting in a chair with an empty chair alongside them, the chair that they were in represented (to them) security, while the other chair represented passion. The chairs were then placed opposite each other and the client moved between them and spoke from the perspective of what each chair represented using “I” statements. Both clients experienced increased clarity as a result of their brief sessions.

I would highly recommend that you attend any future workshops delivered by Peter, and would like to extend my thanks to the AHA committee for organising such a valuable and enjoyable workshop.

Written by **Georgina Mitchell** - Hypfocus: Therapies and Training. Membership No: PM2015096
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Change – We can all do it.



Change is one of those things that is constantly present and is all around us, just like the four seasons.

Whether it is the environment, our ageing process, our physical health, our friendships or relationships, one thing is certain, there is always change going on. It can either be subtle or 'in your face'. Change can be stressful, but it always provides us with an opportunity to grow our spirit.

One of the unique factors of being human is that we not only have an enormous ability to change, we also have the ability to be aware of changes within ourselves and others. This ability stimulates the human psyche to adapt and accept life's challenges.

We are all unique and some of us embrace change quickly whilst others struggle. Change can trigger many emotions. For example, if you move countries, cities or towns – this change can trigger feelings of grief and loss for the familiarity of people and places left behind. This grieving can continue until one establishes a 'sense of belonging' in the new place.

So how do People Change?

Knowing the process of change can be helpful. Research on change has shown that often people have to attempt change several times before it becomes permanent.

This can be explained by the 'Stages of Change' model which was developed in the late 70's by researchers Prochaska and DiClemente – the main points are:

- Change occurs gradually and relapses are an inevitable part of the process. People often begin by being resistant and feel they have no control.
- Then there comes a stage of '**Contemplation**' in which people begin to see the potential benefits, but there remains conflict and ambivalence often marked by a feeling of having to give something up. This stage may last a long time.
- The next two stages are called '**Preparation**' and '**Action**' in which there may be some experimentation with small changes, collecting of information and even some writing down of goals. You are more likely to move through '**Preparation**' into the '**Action**' stage if you write down goals, prepare a plan of action and seek some support and motivation. During the Action stage, make sure you keep yourself motivated by rewarding your successes and developing a list of motivating statements.
- The next stage is '**Maintenance**' of the new behavioural changes. During this stage you may feel confident especially if you have remembered to reward your successes. If you do relapse, don't be too hard on yourself. In any behavioural change, relapses are common. Identify the triggers and take steps to overcome them. Reaffirm your motivation, plan action and commitment to your goals.

Get fit for change

Dealing with change depends upon your adaptability and your capacity to see things in new ways. In the same way as you might train for a marathon starting with little jogs, you can train for big changes by practicing little ones. Often our well-worn habits are the main blocks to seizing the opportunities of change. Do something different each day to break those habits and get fit for change e.g.

- Take a different route to work tomorrow.
- Spend your lunch hour in a totally new way.
- Next time you are in a restaurant order something you've never ordered before.
- Get up earlier and go for a walk.
- Move your desk.
- Plan to do something this weekend you've never done before.
- Volunteer to do something you wouldn't normally do.
- Ask somebody a question you've always wanted to ask.

A few change quotes:

"If you change the way you look at things, the things you look at change." [Wayne Dyer](#)

"The only way to make sense out of change is to plunge into it, move with it, and join the dance." [Alan Watts](#)

"Everyone thinks of changing the world, but no one thinks of changing himself." [Leo Tolstoy](#)

Chris Newell: Counselling, Psychotherapy, Hypnosis & Nutrition. 0412 269 995



Depression: Myths and Stigma

Isabella Parker, Clinical Hypnotherapist

It isn't all that long ago - probably as little as fifty years ago - that anyone experiencing *non-endogenous depression* (see 'Types of depression' below) would be labelled as having a 'nervous breakdown' and could be 'put away' indefinitely in a 'mental asylum'. They would quite likely be treated with electric shock treatment, the forerunner of today's electroconvulsive therapy (ECT). It was a simple procedure to have a depressed family member or a wife 'put away', requiring just a couple of signatures of family members.

They were regarded as 'crazy' and as anyone who has experienced an episode of depression can attest, when you feel depressed and are already afraid you *are going crazy*, and unsympathetic or unsupportive family or spouse tell you that you *are crazy*, it just confirms your own fears. Hence, the prognosis was not always very good for anyone who was unfortunate enough to be 'put away'.

These patients with a 'nervous breakdown' were mainly women, hence the view that women were weaker and more at risk of depression. Of course men had 'nervous breakdowns', but their depression was hidden by alcoholism (ie, self-medication with alcohol). Anyone who recovered from a 'nervous breakdown', particularly if they had been *put away in a mental asylum*, lived with a dark cloud hanging over their head and the stigma remained for the rest of their lives. As a child, I recall hearing, in hushed tones, the comments referring to individuals who had at some stage in their life had a 'nervous breakdown' and had spent time in a 'mental asylum'. These people seemed to be branded for life as being fragile and mentally defective and were not expected to be capable of meeting the demands of everyday life.

Even in the not-too-distant past, hypnotherapists were advised to not treat people with depression - or any *other* mental illness. Hardly an endorsement for a profession that is supposed to understand the mind! The fact is that patients with depression are no different from any other hypnotherapy clients. They have the same issues and the only difference is that the unresolved 'issues' of the depressed person have not been acknowledged or have been ignored too long and allowed to 'progress' to precipitating a depressive episode. Another fact is that those with bipolar disorder and schizophrenia can benefit from hypnotherapy since they are not immune from psychological and emotional 'issues'. Caveat: Don't try this during a manic or psychotic episode!

Challenging the stigma

While hypnotherapists are no longer afraid to treat depressed clients, has anything really changed? People with depression are not 'put away' anymore - but then, schizophrenic patients with scary unpredictable violent behaviour are no longer committed to an asylum either, but are allowed to live in the community. There is still undeservedly a stigma attached to depression, perhaps mainly due to the ongoing erroneous view that people who become depressed have a genetic flaw or are weak and unable to cope with life. Further, there is the view that they are 'not responsible' for their actions, promoted by lawyers grasping for a defense for their clients' criminal or anti-social behavior.

First, let's clear up some misconceptions. Contrary to the common view, the reality is that being 'weak' is not a risk factor for depression and being 'strong' is not a protective factor. The issue of strength, or lack of, is completely irrelevant. 'Strong' people may sometimes be at increased risk because they ignore their own needs, put the needs of too many others first and take on too many responsibilities that are not really theirs. They may stoically put up with untenable circumstances for too long and create 'life traps' for themselves. Caught in a trap of old patterns of responsibility to and for others, they feel 'hopeless' and 'pessimistic' that the situation will ever improve, and 'powerless' to make the changes required to improve the situation or escape that trap. And then the *higher self* takes over and says, "Enough"!

Periodically, there are calls to increase awareness of depression and remove the stigma so depressed people will seek treatment rather than suffer in silence and be at risk of suicide. Ironically, contrary to this stated desire to reduce stigma, it is the *media and spokespersons for the medical profession and mental health* that actually perpetuate stigma. They do this by persisting in referring to depression as a 'mental illness' or a 'mental disease' or a 'psychiatric disorder'. However, depression is classified by DSM as an 'affective (mood) disorder'.

In addition, like having a criminal record, having a medical history that includes a diagnosed episode of depression, even if it is just non-endogenous depression, may brand a person with the shame of having a lifelong 'mental illness', resulting in being regarded as unsuitable in certain areas of employment. Ironically, individuals without a 'history'

who are chosen for those employment positions may be at equal risk of having an episode of depression if confronted by adverse life circumstances.

Added stigma is the use of a 'mental illness' (ie, depression) as an excuse for high profile 'celebrities' engaging in anti-social behavior or people committing crimes such as fraud, as if depression is responsible for bad behavior or losing their moral compass or losing control over their behavior. A person in the manic phase of bipolar disorder may engage in 'out there' behavior and ignore the social norms, but a depressed person won't. Impaired cognitive function when severely depressed may lead to some *unwise* decisions in business, personal finances, relationships or driving a motor vehicle, due to *un-thought-out* decision making and slowed responses, but definitely not the kind of criminal decision making that involves motivation and sustained high-level cognitive functioning necessary for planning, secrecy and ongoing deception.

The only people depressed individuals are likely to murder are themselves, ie, suicide. I suggest that a mother with severe 'post natal depression' who commits suicide because she cannot see any other solution, and kills her children first, is not committing murder as such. She is acting on her mother instinct to *not abandon* her children and is *taking them with her*. (This does not include *clearing the way for a new boyfriend* or the non-custodial parent *seeking revenge* on the custodial parent after a relationship breakup).

Stigma of depression is caused by misunderstanding, misrepresentation, ignorance and a desire for society to separate or distance itself from what is feared or not understood – and what is not understood is feared. Pathologising depression as a 'mental illness' does nothing to *empower* 'patients' or promote *understanding* by society. Instead, it *disempowers* the 'patient' and prevents understanding, thereby legitimizing the fear and distancing by society. However, the truth is that there is no 'us' and 'them'. Given the right (or wrong) circumstances such as experiencing a major loss or a set of chronic or acute adverse life events, plus lack of support and 'no light at the end of the tunnel' and feeling powerless to change the situation, *anyone* can be vulnerable to experiencing an episode of non-endogenous depression. This is 'normal' and 'natural', can be 'worked through' or treated, and is not to be feared and not to be stigmatized.

The mental health profession is not spared this ignorance although it may in part be due to backing by pharmaceutical companies. I spent quite a few years working as a research psychologist at a mood disorders unit which carried out research on depression and was a *tertiary referral* unit for 'treatment resistant' depression. Of course, there is no such animal as 'treatment resistant' depression – just depression that has been incorrectly diagnosed and treated – generally that meant focusing on trialing various classes of antidepressants whilst ignoring the need to address psychological issues. I used to be horrified at the patient histories that included numerous antidepressants and multiple ECT treatments - and recommendations at the unit were 'tweaking' medication dosages and even more ECT – even when it was obvious to Blind Freddie that there were psychological issues that were being ignored.

Types of depression

There are two basic types of depression: *Endogenous* or *biological* depression, which includes 'melancholia', 'bipolar disorder' and 'psychotic depression', accounting for about ten percent of depression cases. The other ninety percent of cases are *non-endogenous* depression, which is *psychological-situational* in nature. This may be sub-typed by personality types or cognitive styles which are regarded as being at a higher risk of experiencing depression as a reaction to adverse life circumstances or a propensity to subconsciously attract or create 'life traps' for themselves.

Depression is considered to be hereditary, with 'family history' of depression being regarded as evidence. There may be a genetic predisposition to *endogenous* depression. However, what is more likely 'inherited' when there is family history of *non-endogenous* depression is *role modelling* of learned dysfunctional thinking and ineffective coping styles (which may include reliance on medication, cigarettes or drugs and alcohol to cope). There may be a family history of unresolved emotional issues or adverse life circumstances or learned patterns for getting into or creating unhappy relationships or being stuck in life situations that turn into *traps*.

Post Natal Depression:

Is post natal depression *endogenous* or *non-endogenous*? Undoubtedly there is a role of neurotransmitters and perhaps hormonal changes interfere with this balance. However, my clinical experience is that there is generally some *pre-existing* psychological issue or emotional problem or unresolved childhood stuff that the woman has been coping with relatively successfully. With the birth, the combination of biochemical changes and challenges of changed life circumstances may overwhelm her normal coping mechanisms, precipitating an episode of depression. There may be surprise when 'strong' or successful career women succumb to PND, but then, these women can also have unresolved 'stuff' which has been pushed down into their subconscious mind or even used as their driver for achievement such as a need for parental acknowledgement.

Young fathers may also be at risk of post natal depression, particularly if they have a sensitive or anxious personality style and *perceive* their partner to not be coping very well with the new baby. With the focus generally being on the new mother, vulnerability of a new father may be overlooked. He is unlikely to speak up because he is supposed to be strong and supportive for his partner. Male brains are hardwired to be the ‘problem solvers’ but if their partner has post natal depression, they cannot provide a solution that will resolve her depression, but that may not stop them feeling they are inadequate and failing her.

A report on a small local study revealed that some fathers felt ‘marginalized’ in the birth process and after a difficult birth, some fathers experienced symptoms of Post Traumatic Distress Disorder and some were so traumatized they considered having a vasectomy (but were probably too squeamish to go through with it)! Gee, toughen up, guys! If men are inclined to be squeamish and feel traumatized by watching a difficult birth and feel marginalized because there is no clear role for them, perhaps we should go back to the ‘old days’ where men were kept out of the way by being sent off to ‘boil water, lots of water’.

Models of non-endogenous depression

Medical Model:

The view of a ‘medical model’ of depression of both endogenous and non-endogenous types is that depression is caused by lack of or insufficient available neurotransmitters (such as serotonin) involved in mood regulation. This rationale is based on the effect of anti-depressant medication in alleviating depressed mood by a process of making the serotonin more available in nerve synapses in the brain.

However, a significant point overlooked by proponents of this model is the warning given in basic statistics in Research Methods 101 to ‘not confuse causation with correlation’. Or, is it ‘not confuse correlation with causation’? While depression is associated with reduced availability of neurotransmitters, this is just an *intermediary mechanism*, rather than the *cause*. This simplistic model fails to address the etiology back far enough to ask the questions: What causes the deficit in available serotonin? For *non-endogenous* depression, what role do psychological factors play?

Research has demonstrated that for depressed patients who improve after some form of psychotherapy - *without* intervention by anti-depressant medication - *neurotransmitter function returns to normal* (Antonuccio & DeNelsky, 1995). So, for non-endogenous depression, what *causes* the deficit in neurotransmitter function?

Mainstream medicine acknowledges the impact depressogenic circumstances has in *precipitating* a depression episode and also acknowledges the impact stress has on neurotransmitters such as adrenaline and cortisone in the body. Hence, it isn’t all that much of a stretch to consider that severe or prolonged stress of depressogenic life circumstances can interfere with function of mood regulating neurotransmitters such as serotonin. Therefore, although antidepressant medication may *relieve symptoms* of depression to some degree, if the patient is to achieve satisfactory recovery, these *precipitating* life circumstances need to be addressed. To reduce risk of relapse or recurrence, psychological *risk factors* and any *distal causal factors* (such as unresolved childhood ‘stuff’) also need to be identified and addressed.

The question of *what causes the deficit in neurotransmitter availability in synapses* can also be appropriately asked of endogenous depression. The answer may not be as obvious as it is for non-endogenous depression. Current treatments merely *manage the symptoms* which in itself, suggests that the real cause has not been identified.

When patients with non-endogenous depression recover without receiving treatment, the medical explanation is that the depressive episode ‘ran its course’ or went into ‘spontaneous remission’ which happened as if by magic, or dismissed as the patient having ‘not really been clinically depressed’ in the first place. Although there is some recognition that psychological factors *increase risk* of depression and that depressogenic circumstances play a role in precipitating non-endogenous depression, there appears to be little acknowledgement that *changes in these factors* occurring, without medication, can lead to recovery. The actual reasons for this so-called ‘spontaneous remission’ are likely to be something *real*, such as: (i) the depressogenic situation has resolved itself, (ii) the patient has taken control of their life by confronting and resolving the situation or (iii) had a ‘light bulb’ experience of awareness which has resulted in change in attitude that results in regaining a sense of empowerment.

Personality and Cognitive models:

Negative cognitive style in interpreting events and personality style such as anxious-worrier, while not seen as causal, are regarded as ‘risk factors’, considered to increase vulnerability when stressful life events occur. While personality types and cognitive models of depression are generally approached from different perspectives, any differences are merely in the labelling since they can all generally be identified as having their origins in learning from childhood experiences and circumstances.

For example, if during childhood, nothing much positive ever happened but there were distressing or catastrophic circumstances in which the child felt powerless and unsupported, then it is hardly surprising if that child grew up to view life stressors with anxiety or hopelessness and had negative expectations. Alternatively, these experiences of having to cope with adverse life circumstances from a young age may also foster development of resilience, which may serve as a protective factor against depression. So, the good news is that having a negative view of life such as 'shit happens' or 'life sucks' or an anxious-worrier personality does not mean that an episode of depression during the lifetime is inevitable.

Personality is regarded as part temperament (genetic) and part childhood environment (learning) so the learned component may be responsible for much of the 'vulnerability' for depression, or getting 'trapped' in depressogenic circumstances, rather than the genes. Therefore, these 'types' or 'styles' or 'risk/vulnerability factors' are represented by 'child ego states' which is useful for therapists who work with ego states to know. An example that illustrates a 'dysfunctional cognitive style' which is represented by a child ego state is 'atypical depression'.

Atypical depression -

Typically, depressed patients experience loss of appetite and weight loss. However, some experience craving for carbohydrates (ie, high-calorie food), subsequently putting on weight so they are diagnosed as having 'atypical depression' (Parker et al, 2006). This consumption of carbohydrate has been described as 'self-medication' which has been explained by the 'serotonin hypothesis'. This is a view that eating carbohydrate results in release of *serotonin* (a neurotransmitter), an action similar to that of antidepressant medication such as Prozac. However, this hypothesis has been found to be flawed since the carbohydrate foods consumed also generally contain some protein and/or fat which interfere with the serotonin-releasing action.

A key psychological feature identified in patients with atypical depression is 'interpersonal rejection sensitivity'. This would be represented by a child ego state who felt unloved or rejected by parents, which sensitizes the individual to experiences of rejection or *perceived* rejection by others. The weight gain associated with atypical depression is neither a feature of a valid subtype of depression nor an example of 'self-medication' to release *serotonin*. Instead, quite simply, it is an example of 'comfort eating', releasing *endorphins* which produce brief 'emotional analgesia'. This is an attempt to deal with *both the depression and the feelings of being unloved, unsupported, unworthy of love and support which underlie whatever precipitated the episode of depression.*

Hence, the label 'atypical depression' is a *misnomer*. This depression is actually *ordinary garden variety non-endogenous depression* in a patient who has *psychological risk factors*, and the weight gain is a result of the patient using food to cope. It could be said then that 'atypical depression' is a 'typical' non-endogenous depression experienced by patients who have a *negative cognitive style* of 'interpersonal rejection sensitivity' and a *coping style* of 'emotional eating'.

Consumption of high-calorie food can be regarded as a form of 'self-medication', but as 'comfort eating' for *endorphin release*, not release of *serotonin*. Clearly, consuming high-calorie food provides temporary relief only, and doesn't have any anti-depressant action, since food has to be consumed constantly and the result is that the patient just puts on weight. Gaining ten to thirty kilograms resulting from comfort eating makes them even more depressed. If they didn't know why they were depressed before, then gaining so much weight gives them a good reason to be depressed!

Depression Response:

Another view is that depression is a *response* to negative life events (Yapko, 2001). This view also accounts for non-endogenous depression that *recurs*. In the 'medical model', the view is that depression is a lifelong mental disease which merely goes into *remission* after treatment, and *recurrence* is inherent in the nature of the condition - even if a second episode is ten or twenty years after the first. While this is true for *biological* depression, it is not the case for *psychological* depression. In the 'response' account, it is the nature of life events that is *recurrent* rather than depression itself. Hence, if a person has a *depression response* when serious negative life events occur - and chronic or acute negative life events can recur and people can become trapped in life circumstances - then depression may be recurrent. All the more reason to target the vulnerability factors in therapy to reduce likelihood of a *recurrence* of this *depression response*.

Psychological Pain Paradigm:

For a different 'outside the box' perspective, I think of depression as a 'psychological pain'. This plays a role analogous to that of physical pain which is a *warning* that there is an injury or malfunction in the body that needs attending to (ie, diagnosis and treatment). Likewise, 'psychological pain' (depression) is a warning that there is some malfunction in the psyche or life situation that needs *identifying and addressing*.

According to this Triple P (Psychological Pain Paradigm) Model of non-endogenous depression, anti-depressant medication is equivalent to an *analgesic* medication and while it eases the pain of depressive mood and enables the patient to continue functioning at work, it *does not address the cause of the depression and will not bring about complete recovery*. (Since I have posed the question of the *real, distal* cause of endogenous depression as being a legitimate one, I would also suggest that ‘psychological pain’ of this type of depression may also serve as a *warning of a malfunction* that is the unidentified actual cause).

Ideally, when medical practitioners prescribe an antidepressant medication (ie, a psychological *analgesic*), they also need to refer patients to a therapist to address the underlying psychological causal factors. To ignore the need for psychological treatment is equivalent to simply just prescribing an analgesic medication to a patient who presents with severe or chronic mystery pain, without carrying out a physical examination or diagnostic tests to identify the cause (eg, fracture, rupture, infection, cancer) which they would normally do, then treat the physical condition *responsible for the pain*. To simply treat the pain and ignore identifying and treating the cause would be regarded as medical negligence.

Yet, commonly, medical practitioners consistently engage in this kind of negligence when prescribing antidepressant medication for treating depression. Many rely on the ‘psychological analgesic’ they prescribe and ignore their patient’s need for therapy to address the *causes* in underlying childhood factors that have created the *vulnerability* and the *current psychological-situational factors* that have precipitated the current episode.

Non-endogenous depression can be regarded as a symptom (or a syndrome of symptoms) of the underlying psychological factors that are the *real* problem. If the psychological factors are not addressed in treatment, then even if medication alleviates the symptoms (ie, depressed mood) sufficient to function at work, the patient has not really recovered and is at risk of future episodes. When the psychological factors are addressed successfully, then the patient is better equipped to cope with (or pre-empt) future stressful circumstances with the risk of *recurrent* depression reduced or eliminated.

However, in general, medication is the ‘first line’ of treatment chosen by medical practitioners. This is in accordance with the conventional ‘medical model’ of depression which has a treatment approach of ongoing ‘management’ of the symptoms, without expectation of a cure. Patients are referred on for psychotherapy as a ‘second line’ treatment only when the medication fails to achieve satisfactory results. The psychiatric view of psychological treatments is that they are not ‘stand-alone’ treatments but are merely ‘complementary’ so are used to ‘augment’ medication. Alternatively, patients may request a referral or those who prefer natural or alternative treatments will voluntarily seek out a therapist via ‘google’.

Hard-line prescribers of antidepressant medication who believe exclusively in the ‘medical model’ of depression tend to be dismissive of the efficacy of any form of psychotherapy. They claim that any benefits to the patient are simply a temporary ‘placebo’ effect and nothing more than the benefit from having a chat and a cup of tea with a supportive friend. Yet, due to the plasticity of the brain, a skilled therapist, using an appropriate therapy with a co-operative client, can achieve *real* psychological change. Cozolino, in his book, “*The neuroscience of psychotherapy*” (2002) has provided evidence of new neural pathways being created after successful psychotherapy.

Non-conventional comments

Absurdities of remission and recurrence:

Endogenous depressions tend to be a lifelong condition with patients experiencing recurrent episodes. However, there does appear to be a view that even non-endogenous depression is a lifelong mental disease, and when an episode comes to an end the depression is not regarded as being cured but merely *in remission*. Hence, any subsequent episodes are regarded as a *recurrence* which is used as evidence of the lifelong nature of depression.

Why is this rationale not applied to colds and ‘flu, which tend to be *recurrent*? People generally have a ‘head cold’ and/or ‘flu several or many times during their life, some even as often as every year. Yet, there is no medical claim that when patients *recover* from a cold or a bout of ‘flu, *they haven’t actually recovered*, but merely *gone into remission* until the condition *recurs* - next time.

To illustrate the absurdity: Little Jason has his first nasty cold that has kept him in bed with a fever and runny nose. He has now ‘recovered’ and is up and running around again. The doctor does not say to the mother, “Little Jason may appear to have ‘recovered’ from his cold, but he *hasn’t actually* and it would be dishonest of me to tell you that he has. The medical reality is that the cold he was suffering from last week is just the first episode of a *lifelong disease* which has merely *gone into remission* for now, until it *recurs* - because colds and ‘flu are *recurrent by nature*”. It will probably be argued that different bugs or strains of ‘flu would challenge my absurd suggestion that colds and ‘flu would qualify as lifelong conditions when applying the same diagnostic criteria as is applied to

depression. The answer to that challenge is that the *precipitating events* for each episode of depression are generally also *different*.

I experienced eighteen months of depression during marriage in a depressogenic 'life trap'. I am glad that I did not go on to medication to dull the pain so I could ignore what needed to be faced because the self-analysis in working my way through resulted in coming out the other end with tremendous personal and spiritual growth. However, *according to the 'medical model'*, that depression episode merely 'spontaneously' *went into remission* and I have been living with a 'mental illness' for the last forty years - but *according to the 'medical model'*, that depression episode is going to recur because it is the inherent nature of depression to be recurrent!

Who is at risk?

In spite of research that focuses on identifying who is most likely to experience at least one episode of depression during their life time, the fact is that, given the right (or wrong) circumstances (eg, feeling trapped, powerless, hopeless, experiencing major or multiple losses), *anyone* can experience non-endogenous depression. Anyone with unresolved emotional issues (from childhood or as an adult) such as emotional deprivation, anger, guilt, shame, grief (which is complicated by anger, resentment, guilt, regrets), or abortions (which may be associated grief, shame, guilt, anger, regret) has the potential to experience an episode of depression during their lifetime. Am I trying to scare everyone? No. I am merely illustrating that there is no 'us' and 'them'.

Risk may be increased by dysfunctional or ineffectual coping styles which are mainly learned from parental role models and/or negative life experiences, by low Self Worth which reflect *unmet* emotional developmental needs during childhood, or by taking on excessive responsibilities long term whilst ignoring personal needs and creating some sort of 'life trap'. Risk is increased even more by emotional developmental needs being *violated* by parents during childhood which may have resulted in unresolved issues such as *repressed anger* and *betrayal* (Parker 2014). Depending on severity of impaired capacity to live a happy and fulfilling life and other ameliorating or exacerbating factors in a person's life, any unresolved 'issues' and dysfunctional coping have the potential (but not inevitability) to create vulnerability resulting in depression. While 'risk' does denote some degree of *vulnerability*, it only represents a *statistical probability* – not an *inevitability* of experiencing depression.

It is not necessarily a catastrophic event that precipitates the eventual episode of depression but often is the cumulative effects over time, gradually undermining the individual's psychological coping resources. Then, a relatively minor event may be the 'last straw'. Conversely, depression can be triggered by a single catastrophic event if the individual has had a pretty smooth ride in life, with virtually no previous experience at dealing with devastation or hardship which provides the opportunities to develop coping resources and *resilience*.

Coping can be regarded as a *learned response*, learning from observing parents dealing with the ups and downs of life plus learning from the 'tests' of personal experience. Hence, throughout childhood and adolescence, resilience can develop via a cumulative acquisition of coping resources and strategies that continues as an adult. If parents have protected their children from exposure to life's knocks, in the erroneous belief that this was in the best interests of the children, they have also denied their children the opportunities to develop resilience and learn how to cope. Then, when they may be confronted with one of life's 'knocks', and cannot be protected by the parents or anyone else, they are ill equipped to deal with it effectively and may be at risk of depression.

Role of dreams:

Australian research reveals that almost 16% of people have dreams that cause them to wake in fright, on a regular basis. An attempt has been made to attribute an adaptive function to these nightmares. One theory is that trauma-related dreams with 'general' themes, such as being chased, produce 'threat stimulation' which would give the person a 'slight edge' if they were to experience the same threat in real life. Another theory is that nightmares are used to extinguish childhood fears.

I doubt that either of these theories has any basis in fact. They are contradicted by the nightmare flashbacks experienced by victims of real life trauma. I don't think any one has claimed that these nightmares play any role in 'extinguishing the fear' of the trauma. Rather, they are an exacerbating feature of the ongoing trauma and regarded as a diagnostic feature of PTSD. I don't think anyone who has ever had some form of traumatic experience has ever reported, "Hey, I'm fine, I coped with that traumatic event pretty well and I attribute that to having an 'edge' because I have been getting plenty of 'threat stimulation' while dreaming about this exact same traumatic event for ages prior to it actually happening".

Using common sense, it is more likely that the function of these dreams is communication between the subconscious mind and the conscious mind, since during sleep is the time when the ability of the conscious mind to block out the subconscious messages is shut down. Just as there are numerous means of communication in the physical world, the

subconscious and higher conscious minds also have various means of communicating with the conscious mind. If they are in harmony, then communication is received by the conscious mind as 'intuition'. However, there may be inner conflicts when emotional or traumatic experiences are just buried deep in the subconscious mind instead of being faced and resolved.

My personal and clinical experience is that recurring dreams and nightmares with a *common* theme are the subconscious mind trying to bring these buried issues to conscious attention so they can be addressed and resolved. This would also apply to trauma-related nightmares with *general* themes. Rather than regard them as *practice* which will result in being better prepared for coping with traumatic events that *might* occur, they more likely reflect a *generalized anxiety* and the dreamer would benefit from therapy to address this issue. Likewise for children! If their fear-based dreams are the result of real-life experiences, they need professional help to resolve these fears but if the fears just reflect anxiety or *underlying insecurity*, these issues also need to be addressed with the child. There is also the possibility that a dream can be pre-cognitive, warning of a future event, but its purpose would be to provide a warning so the event can be *avoided* rather than practice to provide an 'edge' when it actually happened.

One difficulty with dreams as communication from the subconscious mind is that often they are in symbols that may not be readily interpreted, just like sending a coded message but the receiver doesn't have the key to understanding the code. A common example is a 'house' representing the 'self', with different rooms representing aspects of self, and the condition of the house reflecting state of physical health or emotional issues. For example, under the house (basement or cellar) represents the subconscious mind, the kitchen where food is prepared represents nurturing, while a broken or blocked toilet represents inability to release emotional waste.

Another difficulty for the subconscious mind communicating via dreams is that even if the dreamer can interpret the dream and acknowledge that some issue needs resolving, they can still ignore the need to take action. After a period of repeated ignoring of the message in the recurring dream, the subconscious mind adopts the next line of communication, via the physical body. This can result in *psychosomatic* symptoms which again, are not easily interpreted except to use the catchall of 'stress-related'. These symptoms cannot be ignored, but again, even if the message in them is interpreted, the *message can still be ignored*.

What happens if the individual continues to ignore the dreams and the psychosomatic symptoms and fails to address the issues which have been buried in the subconscious mind? The next line of communication ultimately is likely to be depression - a *shutting down* that can't be ignored. However, the unresolved issues can still be ignored if the depressed individual chooses to just take medication to dull the pain and avoid addressing the 'real' problem. The implication is that given the high rates of mental health issues such as anxiety disorders and depression, recurring dreams or nightmares should not simply be ignored but the message in them should be heeded.

Why would the subconscious mind resort to communication with dream symbols and physical symptoms after intuition has failed? Language is a relatively new development in the evolution of the human brain while symbolism is much older. Jung has described universal archetypes in symbols. Louisa Hay (1984) has observed links between unresolved emotional issues and physical ailments and areas of the body where they occur.

As we come to rely more on speech and the written word, older systems of communication become redundant. They are not obsolete, but simply, we have 'forgotten' the key to decode them. Likewise, when archaeologists find the artefacts from ancient civilizations, they may have difficulty in interpreting writing and symbols of a lost language. Clients with depression are often able to report on having had recurring dreams with a common theme but have not been able to understand what they meant or had not even realized that there was a message for them in the dream. Well, the good news is that they are a useful diagnostic tool for psychotherapists who choose to explore their meaning and use them.

Outlook, prognosis:

Medication is the first line of treatment and if a person is severely depressed and has to continue to function and hold down a job, then it is appropriate to take an antidepressant to help alleviate the depressed mood. For *endogenous* depressions, the conventional treatments of medication will be necessary, and in severe cases, even electroconvulsive therapy (ECT) may be beneficial. However, for *non-endogenous* depression, I still regard medication as treating *only the symptomatic psychological pain*. To achieve *real improvement* and *reduce risk of recurrence* requires some form of psychotherapy to address the *real problems* which are the *underlying psychological risk factors* and the *specific factors that contributed to precipitation* of the depression episode. I believe in the importance of focusing therapy on the *origins of the vulnerability factors* in childhood, so that we are assisting clients to *rebuild stronger, more secure psychological foundations* and *reduce relapse and recurrence* of depression.

While I have been discussing non-endogenous depression, psychological risk factors also have relevance for endogenous depression types. Endogenous depression does not bestow immunity from psychological risk factors and ongoing stressors and life traps. These patients are just as likely to have stressful life circumstances which may contribute to triggering episodes of depression, mania or psychosis. They may also have learned dysfunctional coping styles and unresolved emotional issues that can exacerbate the episode. Hence, they may also benefit from psychotherapy. (Caution: Hypnotherapy is recommended - and possible - only when the patient is *not experiencing a manic or psychotic episode*).

Conclusion:

Depression is not all bad. We are all familiar with the mantra at the gym: 'No pain, no gain'. Perhaps surprisingly to those who have not experienced depression, many people who have been through an episode of depression describe the experience in positive terms, expressing appreciation for what they gained from it.

While the experience was one of suffering in their private hell, the outcome can be *personal and spiritual growth*, even greater resilience and regaining *a sense of empowerment*. While in this place, alone, where no one else can come and share, it is a time for reflection, self-examination, stripping away denial and facing up to *what needs changing*. The individual experiences an attitudinal change, reassesses what is important in their life and feels empowered to take (or take back) control of their life. This may also require courage since often becoming empowered and making changes can be upsetting to those around who were quite happy with the old situation and may feel threatened by changes.

I wonder if medication interferes with this process of self-examination, change and growth? I say that '*pain can be the instigator of change*'. However, if there is a pill to dull the pain of depression so that an intolerable situation can be tolerated, it can then enable the depressed individual to remain in denial by *ignoring what needs to be faced, addressed and changed*. The downside of reliance on medication as an easy option or 'quick fix' is there is *no motivation to change and there is a missed opportunity for personal and spiritual growth and development of greater resilience and inner strength*.

This article is an extract from my book: "Self Worth *BEFORE* Self Esteem: What every parent must know about building the foundations of Self Esteem".

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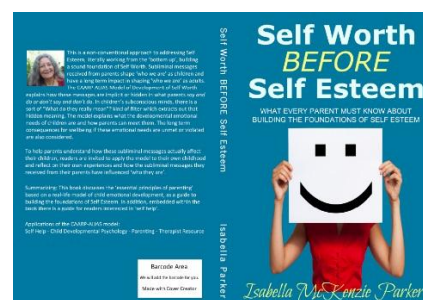
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Isabella Parker is a Clinical Hypnotherapist and former Registered Psychologist, with a working background in depression research at a tertiary referral unit. She has developed the CAARP-ALIAS Model of Child Emotional Development which also has application to adult self-understanding and is the author of: "Self Worth *BEFORE* Self Esteem: What every parent must know about building the foundations of Self Esteem" (amazon.com).

Editor's Note:

Isabella's book, "Self Worth *BEFORE* Self Esteem", 'What every parent must know about building the foundations of Self Esteem', is available on <http://www.amazon.com> as an ebook and in paperback.

Please refer: <http://www.isabellaparkerhypnotherapy.com.au/> for more information on Childhood Stuff, Depression, Weight Issues, Anger, Childhood Sexual Abuse, Drugs and Alcohol, Cancer and Panic Disorder



Embodied Happiness: A Lifetime Journey

Justus Lewis PhD, Ros Turnley & Alex Zannoni

*Journeys bring power and love back into you.
If you can't go somewhere,
move in the passageways of the self.
They are like shafts of light,
always changing,
and you change
when you explore them.*

Context

As counsellors and hypnotherapists we embrace a vocation to assist others in ethical ways to improve the quality of their lives through greater attention to and understanding of what they feel, sense, imagine or think about. To do this effectively involves reflecting on our own feeling, sensing, imagining and thinking. Peer supervision provides a regular opportunity to practice this self-reflection with like-minded colleagues. We expand our sense of what it is to be human beings in today's multi-dimensional, multi-faceted world.

Embodied Happiness arose out of one strand in our collective reflections.

In this exploration, of what we have termed 'organic happiness' or embodied happiness, we recognise that for many people the corporate indoctrination aptly described by Chris Hedges¹, that we will only be successful if we are always happy causes great stress. This belief then morphs into a view of success that holds we can only be happy if we acquire the outward glamorous trappings and possessions that demonstrate a certain lifestyle: particular brands, the latest car, houses, boats and whatever is the latest testament to the power of advertising.

Our view explores the inner world, a path of becoming and knowing, where we discover how happiness resides within and is not due to external expectations or possessions. We venture into the world of mind body health, a place to return to, after surfing the storms and waves of life; a place where we experience a deeper understanding of knowing from within; where we learn to dance with the ups and downs, joys and sorrows, crises and achievements, uncertainties and potential of life. A place of balance, where we can experience the felt sense of happiness, where we tap into the world of neuroscience and neuroplasticity through the capacity of our sensory responses via our neural pathways.

Happiness

Happiness is a slippery concept. Yet who can deny that as human beings we all aspire to happiness in one form or another, whether we call it quality of life, engagement with life, wellness, wholeness or even bliss or something else again. But what is happiness? Can it be measured? And if it can, how might this be done? And where to look for it?

The ancient Greek philosopher, Aristotle, cautioned his audience to 'Count no man happy till he is dead', reminding us of the Chinese story of the man who refused to concur with his neighbours' judgements on the fortune or misfortune of successive dramatic events in his life, preferring to greet all with a 'Maybe'. Also perhaps suggesting that happiness is not an absolute but only part of the picture. Certainly it's easy to think of famous people who were forgotten by the adulatory crowds and ended their lives in poverty and abject circumstances; or apparently successful performers with everything to live for who die of suicide or overdose. Aristotle had a point.

The Scottish novelist, Robert Louis Stevenson, averred that it was better to travel hopefully than to arrive, suggesting that we might be better served by attending to our current emotional responses than to place our hopes on future as yet unrealised goals. 'A bird in the hand is worth two in the bush'. Stevenson's words also suggest that even though we may be doomed to disappointment, we can, during the journey, enjoy the anticipation of a happy outcome. Milton Erickson may have had similar thoughts when he reminded a client, with elegant ambiguity, that 'No one knows what the future may be'. The client apparently took this statement as encouragement to persevere.

More recently, William Glasser, the originator of positive psychology believed that our mental health was best served by treating happiness as a choice: we are only as happy as we make up our minds to be.

Still more recently, Louis Cozolino points to the split second difference in the speed at which the different parts of our brain respond as a major factor causing human unhappiness and hence an ongoing assurance that our profession will have a continuing role to play in the conscious evolution of our species!

Reflection

The starting point for our reflections was a quote from Chris Hedges 2009 publication, *Empire of Illusion: The End of Literacy and the Triumph of Spectacle*.

Hedges in a delightful combination of rant and well-reasoned argument rages against the dangers of the increasingly popularised concepts of positive psychology. He argues convincingly that the massive mainstream acceptance of the ideas of positive psychology by both academia and the corporate sector has resulted in a culture that places the blame for every evil and the responsibility for fixing it squarely on the individual. It is hard to dispute that many do indeed hold quite extreme views as to the extent of individual responsibility: we need go no further than Joe Hockey's comment on the affordability of housing - if people want to buy a house, they should go and find a job that pays good money. The implication is that this social issue has nothing to do with the availability of affordable housing and well paid jobs and everything to do with a person's assumed motivation or lack of it.

Eloquent as the quote from Hedges was, we were not convinced he told the whole story. Surely issues around happiness are a bit more nuanced.

- Sometimes to the observer, it seems easy to determine what would contribute to another's happiness. We considered the case of a client faced with the necessity of moving house. From our own experience, it would seem obvious, for example, to invite a friend or friends to assist with the packing. However, to this client the task appeared overwhelming. She found it impossible to make a simple request to friends. In the end, she was only able to ask for help when she found herself in hospital in extremis. Was landing up in hospital really preferable to lifting up the phone and asking a friend to come round for a couple of hours to help pack?
- Happiness often seems too abstract a concept to be useful in guiding our daily life decisions. But can we ignore it altogether? Wouldn't this be throwing out the baby with the bath water? Isn't it self-evident that we should all be striving to 'leave a trail of happiness' in our wake? Or to engage with 'what makes our heart sing', in other words, what makes us happy?
- How far can we go in ignoring the 'dark' side of life? The inevitability of loss, anger, rejection, frustration, dejection, despair ... ? All these are part of life too.
- In describing the 'facts' as best we can is it better to be a 'glass half full' or a 'glass half empty' person? We can all think of people we know who whatever happens, always manage to see the worst in a situation and we know how energy draining it can be to be in their company for long.
- Does this mean we have some level of obligation to assume a perpetual air of cheerfulness? We don't think so. There are times in all our lives when it is entirely appropriate to be angry, sad, anxious ... Mindfulness teaches us to be in the moment; but not to wallow in the moment.

Conclusions

Embodied happiness refers to these moments of joy that are woven into the fabric of our lives. For a jockey it may be the thrill of galloping down the home stretch to win a race; for a therapist it may be engaging with a client in a genuine open way to determine the next step forward; it may be the scent of a rose; the touch of a hand; the pleasure of a particular piece of music.

Moments of happiness can catch us unaware; but sometimes - perhaps always - we do better when we make conscious choices that either reinforce the habit of recognising potential joy or take small but significant steps to changing our environment so that as Paulo Friere said, 'We create a world in which it is easier to love'. Sometimes neither is possible. But we can travel hopefully. The next moment of now holds the potential to be different. The human condition is one of change and flux. We know that life is yin and yang, light and dark, happiness and misery. The potential for embodied happiness is a part of the big picture of life, a part of the story we tell about who we are and why we are here. But in the end, it only makes sense when it becomes an individualised personal journey, accepted and embraced by each in his or her unique way.

As Rumi so aptly put it, 'Move in the passageways of the self'.

¹ The poet and philosopher Rumi, Persia and Afghanistan (Coleman Barks rendition)

¹ Chris Hedges (2009) *Empire of Illusion: The End of Literacy and the Triumph of Spectacle*

Attachment, Trauma & Intimacy Conference – Boulder, CO. April 2016

Justus Lewis PhD

Summary

The 3-day conference was the culmination of the online course, *Trauma and Attachment Theory*. It gave participants an opportunity to:

- Review the three main attachment styles (avoidant, anxious, disorganised),
- Experience demonstrations of work with each of these styles,
- Benefit from and interact with expert speakers on a variety of topics focusing on attachment theory and intimacy,
- Become familiar with a range of other approaches including ego state therapy, Hakomi and Internal Family Systems
- Interact with invited experts through panel discussions
- Meet with other online course participants as well as a range of local participants.

Some of the underlying themes within the conference included:

- One of our key tasks as therapists is to help build clients' capacity to experience more of secure attachment.
- The value of becoming acquainted with at least three other therapeutic models apart from one's own so that one has more resources and tools to meet clients' needs
- All roads lead to Rome. We are all as therapists on the same path and committed to supporting people to become more truly their Self with a capital S.
- The importance of resourcing clients in a variety of ways.
- The importance of creating a safe space for each client. The basic requirements may stay the same but we should be aware of individual clients' particular needs.

About The Conference

This three-day *Attachment, Trauma and Intimacy Conference* in the Millennium Hotel, Boulder, Colorado (8-10 April, 2016), organized and designed by Diane Poole Heller, PhD, as part of her DARE (Dynamic Attachment Repatterning Experience) program, was designed to consolidate and integrate the learning started in the online program ... and 'to enhance practitioners' confidence and skill in applying mastery of Attachment and trauma resolution with clients'. It also had a focus on broadening practitioners' understanding of other modalities that used different theoretical frameworks to address issues relating to the relief of human suffering through psychotherapy; (see the list of invited speakers below).

Although the conference schedule suggested an expectation of set piece presentations, the experience was of being part of a community of like-minded therapists and researchers exchanging wisdom about what most interested and concerned them.

From a broader perspective conference publicity describes the event as being, 'all about LOVE and an expansion of Welcome to the World'.

Welcome to the World is one of Diane's signature activities. Participants are invited to visualize exactly how they would like to be 'welcomed to the world' on birth. The variety of descriptions that have been given by people who have participated in this exercise bears testimony to the broad and varied range of experiences that enable us to experience secure attachment.

Each of the three days started with an interactive presentation from Diane on an aspect of Attachment Styles (Avoidant, Ambivalent, Disorganised - in each case showing how a particular style related to Secure Attachment) and included demos of activities and exercises that could be used to assist clients. This was followed by a clinical demonstration of how each style might be addressed using volunteer participants from the conference. Each afternoon included two sessions from invited experts followed in the early evening by extended Q&A panel sessions. The panels comprised Diane plus the two expert speakers from that day. Each session included ongoing opportunities to ask questions. Microphones for the conference participants ensured that all questions could be heard by all present. The whole conference was also broadcast live around the world by streaming video. A gourmet sit down lunch was included each day as part of the conference. The lunch was presented in an adjacent room to that of the conference, guests being seated at round tables to encourage interaction. Both rooms overlooked an attractive open space dotted with trees, adding to the supportive ambience of the event.

The visiting experts for the afternoon sessions were:

John Howard:	Bringing Interpersonal Neuroscience into Couples Therapy
Jaci Hull:	Tolerating Intimacy: Hakomi & Cultivation of Healing Relationship
Amir Levine (<i>unrelated to Peter Levine</i>):	Deciphering Attachment Styles in Everyday Life for Dating & Relationships
Ellen Bader (co-Founder with Peter Pearson of <i>The Couples Institute</i>):	Working with the Developmental Stages of Couples to Deepen Intimacy, Expand Understanding, and Enhance Maturity
Maggie Phillips:	Somatic Approaches to Working with Shame, Trauma, and the Social Engagement System
Richard Schwarz:	Working with the “I” of Trauma Using Internal Family Systems (IFS)

Big Picture Takeaways

I initially became interested in Diane’s training through seeing a number of her free online videos (www.dianepooleheller.com) in which she gives overviews of the various attachment styles together with comments on the clinical relevance of the information. Attachment theory struck a chord. Although I was aware of the basics, I had never looked at the implications in any depth.

In another of the modalities that I practice, the EMF (electromagnetic field) Balancing Technique®, transformation of relationships is a major focus in Phases 9-12. In these phases, the giver and the receiver in the course of four sessions work sequentially and experientially with four major archetypes of relationship: The Universal Human, The Universal Parent, The Universal Partner/Beloved, and The Universal Evolutionary. As an EMF Balancing teacher I had long thought that a deeper understanding of Attachment Theory would enhance the teaching and practice of these phases.

I was also intrigued to notice another similarity between Diane’s interpretation of Somatic Experiencing and EMF Balancing. Both focus on conscious experience of the energy of love. During the conference I had a very real experience of being in an actively loving environment emanating from Diane’s loving energy at its centre. My perception was of interactions amongst participants infused with compassionate acceptance. Diane’s apparently boundless energy was apparent at all times together with her genuine wish to connect with each of us in an authentic non-intrusive way. As a veteran conference attendee and professional development workshop junkie, I was struck by this new and impressive experience.

During the conference, Diane shared that several years ago, after life-threatening surgery, she had made a decision to live her life only in connection with others who shared her vision of consciously living and teaching the skills and competencies that support and encourage the capacity to love more effectively. She had let go people and activities that no longer attuned with this focus and reached out to those who shared her passion. The impressive group of experts contributing to the success of this particular conference is certainly an indication of the manifestation of this intention. I was reminded of Paulo Friere’s ‘creating a world where it is easier to love’.

Specific Takeaways

1. Live Demos. The daily live demos given by Diane opened me to a deeper understanding of the clinical applications of Somatic Experiencing. Several of the other presenters also gave demos or presented videos of sessions. My admiration for Maggie Phillips and her work continues to deepen. I was privileged to meet Ellen Bader in person and enjoy her insightful teaching of couple therapy using an edited video made by herself and her husband, Peter Pearson.
2. Active Participation. Participation by all attendees was actively encouraged throughout as well as in the Q&A sessions that rounded off each day. Sharing of wisdom was the order of the day. Diane’s presentations were interpreted with a variety of exercises and activities that could readily be adapted to use with clients.
3. ‘Let a thousand flowers bloom’. Well, not quite a thousand but Diane expressed a conviction that as therapists, we should all be familiar with three different modalities in order to provide the best service for our clients. She reinforced this by inviting experts of other persuasions to introduce us to their approaches. For example, Maggie Phillips introduced Ego State Therapy, including a demo with a conference participant, and Richard Schwarz explained the basics of the Internal Family Systems approach, showing us a teaching video made with one of his clients.

For more information please contact:



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Accredited supervisory teacher of EMF Balancing Technique® Phases I-XII, accredited Practitioner of Phases I-XIII.

PhD, MA Hons {Edinburgh} (First Class), Dip Ed (Monash) (Tert), Diploma & Advanced Diploma in Solution Oriented Hypnosis (Centre of Effective Therapy Melbourne).

Reiki Master, NLP Master Practitioner, Strength Deployment Inventory, Aura Light Practitioner and Teacher, Certificate IV in Teaching and Assessment.

Letters to the editor



I would like to share with members and those who are reading the AHJ, about the availability of having a FIRST AID book on your mobile, iPad and iPod.

St John Ambulance Australia has sent me an email, advocating for me to refresh my CPR qualifications on an annual basis. The reason quoted was to tell me that training is forgotten after three months if not practiced regularly. The email advised that after two months, there is a 50% decrease in CPR skills and after three years, only 2 percent of people can perform CPR effectively.

Searching on the Net, I found St. John's Ambulance now have a First Aid app that you are able to download. It said that you must have iPhone, iPad and iPod Touch app. I have listed here the link on itunes where you can read all about it: <https://itunes.apple.com/au/app/first-aid/id375699406?mt=8> St John say the App is Australia's only iPhone app and costs \$5.99.

The following app is for Android Operating Systems. The official Australian Red Cross First Aid app. This app is absolutely FREE. <https://play.google.com/store/apps/details?id=com.cube.qdpc.aus&hl=en>

I have a mobile phone which is the Android Operating System. As I already had a Google g-mail account, I was able to use this and easily filled in the needed information. WOW! It downloaded to my mobile phone and I now have the complete First Aid book information on my mobile phone. You don't need to worry if you haven't got a Google account, as you are given step-by-step instructions on how to set one up.

The First Aid app is very easy to use. Just touch on the area you want to read, and the link takes you directly to the page you want to view for information. Works great.

Warm wishes to everyone.

Bruni Brewin

Writing a Journal Article

Further to the article in the previous journal and requests by State SEO's at branch meetings, a gratifying number of well written articles have been sent in, many of which have been published in this journal.

The AHA Journal remains on the Journal archives on the AHA website for many years. Editions are also stored at the digital archiving section of the National Library of Canberra.

The articles in the AHA Journal may be used as research material for allied health professionals. Therefore, it is up to the members of the AHA to ensure that the contents of this journal represent the best we have to offer as hypnotherapists

One of the main keys to being a good writer is to be a prolific reader. Don't just read articles on hypnotherapy or NLP, read anything that appeals to your sensibility.

For example: Brainwave Frequencies are associated with various mental states. Certain frequencies can coax your brainwaves to achieve the mental state associated with that frequency. The human voice uses an incredible range of frequencies and as hypnotherapists we use sound in ways that we may not be aware of to influence clients. <http://www.lunarsight.com/freq.htm> 16.4.16

The Academy of Applied Hypnosis has a number of Mini Lectures available on-line for the convenience of rural and remote members. Most council libraries have online facilities and some offer courses in writing.

Explore your potential. There is no limit to what you can achieve with will and imagination.



Chereyl Jackman

BVA; MEd; Dip. Hypnotherapy; Dip. Kinesiology; NLP & NOT Practitioner; CranioSacral Therapist.
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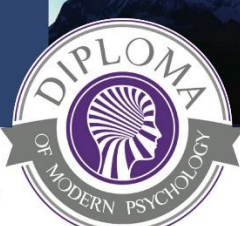
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Trainers and Assessors

Alex Collins

(69828) Grad Dip of Counselling Supervision, BA Counselling Psychology, Dip in Counselling and Communication, Dip Professional Counselling
MISOCCS, MACA

Tabitha Veness

Grad. Dip C. Supervision, BA (Psych), Grad. Dip. Counselling, Dip Ego State Therapy, Dip of Health – Hypnotherapy, Cert in Counselling and Conflict Resolution, Cert IV TAA,
MISOCCS, MACA, MAHA, MCSH

Program Designer, Developer & Author

Veronika Basa

Managing Director



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The Supervision training program has been adopted from the AQF accredited supervision course, the (69828) Certificate IV in Counselling Supervision, designed and developed by Veronika Basa from Basa Education and Counselling Services (BECS).

For the purposes of this training, the term '*Supervision*' is utilised to describe the foundation skills relevant to supervisory relationships that can be adopted and provided by a range of professionals of different training and accreditation background such as hypnotherapists, counsellors, psychotherapists, mental health nurses, psychiatrists, psychologists, social workers, or anyone else in the helping profession.

WHO SHOULD ATTEND

- Experienced therapists interested in learning about supervision and want to supervise other therapists
- Practicing supervisors who have no formal training in supervision and wish to be formally recognised.
- Therapist who wish to use this program as a professional development activity.

ESSENTIAL ENTRY REQUIREMENTS

ISOCCS recommends a minimum of 5 years of post-qualification experience and having undertaken regular supervision and ongoing professional development each year as required by relevant Professional Associations. If your circumstances are different, please contact ISOCCS.

DELIVERY

PART 1 - Preparation to Workshop (20hrs)

Students are expected to read the resource materials in preparation to the workshop.

PART 2 - Workshop (42hrs)

1. Theoretical component (24hrs):

- The importance, scope and definitions of supervision
- Models of supervision
- Supervision Interventions (live, individual and group)
- Supervision relationship
- Culture in supervision
- Ethical and legal considerations
- Stages of Supervision
- Managing Supervision (induction, delivery, closure)
- Evaluation
- Supervision Tools/Instruments (contracts, group rules, agreements, etc.)

2. Experiential Learning component (18hrs):

- Oral presentations,
- Class discussions (ethics, scenarios (provided by facilitator and participant))
- Demonstrations /Role plays of supervision skills (induction, live, individual and group (4-6))
- Practice dyads (induction, live, individual)
- Live supervision of supervision

Workshop Time Table 2016

City	Date	Month
Melbourne VIC	3 rd & 4 th	September
	8 th & 9 th	October
	5 th & 6 th	November
Wollongong NSW	10 th -11 rd	September
	15 th & 16 th	October
	12 th & 13 th	November

PART 3 - Practicum (12hrs)

(Live Supervision of Supervision 4X3hrs)

Practicum is mandatory in order to satisfy accreditation requirements. If the student cannot attend the practicum Skype supervision of supervision can be negotiated.

Practicum Time Table 2016

City	Date	Month
Melbourne VIC	4 th & 5 th	February
	4 th & 5 th	March
	1 st & 2 nd	April
Wollongong NSW	11 th & 12 th	February
	11 th & 12 th	March
	8 th & 9 th	April

PART 4 – Assessment (12hrs)

1. **Formative** – Ongoing assessment during the Training Program with ongoing constructive feedback:

- Oral presentations,
- Contribution to class discussions, case studies and scenarios,
- Demonstrations (live supervision of supervision) with real life scenarios in induction, live, individual and group supervision.

2. Summative (Final Assessment)

The final assessment (written and/or practical) evaluates students' learning at the end of the learning program and are mandatory as they are benchmarked against the requirements of relevant associations.

This will require all students to undertake:

- Written assignments (Scenarios, Projects)
- Practical assignments (One live face to face 60 minute assessed supervision session, no role plays)

TRAINING OUTCOME

By the end of the training, participants will be able to:

- Use relevant supervision contracts and agreements
- Implement supervision theories and models
- Facilitate live, individual, and group supervision
- Build a safe supervision relationship
- Solve supervisory issues
- Practice cultural competence
- Make and implement ethical and legal decisions
- Manage each stage of Supervision
- Give accurate and constructive feedback and support
- Implement evaluation processes (formative and summative)
- Use authority appropriately
- Practice self and supervisee self-reflection
- Be aware of own and supervisee limitations
- Be aware of own and supervisee needs for professional development and plan accordingly.

RECOGNITION

This program satisfies the requirements of a supervision training program of:

- The International Society of Counselling and Clinical Supervisors (ISOCCS).
- The Australian Counselling Association (ACA),
- The Australian Hypnotherapists Association (AHA)
- The Australian Community Counselling Association (ACCA)
- The Psychotherapy and Counselling Federation of Australia (PACFA),

FEES

Delivery = \$1,500.00 (GST included)

Practicum = \$700.00 (GST included)

Total = \$2,200.00 (GST included)

Fees are based on a minimum of 6 attendees.

There is a 10% discount for a group booking.

Payment Options: Bank transfer – Please call BECS

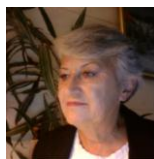
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PROGRAM DESIGNER, DEVELOPER & AUTHOR

Veronika Basa

MANZMHA, MISOCCS, MINDTC,



Veronika is an educator, counsellor, supervisor, trainer and assessor, VET designer, facilitator, and speaker.

She has worked with both Government and Non-government Organizations in the areas of Education: DEST – Commonwealth and

State – Indigenous Unit – Monash University Melbourne, Curtin University Perth, Chisholm TAFE Institute, and Secondary Colleges; Counselling and Supervision: in Community settings and her private practice.

Veronika is the course designer, developer, and author of the (69828) Certificate IV in Counselling Supervision and the (69795) Graduate Diploma of Counselling Supervision.

Alex Collins

MISOCCS, MACA,



A native of Uruguay South America and passionate about humanitarian and behavioural causes, Alex embarked the pathway of counselling psychology in 1993 whilst residing in the US.

By 1997 she was a qualified counselling psychologist and in 1999 she migrated to Australia where she pursued getting

further qualifications in professional counselling, counselling supervision and workplace training and assessment.

Alex has been supervising and training clinicians since 2010 and is also a Master Mental Health First Aid instructor after have presented across Australia over 35 courses.

As a chartered individual, child family and couple counsellor, Alex works from an eclectic approach blending in elements of Mindfulness, Gestalt, Psychoanalysis and CBT.

Tabitha Veness

MISOCCS, MACA, MAHA, MCSH



Tabitha is a hypnotherapist counsellor, supervisor, trainer and assessor.

A Trainer and Assessor with 7 years of experience in the training industry. She has worked with various RTO's including the Institute of Counselling and Community Services, Child Wise and On the Line. Tabitha has trained novice counsellors since 2009 and professional counsellors since 2013.

She is also a Counsellor with 8 years of experience in the counselling industry who understands the demands of working in different counselling environments having worked for a number of organisations in the community services sector.

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Margarete Koenning

27th & 28th August 2016

FAMILY/SYSTEMIC CONSTELLATION is a phenomenological process that allows us to reconnect with our ancestors. Through difficult circumstances such as war or cultural atrocities, the connection to our lineage is often interrupted or severed. To regain familial strength and support, Family Constellations provide a strong restorative process, healing the disruptions to reach out movements within family systems and nations. The process works with symptoms such as illness, addiction and strong emotions. Practitioners are drawn to this work as it provides a strengthening healing capacity on a deep soul level that works from profound respect and humility to acknowledge what is trying to be seen and resolved in families and other systems. It is currently used as a reconciliation process throughout the world with individuals, schools, communities and organisations. Margarete Koenning is a PACFA Supervisor and a Senior Gestalt Therapist with a BA in Social Work since over 33 years. She is a trainer and a facilitator in Family and Systemic Constellation and Gestalt Therapy.



Pornography ~ A Modern Day Dilemma
Dip. G.T Cert C.H. Masters in Gestalt therapy
Clinical Member of GANZ
2 days W/E 5

Tanya Field

24th & 25th Sept. 2016

This weekend we will be exploring human sexuality in contemporary society & the contextual influences that impact healthy sexual & relational development. We will be examining further, the bio-psycho-social model in exploring sexual health & the gestalt approach to working with various presentations



New Dates for 2016

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 - Evaluation processes
 - Using Supervision Tools/Instruments

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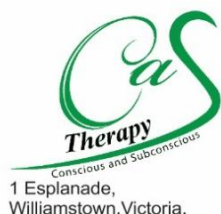
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The Professional Counsellors Association of the ACT and NSW Inc
presents a Symposium on ...

DBT ~ ART ~ SEX ~ SELF

Dialectical Behaviour Therapy

Megan Shiell is a specialist in Dialectical Behaviour Therapy (DBT), a registered Art Psychotherapist, an ACA Level 4 Counsellor and a Registered Clinical Supervisor. Megan has worked as a DBT trainer/consultant around Australia over many years.

Megan will present her specialities in Dialectical Behaviour Therapy (DBT) and Art Psychotherapy and explain the four modules of DBT Skills Training and its increasing application for a diverse range clients who have 'difficulty in regulating emotions' eg: self-harm, suicidal thinking, substance abuse, PTSD, sexual abuse, and eating and mood disorders. Megan's workshop will be creative and experiential and teach at least two DBT skills.



Is it Sex or Intimacy? Sexuality in our Split Culture



Doug Sotheren first trained as a relationship counsellor in 1969 - 1973. He has been training Counsellors and leading intensive workshops since 1975. His experience includes over 27,000 hours of counselling and thousands of hours of group training in the field of Relationship Counselling, Clinical Supervision and Somatic approaches to counselling practice.

Doug will present Effective Couple Counselling that requires some unique couple focused skills and ways of understanding *coupleness*. Added to this is the complexity of working with sexuality in our current split culture. This session will present and demonstrate an approach to working with couples who present problems with sexuality.



Don't miss out on this one day
extravaganza

- Two amazing presenters with a wealth of knowledge to impart
- 16 points of OPD



AGENDA

- 9:00 Registration
- 9:30 Welcome President - Grahame Smith
- 9:45 Megan Shiell
- 10:45 Morning Tea/Coffee
- 11:15 Continuation Megan Shiell
- 12:15 AGM
- 12:45 Lunch
- 1:30 Doug Sotheren
- 2:45 Afternoon Tea/Coffee
- 3:15 Continuation of Doug Sotheren
- 4:15 Closing address
- 4:30 End - Certificates of Attendance provided

Registration Details

<http://www.pcaonline.com.au/event-2247269>

27th August, 2016
Registration 9.00am
Commencing 9.30am

Ryde-Eastwood Leagues Club
117 Ryedale Rd, West Ryde NSW

Free parking is available
4 minute walk from train station



Mastering the Fundamentals of Ego State Therapy

Designed to give an overview of Ego State theory and therapy as well as teach the core skills to enable you to implement and integrate Ego State Therapy into your practice.

Weekend Training - \$550 Early bird \$500

16 & 17 July, 2016

Intermediate Training II

This in depth training will extend your practical knowledge to cover most presenting issues in practice.

\$2750 Early bird discount \$100

6 & 7 August, 2016

12 & 13 November, 2016

10 & 11 September, 2016

17 & 18 December, 2016

15 & 16 October, 2016

Includes 1 x one on one supervision session and one therapy session

Graduate Series

This series, focused on specific topics, is for those who have completed the Diploma or Clinical Qualification in Ego State or Resource Therapy. We will go deeply into specific areas of practice

One day workshops \$250. For details register your interest at julie@juliemadden.com.au.

Enrichment Series

This series is designed to expand knowledge of ideas that will complement your Ego State Therapy work. These workshops will be presented by professionals with extensive knowledge in their field.

One day workshops \$250. For details register your interest at julie@juliemadden.com.au

Supervision

Individual supervision in person, via Skype or telephone is available. In Melbourne there are two supervision groups – one for beginning practitioners and one for advanced. For details contact julie@juliemadden.com.au

Training days are 9.00am - 5.00pm in Brunswick or Fairfield, Victoria



Trainer: Julie Madden

As one of Australia's leading exponents of Ego State Therapy Julie Madden's extensive knowledge of both theory and therapy together with her practical experience of ego state interventions, will help you integrate learning the model with useful applications for your practice.

Julie's dynamic presentation style is engaging. Her experience supervising Ego State therapists in group and individual supervision adds another dimension to her training.

Julie has been in private practice for over 15 years using Ego State Therapy exclusively. Julie works with children, adolescents and adults with a wide range of presenting issues. She brings her in-depth knowledge and practical experience of working with thousands of clients to the training.

Julie is a Life Member of the Australasian Ego State Therapy Association and is an approved AESTA Supervisor. Julie is a Fellow of the Australian Hypnotherapists Association and is an approved Supervisor with the AHA.

Mastering Ego State Therapy can add a powerful set of tools to your therapeutic toolbox. With or without hypnosis this therapy can bring about powerful and long lasting change.

It can foster an improved psychological and physical experience of life. Working directly with the state that needs assistance provides the shortest distance between the goal and the solution. The practical techniques help you to locate ego states in pain, trauma, anger or frustration and facilitate expression, release, comfort, and empowerment.

Ego State therapy is a focused therapy which facilitates the part of the client with the problem to come forward so the origin of the problem can be directly addressed.

The course covers theory, demonstrations, practical applications and practice. The Intermediate course includes supervision and therapy.

For further information: 0408 355 592

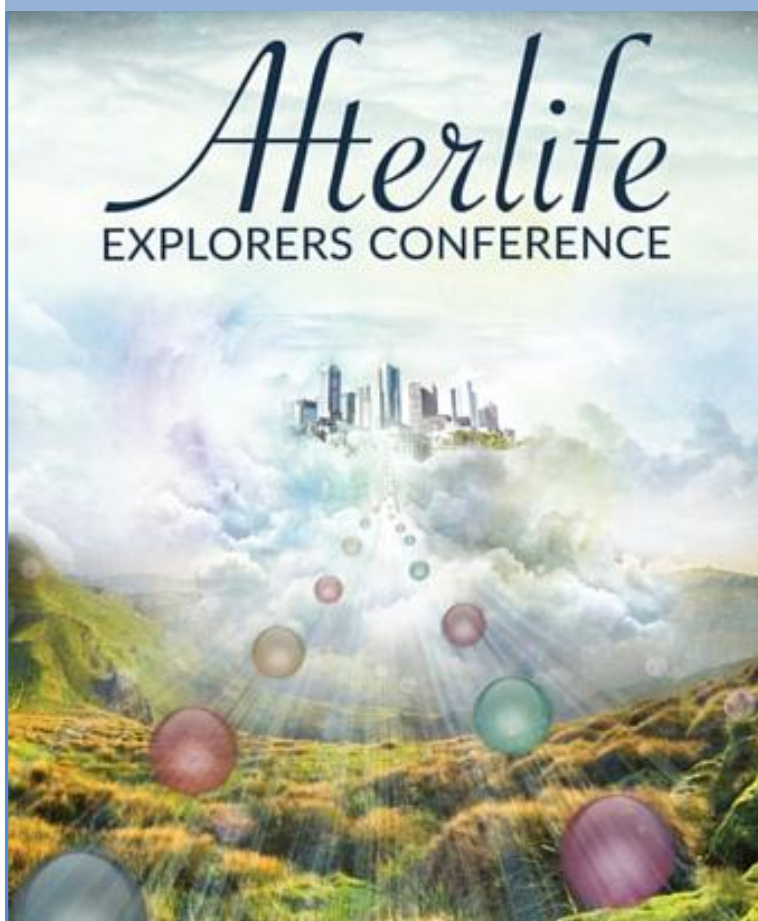
or julie@juliemadden.com.au



Keynote speakers:

- Dr Linda Backman (USA)
- Mary Rodwell (AUS)
- Rosemary Ellen Guiley (USA)
- Dr Robert Davis (USA)
- Michael Roads (AUS)

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Aspects of Awareness: The
Quantum Theory and NDEs

Dr Robert Davis

Star Kids: The New Human

Mary Rodwell

A New Approach to Out-of-Body
Experiences

Robert Bruce

Prayer & Healing: The Creative
Power that Weaved a Miracle

Caroline Cumming

Eternal Soul Archetype:
Your Essential Soul Nature

Dr Linda Backman

Soulmates, Twin Flames,
Synchronicity and Past Life
Connections

Lorna & John Jackson

'Double or Nothing' –The Soul's
Ultimate Gamble: Adoption

Andrew Reay

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Pateena Donnelly

NDE Activations Encoded by the Soul
Paulina Howfield

The Why's & What's of Mediumship
Val Hood

Awakening a New Reality – Becoming
the New Human

Elizabeth Robinson

The Science of Ghost Research
Dr Vladimir Dubaj

SATURDAY 14 JAN 2017

Identifying Embodied ET Souls:
Why are they Here?

Dr Linda Backman

Dream Visits from the Dead
Rosemary Ellen Guiley

The LBL Experience – Igniting &
Embodying your Soul Connection
Here & Now

Colleen Dooley

Life Changing Insights from the
Afterlife

Barry Eaton

What is Life? What is Death? What
is Being Human?

Michael Roads

Deliberate Creation: What does your
Soul want YOU to Create?

Karen Swain

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Location: Perth Enterprise Centre, 18 Stirling Street, Perth

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“The best way to predict your future is to create it.”

AHA State Workshop Reports

QLD – Chereyl Jackman, Secretary

29th May 2016

TENSION, STRESS, TRAUMA RELEASE - TRE SPECIALIST

Sharon Mullan presented an extremely interesting session on Trauma Release. Sharon is a qualified counsellor. She achieved a Diploma of Counselling & Communication from the Australian College of Applied Psychology 2005. She has also trained extensively with David Lake (Clinical Supervisor) & Steve Wells in Simple Energy Techniques i.e. Tapping. Sharon began her TRE, Trauma Releasing Exercises, training in 2010 with Richmond Heath and continued with David Bercei (TRE founder) to complete her Level II qualification.



What is Trauma?

Trauma is the experience of being overwhelmed by life experience. Trauma can be described as “hard trauma” or “soft trauma”. Hard trauma includes serious bodily harm or natural disasters and is often easier to heal than soft trauma which may be locked in the unconscious as a result of prolonged psychological or emotional abuse, domestic or social violence.

Anticipation of negative life issues creates stress. The body requires a large amount of energy to maintain dysfunctional systems that are locked in fight/flight or freeze.

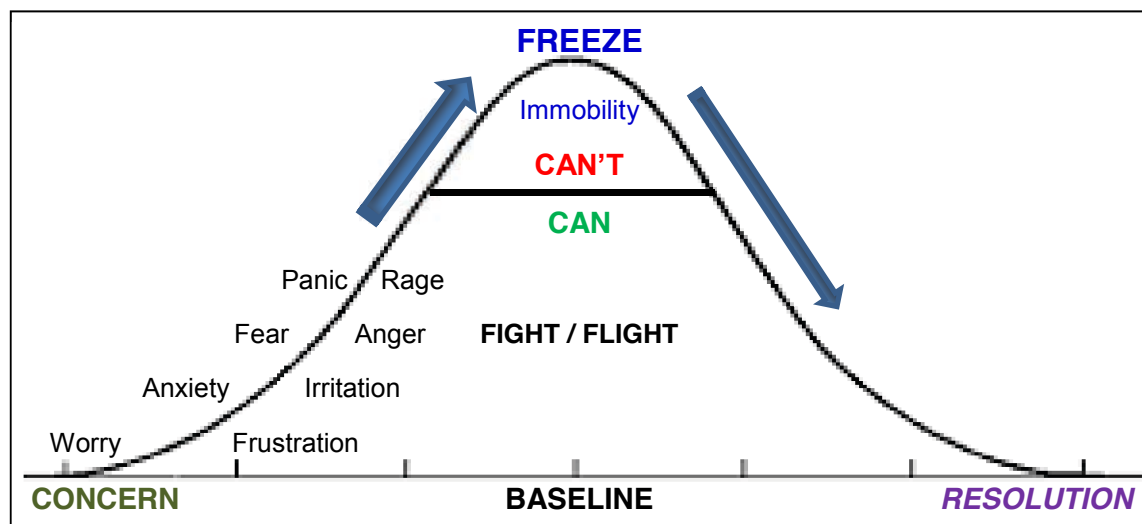
TRE helps to resolve deep chronic tension which has resulted from trauma. TRE also relieves everyday stress which accumulates and manifests in the body in patterns of muscle tension.

Humans are genetically encoded to experience, endure and recover from trauma as part of the evolutionary process. Trauma forces us to think in new ways, to feel emotions at much deeper levels and to relate to each other in more compassionate ways. The evolution of the human species is about the inner development of compassion, caring, sensitivity and connectedness to all forms of life.

All traumas affect the physical body, therefore all healing of trauma must begin in the body. Muscle contractions protect the body during trauma and these contractions must be released to restore equilibrium and to prevent the development of chronic physical pain and discomfort.

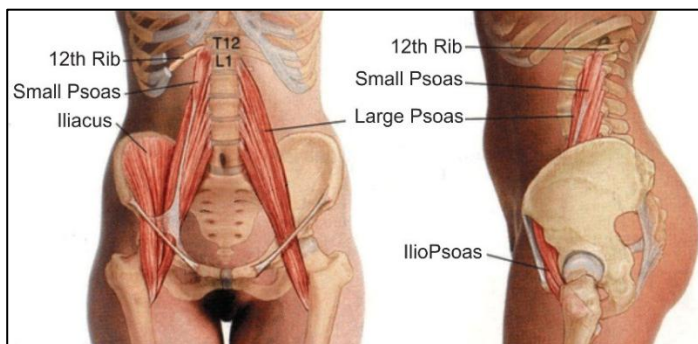
Once the trauma is over the nervous system is designed to literally shake out deep muscular tension with reactive tremours to return the body to its normal state. Overemphasis on the mind and habitual thinking distorts and deadens the body's sensitivity, causing the body to carry the affects of the trauma long after it is over. Repeated and prolonged experiences of trauma causes the mind to immediately freeze, become numb or dissociate to reduce the inevitable pain of the next traumatic experience. This dissociation overrides the tremouring or shaking mechanism that would normally return the body to stasis.

FLIGHT/FIGHT FREEZE MECHANISM



Post-Traumatic Stress Disorder is the term used to describe ongoing symptoms that persist even after the trauma is over.

The body stores the overwhelming emotional and psychological memories and experiences associated with trauma for later processing. The high chemical charge remaining in the body constantly seeks discharge. When this does not occur the charge converts to intense emotions such as rage, hatred, shame, terror, sadness, etc.



David Bercei: The Psoas is the trauma muscle of the body.

PTSD is just the tip of the iceberg. Most people have some kind of trauma, i.e. motor accident, domestic violence, childhood abuse, etc. TRE moves the client from the state of freeze to fight/flight where they have a better chance of survival.

Trauma Release Exercises

There are a number of preliminary exercises which prepare the body by fatiguing the large muscle groups associated with fight/flight. The two main positions require the client to lie on their back, bend the knees and place the soles of their feet together. Palms should be placed on the stomach; breathing should be deep and even.

The next step is to lift the pelvis and lower back off the floor and hold that position until it becomes too uncomfortable or painful to maintain. The hips are then gently lowered to the floor while the soles of the feet remain together. Raising the knees increases tension on the major muscles of the pelvis and promotes the release of deep chronic muscle contraction and undischarged biochemical energy created by severe shock or trauma. The release starts from the body's centre of gravity and moves outwards. Once the muscle trembling has started it should be followed through to its conclusion.



1. Lie on back, soles of feet together, raise knees.
2. Raise pelvis.
3. Lower pelvis to floor, follow muscle release.

The sign that an emotional release is over may be a change in breathing or skin tone and a deep sense of relaxation.

Trauma Release Exercises do play havoc with the CranioSacral system. Placing one hand gently over the forehead and cradling the back of the head with the other hand while monitoring the breath is an effective way to calm the mind and body. (Emotional Stress Release - Kinesiology).

An Integration exercise after body work so that the client will relax more is to have the client take the practitioner's hands, relax the shoulders, and the practitioner pulls downwards to release the stiffness in the shoulders. To test for the level of relaxation, move the arms about to check that there is no resistance. Next, lift the legs up towards the ceiling (Shiatsu technique), try to get them rather straight, cross your forearms over the front of the toes. Relax, integrate and relax and breathe. Stretch out the legs. Test level of relaxation by moving the body to see if the movement goes right up to the head. Put a hand over the client's chest or belly and note their breathing.

For more information please refer:

Advanced Bodywork for Treating Trauma
Sesión de bioenergética con el Dr. Chan (1/2)
Advanced Bodywork for treating trauma by Dr. Carlos Chan
Dr. Carlos Chans Bioenergetic Method.

<https://www.youtube.com/watch?v=W7f92fscxUQ>
[https://www.youtube.com/watch?v=jigGwk7ydJs`](https://www.youtube.com/watch?v=jigGwk7ydJs)
<https://www.youtube.com/watch?v=cTVpGfmnr2k>
drcarloschan.com

Chereyl Jackman
Secretary, AHA QLD

AHA State Reports

State Links

The NSW State Report

Go to the AHA – NSW website for further updates:

http://www.ahahypnotherapy.org.au/nsw_workshops.htm

The ACT State Report

Go to the AHA – ACT website for further updates:

http://www.ahahypnotherapy.org.au/act_workshops.htm

THE QLD State Report

Go to the AHA Queensland website for further updates:

http://www.ahahypnotherapy.org.au/qld_workshops.htm

The TAS State Report

Go to the AHA – Tasmania website for further updates:

http://www.ahahypnotherapy.org.au/tas_workshops.htm

The NT State Report

Go to the AHA – NT website for further updates:

http://www.ahahypnotherapy.org.au/nt_workshops.htm

The SA State Report

Go to the AHA – SA website for further updates:

http://www.ahahypnotherapy.org.au/sa_workshops.htm

The VIC State Report

Go to the AHA – Victoria website for further updates:

http://www.ahahypnotherapy.org.au/vic_workshops.htm

The WA State Report

Go to the AHA – WA website for further updates:

http://www.ahahypnotherapy.org.au/wa_workshops.htm

Victorian Report for June 2016 Journal

A great thank you to all who have attended our workshop on the 5th June 2016 at the Caulfield RSL. We had very positive feedback about Peter Harris lecturing “Gestalt and existential work” and I would like to thank Georgina Mitchell for writing our workshop report. It is nice to see members getting involved and we need as much help as possible, very much appreciated. 60 people have registered and we have noticed an increase of attendance to our workshops, which is very encouraging and rewarding.

The workshop was followed by our AGM with Mailin Colman, our National President, who came especially from Alice Spring to meet and greet the Victorian members.

I am happy to announce the elections of the Victorian Committee for the year 2016 as:

State Executive Officer:	Marc Ponzi
Membership Secretary:	Marc Ponzi
Secretary:	Raeleen Harper
Treasurer:	Shelby Ingram
Workshop Coordinator:	Stella Dichiera
Committee Member/ Peer support:	Sylvia Meletis
Committee member:	Helen Wayland

I am also grateful of the input of Justus Lewis, Ros Turnley and Alex Zannoni for writing “*Embodied Happiness; A lifetime Journey*” and “*Trauma and Attachment Theory*” by Justus Lewis.

I am looking forward to seeing you at our next workshop on Sunday 4th September 2016.

Thank you all for your support and dedication to Hypnotherapy and the AHA.

Marc Ponzi – National Director & SEO Victoria



Mailin Colman



Marie Element & Gwen Pasin



Chereyl, Marie & Mailin



Marilyn Colvin Boon & Mailin Colman



Marie Element

**AHA AGM
Queensland
29.5.2016
Photographers:
Edward Fearn
Greg Mirkin**

AHA Queensland Report June 2016

I would like to introduce myself as the new SEO for Queensland. I have been on the Queensland committee for the past five years as supervision coordinator and one year as the national supervision coordinator. Therefore, I have had the pleasure of meeting many of our members and I hope to get to know each of our members personally.

The direction forward is to ensure that we continuously challenge ourselves to run our State in a professional manner; whilst at the same time creating a place where all our members feel they are supported, belong; and can grow together as an association.

Queensland welcomed Mailin Colman at our AGM on 29 May. It was wonderful to see how many members had connected with Mailin's gregarious personality. We sadly saw Marie Element stepping down from SEO after 5 years where she made a tremendous contribution to Queensland and was highly respected in her role. We also saw Marilyn Colvin-Boon step down from workshop coordinator where she made a big effort setting up both Try booking and MailChimp in her year on the committee. We would like to thank both Marie and Marilyn for their contribution.

We start off with an exciting new committee ready to support the members. I would like to acknowledge and introduce the following committee members and their portfolio; and thank them for their commitment:

Committee Role	Name	Email	Telephone
SEO	Gwen Pasin	gwenpasin@icloud.com	0404 705 453
Treasurer	Bernie Rizzo	bernadette@ahahypnotherapy.org.au	0401 082 077
Secretary	Chereyl Jackman	ecs nt@bigpond.com	0434 936 613
Membership Secretary	Marie Element	Marie@marieelement.com.au	0421 396 994
Workshop Coordinator	Jeni Langdon	jeni@impacthypnosis.com.au	0414 448 719
Supervision Coordinator (Brisbane & Sunshine Coast)	Evonne Fisher	efh@evonnefisher.com.au	0401 008 823
Supervision Coordinator (Gold Coast)	Deborah Bow	azurisperfect@hotmail.com	0404 875 574
North Queensland	Jeffrey Mack	tsvlmodernhypnosis@gmail.com	0428 968 777

The database shows that the membership in Queensland, including north Queensland, presently stands at 162; and the breakdown is listed.

Membership	Number of members	Membership	Number of members
Affiliate	1	Clinical	71
Student	48	Fellow	1
Professional	31	Life	2
		Total	162

Northern Territories is also administered under Queensland, and the numbers include:

Membership	Number of members
Professional	1
Clinical	1
Fellow	1
Total	3

We have an exciting year ahead of workshops planned. Please ensure you put the following dates on your calendar.

28 August 2016 ***Coming Home to Ourselves***
 Morning Session: *How to work with grief and loss and heartbreak*
 Afternoon Session: *The NLP Archetype Process for Healing and Success.*

Alistair Horscroft

27 November 2016 ***Gottman's Sound Relationship House in Practice:***
Linking couples theory to practical interventions

Trish Purnell-Web

Christmas Lunch
 Shelley Stockwell Nicholas

2017

19 February 2017 ***Resource Therapy***

Dr Gordon Emmerson

Presenters and information for other workshop dates on 28 May, 27 August and 26 November TBA

Hope to see you all at the workshop on 28 August. Looking forward to a great year.

Warm regards,

Gwen Pasin
 SEO Queensland

WA STATE REPORT

Western Australia had its AGM on May the 7th and it was great to see Mailin Colman again in the West. It was also wonderful to see how well she has taken to the Role of President. I knew she would. I would also like to take this opportunity to thank the outgoing Executive and Committee and Lyn Robinson [who due to personal reasons had to step down as SEO during the year], for all the time and effort they have put into their respective roles. It has made my transition into the position of SEO so much easier. I would also like to thank in advance the incoming Executive and Committee for taking the leap and donating their time and effort to further advancing the cause of AHA in WA.

After our AGM and Mailin's Q&A session, Joshua Hawkes presented us with a very informative workshop on Psychological Critical Incident Management. Joshua is an experienced and knowledgeable facilitator is very down to earth and interacts well with his audience. Overall the workshop was well received by attendees who found the presentation interesting and well covered. Although most attendees admitted little experience in the topic they indicated that it was important to Clinical Hypnotherapy.

Our next workshop will be held on Sunday the 7th of August.

The guest speaker will be Peter Smith. Peter is the author of Quantum Consciousness and Creator of the Quantum Consciousness Experience. Please watch your email inbox for the WA workshop flyer so you can receive more information on what Peter promises to be an interactive experience. I look forward to seeing you all there and supporting the WA branch of the AHA.

Kind Regards

Linda Milburn

SEO/AHA/WA

South Australia State Executive Officer Report – AGM 2016

We held our first official AGM for a couple of years this year, and I am happy to say that we will now be functioning as a productive chapter of the AHA from 2016 onwards. We currently, after renewals this year, have 47 members in SA – 9 students, 23 Professionals and 15 Clinical.

Our first workshop for the year was presented by Jan Sky is ESI™ (Executive State Identification), a Mapping Tool developed from ego state personality theory. It has evolved from the work of Freud and Federn, making its way into the current day counselling and coaching environments.

In July of this year, we are lucky enough to be holding the National AGM. This is a first for us in Adelaide and we are pleased and excited to host this very special event.

We are planning another Workshop on the 17th September, where we will introduce two of our members who have exceptional knowledge and talents in Hypnotherapy.

Our final workshop for the year will be in November, and we have secured Shelley Stockwell from the US to present a half-day workshop for us as she travels around the Nation. The other half-day is open to having another one of our SA talented therapists take us through some of their professional expertise.

Rona Spicer
State Executive Officer
South Australia

AHA State & National Committees

National Committee



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0417 184 355
mailin@ahahypnotherapy.org.au



Vice President
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0401 082 077
bernadette@ahahypnotherapy.org.au



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Director – WA Representative
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glmilburns@bigpond.com

Supervision/Peer Group Co-ordinator



Webmaster NHRA Register / Committee Member
Antoine Matarasso
antoine@ahahypnotherapy.org.au



**National Head Office & Free Advisory Line
National Administrator
Membership, Health funds, Database**
Amanda Healy (on leave)
Mailin Colman or other national committee
1300 552 254
admin@ahahypnotherapy.org.au

NSW / ACT Committee



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NSW Peer Group Supervision/Co-ordinator
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Victoria /Tasmania Committees



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pureintuition@optusnet.com.au



Vic State Secretary
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missrae@modernhypnosis.com.au



Vic State Treasurer
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Vic Committee Member
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helen@counselling-hypnosis.com.au

Vic Committee Member / Peer Support
Sylvia Meletis
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massageandtherapies@gmail.com



Tasmanian Representative
Noeline Robinson
03 6224 2060
noelinerobinson@bigpond.com

South Australian Committee



State Executive Officer

Rona Spicer
0408 816 118
rona@strategicmc.com.au



SA State Secretary

Marilyn Peterson
0408 825 932
info@innerresolve.com.au



SA State Treasurer

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AHA Journal – Benefits of Submitting Quality Articles

The Australian Hypnotherapy Journal Benefits

Getting published in the journal, especially now that it is recognised and stored at the National Library, boosts your credibility and begins the trust cycle with your readers, as well as:

- **Boosts Your Personal and Business Credibility:**
For many authors, being published in the Journal is an excellent way to get started. Having your articles in The Australian Hypnotherapy Journal allows them to pre-sell your ideas without you having to make any cold calls or face-to-face sales appointments to advertise your services.
- **Builds and Markets the Brand Called 'You':**
Having your articles published in the Journal builds 'you' as a brand name, builds your business, and advertises your expertise. It begins or reinforces in your colleagues and prospective clients' minds what you can do for them.
- **More Effective than Regular Advertising:**
Publishing your article in the Journal means you become known as the expert by the reader and this encourages trust by potential clients, before they even visit your website. There is no better way to "pre-sell" you, as the expert, than by article marketing.
- **Exposure to the Hundreds of Readers:**
Your articles may be viewed by the hundreds of AHA members and other associations' members as well as the public that visit the AHA website every month! We work very hard to deliver a positive, fast and reader friendly experience that keeps readers returning for more.
- **Receive Quality and Relevant Leads to Your Website:** People who read your articles and then click on your website link at the end of each of your articles, for further information; are highly-motivated prospects by the very nature of how they initially found your website.
- **Increases Traffic to Your Website:**
This is caused by the various e-zine publishers who regularly scrutinise the latest copy of the Australian Journal throughout the year to pick up quality articles for their email newsletter or website in addition to our hundreds of members who are looking to immediately benefit from your expertise. When your articles get picked up for reprints, you will often get a surge of traffic to your website, as your articles are introduced to other associations' email list members etc.
- **You May Receive Free Ads in other E-zines:**
When other e-zine publishers come to the Journal to pick up and reprint your articles to their newsletter base, this is essentially a free ad in their newsletter. The better quality you put in your article, the higher your chances are of increased distribution by other e-zine publishers who use the Journal to find quality content to send to their readers.
- **Optimise Your Existing Article Archive:**
If you have already produced a series of quality articles, why not submit them to get even more readers and promotional mileage for your efforts? After all every article you submit to the Journal will reach new readers that would have never found your articles or website before.
- **Get Continual Traffic to Your Website for Many Years to come for Free:**
Your articles will be stored in the Journal archives on the AHA website for many years. They will also be stored at the National Library of Canberra digital archiving section:

<http://pandora.nla.gov.au/tep/114491>.
- **E-Zine Publications:**
It is also the case that many e-zine publishers will pick up your articles for reprints and this could mean continual traffic over the next decade or more.

The Australian Hypnotherapy Journal

Advertising Guidelines

Submissions - News and Articles

We welcome your feedback and input in the form of news, views, poetry, letters, articles etc. Please forward these to the editor, Chereyl Jackman at:

ecs_nt@bigpond.com by the date/s noted below.

Schedule of Issues

Spring: Submissions received by 20th September for publication beginning October.

Summer: Submissions received by 10th of January for publication at end of January.

Autumn: Submissions received by 20th of March for publication early April.

Winter: Submissions received by 20th June for publication early July.

Advertising Guidelines

1. The Journal will refuse an advertisement if we do not consider it suitable.
2. The inclusion of an advertisement in the Journal does not imply endorsement of the product, the company advertising the product or the service being advertised.
3. It is the responsibility of the advertiser to ensure they don't offer products and/or services that are unsafe or defective.
4. Advertisers are responsible for complying with the relevant Australian guidelines for advertising their products and must be able to substantiate any claims they make.
5. Advertisers are responsible for ensuring that all claims about your goods and services are accurate. Do not claim that your goods and/or services have any special sponsorship or affiliation that it does not have.
6. When advertising the price of goods or services, the total cash price, including GST, must be provided. You must show the full price, including any commissions, charges, or postage and handling.
7. Advertisers should not advertise goods or services at a specified price if they are aware, or should be aware, that they are unable to supply reasonable quantities at that price for a reasonable period. Advertisers must not make false or misleading representations about the products and/or services being advertised. Misleading behaviour includes any kind of conduct or behaviour in business that could give a customer the wrong impression or may potentially breach the Trade Practices Act

8. Disclaimers should be specific, clear and highly visible.
9. Advertisers do not exert any influence on the editorial content, selection of content or presentation of material in the Journal.
10. If you follow a link from an advertisement you may be taken to a third party website. The Journal does not review or control the content of third party websites and is not responsible for the accuracy of the information contained, or the views expressed, in those sites. If you supply information to those sites, or access their products and service you do so at your own risk.
11. Advertisers should not accept payment if they know, or should know, that they cannot provide the kind of goods or services promised.
12. Comparative advertising is acceptable as long as it is legal, truthful and does not mislead in anyway.
13. When the disclosure of qualifying information is necessary to prevent an ad from being deceptive, the information should be presented clearly and conspicuously so that consumers can actually notice and understand it. The Journal Advertising Policy may be revised periodically.

Artwork

Artwork is the responsibility of the advertiser and needs to be sent to the editor as an email attachment. Preferred document types are Microsoft Word or JPEG (300dpi).

Bookings and Payment

Please provide your advertisement together with your payment to ecs_nt@bigpond.com before the submission date as the AHA only accepts a limited amount of advertising for inclusion in each issue of The Australian Journal of Hypnotherapy.

Please note advertising will not be accepted without the accompanying payment. Payment details are listed below.

Direct Deposit

The Australian Hypnotherapists Association,
CBA, Paddington, NSW
BSB: 062 220
A/C: 10012818

Advertising Rates

Full page	\$75.00
½ page	\$45.00
¼ page	\$25.00

Benefits of AHA Membership

Once you are a member, the AHA offers you a unique combination of benefits.

These benefits include:

Professional Opportunities:

- The prestige of being part of the oldest and largest professional hypnotherapy association in Australia recognised nationally and internationally
- The opportunity to attend international and national hypnosis conferences at reduced registration
- The circulation of details of forthcoming AHA workshops and seminars giving you access to advanced specialist hypnotherapy training
- The opportunity to be published in the Australian Hypnotherapy Journal
- Free subscription to 4 issues per year of the Australian Hypnotherapy Journal – this journal is subscribed to by universities and libraries around Australia
- Free publication and distribution of regular *News Bulletins*
- Upgrading to higher membership levels as soon as you qualify.

Promotional Opportunities:

- Free listings on the National Hypnotherapists Register of Australia™ (NHRA™) which includes:
 - “find a Hypnotherapist” search by postcode, suburb or name
 - Free active link to your own email address and website(s)
 - Personalised description of your qualifications and specialities
 - Able to update any time for no cost
- Use of *AHA & NHRA™ Logo*
- Free inclusion (where applicable) in the *Foreign Language Speaking Register*
- Free dedicated referral facilities from the AHA National Advisory Line by an experienced, specialist hypnotherapist to all professional and clinical members (our 1300 55 22 54 number is available to members and the public between 9:00 am to 12:00 pm Monday to Friday)

Professional Support:

- Strong support network – access to professional supervision with trained AHA supervisors willing to support your career progress
- The publication (within the AHA website) of regional information to Registrants seeking peer group or personal supervision arrangements
- Access to AHA administration support willing to assist with clinical and administrative information / support
- Receive all membership mail outs
- The Forum – online case discussion where you can ask questions of other members about any issues you may encounter
- As a member of the AHA you have the opportunity to establish professional relationships with hypnotherapists throughout the world

Professional Security / Credibility:

- Access to **discounted Professional Indemnity & Public Liability Insurance**
- **Health fund provider numbers** allowing rebates for your clients (the list of health funds can be found here: http://ahahypnotherapy.org.au/aha_members_area/)
- Advice with regard to obtaining *Criminal records bureau disclosures* (WWC and Police checks)
- Ongoing updates with regard to government legislation concerning the hypnotherapy field

- Opportunity to create positive change in the industry by becoming a committee member
- Representation to and dissemination of relevant information from the Department of Health and Aging and other relevant agencies
- The provision of relevant information on all aspects of the profession to registrants, the media and public

International reciprocal alliances:

- Automatic acceptance under an *international reciprocal alliance* into either the General Hypnotherapy Standards Council (GHSC UK), the Association of Registered Clinical Hypnotherapists (ARCH Canada) or the New Zealand Association of Professional Hypnotherapy (NZAPH) if relocating to those countries. Please also note that the application process and standards apply if you are entering Australia. Please call 1300 55 22 54 for further information.
 - [The General Hypnotherapy Standards Council \(UK\)](#)
 - [Association of Registered Clinical Hypnotherapists \(Canada\)](#)
 - [New Zealand Association of Professional Hypnotherapists \(New Zealand\)](#)

Access to the above benefits in individual cases is always at the discretion of the AHA Executive

Member Associations:

- The AHA is a member association of the Hypnotherapy Council of Australia (HCA)
- The AHA is an affiliate member of PACFA.

For details on how to become an AHA member go to:

<http://ahahypnotherapy.org.au/about-australian-hypnotherapists-association/how-to-join-the-aha/> and download the prospectus and application forms.

AHA Information and Updates

Workshops for 2016

NSW	Sunday	4th September 2016	GM & Training
	Sunday	27th November 2016	GM & Training
QLD	Sunday	28th August 2016	GM & Training
	Sunday	27th November 2016	GM & Training
Vic	Sunday	4th September 2016	GM & Training
	Sunday	4th December 2016	GM & Training
WA	Sunday	7th August 2016	GM & TBC Peter Smith
	Sunday	19th November 2016	GM & Dr Michelle Middlemost

AHA National office toll free number
Available to members and the public
Email:

1300 552 254
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admin@ahahypnotherapy.org.au