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Recognising your Client's Subjective Interpretations

by Stephen Brooks UK

Clients make subjective interpretations about why they have problems.

When Clients enter therapy they bring with them vast amounts of information. Some of this information is based on fact, some is based on fantasy. The fantasy portion of their reports are subjective. As Therapists we find it easier to work therapeutically with real actual behaviour. These behaviours or symptoms or real causes are given to us by the Clients in the form of factual information. However because Clients are so tied up with their problems, they usually give us vast amounts of information based on their own subjective interpretation. Clients interpret their symptoms and their behaviours and their problems in many different ways. Many of these interpretations are not useful to the Therapist. In fact if the Therapist gets involved in attempting to understand these subjective interpretations or, at worst, believing these interpretations, then therapy can be a very long procedure.

Clients make subjective interpretations about why other people have problems.

Because many Clients' problems involve other people, Clients also interpret the behaviours of others from their own subjective viewpoint. For example a husband may interpret his wife's behaviour purely from his own subjective understanding, when,

in reality, her behaviour is caused by something different. This mind reading on the part of the Client can contaminate the therapeutic process as it is usually not based on fact and is only a subjective interpretation.

It is very important for the Therapist to acknowledge the subjective reports that Clients make about their behaviours and the behaviours of others, if only for the sake of maintaining rapport, but then to pursue relevance. If not, the Therapist may get drawn into the Client's own beliefs and end up being just as confused as the Client.

Interpretations limit a Client's chances of getting better.

Because these subjective interpretations are based on hearsay, unconfirmed beliefs or popular psychology references, they can easily side-track the Therapist, especially if the proposed interpretation is based on a plausible or an attractive idea. If, as a Therapist, you discover yourself being distracted away from your main line of questioning, you have probably been influenced by an interesting subjective interpretation given by the Client. There are a number of different classes of subjective interpretation offered by Clients, here are some examples:

Hereditary Interpretations: "my mother had the same problem".

Prediction Interpretations: "he will say the same thing next time".

Cause and Effect Interpretations: "I always feel depressed when our daughter forgets to phone".

Biological Interpretations: "it's my hormones".

Personality Interpretations: "that's

the way I am / he is".

Casual Interpretations: "she acts just like that girl did in that play about depression".

Medical Interpretations: "the doctor says I am depressed and it could last for years".

Cognitive Interpretations: "he's thinking about his work all the time".

Nominalised Interpretations: "she's confused and doesn't understand, her expectations are preventing us communicating".

Judgmental Interpretations: "people shouldn't behave like that, should they?"

Emotional Interpretations: "I have always been up tight, it's my nerves

Motivational Interpretations: "she's trying to punish me for forgiving my mother".

New Age Interpretations: "my inner child lost her shamanic healing crystal in a past life".

NLP Interpretations: "I can't visualise the submodalities of my future time line ever changing unless I can contact the part responsible for anchoring the dissociated state that my unconscious accessed during that congruency exercise."

You will notice that some interpretations fall into more than one class of interpretation, for example with this interpretation "my mother reacts the same way whenever she sees a spider" falls into both the Hereditary and Cause and Effect class of interpretation.

Giving Birth and Labour Pains

by Bernie Siegel, MD

"There is no greater blessing than the capacity to give birth, for it is the one opportunity we have to truly create, and to create something from our own flesh and blood." These are the words of Rabbi Menachem Mendel Schneerson in the book *Toward A Meaningful Life*. He goes on to say that we are creating something out of nothing and that bearing children is our one opportunity to act in a Godlike manner and to touch eternity.

He also asks would it not be easier if we were created as adults instead of children and able to provide for ourselves. "But there is a beautiful lesson in childhood itself—above all, that a child is genuine and innocent, and that such innocence is the foundation of life.

From my work as a physician with people with life threatening illnesses I have come to see how vital it is to grow up feeling loved and with mottoes to live by and not die by.

For the first six years of a child's life its brain wave pattern resembles that of someone under hypnosis. So the child is being entranced by the words it hears from the authorities in its life. When a child grows up hearing negative messages about how it disappoints and embarrasses its parents, never feels a loving touch and is abused physically and psychologically with indifference and rejection it will choose a path of self destruction, addictions and revenge. When this

happens the world and its inhabitants suffer from their actions.

Studies show that those children who do not feel loved have almost a 100% incidence of major illnesses by mid-life. While those who felt loved as children have closer to a 25% illness rate by that age. Information is not what children need. They need inspiration and a feeling of self worth and esteem. You do not have to like what they do but you have to love them. You can point out what you don't like rather than ask, "What's wrong with you?" and have your words eat away at them for a lifetime.

Children need to grow up with mottoes to live by. Parents, who tell them to do what makes them happy, when they have decisions to make, will put them in touch with their feelings and heart's wisdom. When troubles occur they can be told, "It was meant to be God is redirecting you; something good will come of this." Thus their view of the future becomes a hopeful one and not a destructive one. Let them know that material things are to make the world a better place for us all to live and that when you are happy you are a success but when you are a success you are not happy. I always remember the young man in my office who said, "My father ruined my life when I was twenty one. He gave me a million dollars. I had to be a success." I keep thinking about what his father would have said if he came home and said, "Dad, I started a charity for sick children." Would he have yelled at him for wasting his money?

And as Martin Buber shares when God doesn't answer your

prayers it is because you are at full term and like a woman ready to give birth are to be born again through your own efforts and labour pains.

For me life is a labour pain and when we can accept that we will have less pain because giving birth to our child or ourselves is worthwhile and justified. The key in life is to teach your children that they decide which pains are worthwhile to experience because of the final result and not subject themselves to pain and problems because others prescribe them.

When we are loved we are immortal and our consciousness and presence is never lost to our survivors. In my book *Love, Magic & Mudpies* I give lots of practical advice about how to make the magic happen and turn the mud pies into castles. When we raise every child to feel loved, be kind and make a difference the world's problems will all be resolved.

Bernie Siegel, MD author of: *Love, Medicine & Miracles*; *Help Me to Heal*; *Love, Magic & Mudpies* and more...

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From Counselling Today July 2009

by Kim Johancen-Walt LPC

The initial interview with the self-harming and suicidal client

Deidre, age 24, had agreed to see me after confiding to a close friend that she was thinking about killing herself. During our first session, she discussed how self mutilation and an eating

disorder had allowed her brief moments of relief from isolation and self-hatred. Deidre had been self-harming for more than 10 years and, although her behaviours had helped her survive unbearable emotional pain, she had become increasingly hopeless, desperate and suicidal.

As a licensed professional counsellor and therapist working with clients who are suicidal, self-harming or engaged in both behaviours simultaneously, I have learned the importance of the initial interview. So many of our clients, like Deidre, have been doing the best they can yet still feel caught in a landslide with suicide rolling toward them. During this first critical meeting, counsellors need to create an environment that will become a therapeutic foundation communicating hope and connectedness to a caring other and nurturing a commitment to treatment.

Counsellors working with this population must assess lethality (throughout treatment) while also targeting the painful thoughts and feelings fuelling the client's potentially life-threatening behaviour. Through my research, experience and constant search for more effective treatment, I have created a model that allows the counsellor a vehicle to accomplish these tasks effectively from the very first interaction. It blends strategies with assessment tools to create a therapeutic space in which change can happen for even the most difficult of clients. Here, I offer an overview of the three stages that have guided treatment for my clients, helping them achieve success in their efforts

to create lives worth living.

Stage 1 : Creating safety

One of my clients recently likened counselling to a living, breathing diary, with the added benefit that a counsellor can offer support and sound advice. We have to embody that kind of safe container for the vulnerable individuals we are treating. As my clients begin telling me their stories of self-harm and survival, I offer my belief that people do not engage in these behaviours without reason. Our clients are hurting themselves or wanting to kill themselves because they are desperate to end their emotional suffering. Through understanding and accepting their behaviour, we can directly target feelings of shame and isolation that may be keeping our clients chained and silent. Regardless of their behaviours, it is important to remind our clients that they are doing the best they can and that their lives are worth saving.

Many therapists focus on behaviour instead of asking questions about the painful feelings fuelling that behaviour. It is of utmost importance, of course, to find out if clients' actions are putting their lives-at risk, but if we are interested solely in the behaviour, we will find ourselves only treating symptoms. In our efforts to help clients feel safe and understood, it is important to ask them why they are self-harming or suicidal. Many of my clients have had their self-esteem and sense of self-worth shredded through a variety of traumas. In these instances, the need to punish themselves for their perceived flaws may be fuelling their self-harming and suicidal behaviour.

Samantha, age 18, had become suicidal after experiencing sustained trauma while growing up with an emotionally and physically abusive mother. These experiences led Samantha down a road lined with isolation, rage and self-hatred. In a desperate attempt to end her emotional pain, she found herself with a knife in her hand and a desire to slit her own throat. Thankfully, Samantha did not kill herself, but she was obviously drowning in unbearable emotional pain. By focussing on what had fed this suicidal gesture, she was able to resolve many of her issues and was no longer suicidal. She left therapy soon after with her prevention strategy plan firmly in place.

As the story of each client's unique and painful journey unfolds, I am diligent about checking in repeatedly during the interview to ensure that the individual is feeling safe and accepted. Furthermore, I request that the client correct me if at any point I miss or misinterpret any part of the story. This type of questioning creates a collaborative environment in which the client feels like her/his input is an important part of the process. Matthew Selekman, a respected therapist and internationally published author, discusses how this approach can be richly therapeutic because it makes clients an active participant in their treatment and takes the therapist out of the "expert" role.

Stage 2: Assessing risk of suicide

After a sense of safety has been established and the counsellor has communicated the critical role that the client plays in her/his own

treatment, it is imperative to assess the client's level of risk for life-threatening behaviour. Jack Klott, a therapist with more than 40 years of experience working with this population, explains that clients who are talking about suicide are ambivalent. This ambivalence leads them to talk about the part of them that wants to live and the part of them that wants to die.

These discussions offer the counsellor a wealth of information about what is keeping the client alive while also supplying details about the irrational belief systems that may be leading the client toward attempting suicide. Cognitive restructuring techniques can be extremely effective in these situations, allowing the counsellor an opportunity to challenge the client's irrational thoughts and beliefs.

Victoria, 19, was in my office describing an incident in which she had contemplated hanging herself. A survivor of child sexual abuse and incest, she discussed what led her to this moment of crisis, including the irrational belief that her life would be "better" if she were dead. Through flowing tears and rapid speech that conveyed her need to release the story and the pain attached to it, she recounted how she had tied the sheet around her neck but decided not to commit suicide at the final moment. When I asked her about this life-saving decision, she shared how thoughts of her nieces and nephews had kept her from completing her suicide attempt.

While discussing what was keeping Victoria alive, I was also able to challenge the belief that her life would be better if she killed herself.

We talked about the skills Victoria had used to stand up to suicidal impulses since this incident. She explained that, at times, focussing on a future career as a doctor helped her stand up to suicidal urges; other times, it was the memory of that day with the bed sheet that reminded her of her strength to survive.

Throughout my career, I have compiled a list of the factors that most commonly heighten clients' risk level for suicide. For example, although it is a myth that all clients who are self-harming or suicidal have been sexually abused, it is important to note that 12 out of the 14 suicidal high school students I worked with last year reported previous sexual trauma. Other common risk factors include overwhelming feelings of rage, isolation and hopelessness. Clients who have not resolved issues surrounding previous suicide attempts are also at risk of completion. Obviously, the more red flags our clients present to us in treatment, the more at risk they are for life-threatening behaviour. According to Anne Marie Albano, director of the Columbia University Clinic for Anxiety and Related Disorders, adolescents who have an untreated anxiety disorder at age 13 are also more at risk for depression by age 15. Add to that a substance abuse disorder, and you have a client who is at a heightened risk for suicide.

Stage 3: Identify strengths and resiliencies

One of the purposes of the assessment interview is to gather information about the level of risk facing our clients. It can also be a valuable therapeutic experience that

immediately targets feelings of hopelessness and isolation. By offering our clients a belief that they have the answer and solutions to their problems, we are encouraging them to focus on their ability to overcome and survive.

Tess, 21, had previous success standing up to the shame and isolation associated with an eating disorder. In therapy, we explored how she had "pulled this off" in the past by focussing on her long-term goals (graduating from college) and through her daily practice of mindfulness techniques. We also discussed ways Tess could transfer her previous successes to new crises as they arose.

By encouraging our clients to look at themselves through this solution-driven lens, we communicate faith in their ability to stand up to self-harm and suicide. It is critical that we begin this process at the beginning of treatment because so many of them are coming to our offices feeling isolated and hopeless. In some cases, they have experienced several failed treatment attempts. Many of these clients are becoming increasingly suicidal.

Lisa, 18, came to therapy feeling gradually more suicidal. She had a history of significant substance abuse, bulimia and cutting, and she had walked up to the edge of a busy highway in Denver one hopeless night with thoughts of stepping out into traffic. Lisa was quickly spiralling downward and had become increasingly depressed and withdrawn. During our initial meeting, we talked about how in spite of incredible suffering, she had stood up successfully to many of these

behaviours. We talked about her inherent strength and her determination to find meaningful connection with others. Subsequent treatment included validating pain associated with previous trauma, tending seeds of change and identifying the skills and strengths Lisa had used to confront so many challenges in her 18 years of life.

By offering our clients a powerful experience during the initial interview, we can help them uncover the path to hope and recovery. Counsellors can use the assessment model discussed in this article in many ways, because that is the dance of therapy. But if the counsellor keeps the elements of this model in mind from the very first interview, then therapy can be a collaborative experience that allows us a deeper look into the client's world. It can also become a protected space for clients to explore and find the ground beneath their feet as they continue their journey toward a life worth living.

Study Shows Possible Link Between Deaths and ADHD Drugs

by Shankar Vedantam

*Washington Post Article
Tuesday, June 16, 2009*

Children taking stimulant drugs such as Ritalin to treat attention-deficit hyperactivity disorder are several times as likely to suffer sudden, unexplained death as children who are not taking such drugs, according to a study published yesterday that was

funded by the Food and Drug Administration and the National Institute of Mental Health.

While the numbers involved in the study were very small and researchers stopped short of suggesting a cause and effect, the study is the first to rigorously demonstrate a rare but worrisome connection between ADHD drugs and sudden death among children. In doing so, the research adds to the evolving puzzle parents and doctors face in deciding whether to treat children with medication.

Doctors have speculated about such a connection in the past because stimulants increase heart rate and have other cardiovascular effects. Physicians are currently advised to evaluate patients for cardiac risks before prescribing the drugs, and FDA officials said yesterday that those guidelines do not need strengthening in light of the new study. About 2.5 million children in the United States take ADHD medications such as Ritalin and Adderall.

In a press briefing called on short notice yesterday, FDA officials said that given the seriousness of ADHD and the rarity of sudden death -- which strikes fewer than 1 in 10,000 children -- the benefits of the drugs outweigh their risks. Agency officials urged parents to discuss concerns with doctors rather than deciding on their own to discontinue a child's medication. The study's lead author, Madelyn Gould, a professor in child psychiatry and epidemiology at Columbia University, said she agreed with the FDA's advice.

"This study reports a significant association or 'signal'

between sudden unexplained death and the use of stimulant medication, specifically methylphenidate," the study researchers concluded, referring to the chemical name of Ritalin. "While the data have limitations that preclude a definitive conclusion, our findings draw attention to the potential risks of stimulant medications for children and adolescents."

Since an experimental study comparing the risk of sudden death among children taking medications with those not taking medications would have had to include millions of children to generate a useful scientific result, Gould and a number of colleagues conducted what is known as a matched case-control study: They obtained information about 564 children in the United States who died suddenly and inexplicably between 1985 and 1996. The researchers evaluated how many of the children who died had been taking stimulant drugs by asking their parents and caregivers and by reviewing medical documents.

For every child who died suddenly and inexplicably, the researchers then found another child closely matched in terms of age, sex and other variables who died in a traffic accident. Taking a stimulant drug is unlikely to have played any role in a child getting killed in an accident. If stimulant drugs had nothing to do with sudden, unexplained death, then the number of victims on stimulant drugs who suffered such deaths and the number of victims on stimulant drugs who died in traffic accidents ought to have been about the same.

But Gould found that 10

children in the group that suffered sudden, unexplained death had been taking stimulant drugs, whereas only two children in the group killed in traffic accidents were taking such medications.

Robert Temple, director of the Office of Drug Evaluation at the Centre for Drug Evaluation and Research at the FDA, said that the study had been well conducted, but that he was concerned that not all parents may accurately recall whether children who died were taking stimulant drugs. When a child dies suddenly, he said, it is natural for a parent to pay close attention to all the medications the child was taking at the time and to report that to researchers. By contrast, he said, parents whose children die in traffic accidents may be less likely to note whether their children are taking medications -- and less able to report it years later.

In an editorial accompanying the study, Benedetto Vitiello of the National Institute of Mental Health said that ADHD itself might have increased the risk for sudden, unexplained death. If that were the case, he said, it would explain why more children taking stimulant drugs were found in the group that suddenly died than among the children who died in traffic accidents.

The researchers who conducted the peer-reviewed study acknowledged that its design precluded definitive answers, but they said that they had taken care to eliminate each of these potential confounders. They did not consider cases of sudden death in which children had asthma or cardiac abnormalities -- conditions known

to be associated with ADHD -- because those factors might have independently raised the risk of sudden death. They also included one child who died in a traffic accident who seemed to have been abusing amphetamines, rather than taking an ADHD medication.

Gould said she and her colleagues had compensated for biases not only on the part of parents, but in medical records -- medical examiners are more likely to conduct toxicology tests among children who die suddenly than among children who die in traffic accidents. The researchers first eliminated all records that relied on parental memories and looked only at medical records. They then eliminated all cases that had medical records and looked only at what parents reported. No matter how the data were sliced, Gould said, there were significantly more children taking stimulant drugs who suffered sudden, unexplained death than those were killed in traffic accidents.

Vitiello said Gould's study underscores that ADHD drugs are not innocuous. Indiscriminate prescription of the drugs for general behavioural problems and the growing number of healthy teenagers and adults using the drugs to boost mental performance could have deadly consequences, he added.

Book Review

Submitted by Michael K.
Kivinen, M.A., L.L.P., CHT

Hypnosis for Inner Conflict Resolution:

**Introducing Parts Therapy
Author: C. Roy Hunter**

Like ego state therapy, parts therapy "is based on the concept that our personality is composed of a number of various parts. Our personality parts are aspects of the subconscious" (Hunter, p. 1). Roy Hunter calls ego state therapy a variation of parts therapy. Both ego state therapy and parts therapy derive from the work of Paul Federn and John G. Watkins. Both address what is also known as "subpersonalities" or what C. G. Jung called "complexes" or "fragmentary personalities" and described in 1935 as "autonomous groups of associations that have a tendency to move by themselves, to live their own life apart from our intentions." The differences between parts therapy and ego state therapy are a matter of emphasis rather than essentials. Both deal with the same reality, but the former approach is geared more toward the "lay hypnotist" (a hypnosis professional who does not necessarily have additional clinical training or credentials) while the latter is more clinically-oriented. In this excellent introductory textbook of parts therapy, *Hypnosis for Inner Conflict Resolution*, author Roy Hunter credits his late mentor and "twentieth century hypnosis pioneer" (p. ix) Charles Tebbetts with borrowing parts

therapy from Federn and evolving it into a client-centred approach.

Hunter requires his students to read Gordon Emmerson's Ego State Therapy, and he cites that work several times in Hypnosis for Inner Conflict Resolution. Neither book is necessarily "better" than the other; rather, each powerfully complements the other, enough so that one could view these books as forming a two-volume set. Each offers specific techniques not found in the other. The many strengths of Hunter's work include its organization; the direct, easy-to-read writing style; and practical, judicious use of repetition to reinforce conceptual recall. The book includes clear, step-by-step instructions to thoroughly prepare clients for parts therapy and facilitate the sessions. Hunter devotes an entire chapter to "Potential Pitfalls and Other Concerns," and he offers guidance on when to make referrals to (or seek supervision from) mental health professionals. One example would be if a lay hypnotherapist realized that his or her client had multiple personality disorder (now known as dissociative identity disorder).

One area in which Hunter's book surpasses Emmerson's is his section on working with what Emmerson calls "Inner Strength" but what others have termed the "Higher Self." Hunter acknowledges having often used "an application of parts therapy to access that part of the inner mind that is most closely connected to God, or the client's perception of Higher Power" (p. 167). His aim here is not to promote a particular metaphysical viewpoint, but rather to empower clients and promote their

access to untapped internal resources. Elsewhere--with respect to past life regression--I have said that the therapeutic value of such work trumps its literal truth or falsity. Hunter takes a similar perspective regarding working with "Higher Self." He says, "My opinion does not matter, because the client was empowered" (p. 159), and "Whether or not one believes in God or a Higher Power, the subconscious (or unconscious) contains access to an inner wisdom that sometimes far surpasses that of ordinary consciousness" (p. 167). That Hunter's book includes an index and far fewer typographical errors than were at times distracting in Emmerson's Ego State Therapy also warrants favourable mention. Both books deserve wide professional readership and a place on the shelf of any hypnotherapist, addictions counsellor, or trauma therapist.

Crown House Publishing Limited, 2005 (reprinted 2006, 2008) ISBN: 978-1904424600

Many Ways of Healing by Dr. Okka Holthuis

What if there were as many different approaches to healing and well-being as there are roads leading to Rome, and yet all healing would be self-healing?

Let us for a moment, think about health as a state of balance and illness or disease as a state of imbalance. And let us further assume that our body is capable of maintaining a state of balance. And even when we feel sick or are

challenged with a disease, even then most of our billions and billions of cells are functioning properly and healthy. Our body somehow knows how to maintain a balance while constantly and simultaneously millions of inter- and intracellular processes take place. The simple fact that tears cried due to happiness have quite a different chemical consistence than tears cried from pain or grief shows us how amazingly differentiated our bodily responses are and how much inner wisdom our body has. And it is ours to access.

Now, when health is a state of balance and disease is a state of imbalance, and then healing is the process of re-turning to a balanced state. This means the body is working to re-establish harmony while using all available sources to reach this goal. Would it therefore be appropriate - and in a sense, be respectful toward ourselves, to see all healing as self-healing?

What would it be like when we were to change our point of view and intentionally utilize the healing powers within; while using the various forms of treatments and approaches as possibilities to assist us on the road of self-healing?

Through a study done by the Institute of Heart Math it was discovered that the DNA changes its shape according to feelings felt by the researchers. When gratitude, love, and appreciation were felt, the DNA responded by relaxing, the strands unwound and the DNA became longer. When the researchers felt anger, fear, frustration, or stress, the DNA responded by tightening up, becoming shorter and even switching off some of the DNA codes. This

effect was reversed and the codes were switched on again when feelings of love, joy, and appreciation were felt by the researchers.

What have these results to do with healing and self-healing? Each cell in our body has a strand of DNA, within which – among many other things – the information of a healthy, properly functioning cell is located. And since we are in charge of what to think or feel, we can support our healing process by learning to relax – regardless of the environment – and use all our senses and abilities to envision and feel the perfect outcome.

The following is an exercise called 'Safe Place' that will assist you in creating this place within, where there is peace and quiet, where you have access to your inner wisdom and can co-create the outcome you desire. I wouldn't recommend practising this every day, only as often as you would like to feel relaxed, safe and connected.

Safe Place Imagery Script

[You may read this into a CD or have someone say this to you as you begin to enjoy the following script.]

Now, as you will, just find a comfortable position and take a few nice, deep breath in, and while breathing in through your nose into your belly, imagine this breath being filled with relaxation and inspiration. When breathing out through your mouth, exhale all that you are ready and willing to let go off now. And as you continue to breathe easily and effortlessly... breathing in, relaxing, breathing out, releasing... I would like you to envision – in your minds eye

– a place where you feel absolutely safe and comfortable. This can be a place that you know well and have been to before, or maybe it is a place you would like to visit some time, or maybe it is a place in your imagination, it does not matter, just allow yourself to be there fully now. And as you experience this place with all your senses, become aware that this is your place. It is there for you alone. It is your place of calm and peace and harmony; your place of relaxation and tranquillity. And only by invitation through you, other people or things can be there.

And while you enjoy this safe place of yours, you may notice the air, the smells, the temperature, the sounds, and the texture. You might also become aware that, as your body relaxes more deeply, so does your mind, and you drift away into your inner place of harmony and peace. This place within, where you can just be. This place within, where you can pause, breathe and let go. And as you let go and be calm and safe, you might be surprised to find that this calmness and peace spreads further then you might have thought possible. Being so calm and peaceful within and without, you might be astonished to find within, the path to your inner wisdom. This path that is connecting you with your spirit, with your inner source of wisdom, peace and harmony. And if you had questions of some sort before you got here, maybe in the safety and stillness of your inner place answers will come, now, or later, at the perfect time for you. Just be. Be there for as long as it feels good. And whenever you are ready to come back into the present time, do so at your

own pace, knowing that this inner sanctuary resides within, was yours, is yours and will always be yours. Yours to visit, to discover, to enjoy...

Okka Holthuis, Doctor of Natural Medicine and Certified Hypnosis Instructor, is the Founder of Rainbow Healing Centre, based in North Palm Beach, FL - USA. In addition Okka is one of the directors of the Transformation All-Star-Team. Okka has studied many alternative methods of healing, and developed her own energy based healing modality LuxMani. She teaches LuxMani classes – as well as other classes related to the field of Energy Medicine – throughout the United States and Europe.

Pain Relief Script by Linda Iverson, CHT

Do A Standard Induction...

Now you are going to go to your safe place, this is your very own place that only you know about except for your spiritual guides and your higher power. They are here with you – surrounding you, enfolding you, their warmth, love and empathy seep into you. They help you feel safe, secure and strong. You are comfortable, surrounded by love, enfolded in their caring and you feel very safe.

Perhaps at this time, you can consider adding another advisor to this gathering – with the ones who are present to help you relieve your pain. The entity we are calling to join you is your Inner Advisor. While also supporting you – feeling safe, secure and strong, the Inner Advisor also has the answers to help you relieve your discomfort. Would you mind asking your Inner Advisor to join this gathering in your safe place? Let me know by nodding when they are present. Good. It is easy to speak now

and answer my questions. Can the Inner Advisor see everyone else who is present in your safe place? Good. Can the others see the Inner Advisor and do they agree to work toward your highest good in helping solve the issue of your discomfort? What do they say? Good.

Now ask your Inner Advisor what messages your place of discomfort has for you. What does it say? Are you willing to follow the suggestions of the Inner Advisor? Good.

(Give post hypnotic suggestions based on the messages given by the client, adapt the script to the individual using their own words)

For example: Thank your body for using pain to give you notice that something in your body needed attention. You now have been alerted, so it is OK to let this signal fade away. I am going to count from 10 to 1. As I count, the signal will diminish by 50% 10-9-8 diminishing the signal now 7-6-5-4- the signal has been turned down by over 25% 3-2-1. You are there. The discomfort signal has now been diminished by 50%. Thank your Inner Advisor for this suggestion, and thank your body for cooperating in diminishing the discomfort signal by 50%.

Now go to the part of your body that sent the signal. Focus your attention on that part. You notice a healing white healing light. It is just the right temperature and very soothing, streaming in through the top of your head – it is coming in floods – as fast as you can imagine. The white light goes directly to the part that needs attention – as it approaches the part, it becomes a

laser stream – concentrated white light – as it meets the part needing attention, it pools around that part in a ball of white light that cocoons the part with a margin of at least 2' all around the part. As more white light streams it – it becomes more and more concentrated – bleaching out the remaining discomfort in the part. Concentrate on the white light doing its clearing work – it is getting brighter and brighter – more and more concentrated – doing its perfect clearing work – bathing all of the cells and the nerves in its healing stream. The light is so strong now that it starts to sparkle – it is shimmering – the more discomfort it absorbs – the more sparkling and then translucent it is becoming – it is almost clear now. Concentrate and watch the white light turning translucent and clear as it absorbs all of the remaining discomfort. The light has become so translucent that it seems to fade to clear – you can hardly see it now. As it dissipates – it has done its work and taken all of the discomfort with it. It is gone now.

You now not only feel strong, secure and safe, you feel relieved, relaxed, refreshed and rejuvenated. You feel so wonderful knowing that if the discomfort ever does come back, you can just notice it and let it drift away – you have already received its message and so it no longer has a use and you can just let it go now. If the discomfort comes back, it just drifts away.

Keeping this feeling of comfort, safety, strength and relief, you are getting ready to come back now, You remember everything you need to know from this session and you come back feeling refreshed and

relaxed and relieved of discomfort of any kind.

Counting back now – coming back to this time and place – 1 etc – 2 etc.....

Hypnotic Coaching by Dr. Brick Saunderson, RCCH

There is a powerful coaching process that can create some serious changes very quickly.

Before I discuss this, here is a caution. The very simple basics I am about to discuss are very powerful and can lead to some profound revelations. Unless you have been trained in clinical hypnosis and are certified in coaching, consider the following as 'insight' and not guidelines to facilitate change in client.

This process of coaching with a client has some obvious advantages over "standard" coaching methods in that we are using intentional covert hypnotic techniques with the "mastery" coaching model.

Hypnotic Coaching Process

Once the initial rapport building, contracting and administrative discussions have taken place, the first step is to discover what the client's goals are for the coaching experience. Through these discussions I will be covertly reframing the experience, the expected results and some of the existing beliefs the client has that are possible roadblocks to reaching their desired goals.

Covert Hypnotic Trance Inductions

Throughout the process I will be taking them gently through a covert trance induction. When talking about goal setting, this is easy to do. What is essential here is to have them believe "subconsciously" that the goal has already been reached by vividly visualising the results.

Goal Setting

Use whatever goal setting mechanism you are comfortable with so long as it is comprehensive enough to examine both the current situation and the desired results. The essential key question here is what has stopped the client from achieving the goal in the past. If they have never thought of it before, then you need to look at what is creating the roadblocks to success. If they have tried and failed before then you need to get them to explore what created that failure. It is important here to consider Secondary Gain and Hidden Agenda and the possible use of Secondary Gain Protocol.

Perceptual Positions Exercise

Once you have fully explored these areas, I like to have a client engage in a perceptual positions exercise. Perceptual positions is a psychology term denoting that a system (issue/problem/goal) may look very different, and different information will be available, depending on how one looks at it and one's point of view. For example, consider a situation or relationship from the perspective of self (1st position), another person involved (2nd position) and from a neutral, objective, detached point of view (3rd position; "a fly on the wall").

What you are looking for is

the beliefs, values and identity. A great question when a client is in second position is "Who do you have to be to create this result?" Obviously you might need to reframe this question and plumb the depths a little to get the answers that you are looking for.

Consider for a moment what your client will have achieved by this stage of the process. First, they will be in some heavy duty trance state, since you will have had them visualising, stepping into imaginary future selves and bouncing between the past, present and future. Secondly, they will have a contrast between who they currently are and the future person they will have to be to create the results they are looking for.

Time Line Protocol

You can use any of your favourite Progression Hypnosis Techniques to get rid of the limiting beliefs and install the beliefs needed to achieve the outcomes. Personally, I like to use time line processes because with a slight reframe you can look at the whole perceptual positions exercise as a time line. The neutral, objective, detached point of view is good in this protocol because, again with a slight reframe, you can get your client to see the changes in the time line out towards the future.

If you are thinking of a time line approach, remember you are not restricted to staying within the boundaries of present and future self. Going back further in the past to find the source of the values, attitudes and beliefs is useful. Going further out into the future beyond the outcome to see the long-term results could be

good for a whole lot of things including building motivation and desire.

Values, Attitudes & Beliefs Change

Realize you are not restricted in using a time line protocol to facilitate change work. The issue is not the change process but how you elicit the beliefs and values that were limiting and the ones that will support the desired result. Time line can be a launch pad for Parts Therapy as well, for an example.

Finally, there is the usual coaching clean up and environmental influence checks to do. The *memes* that influence us should also be examined.

I generally allow for five to six sessions and am generally done in three when working one to one with a client with this sort of process. This can be done face to face or on the phone. I usually do email consultation between the sessions as well.

I have just finished my certification as a Mastery Coach and am in the midst of developing a training programme for those interested in becoming a Certified Hypnotic Mastery Coach. I will keep you posted.

Dr. Brick Saunderson is the training facilitator of the CrossRoads Training Institute and Dream Facilitators (Coaching and Coach Training Group). He is Certified by the School of Coaching Mastery as a SCM-CMC and a member of the International Association of Coaches. He is also an ARCH Registered Clinical Counselling-Hypnotherapist.

The Power Of Words

by Bernie Siegel, MD

As doctors we are not trained to communicate and understand the power of our words as they relate to a patient's ability and desire to survive. It is also not only doctors but all the authority figures in our patient's lives that affect their ability to survive and the outcome of their disease. Parents, teachers, clergy and physicians change lives with their words. It is hypnotic for a child or patient to hear an authority figures words. As I am always sharing, wordswordswords can become swordswordswords and we can kill or cure with either words or swords.

Up to the age of six a child's brain wave pattern is similar to that of a hypnotized individual. To quote a woman, whose mother only gave her failure messages and dressed her in dark colours, and who as an adult has more trouble with her mother's words than she does with cancer. "My mother's words were eating away at me and maybe gave me cancer." We know from recent studies that loneliness affects the genes which control the immune system. So as doctors we need to ask the right questions and know what a patient has experienced and is experiencing in their lives. Can you imagine treating Christopher Reeve's wife for cancer without knowing her family history?

I recently received two emails; one from a woman who had a recurrence of her cancer and has decided to not undergo chemotherapy again. Her doctor said, "Then you might as well go home

and commit suicide." The other email came from a woman who asked her doctor if they could become a team as she had just finished reading my book. He told her no and that he was the doctor and in charge of her care. She packed her belongings and walked out of the hospital and has found a caring oncologist to work with. She is a survivor and not a submissive, sufferer or from the doctor's perspective a so called good patient.

We need to listen to our patient's words and treat their experience. Helen Keller said it very well when she said, "Deafness is darker by far than blindness." We also need to understand that patients do not live a disease they live an experience and we need to ask how a patient would describe their experience and then treat them accordingly. The words they use, like draining, failure, denial, pressure, gift and wake up call are always about what is happening in their life. So we can help them to heal their lives and improve the chances of curing their disease.

I did a great deal of children's surgery and I meet many of these children today, as young adults, and am amazed at how vivid their memories are. It is obvious how important this event was to them and the details they recall. I learned how powerful my words were when I began to notice children falling asleep as we wheeled them into the operating room. One boy turned onto his stomach and fell asleep as we entered the O.R. I turned him over on the operating table and he said, "What are you doing? You told me I would go to sleep in the operating room and I sleep on my stomach." I

told him I needed to operate on his stomach to get to his appendix so we reached a compromise.

I would rub an alcohol sponge on a child's arm and tell them it would numb their skin and a third would not feel the needle and ask why other doctors didn't do that. I called it deceiving people into health. Give someone who has faith in you a placebo and call it a hair growing pill, anti-nausea pill or whatever and you will be amazed at how many respond to your therapy.

Years ago psychologist Bruno Klopfer was involved with a cancer patient involved in a study to determine the effectiveness of Krebiozen. His patient responded dramatically until the initial report came out saying it didn't seem effective. Then Klopfer told him the problem was that he hadn't received the super refined Krebiozen and it was coming next week. He purposely told him that to build up the intensity of the situation. A week later he told him it came and gave him an injection of a placebo and his cancer melted away and he remained well until six months later when the final report was published declaring the drug was of no use in the treatment of cancer. He died within the week.

Doctor Milton Erickson, from his childhood experience with polio and hearing his doctor's dire predictions to his mother that he wouldn't see the sun rise, knew how important words were. As a child his anger led him to defy the doctor's predictions. As a psychiatrist, and hypnotherapist, he knew how to talk to patients to achieve the best outcome. There are many books

about his work. One by Dr. Sidney Rosen is entitled "My Voice Will Go With You". And our voices do. At the conclusion of an operation, while patients were still under anaesthesia, a time when they hear their surgeon's words, I would say, "You will awaken comfortable, thirsty and hungry." I did that until I noticed many of my patients were gaining weight and so I added these words, "but you won't finish everything on your plate."

One last story and it is hard for me to stop because there is only one thing truer than the truth; a story. Stories change people while statistics give them something to argue about. Erickson would write on a patient's chart and then excuse himself and leave the room. Of course he expected the patient would get up and go look at what he had written and he wrote, "Doing well." So give your family mottoes to live by like; "Do what makes you happy", so they pay attention to their feelings and difficulties are God's redirections, so they keep an open mind about the future and remind your doctor that their words can become swords and like a scalpel kill or cure.

Bernie Siegel, MD author of: Love, Medicine & Miracles; Help Me to Heal; Love, Magic & Mudpies and more...
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The Significance of Age Six

by Elizabeth Payne
Canwest News Service

*By the time we are six,
our future may already be set*

They can be bouncy and bossy, hyper-focussed one minute and

driven to gap-toothed silliness the next. But pay attention, to spend time with a six-year-old is to witness the future. Every childhood milestone is important, but six is magic.

Author A.A. Milne captured the sense of optimism that defines the age in his poem *The End*, which finishes with the lines: "But now I am six, I'm as clever as clever, So I think I'll be six now for ever and ever."

I recited the poem to both of my children when they turned six and have clear memories of my own sense of invulnerability at that age. But not every six-year-old shares that optimism.

Six can also be an age at which things begin to fall apart for children who are not ready to learn, to socialize or to be part of a classroom.

If the issues that have slowed their development are not addressed, they will be less likely to finish school or to succeed in life than their peers and more likely to come into conflict with the law. Which makes the findings of a study into the school readiness of Canadian children both crucial and worrisome. While the vast majority of the children studied were ready for school, a significant number -- about 27 per cent -- were "vulnerable" in at least one area when it came to school readiness.

The School Readiness to Learn in Ottawa report is the result of a 2005-06 study of more than 7,500 kindergarten students using a checklist developed by the late child psychologist Dr. Dan Offord and Dr. Magdalena Janus at McMaster University's Offord Centre for Child Studies.

The checklist looks at physical

health and well-being, social competence, emotional maturity, language and cognitive development and communications skills and general knowledge.

The study, which breaks down its findings by Ottawa neighbourhoods, draws a socio-economic map of the city in which children in poorer neighbourhoods tend to be less ready for school than their peers in wealthier neighbourhoods.

In addition, girls were significantly more ready for school than boys, older children (whose birthdays are earlier in the year) were significantly more ready than their younger counterparts. It also found that students with English as a second language or French as a second language were less prepared than their peers and that students in French immersion were more prepared for school than their peers.

The results are, in many ways, predictable. Socio-economic status is often associated with school performance. So how can knowing that change things for students who are lagging behind?

There are ways to improve the outlook of these children, Janus says. Just doing the study is a good start -- it helps focus the attention of school board and other officials on school readiness problems and to seek solutions to improve their prognosis.

And while it may seem that some children are fated to be less prepared for school, Janus says socio-economics are often a "proxy" for other things. So, while you may not be able to change parents' incomes, you can change their attitudes toward their children's

education and resources available to them and their children.

The Ottawa study comes at a time when increasing attention is being paid to who succeeds in life; Malcolm Gladwell in his recent book *Outliers* concluded it isn't always based on talent or potential. He interviews Chris Langan who, with an IQ of 195, is believed to be the smartest man in America. His most recent job? Bouncer at a bar.

Despite his intelligence, Langan lacks many of the advantages shared by his middle-class peers, Gladwell concludes. As a result, he had difficulty navigating the world.

The results of the Ottawa School Readiness to Learn research suggest there are children like Langan in some city neighbourhoods -- full of potential that may not be tapped without intervention.

The study is one step toward a worthy goal, to make sure all children reach that magical milestone of six looking forward to great futures.

Swamps, Alligators and Thinking Preventively

by Dr. Michael Yapko

There's an old saying, "It's hard to remember you were sent to drain the swamp when you're up to your behind in alligators." Loose translation: It's easy to lose sight of the longer term goal when you get sidetracked by more immediate demands.

We are so focussed on the immediacy of generating and delivering effective treatments for depression that we barely pay attention to the potential for

prevention. There is no place where the old adage that, "An ounce of prevention is worth a pound of cure" is critically true than in the realm of depression. When someone suffers depression at a young age, it sets up a downward spiral that gets progressively more severe year after year in its harmful effects. Negativity sets up more negativity, failure breeds more failure, and rejection breeds more rejection. To prevent that initial down-slide would have an enormous benefit on so many levels.

I want to draw your attention to some research in the area of prevention of depression in high risk teens that was published in the *Journal of the American Medical Association's* June 3rd issue. A cognitive behavioural therapy (CBT) program that teaches cognitive reappraisal (challenging and re-deciding the meanings of experience) and problem-solving skills to adolescents who are at high risk for depression (for a variety of reasons including family history, poor coping skills, family stressors, etc.) has been shown to help prevent them from developing depression.

The study involved 316 adolescents, aged 13-17 years, who had at least one parent or caretaker with either a history of or a current depression. The teens were enrolled in the multi-centre study, conducted at 4 sites in 4 states over a span of over 5 years. The program consisted of 8 weekly 90 minute sessions, followed by six monthly sessions, with mixed-sex groups of 3 to 10 individuals. Through the sessions, the teens learned problem-solving skills and techniques to identify and manage unrealistic and negative thoughts.

They also learned behavioural, relaxation and assertiveness skills. Participants had more than 11% lower a rate of depression than equally matched kids who did not go through the program. Skill building as a means of empowering people of all ages is the core of both good treatment and prevention.

There have been other prevention programs developed by other researchers over the years, some with even more impressive success rates than this new study. So, why aren't prevention programs readily embraced and implemented, ideally with all kids, but at the very least, with kids at an elevated risk? I think the answer has something to do with swamps and alligators... and the fact that there's no financial profit to be had in prevention.

Is Your Malpractice Defence Lawyer Working Against You?

by Brian S Kern, Esq.

Authors and Disclosures

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I Note from ARCH - the opinion here is based on Medical Malpractice for Physicians in the USA and not Hypnotherapists in Canada. Never-the-less the general inference for us is worth keeping in mind. I

Introduction

Being sued for malpractice is a terrible experience. The prospect of having to defend your level of care and competence in a court makes many doctors feel as though their malpractice Defence attorney is their only lifeline, and the only one who can save them.

It's natural for a physician to think that his malpractice Defence attorney shares his single goal: to save the physician from a verdict against him; clear the physician's name, and vindicate his reputation, especially if he's done nothing wrong.

But that's not always the case. Your attorney may have conflicting goals. Every medical malpractice insurance company has to navigate a delicate balance between successfully defending physicians to maintain a reputation as a strong, successful defender of physicians, and on the other hand, staying profitable. These 2 interests sometimes conflict. The cost of defending your case; or the potential for a runaway verdict that would deplete the insurance company's financial reserves may be greater than the cost of settlement -- even where there is little evidence that you've done anything wrong.

Whether you have any say in the decision to fight or settle typically depends on 2 seemingly innocuous policy features. The first is a "consent to settle" clause. This provision precludes your insurance carrier from settling a case without your permission. Without this clause, the carrier can settle a case over your objection.

A second feature of some policies allows physicians to elect to have Defence costs "inside" or "outside" the liability coverage limit. This provision can prove equally troublesome. When Defence costs are inside the limit, money spent on defending your case (eg, legal fees, expert witness fees, court costs, etc) directly reduces the amount of money available to either settle a case or pay a judgment. For example, if

your liability coverage limit is \$1 million, and your legal fees, witness fees, and court costs add up to \$200,000, you can't settle the case for more than \$800,000 -- unless you pay the remainder out of your own pocket. Or if you lose the case and the award is \$1 million, you'll need to come up with the \$200,000 to reach that amount. By contrast, if Defence costs are outside the limit, then the money available limit remains intact regardless of how much money is spent trying a case. However, a company may be more inclined to settle a case if the liability limit is not reduced by expense costs.

These options affect your policy cost. Usually, if you opt to keep the Defence costs inside the limit, you'll pay less for your malpractice insurance policy. Similarly, a "consent to settle" clause may increase the cost of your policy.

Your Attorney's Conflicts of Interest

These provisions and terms can create inherent conflicts of interest for malpractice Defence attorneys for a variety of reasons:

Trying a malpractice case is expensive, between legal fees, expert witness fees, and court costs. Some insurance companies will settle if they believe that the cost of settlement is less than the cost of defending a case, even if they believe the case against you has little merit.

Conflicts can arise from the relationship between insurance companies and the Defence attorneys they use. Generally, insurance companies have a limited panel of private attorneys that they use to handle claims, while some companies

also use their own in-house counsel. Although the attorney appointed for you has a fiduciary duty to you as the client, the fact remains that the attorney is selected and paid by an insurance carrier that maintains significant influence over the Defence of a case. If the attorney consistently refuses the direction of the carrier, it is unlikely that he will remain in the panel.

By settling a case, a carrier avoids any issues of "bad faith." "Bad faith" laws vary from state to state, but were created to make sure the insurer pays for a verdict in excess of coverage, rather than making the insured physician pay. As a result, insurance companies that do not attempt to settle a problem case within policy limits may be found to have demonstrated bad faith, and forced to pay for entire award, regardless of its amount.

While these laws are set up to protect insureds, they also force companies to settle some cases they otherwise would not. For example, in a "bad baby case," even if there is little or no evidence that the physician was at fault, the insurance company may still want to settle the case if the policy limit is \$1,000,000 and there is a chance of a multi-million dollar verdict.

Your Defence attorney may have another conflict of interest if the suit you've been named in includes other physicians -- especially if some of them are also covered by your carrier. More and more often plaintiff attorneys name as many defendants as possible in an effort to increase the amount of available recovery. Defendants may include an employed physician and her employer; 2

partners, or perhaps several physicians that all work together.

If, for example, you and another physician in your practice are both named, and your company policy covers both of you within the same policy limit, an insurance company will frequently use the same attorney to represent all of the "policyholders," whether individuals, partnerships or larger healthcare corporations. From their point of view, it makes sense.

However, each physician's interests may not align. For example, one physician may have had only limited contact with a patient, while the other physician saw the patient routinely. If the case involves a failure to diagnose, the physician with limited contact may well have been justified in relying upon the incorrect diagnosis determined by the physician who had regular contact with the patient. Yet, both are sued. In these cases, each physician should demand separate representation. Too often companies formulate a Defence strategy to address all covered insureds when, in many cases, the best advice for one defendant is not the best for another.

If you're in a situation in which the same attorney is defending you and other doctors, take the time to analyse and understand the ramifications of this strategy. Are you prepared to subjugate your interests to the good of all of the defendants? That could be dangerous. Because any malpractice payment is reported to the National Practitioner Data Bank as well as to many state licensing boards, the best interest of the group may not be your best interest.

What Can Physicians Do to Help Themselves?

One way to avoid having a carrier settle a case that you do not want settled is to make sure you have a "consent to settle" clause in your policy. This is offered as an option in many (but not all) professional liability policies. Although it may add to the cost of the policy, the provision is generally a small percentage of the overall premium.

This clause takes the power to settle a case from a carrier and gives it to a physician. Although physicians should be cautious in going against the advice of a carrier, they may also want to complete the discovery process prior to consenting to a large settlement.

If the carrier advises dropping or settling the case, the physician should say, "No, not yet. I want to complete the discovery process before I decide whether or not to agree." A successful deposition can turn a case around, and physicians should not deprive themselves of that opportunity, unless they believe that further discovery would be pointless and could further damage their reputation or professional standing.

Physicians must be aware of all the underlying factors in their case, maintain involvement in the decisions of Defence counsel, and ask the tough questions if they feel that their interests are not being properly represented. They should be especially concerned when depositions haven't been taken, experts haven't been retained, or motions to dismiss in frivolous cases have not been made. These signs may mean that the carrier has already made the decision to settle, or that your attorney has not

given your case the time and attention it deserves.

If you believe your interests are not being properly represented, consider hiring your own attorney to oversee the process and provide an unbiased second opinion. Be sure that the independent lawyer you hire does not have a relationship with any of the carriers involved in your case, to avoid any possibility of mixed loyalty. Your independent counsel may review the situation and will assure you that you can maintain confidence in your carrier-appointed counsel. Or, he or she may give you information you need to demand additional discovery, more aggressive motion practice, for example, seeking to limit the issues before a jury, or separate counsel who does not have a potential conflict of interest with other defendants.

In summary, if you ask probing questions and receive responses that are ethical, strategic and non-biased, this can strengthen the attorney/client relationship, and help instill confidence on both sides. You might also consult with your insurance agent or other independent consultant, who can be an invaluable resource throughout a legal proceeding and can help keep it on the right course.

To make sure that your case receives the best possible Defence, you need to play an active role in the process and understand the inherent conflicts between you and your insurance company and appointed counsel.

The Fraser Institute National Conference

The Fraser Institute is excited to host the upcoming national conference:

Complementary and Alternative Medicine Policy in Canada: A Better Approach

on Saturday, September 26th 2009.

Location:

Four Seasons Hotel
791 W Georgia St
Vancouver, BC Canada

Registration Closes:

September 21, 2009 @ 11:59 PM

Cost:

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Exceptional speakers include:

Shawn Buckley,
Buckley and Company,
Dr. Shirley Svorny,
California State University and
Cynthia Ramsay, Elm Consulting

For more event details, please visit:

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Men Are Just Happier People The Less Serious Side

NICKNAMES

If Laura, Kate and Sarah go out for lunch, they will call each other Laura, Kate and Sarah.

If Mike, Dave and John go out, they will affectionately refer to each other as Fat Boy, Godzilla and Four-eyes.

EATING OUT

When the bill arrives, Mike, Dave and John will each throw in \$20, even though it's only for \$32.50. None of them will have anything smaller and none will actually admit they want change back.

When the girls get their bill, out come the pocket calculators.

MONEY

A man will pay \$2 for a \$1 item he needs.

A woman will pay \$1 for a \$2 item that she doesn't need but it's on sale.

BATHROOMS

A man has six items in his bathroom: toothbrush and toothpaste, shaving cream, razor, a bar of soap, and a towel.

The average number of items in the typical woman's bathroom is 337. A man would not be able to identify more than 20 of these items.

ARGUMENTS

A woman has the last word in any argument. Anything a man says after that is the beginning of a new argument.

FUTURE

A woman worries about the future until she gets a husband.

A man never worries about the future until he gets a wife.

SUCCESS

A successful man is one who makes more money than his wife can spend.

A successful woman is one who can find such a man.

MARRIAGE

A woman marries a man expecting he will change, but he doesn't.

A man marries a woman expecting that she won't change, but she does.

DRESSING UP

A woman will dress up to go shopping, water the plants, empty the trash, answer the phone, read a book, and get the mail.

A man will dress up for weddings and funerals.

Men wake up as good-looking as they went to bed.

Women somehow deteriorate during the night.

OFFSPRING

Ah, children. A woman knows all about her children. She knows about dentist appointments and romances, best friends, favourite foods, secret fears and hopes and dreams.

A man is vaguely aware of some short people living in the house.

THOUGHT FOR THE DAY

A married man should forget his mistakes. There's no use in two people remembering the same thing!

PROOF THAT MEN HAVE BETTER FRIENDS.

Friendship among Women:

A woman didn't come home one night. The next morning she told her husband that she had slept over at a friend's house. The man called his wife's 10 best friends. None of them knew anything about it.

Friendship among Men:

A man didn't come home one night. The next morning he told his wife that he had slept over at a friend's house. The woman called her husband's 10 best friends. Eight confirmed that he had slept over, and two said he was still there.

(Editors Note: noone claims responsibility for this comedic moment - even though most of it is probably true)

Closed-eye History Taking

By Brian Alman, PhD

Have your patients tell you their own story with their eyes closed so that they convey experiential recollections instead of intellectualizations.

One simple skill--"closed-eye history taking"--can be helpful for diagnosis. For difficult cases, this technique can be a powerful adjunct to the traditional method of obtaining the medical history. Closed-eye history taking is a simple, effective technique that involves only one activity: asking the patient to close his or her eyes while the medical history is being obtained, "... the better to focus on things." Dr Albert Ray describes his experience with this

technique in "Closed-eye History Taking," a videotape available from KP San Diego's Department of Preventive Medicine. (Contact Vincent.J.Felitti-MD@kp.org.) Dr Ray was bold enough to try this approach for the first time in the urgent appointment clinic. This videotape includes long-term follow-up of his patient so you can see the often-profound results of this small change in practice.

Whether using medical hypnosis or parahypnotic techniques such as closed-eye history taking, you should understand that a unique treatment approach is necessary for each patient and for each situation. Recognize that the patient's condition will naturally improve when unconscious obstacles within the patient are removed. Expect change to be not only possible but inevitable. Emphasize the positive, including the effort to discover what

is right about that person's life. Have your patients tell you their own story with eyes closed so that they convey experiential recollections instead of intellectualizations. Understand that whatever you do, you will influence each patient; the question is how to ensure that the influence is beneficial. Offer patients an alternative to their symptoms--an alternative more positive than the patient's current belief. Use metaphors and stories to plant the right suggestion, and then be willing to give each patient supportive follow-up by telephone and e-mail. I use a computer-driven system of automated telephone calls that pose questions and that record the patient's answers while interposing supportive responses.

This idea was taken from a research Article, Medical Hypnosis: An Underutilised Treatment Approach
By Brian Alman, PhD

We Need Your Help

This year has been a real challenge for the volunteer staff who worked very hard at making sure you had all your yearly insurance and membership renewal paper work completed and submitted in a timely manner.

Unfortunately, they cannot continue to pursue you with the same commitment next year as they did this year. So we need your help with these questions:

1. "What can we do to make the Renewal Process easier for you, rather than have the staff hound and chase you next year?"
2. "What was it that made the Renewal Process so difficult for you this year?"
3. "What suggestion can you make to us that will streamline the Renewal Process for you?"

Please email your suggestions and ideas to office@archcanada.ca

