The Hypnosis Examiner

Feature Article:
"DEPRESSION"

Millions of people suffer with depression and it does come in a number of forms. The most common, clinical depression, causes general sadness, a loss of interest in activities that were once fun and pleasurable, and oftentimes, causes thoughts of suicide.

There are lots of symptoms that doctors use to diagnose the condition but if you've been feeling sad or you're worried about a loved one, you can look at these symptoms and come to a conclusion. Take a look at these top 10 most common symptoms of depression and see if your condition or a friend's condition, is worth speaking to a doctor about.

Generally if you have even just a few of these symptoms, it is possible that you are suffering from this psychological condition.

1. Fatigue

Though a symptom caused by lots of other conditions, when combined with other depression symptoms, fatigue is a tell-tale sign that you have the condition.

People with depression will experience emotional changes that can impact their physical health, making them feel overall more tired and unable to move as quickly. Their thought processes will slow down and they will have very little energy to get up and around and get things done like they used to.

American Cancer Society marks the **Great American Smokeout** on the 3rd Thursday of November each year.

Smokers are encouraged to use the date to make a plan to quit, or to plan in advance and **quit smoking** that day.

Tobacco use remains the single largest preventable cause of disease and premature death in the US, yet about 42 million Americans still smoke cigarettes.

With the addition of the e-cigarette, smokers have found a way to get around **quitting** and still be somewhat socially acceptable.

Don't buy a cheap imitation! **Just stop smoking**!

~The Editor

DEPRESSION *(from front page)*

2. Sleep problems

There are two ways that depression might affect your sleep. First of all, you might find it difficult to become relaxed enough to fall asleep. You may find that you can put your head down on a pillow but have to wait hours until you fall asleep, as a result of your low feelings distracting you.

Some people, however, will sleep for more than 12 hours each day and still feel depressed or tired as a result of having no emotional interest in doing something with their day.

3. General irritability

Instead of seeming like a person is down or sad, a person with depression might just be short tempered and irritable. This is particularly common in men who get angry about their low feelings and can easily lash out.

As a result of constantly feeling down or depressed, men often get angry and this can be particularly noticeable to close friends and family – so watch out for sadness combined with anger.

4. An inability to concentrate

As a result of having a lack of interest in daily activities, a person can also begin to find it difficult to concentrate. This is known as psychomotor retardation, meaning that the brain is unable to process information as quickly as it used to, making it practically impossible to complete tasks that would usually be considered easy or at least, achievable.

Depression takes over the whole brain with depressing thoughts, meaning that anything other than these thoughts of sadness are unable to receive the focus they need from the brain.

5. Anxiety

Though anxiety is actually a condition reported by many and diagnosed by itself, it can come hand in hand with depression. Research has shown that there are strong connections between depression and anxiety disorders.

It's now known that men are more likely to experience depression whereas women are far more likely to experience anxiety.

6. Alcoholism/drug taking

Substance abuse, whether it involves illegal drug taking, or alcoholism, is prevalent among people with depression. Research has shown time and time again that people with depression are more likely to abuse alcohol and drugs, and in that alcoholics are more likely to suffer from depression.

It seems like these two problems go hand in hand and if you notice a friend drinking too much or taking drugs constantly, then they may have an underlying mental condition like depression.

7. Erectile dysfunction

In men, erectile dysfunction is common when suffering from depression. Erectile dysfunction occurs as a result of men not having any real interest in sex which manifests itself physically. Though many men don't report the issue, likely as a result of being embarrassed, it has been known for many years that erectile dysfunction goes hand in hand with the problem and is relatively likely to occur in men with depression.

8. Suicidal thoughts

This is one of the most serious symptoms of having depression and it involves constant thoughts about how one might kill oneself. These thoughts can quickly manifest into a serious attempt of trying to end one's life, making this a worrying problem that family should try and solve right away.

If you are having suicidal thoughts, it's essential that you speak to your doctor or your closest family immediately. Remember that depression can be treated and no matter how bad you feel right now, it isn't as hopeless as you think.

9. Trouble making decisions

If a person suddenly has trouble making decisions and they have never acted like this in the past, then it is possible that they are suffering from depression. A bizarre, yet common, symptom of depression is difficulty making decisions.

So if somebody is suddenly acting as if they don't know what to do or how they want to go about their day or even something as simple as not knowing what to eat, try and find out more about what's going on.

It's possible that the depression is taking over their thought processes and damaging their ability to make decisions as a result.

10. General stress

Finally, stress will be a likely accompaniment to depression. When you suffer from depression, it becomes more difficult to go about your life and if you are at work, you're going to find it even more tiresome and difficult to do what your boss requires of you.

Sports Page

"WHAT IS SPORTS PSYCHOLOGY?"

Sports psychology is the study of how psychology influences sports, athletic performance, exercise and physical activity. Some sports psychologists work with professional athletes and coaches to improve performance and increase motivation. Other professionals utilize exercise and sports to enhance people's lives and well-being throughout the entire lifespan.

Professional sports psychologists often help athletes cope with the intense pressure that comes from competition and overcome problems with focus and motivation.

They also work with athletes to improve performance and recover from injuries. But sports psychologists do not just work with elite and professional athletes. They also help regular people learn how to enjoy sports and learn to stick to an exercise program.

Sports psychology is a relatively young discipline within psychology. In 1920, Carl Diem founded the world's first sports psychology laboratory at the Deutsche Sporthochschule in Berlin, Germany. In 1925, two more sports psychology labs were established – one by A.Z. Puni at the Institute of Physical Culture in Leningrad and the other by Coleman Griffith at the University of Illinois.

Griffith began offering the first course in sports psychology in 1923 and later published the first book on the subject titled, The Psychology of Coaching (1926). Unfortunately, Griffith's lab was closed in 1932 due to lack of funds.

After the lab was shut down, there was very little research on sports psychology until the subject experienced a revival of interest during the 1960s.

Ferruccio Antonelli established the International Society of Sport Psychology (ISSP) in 1965 and by the 1970s sports psychology had been introduced to university course offerings throughout North America.

The first academic journal, the International Journal of Sport Psychology, was introduced in 1970 which was then followed by the establishment of the Journal of Sport Psychology in 1979.

By the 1980s, sports psychology became the subject of a more rigorous scientific focus as researchers began to explore how psychology could be used to improve athletic performance, as well as how exercise could be utilized to improve mental well-being and lower stress levels.

Contemporary sports psychology is a diverse field. While finding ways to help athletes is certainly an important part of sports psychology, the application of exercise and physical activity for improving the lives of non-athletes is also a major focus.

There are a number of different topics that are of special interest to sports psychologists. Some professionals focus on a specific area, while others study a wide range of techniques.

- Imagery: This involves visualizing performing a task, such as participating in an athletic event or successfully performing a particular skill.
- Motivation: A major subject within sports psychology, the study of motivation looks at both extrinsic and intrinsic motivators. Extrinsic motivators are external rewards, such as trophies, money, medals or social recognition. Intrinsic motivators arise from within, such as a personal desire to win or the sense of pride that comes from performing a skill.
- Attentional Focus: Involves the ability to tune out distractions, such as a crowd of screaming fans and focus attention on the task at hand.

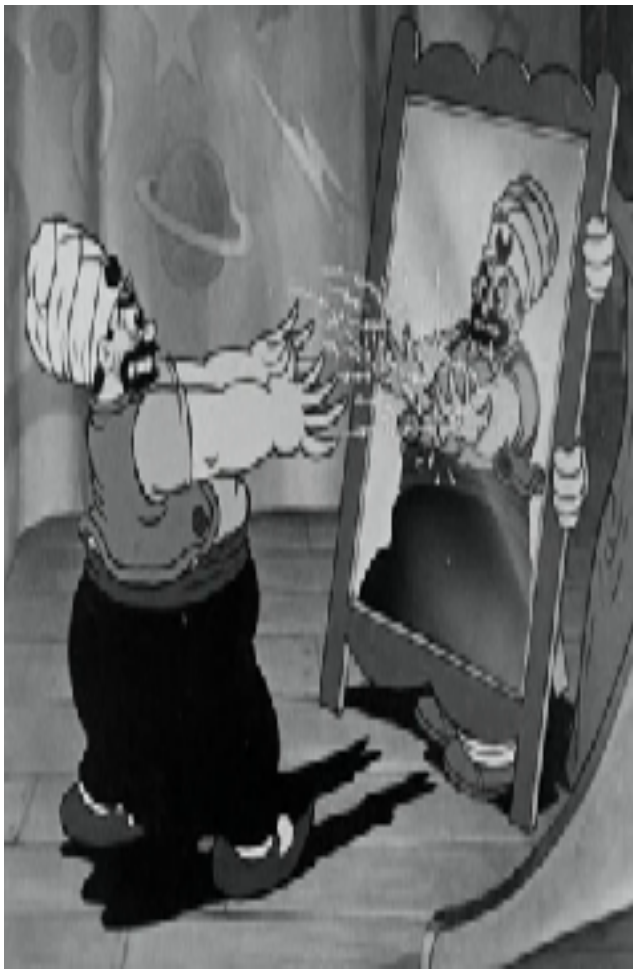
Sports psychology could be an exciting career choice. The American Psychological Association describes sports psychology as a "hot career" especially for those working in a university athletic department earning around $60,000 to $80,000 per year.

The Blog Post

THE 'HORRORS' OF HYPNOSIS, Part 2: Embarrassment

Posted on February 23, 2014

This is a new corner of our newsletter that will appear regularly. It is a contribution of the editor's colleague and friend Ara Trembly, a Board Certified Hypnotherapist and Licensed Professional Counselor based in St. Marys, GA. He maintains a web site at www.10-10hypnosis.com and a blog at www.10-10hypnosis.com/blog.



In our first installment, we looked at one of the prime reasons some people are afraid of hypnosis–mainly the negative portrayal of hypnosis and hypnotists in popular media. In this posting we will continue to consider how the media views hypnosis, but the focus will be on a different problem that makes the masses fear hypnosis–the idea that those hypnotized will be embarrassed somehow.

I'm going to turn again to The Woman in Green, our Sherlock Holmes movie, but this time to a different scene involving hypnosis. Again, the film assumes that hypnosis can be used to make anyone do anything, including committing crimes. This, of course, is utter nonsense, but pay attention to the latter part of this clip when the estimable Dr. Watson is himself hypnotized at the Mesmer Club. (Mesmer, you may know, was one of the pioneers of what we call hypnotism today, although his methods and ideas have been discredited.)

Watson, ever the scientist, doesn't believe that hypnotism works, but once he emerges from his hypnotic session, there can be little doubt that he has followed the hypnotist's suggestions. And that is the point. Watson went along with the suggestion that he was on holiday in Scotland and that in crossing a stream, he needed to remove his shoes–and he does so. These suggestions are harmless and probably would have been pleasant for Dr. Watson, so of course, he went along with them. His actions under hypnosis are not at all embarrassing. What makes for the later embarrassment is his prior insistence that he would not react to being hypnotized.

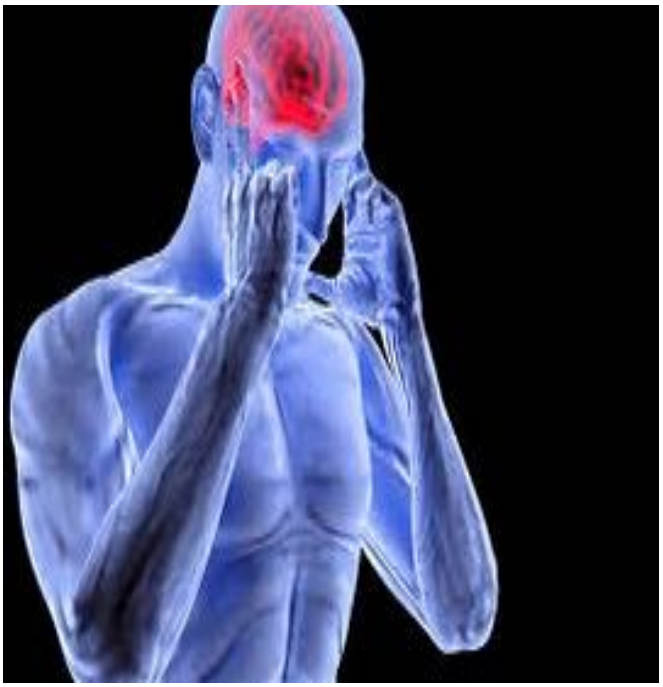
But haven't we seen people involved in embarrassing behavior under hypnosis in stage shows? The answer is yes… and no. The behavior observed in many "hypnotized" subjects on stage (clucking like a chicken, for example) is certainly embarrassing to any family and friends who might be present. But it is not embarrassing to the subject who wishes to cooperate with the hypnotist and to be part of the fun of the show. This is why you will see stage hypnotists ask for audience volunteers for hypnosis, but eliminate many who walk up. The hypnotists are not necessarily looking for people who are highly suggestable; they are looking for people who want to cooperate and be part of the show.

Finally, no competent clinical hypnotist would subject his or her clients to anything that would embarrass them. Stage shows have their place in entertainment, but clinical hypnosis is used for health and healing. For more on this subject, please visit www.10-10hypnosis.com. And if you have had a hypnosis experience on stage, feel free to tell us about it!

This blog article is printed unabridged, verbatim, without editing and/or spell corrections. It is not necessarily the same views shared by the editor.

Therapist's Corner

GUIDED IMAGERY



Guided imagery is a mind-body intervention by which a trained practitioner or teacher helps a participant or patient to evoke and generate mental images that simulate or re-create the sensory perception of sights, sounds, tastes, smells, movements and images associated with touch, such as texture, temperature, and pressure, as well as imaginative or mental content that the participant or patient experiences as defying conventional sensory categories and that may precipitate strong emotions or feelings in the absence of the stimuli to which correlating sensory receptors are receptive.

The practitioner or teacher may facilitate this process in person to an individual or a group. Alternatively, the participant or patient may follow guidance provided by a sound recording, video, or audiovisual media comprising spoken instruction that may be accompanied by music or sound.

There are two fundamental ways by which mental imagery is generated: voluntary and involuntary.

The involuntary and spontaneous generation of mental images is integral to ordinary sensory perception and cognition, and occurs without volitional intent. Meanwhile, many different aspects of everyday problem solving, scientific reasoning, and creative activity involve the volitional and deliberate generation of mental images.

Involuntary - The generation of involuntary mental imagery is created directly from present sensory stimulation and perceptual information, such as when someone sees an object, creates mental images of it, and maintains this imagery as they look away or close their eyes; or when someone hears a noise and maintains an auditory image of it, after the sound ceases or is no longer perceptible.

Voluntary - Voluntary mental imagery may resemble previous sensory perception and experience, recalled from memory; or the images may be entirely novel and the product of fantasy

Mental imagery can result from both voluntary and involuntary processes, and although it comprises simulation or recreation of perceptual experience across all sensory modalities including olfactory imagery, gustatory imagery, haptic imagery and motor imagery. Nonetheless, visual and auditory mental images are reported as being the most frequently experienced by people ordinarily as well as in controlled experiments with visual imagery remaining the most extensively researched and documented in scientific literature.

In experimental and cognitive psychology, researchers have concentrated primarily on voluntary and deliberately generated imagery, which the participant or patient creates, inspects, and transforms, such as by evoking imagery of an intimidating social event and transforming the images into those indicative of a pleasant and self-affirming experience.

In psychopathology, clinicians have typically focused on involuntary imagery which "comes to mind" unbidden, such as in a depressed person's experience of intrusive unwelcome negative images indicative of sadness, hopelessness, and morbidity; or images that recapitulate previous distressing events that characterize post traumatic stress disorder. In clinical practice and psychopathology, involuntary mental images are considered intrusive when they occur unwanted and unbidden, "hijacking attention" to some extent.

The maintenance of, or "holding in mind" imagery, whether voluntary or involuntary, places considerable demands upon cognitive attentional resources, including working memory, redirecting them away from a specific cognitive task or general-purpose concentration and toward the imagery.

In clinical practice, this process can be positively exploited therapeutically by training the participant or patient to focus attention on a significantly demanding task which successfully competes for and directs attention away from the unbidden intrusive imagery, decreasing its intensity, vividness, and duration, and consequently alleviating distress or pain.

OBSESSIVE-COMPULSIVE DISORDER

Obsessive-Compulsive Disorder (OCD) is a common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over.

People with OCD may have symptoms of obsessions, compulsions, or both. These symptoms can interfere with all aspects of life, such as work, school, and personal relationships.

Obsessions are repeated thoughts, urges, or mental images that cause anxiety. Common symptoms include:

- Fear of germs or contamination.
- Unwanted forbidden or taboo thoughts involving sex, religion, and harm.
- Aggressive thoughts towards others or self.
- Having things symmetrical or in a perfect order.

Compulsions are repetitive behaviors that a person with OCD feels the urge to do in response to an obsessive thought. Common compulsions include:

- Excessive cleaning and/or hand washing.
- Ordering and arranging things in a particular, precise way.
- Repeatedly checking on things, such as repeatedly checking to see if the door is locked or that the oven is off.
- Compulsive counting.

Not all rituals or habits are compulsions. Everyone double checks things sometimes. But a person with OCD generally:

- Can't control his or her thoughts or behaviors, even when those thoughts or behaviors are recognized as excessive.
- Spends at least 1 hour a day on these thoughts or behaviors.
- Doesn't get pleasure when performing the behaviors or rituals, but may feel brief relief from the anxiety the thoughts cause.
- Experiences significant problems in their daily life due to these thoughts or behaviors.

Some individuals with OCD also have a tic disorder. Motor tics are sudden, brief, repetitive movements, such as eye blinking and other eye movements, facial grimacing, shoulder shrugging, and head or shoulder jerking. Common vocal tics include repetitive throat-clearing, sniffing, or grunting sounds.

Symptoms may come and go, ease over time, or worsen. People with OCD may try to help themselves by avoiding situations that trigger their obsessions, or they may use alcohol or drugs to calm themselves. Although most adults with OCD recognize that what they are doing doesn't make sense, some adults and most children may not realize that their behavior is out of the ordinary. Parents or teachers typically recognize OCD symptoms in children.

If you think you have OCD, talk to your doctor about your symptoms. If left untreated, OCD can interfere in all aspects of life.

OCD is a common disorder that affects adults, adolescents and children all over the world. Most people are diagnosed by about age 19, typically with an earlier age of onset in boys than in girls but onset after age 35 does happen.

The causes of OCD are unknown, but risk factors include:

Genetics - Twin and family studies have shown that people with first-degree relatives (such as a parent, sibling, or child) who have OCD are at a higher risk for developing OCD themselves. The risk is higher if the first-degree relative developed OCD as a child or teen. Ongoing research continues to explore the connection between genetics and OCD and may help improve OCD diagnosis and treatment.

Brain Structure and Functioning - Imaging studies have shown differences in the frontal cortex and subcortical structures of the brain in patients with OCD. *(continued on next page)*

OCD *(from page 6)*

There appears to be a connection between the OCD symptoms and abnormalities in certain areas of the brain, but that connection is not clear. Research is still underway. Understanding the causes will help determine specific, personalized treatments to treat OCD.

Environment - People who have experienced abuse (physical or sexual) in childhood or other trauma are at an increased risk for developing OCD.

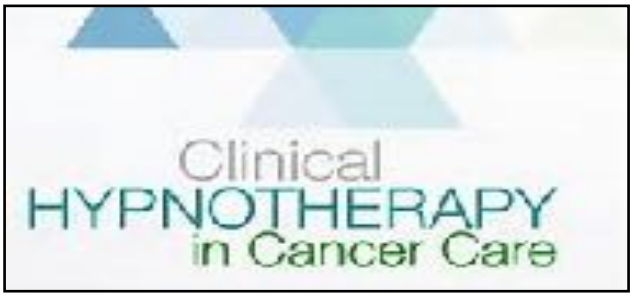
In some cases, children may develop OCD or OCD symptoms following a streptococcal infection. This is called Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS).

OCD is typically treated with medication, psychotherapy or a combination of the two. Although most patients with OCD respond to treatment, some patients continue to experience symptoms.

Sometimes people with OCD also have other mental disorders, such as anxiety, depression, and body dysmorphic disorder, a disorder in which someone mistakenly believes that a part of their body is abnormal. It is important to consider these other disorders when making decisions about treatment.

HYPNOSIS AND CANCER

Hypnosis has been specifically employed in the palliative care of cancer patients to reduce symptoms associated with radiation and chemotherapy, such as pain, nausea, fatigue, hot flashes, and sleep dysfunction. Length of hypnotic treatment varies depending on the nature and severity of the problem. Clinical hypnosis treatment for cancer patients may range from a single session to multiple sessions. In research, cancer patients undergoing clinical hypnotherapy typically receive approximately five sessions or more of clinical hypnosis, each involving a hypnotic induction and instruction in self-hypnosis. The practice of self-hypnosis helps patients achieve a relaxed, therapeutic, hypnotic state. Professionals



serve as facilitators of self-hypnosis, often providing hypnosis audio recordings for patients to use between sessions.

Hypnosis is frequently offered in conjunction with other therapies such as cognitive behavioral therapy (CBT). Research suggests that using a combination of hypnosis and CBT improved outcomes more than those achieved for at least 70% of patients who used CBT alone. Additionally, CBT techniques can be utilized in a hypnotic context by preceding the CBT technique with a hypnotic induction.

Clinical hypnosis is a viable option for cancer patients, who, once trained in self-hypnosis, may employ these techniques to manage myriad symptoms.

In particular, hypnosis as an adjunct treatment for cancer patients and survivors can be effective in treating pain, nausea, fatigue, hot flashes, and sleep disorders. While current research into the efficacy of clinical hypnosis for the palliative treatment of cancer patients is extremely encouraging, some studies have been limited by less-than-desirable sample sizes, and there is a dearth of large randomized controlled trials. Additional research will be needed for clinical hypnosis to become a well-established evidence-based treatment for the palliative care of cancer patients. However, the existing evidence from all clinical research supports inclusion of clinical hypnosis as an effective adjunct therapy in the palliative cancer treatment milieu, and therefore hypnosis should be considered for patients with cancer on a case-by-case basis.

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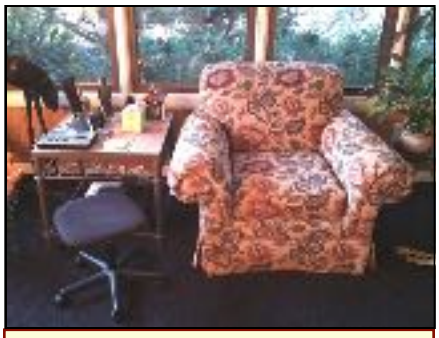

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COMEDY CORNER

"Mahatma Gandhi, as you know, walked barefoot most of the time which produced a impressive set of calluses on his feet. He also ate very little which made him rather frail and with his odd diet, he suffered from bad breath.

This made him . . . what?

A super-callused fragile mystic hexed by halitosis."

"Of puns it has been said that those who most dislike them are those who are least able to utter them!"

Heard a good joke lately?

Send it to the Editor at: tophypno@aol.com. Subject line: COMEDY CORNER

APHENPHOSMOPHOBIA

Aphenphosmphobia is the morbid and irrational fear of touches or being touched. People with this phobia absolutely despise any sort of physical contact. Furthermore, this does not only refer to those who hate being touched, but it also refers to people who fear touching others.

Physical touch also refers to many different actions. These include touches of affection (i.e., hugs, kisses, etc.), touches while walking (when people bump into each other), or even just simple hand touches, such as high fives.

Symptoms of aphenphosmphobia will vary from one person to another depending on a variety of factors. Some people are just more susceptible to fear and their reactions than others. However, there is a list of general symptoms which include, but are not limited to, avoidance of social situations, extreme anxiety about being in public, suffering of relationships (any type-romantic, family, friendship, etc.), and more.

Aphenphosmphobia could also lead a person to go into a full blown panic attack if they are touched. Panic attacks are loosely defined as states of extreme anxiety or terror. Panic attacks also have other symptoms which include a rapid heart beat, difficulty breathing, tingling or numbness in the hands or fingers, excessive sweating, chills, feeling a loss of control, and chest pain.

Causes of aphenphosmphobia will also vary from one person to the next. Most often, phobias are caused by a trauma, which typically occurs during childhood. Physical or sexual child abuse are very common causes of aphenphosmphobia. When a child is exposed to this type of environment, especially since they are at such an impressionable age, they begin to lack trust in others. They often associate any type of touch with pain, since they are what they were used to whilst growing up. Domestic abuse or violence could also lead to this phobia later in life.

Some people could also be predisposed to anti-social personality disorders. These disorders cause distance and a lack of understanding about human emotions and physical interactions in the sufferer. Because of their disorder, many of these people often fear physical touches.

However, it is also possible that some people just fear being touched for no obvious reason at all, or that the fear of touches stems from some other fear. Claustrophobia is a common reason why many people also fear being touched, because of the feeling of confinement.

The best treatment option for aphenphosmphobia will depend upon the individual. A great starting place is therapy since there are many different forms which people can try. Cognitive-behavioral therapy, hypnotherapy, exposure therapy and group therapy are just a few mentionable.

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