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ISMA-USA NEWSLETTER is published twice a year. We invite all members of ISMA-USA and ISMA members from other countries to submit articles for publication in our newsletter. We will also accept articles with information of interest to ISMA from nonmembers. It is the newsletter's policy to include contributions with various points of views; however, these do not necessarily represent the views of ISMA or ISMA-USA Branch. Announcements of services or programs do not imply an endorsement. We reserve the right to edit any material that is received. Deadline for receiving copy for the Spring 2004 issue is March 15, 2004. Send to **Serena Wadhwa** or **Betty J. McGuigan** via e-mail attachment.

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LETTERS

LETTER from EDITOR

Serena Wadhwa

Dear Members:

Welcome to the fall edition of the ISMA-USA newsletter. I struggled with what to write about in the edition and as I did, a thought occurred to me. How much do we struggle with the various areas of our lives? People struggle with things all the time and this in itself is stressful. I recognized that my struggle to write something meaningful, brilliant, or creative was an experience I am not unfamiliar with. However, I also realized that I am able to utilize my inner resources as well as external ones to cope.

This edition discusses various resources to use when a client or we are experiencing a struggle. There are some resources for depression and motivation. I hope that these will encourage you to practice some in your daily life and inspire your creation of new ones.

Warmest Regards.

> Keep us informed on your new stress management publications.
> Both the readers of this newsletter and the visitors to our web site welcome this information.

::front page::

FOCUS on STRESS MANAGEMENT

LIFE-SPAN STRESSORS

Margreta Klassen, Ph.D.
Fellow of American College of Advanced Practice Psychologists

"There are more things, Lucillius, that frighten us than injure us, and we suffer more in imagination than in reality." Seneca, Epistulae ad Luciliium

Stress is the global term that encompasses the events in one's life stresses as well as the physiological response that accompanies the interpretation of those events. The key word is interpretation. Without experience, a person may imagine more drastic consequences than is realistic. Stress management involves relaxation training, which helps to quiet the negative physiological reactions to the interpretation. Life management skills can empower a person to face adversity with less trepidation.

Research focusing on those life events which cause stress reactions, such as the Holmes-Rahe Life Events Scale, identified the loss of a mate through death or divorce as the most significant event provoking stress. What then is the most significant stressor to an older single parent dependent on an adult child? Might not the loss of the child be as traumatic a life event as the loss of a mate? Perhaps a better category might be loss of a significant resource of interdependence. A Catholic priest who is ex-communicated may experience the same intensity of stress as a married person losing a mate through divorce or death. His source of sustenance and his role identity has drastically been eliminated.

Informal clinical observations conducted by the author while working in a university-counseling center as a stress management program coordinator confirmed that stressors varied by age and by college major. Non-traditionally aged students in the special program for older adults returning to college and graduate

students were more stressed by their relationships than younger students who found exams and grading practices to be the predominant stressors.

It is important when undertaking research and clinical applications in stress management to consider age as an essential contributing factor to identifying perceived stressors. Children of parents who are divorcing have a unique stressor to which they must adjust, and often their imaginary fear is abandonment by both parents. University students are stressed by changes in the employment and housing market as they approach graduation and make the transition from parental support to life on their own. Persons in mid-life are struggling with stress related to concern for elderly parents and launching their children into adulthood. Elders face unique stressors of perceived loss of status, reduced resources, age-related physical and mental changes, and facing their own death.

When conducting stress management education or therapy, educators and clinicians should include the identification of age-related issues in the initial assessment. In clinical treatment, an appropriate intervention might include a list of referrals to resources available in the patient or student's community that address those issues that are reported as prevalent to a particular age cohort.

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ATTITUDES IN THE AMERICAN WORKPLACE IX

Submitted by **Fran McAfee Rosenberger**

Polling for The Marlin Company by Harris Interactive
North Haven, Connecticut

There are reports of fear and anxiety about world events as well as stress about the economy. There are increases in emotional ailments, such as depression, insomnia, substance abuse or family conflicts and increases in physical ailments, such as headaches, colds or stomach problems.

Workers report incidence of anger, complaints, and rudeness among co-workers. Some say that even customers are tougher to deal with this year. These were some of the findings of the new Attitudes in the American Workplace IX, The Marlin Company’s ninth annual national workplace survey.

Overall, 43% of American workers say that people in their workplace express fear or anxiety about national or world events at least several times a week; 33% say they have observed an increase in anxiety or stress-related physical ailments in their workplace in the last year, such as headaches, colds or stomach problems, and 27% report an increase in emotional problems, such as depression, insomnia, substance abuse or family conflicts. Those who report that fellow workers are expressing fears or anxiety about national/world events at least several times a week are also more likely than those who do not hear these fears expressed on a regular basis to report that there has been an increase in both physical and emotional ailments related to stress among co-workers in the last year.

The survey was done for The Marlin Company, a North Haven,Connecticut, workplace communications firm, by Harris Interactive®, based on 752 interviews among a nationally representative sample of American full-time and part-time workers. The margin of error is +/-3.6 percentage points. Harris Interactive® conducted telephone interviews from May 22-29, 2003.

Twenty-eight percent said the economy caused them the most stress, followed by family (27%); war/terrorism (24%); and job (15%).

Marlin President Frank Kenna, III, said, "Interestingly, employees report that most of this stress is coming from outside of the workplace, but they bring it with them on the job regardless of the source. Managers must find a way to deal with these outside factors if they want to have a smoother-running workplace. This is

a tall order, as the past assumption has been that most stress is job-related. Unfortunately, today's managers were schooled in yesterday's techniques and woefully lack the skills needed for today's environment. They must listen and respond to what their employees are feeling if they want to have any chance of defusing the stress time bomb."

Other results:
42% reported an increase in complaints among co-workers in the last year; 33% reported an increase in gossip, 24% an increase in rudeness, and 29% an increase in anger.

44% said it's a source of irritation that people don't follow the company attendance schedule; 29% said the same thing about offensive jokes.

27% said morale is lower than it was a year ago and 30% said their own ambitions are less important now than 12 months ago.

35% reported an increase in the number of stressed customers; 31% said there's been an increase in the number of customers who are hard to deal with, and 25% say they have seen an increase in customer complaints.

Those who say they hear fear or anxiety about world events also report higher levels of physical and emotional ailments in their workplace as well as higher anger levels among co-workers in the last year.

54% say management is helping employees deal with stress and that's healthy, according to the findings. Where management helps, employees report fewer emotional and physical ailments, higher morale, fewer complaints, less gossip and lower stress levels.

Mr. Kenna said, "Stress can kill. Imagine a doctor telling a patient he has a heart condition but not bothering to prescribe treatment. That's not unlike what happens with stress. Lower stress levels help prevent disease. They also boost morale, reduce health-care costs and absenteeism, and generally help a workforce build trust, develop team skills and create a mind set in which people can deal with conflicts before they become crises."

The Questions:

How often do people in your workplace express fear or anxiety about national or world events?
Several times a day.....14%
Several times a week.....29%
Very rarely.....45%
Never.....11%

Have you observed an increase in anxiety or stress-related physical ailments in your workplace in the last year, such as headaches, colds or stomach problems?
Yes.....33%
No.....66%

Have you observed an increase in anxiety or stress-related emotional problems in your workplace in the last year such as depression, insomnia, substance abuse or family conflicts?
Yes.....27%
No.....71%

Has there been an increase in anger levels among co-workers in the last year?
Yes.....29%
No.....69%

For each of the following, please tell me whether you have noticed an increase, a decrease or no change in

your workplace in the last year:
Rudeness:
Increase.....24%
Decrease.....11%
No change.....65%

Support, encouragement, and understanding among co-workers:
Increase.....40%
Decrease.....11%
No change.....48%

Arguments among co-workers:
Increase.....20%
Decrease.....9%
No change.....70%

Complaints:
Increase.....42%
Decrease.....5%
No change.....51%

Gossip:
Increase.....33%
Decrease.....5%
No change.....62%

Would you agree or disagree with the following: In the last year, my own ambitions at work have become less important to me.
Agree.....30%
Disagree..…69%

Please rank each of the following items in order according to how much stress they cause you to feel.
Most stress:
Economy.....28%
Family.....27%
War/Terrorism.....24%
Job.....15%

Are you having a tougher time doing your job now than a year ago because of stress, anxiety, or from being distracted?

Yes.....22%
No...…....76%

Have you observed an increase in any of the following in the last 12 months?

The number of your company's customers who are stressed:
Yes.....35%
No.....57%
Not applicable.....4%
Not sure.....4%

The number of your company's customers who are hard to deal with:
Yes.....31%
No.....63%

Not applicable.....3%
Not sure.....3%

Customer complaints:
Yes.....25%
No.....70%
Not applicable.....3%
Not sure.....2%

Is the morale among employees in your workplace higher, lower or the same as 12 months ago?
Higher.....…17%
Lower.....…...27%
The same.....54%
Not sure.....…...2%

In the past year, have you been angered by a co-worker to the point where you felt like striking him or her but didn't't?

2003	2001	1999	1995
Yes.....14%	Yes.....15%	Yes.....16%	Yes.....21%
No.....….85%	No.....84%	No.....83%	No.....79%

(Note: Results for 2001 and 2003 from Harris Interactive®; other years from the Gallup Organization.)

Is management at your company helping employees deal with stress?
Yes.....54%
No.....43%
Not sure..…..3%

Is your boss spending more time now than a year ago dealing with conflicts among employees that result from stress and anxiety?
Yes.....26%
No.....67%
Not sure.....7%

In general, how stressed do you feel at work?
Extremely.....…...5%
Quite a bit.....…14%
Somewhat.....….33%
A little.....…28%
Not at all.....…19%

In general, how angry do you feel at work?
Extremely.....2%
Quite a bit.....6%
Somewhat.....16%
A little.....28%
Not at all.....47%

In general, how satisfied do you feel at work?
Extremely.....17%
Quite a bit.....32%
Somewhat.....32%
A little.....…...12%

Not at all.....….....6%

Are people more suspicious of foreign workers in your workplace since September 11th?
Yes.....25%
No.....69%
Not sure.....6%

Are any of the following a sources of frustration or irritation for you in the workplace?

Co-workers who don't always follow the company schedule, such as coming in late or taking longer breaks or lunches than permitted.
Yes.....44%
No.....54%
Not sure.....2%
Co-workers who tell off-color or offensive jokes.
Yes.....29%
No.....70%
Not sure…....1%
Co-workers who neglect to refill the paper in a copier or fax machine.
Yes.....18%
No.....79%
Not sure..….2%
Co-workers who neglect to order supplies, such as pens or paper, after taking the last of them.
Yes.....…...21%
No.....…...75%
Not sure….....3%
Co-workers who neglect to make more coffee after taking the last cup.
Yes.....…..11%
No.....85%
Not sure.…..3%

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HEALTHY LIFESTYLE COACHING, MOTIVATIONAL INTERVIEWING AND STAGES OF CHANGE: OUTCOMES ON WHAT DOES AND DOES NOT WORK

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Introduction:
Among the numerous issues surrounding health care in America is one that is acknowledged but not well-understood, non-compliance. There have been a number of studies in the health care industry that point out that many individuals cannot or will not follow through with agreed upon treatment plans including continuing drug prescriptions and following doctors recommendations. As with all human behavior issues, the reasons are varied and complex. The purpose of this paper is to explore possible remedies for this difficult problem. We think part of the solution is in applying methodologies from other disciplines that are focused on assisting the individual to make the changes necessary to improve their health, methodologies such as "coaching."

Coaching, to motivate, influence, compel or persuade, has long been used to change executive and employee behavior in corporations. Executives, whose success depends on their ability to persuade and influence both

internal and external audiences, must be able to communicate effectively. The goal of these coaching programs is to develop effective skills in persuasive internal and external communications; to assess personal style and hone presentation skills that result in strategic, precise, persuasive, and motivating messages; and to explore a variety of best practices, ranging from the development of a communications strategy to the actual delivery of a message.

Using these corporate coaching programs as a model, another kind of coaching has evolved to meet the needs of those who are attempting to make more healthful lifestyle choices. This kind of coaching is known by many names [healthy lifestyle coaching, motivational interviewing, co-active coaching]. The goal of this kind of coaching is to help people develop more healthful lifestyles and to make and act on decisions either to prevent or to better manage chronic diseases and conditions such as cardiovascular disease, diabetes or obesity.

Healthy lifestyle coaching is designed to help people either prevent or effectively manage lifestyle risks and chronic conditions. To that end, for example, the Minnesota Department of Health has published Healthy Minnesotans: Public Health Improvement Goals 2004 [1998]. This document defines and makes explicit the goals that Minnesotans need to adapt in order to develop a healthier lifestyle. The document provides 3 areas of opportunity as well as the 18 identified public health improvement goals. The report points out that what we do collectively, in our communities and personally, will move us as individuals, as communities and as a state toward a healthier future. Among the Minnesota Public Health Improvement Goals are 2 that relate directly to the issue of helping patients improve their health by understanding and complying with proper treatment:

- Reduce the behavioral and environmental health risks that are primary contributors to unintentional injury;
- Promote early detection and improved management of non-infectious disease and chronic conditions;

Implicit in these 2 goals is the understanding that self-awareness of lifestyle behaviors and genetic pre-conditions e.g. diabetes, congestive heart failure, etc., is a key factor in managing the risks and improving health outcomes. This, in turn, requires that health care professionals need to turn this self-awareness into healthy activities and compliance with health professional's advice. From the health care system perspective, the key to turning self-awareness to activity is in understanding how to help people make the changes in their lives that will bring about positive health outcomes. To do this, we must explore the larger issue of how change is perceived and effected on an individual basis. Among numerous theories that might be helpful is the "stages of change" Transtheoretical model. It is founded on the concept that all human change is based on various states of readiness for change.

Stages of Change and the Transtheoretical Model:

What do we know about the stages of change and how people change their lifestyles? The Transtheoretical Model, developed by Prochaska and his colleagues, is an extremely powerful model that tells us a great deal about how people prepare to change their lifestyles and how they can change successfully. Prochaska and his colleagues have used these stages of change to examine such lifestyle changes as smoking cessation, exercise and supplements to prevent osteoporosis, exercise adoption, diet change, quitting cocaine, weight control, high-fat diets, adolescent delinquent behaviors, safer sex, condom use, sunscreen use, radon gas exposure, exercise acquisition, mammography screening, physicians' preventive practices with smokers, substance abuse, psychotherapy and much more [Prochaska et. al., 1994; Rosen, 2000; Smith, Subich and Kalodner, 1995; Morera et. al. , 1998; Nezami et. al., 2003; Adams and White, 2003; Haggerty and Goodman, 2003; Goldberg, Hoffman and Anel, 2003; Goldberg, Hoffman and Anel, 2002; Spencer et. al., 2002; Froelicher and Kozuki, 2002; Burbank, Reiber, Padula and Nigg, 2002; Konkle-Parker, 2001; Enguidanos, 2001; Sutton, 2001; Cole, 2001; Patten, Vollman and Thurston, 2000; Zimmerman, Olsen and Bosworth, 2000, Burbank, Padula and Nigg, 2000] . This powerful model has also generated thousands of other research projects and publications, a measure of how truly robust this model is.

The stages of change are pre contemplation [person not contemplating change and may be totally unaware of the need to make the change], contemplation [person is aware and is contemplating making the change, e.g.

concerned about the health impacts of smoking], preparation [person is making the preparations needed to make the change, e.g. setting a date to quit, enrolling in a smoking cessation program, speaking with the family physician], action [person is taking action to actively make the lifestyle change a part of her or his life] and maintenance [person has successfully made the change and is able to maintain the changed lifestyle] [Prochaska et. al., 1994]. In one quick assessment of the stage of change, it is simple to ask the person to place herself or himself on a scale of 0-10, where 0 = not at all motivated to make this lifestyle change and 10 = very motivated to make this change.

Some research points out that these stages are well documented for many different conditions in U.S. populations, but that much more research needs to be done for non-U.S. populations and for special populations, such as the elderly, teenagers, diverse racial and ethnic populations, rural populations, those who are illiterate, functionally illiterate or marginally literate. For example, in research by Burbank et. al. [2000; 2002], researchers looked at changing health behaviors of older adults. These researchers found that changing lifelong unhealthy habits can have a positive effect on health for older adults. The Transtheoretical Model of behavior change proposes that people move through a series of five stages and use a variety of processes as they attempt to change a behavior. Among the most important outcomes of this research is evidence that tailoring interventions to an individual's stage of change is most effective in promoting behavior change. These researchers also suggest specific stage-based strategies for nurses to use with both individuals and groups of older adults.

Family physicians have also begun using the Transtheoretical Model or stages of change approach to help patients change their behavior [Goldberg et. al., 2002; Goldberg et. al., 2002; Zimmerman et. al. 2000]. Helping patients change behavior is an important role for family physicians, especially in addressing lifestyle modification for disease prevention, long-term disease management, and addictions. Many family physicians in the past have often focused on patient non-compliance and patient failure at motivation. However, it is now believed that understanding patient readiness to make change, appreciating barriers to change and helping patients anticipate relapse can improve patient satisfaction and lower physician frustration during the long change process. For example, we now know that people who are trying to stop smoking may backslide and smoke again an average of seven times before stopping for good. It is important for both physicians as well as for patients who are trying to stop smoking to know this so that neither becomes discourages with these "failures", which are actually just steps along the way progressing toward a smoke-free lifestyle and a major healthy lifestyle change.

Health Coaching and Healthy Lifestyle Coaching:
We know that healthcare actually exists on a continuum ranging from simply identifying risk factors through health risk assessments (HRA) to triaging of injuries and illness to intensive care such as emergency room and hospital stays and finally, a return to good health or disease containment/management. In a fully integrated healthcare system, people need and should have access to a great deal of support and guidance in managing the transitions across this continuum. Healthy lifestyle coaching can be a very helpful tool. One form of this coaching which may be effective is called "Motivational Interviewing".

Motivational Interviewing:
Motivational interviewing is a person-centered, directive method of communication used for enhancing intrinsic motivation to change by helping a person resolve her or his ambivalence to change [Resnicow et. al., 2002; Miller and Rollnick, 2002]. Motivational interviewing is used in many different settings and for many different lifestyle changes. These include addictions, such as alcohol, drugs and smoking; adopting healthy behaviors, such as physical activity/exercise and fruit/vegetable consumption; and treatment adherence for chronic illnesses and conditions. Motivational interviewing has also been used to encourage contraceptive use among adolescents at high-risk for early childbearing.

We know that generally speaking the usual ways of helping people make lifestyle changes do not work. For example, advice, especially if it is unwelcome advice, can often elicit resistance. In addition, knowing what to do is only weakly correlated with actually adopting a new behavior. Also, people vary in the motivation to change and it has been discovered that the style of helping must match the motivation of the person. This requires knowing what stage of change the person is stuck in order to be of assistance in helping them

progress to make healthful lifestyle changes.

The usual approach to helping people adopt change involves confrontation, education and authority. Motivational interviewing, by contrast, involves collaboration, evocation and autonomy. I tend to think of these differences as the difference between quantitative vs. qualitative research, or the difference between male ways of knowing vs. female ways of knowing.

There is a special spirit of motivational interviewing. This involves a belief in the innate capacity of individuals to naturally evolve in a healthful direction under conditions of acceptance and support, where people use their own positive, creative energy and insight to discover the best solutions for themselves. Motivational interviewing [or MI] uses good listening and counseling skills, with unconditional positive regard, genuineness and empathy.

At the same time, the person herself or himself needs to be willing to believe that the behavior is important; to be able to have confidence that she or he can make the change, and be ready to make the change a priority in her or his life. Most people are ambivalent about changing their behavior, and say, "Yes, but……". Their approach [avoidance conflict] is common and involves such statement as "I want to stop smoking, but if I stop, then I won't be able to…….". Ambivalence is one of the things that keep people stuck and unable to make lifestyle changes, even when they may wish to.

There are a number of tools that are needed in order to do MI, such as getting permission to discuss the lifestyle change with the individual; the use of open-ended questions; reflective listening; eliciting self-motivational statements; assessing on a scale of 1-10 the importance/confidence the person has to make the change; menus vs. single solution [this is elaborated further on in this article], and summarizing. To accomplish these items there are generally six techniques needed:

· Getting Permission: Have agreement from the individual to proceed.
· When Offering Information or Advice: Suggest strategies or information, not forced.
· Asking Open-Ended Questions: delve deeper into intentions and state of mind.
· Using Reflective Listening: The heart of the MI approach is to use the rule of thumb that there needs to be 5 reflective statements for every question.
· Using the Levels of Reflective Listening Pt 1: Here the therapist restates using the client's same word or words. There are a number of reflective listening phrases such as "It sounds as though you are unsure about…..."; "It has been difficult for you to……"; "You have been feeling discouraged about……."; "You are embarrassed that…..."; "You are not happy about……."; and "You believe that others view you negatively because……".
· Using Levels of Reflective Listening Pt 2: This involves content ["You see a connection between your inactivity and being overweight and getting diabetes."]; feelings ["You are scared that if you do not do something about your weight now you will end up like everyone else in your family with diabetes."]; and meaning ["Your children are important to you and you want them to be healthy and learn from your example."]. For motivational interviewing to be effective it is important for the therapist or counselor to elicit "change talk" from the person seeking to change because in this way, people become more committed to doing what they actually say they want do. The therapist facilitates these client statements by stressing the advantages of the behavior change, the disadvantages of the status quo, optimism about being able to change and by reinforcing the client's intentions to change. The counselor also uses an importance/confidence ruler to gauge the person's desire to make the lifestyle change [e.g. on a scale of 1-10, how confident are you that you will make this change?].

The counselor also explores ambivalence being felt by the person. During this phase, the therapist responds to change talk by reflecting and elaborating, by affirming the intention, and by summarizing what the person is saying. It is also important to develop and point out the discrepancy between current behavior and the client's core values. The therapist can also offer menu vs. single solutions, by saying, "Here are some things that have worked for other people…….which of these do you think might work for you?" or "Controlling your weight may involve several different strategies, such as…….which of these do you think are most important for you to work on?".

Goldberg, D.; Hoffman, A.; and Anel, D. [2002]. Understanding people who smoke and how they change: a foundation for smoking cessation in primary care, part 1. Dis Mon. 2002 Jun; 48(6): 385-439.

Goldberg, D.; Hoffman, A.; and Anel, D. [2002]. Understanding people who smoke and how they change: a foundation for smoking cessation in primary care, part 2. Dis Mon. 2002 Jul; 48(7): 445-85.

Grable, J.C.; and Termullo, S. [August 2003] Smoking cessation from office to bedside. Postgraduate Medicine, August 2003, vol. 114, no. 2, 45.

Haggerty, L. A., and Goodman, L. A. [2003] Stages of change-based nursing interventions for victims of interpersonal violence. J Obstet Gynecol Neonatal Nurs. 2003 Jan-Feb; 32 (1): 68-75.

Handmaker, H. S. and Wilbourne, P. [2001] Motivational interventions in prenatal clinics. Alcohol Research and Health, Fall 2001 v. 25, 219 (11).

Kazel, R. [1998]. Cardiac coaching produces better health, savings. Business Insurance, Oct. 19, 1998.

Konkle-Parker, D. J. [2001] A motivational intervention to improve adherence to treatment of chronic disease. J Am Acad Nurse Pract 2001 Feb; 13 (2): 61-8.

Miller, W. R. [1996] Motivational interviewing: research, practice, and puzzles. Addict Behav 1996 Nov-Dec; 21(6): 835-42.

Miller, J. H.; Moyers, T. [2002] Motivational interviewing in substance abuse: applications for occupational medicine. Occup Med. 2002 Jan-Mar; 17(1): 51-65, iv.

Miller, W. R. and Rollnick, S. [2002]. Motivational interviewing: preparing people for change (2nd ed.) New York, New York, US: Guilford Press. (2002)

Minnesota Department of Health [September 1998]. Healthy Minnesotans: Public Health Improvement Goals 2004 [Minnesota Department of Health, Division of Community Health Services, 121 East 7th Place, Box 64975, Saint Paul, Minnesota 55164-0975].

Morera, O. F.; Johnson, T. P.; Parsons, J.; Warnecke, R. B.; Freels, S.; Crittenden, K. S.; and Flay, B. R. [1998] The measure of stage of readiness to change: some psychometric considerations. Psychological Assessment. June 1998 V. 10, No. 2, 182-186.

Nezami, E.; Sussman, S., and Pentz, M. A. [2003] Motivation in tobacco use cessation research. Jan; 38 (1):25-50.

Patten, S.; Vollman, A.; and Thurston, W. [2000]. The utility of the Transtheoretical Model of behavior change for HIV risk reduction in injection drug users. J Assoc Nurses AIDS Care. 2000 Jan-Feb.; 11 (1): 57-66.

Prochaska, J. O.; Velicer, W. F.; Rossi, J. S.; Goldstein, M. G.; Marcus, B. H.; Rakowski, W.; Fiore, C.; Harlow, L. L.; Redding, C. A.; Rosenbloom, D.; Rossi, S. R. [1994] Stages of Change and Decisional Balance for 12 Problem Behaviors. Health Psychology January 1994 Vol. 13, No. 1, 39-46.

Resnicow, K.; DiIorio, C.; Soet, J. E.; Borrelli, B.; Hecht, J.; and Ernst, D. [2002] Motivational interviewing in health promotion: it sounds like something is changing. Health Psychology 2002, Vol. 21, No. 5, 444-451.

Rosen, C. S. [2000]. Is the sequencing of change processes by stage consistent across health problems: A Meta Analysis. Health Psychology November 2000 vol. 19, No. 6, 593-604.

Sellman, J. D.; Sullivan, P. F.; Dore, G. M.; Adamson, S. J.; MacEwan, I. [2001] A randomized controlled trial of motivational enhancement therapy (MET) for mild to moderate alcohol dependence. Journal of Studies on Alcohol, May 2001 v. 62, 389.

Smith, A. J.; Shepherd, J. P.; Hodgson, R. J. [1998] Brief interventions for patients with alcohol-related trauma. Br J Oral Maxillofac Surg. 1998 Dec; 36(6): 408-15.

Smith, K. J.; Subich, L. M.; and Kalodner, C. [1995]. The Transtheoretical Model's stages and processes of change and their relation to premature termination. Journal of Counseling Psychology January 1995 Vol. 42, No. 1, 34-39.

Solomon, J. and Fioritti, A. [2002] Motivational intervention as applied to systems change: the case of dual diagnosis. Subst Use Misuse. 2002; 37(14): 1833-51.

Spencer, L.; Pagell, F.; Hallion, M. E.; and Adams, T. B. [2002]. Applying the Transtheoretical Model to tobacco cessation and prevention: a review of literature. Am J Health Promot. 2002 Sep-Oct; 17 (1): 7-71.

Sutton, S. [2001]. Back to the drawing board? A review of applications of the Transtheoretical Model to substance abuse. Addiction. 2001 Jan; 96 (1): 175-86.

Triad [October 2001]. Impact Evaluation Report on the Coaching.com Intervention for [Client Company] October 2001. Study designed and completed by Triad, 2040 Raybrook SE, Suite 207, Grand Rapids, Michigan 49546 (616-956-6850).

Watson, B. and Gallois, C. [1998] Nurturing communications by health professionals towards patients: a communication accommodation theory approach. Health Communications, vol. 10, pp. 343-355.

Zimmerman, G. L.; Olsen, C.G.; and Bosworth, M. F. [2000]. A "stages of change" approach to helping patients change behavior. Am Fam Physician. 2000 Mar 1; 61(5): 1409-16.

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HEALING THE DARKNESS OF DEPRESSION

Loretta M. Siani, Ph.D.
Clinical Hypnotherapy

Question: On the subject of depression: I would like to know if there is something I can do to avoid an incapacitating reticence to do anything? I don't want to take pills.

Answer: If it's any consolation to you at all, you are not alone. According to the National Institute of Mental Health more than eighteen million people suffer from depression. It is reported to be the leading cause of disability in this country and the world at large. The psychic landscape of clinical depression can be terrifying. It is replete with persistent thoughts of suicide, profound feelings of sadness and total loss of energy and motivation. Many people with clinical depression are unable to get out of bed for days. Feeling ashamed and guilty, they hide behind denial and often are too embarrassed to seek outside help. Often these people, and others suffering from milder forms of depression, look for alternative solutions to conventional medicine and drugs to reverse their symptoms.

My answer to your question will assume that you have not been diagnosed with clinical depression but that you nevertheless feel consumed by it. It will begin with a description of the holistic mind/body model. This will be followed by an outline of some of the mind/body self-help steps used in combination with conventional medicine to promote healing. Each self-help step is followed with a brief explanation of the metaphysical principals that underlie the treatment and how it applies to your problem.

The Mind Body Model and The Link Between Stress and Illness
To understand the mind/body model it helps to get a clear picture of the link between stress and illness. Clinical observation confirming how stress predisposes people to various kinds of illness is cogently described by Dr. O. Carl Simonton in his book *Getting Well Again*. The crux of the link between stress and illness is that unreleased, chronic stress suppresses the body's immune system.

The Effects of Psychological Stress
What is germane to our point is that it is not stressful situations that create disease but rather our psychological reaction to those situations that make us vulnerable. Psychological stress, in the mind/body model, occurs when a person interprets a situation as dangerous, difficult or painful and decides that they don't have the resources to cope with or escape from its clutches. The effect of psychological stress is particularly acute when it threatens the person's core identity. This often occurs when an individual looses a loved one or spouse through death or divorce, retires from a life long career or experiences significant life role changes. These situations often create a crisis that the individual interprets as beyond their ability to handle. Often the crisis is reminiscent of an early childhood event and so works to re-open old psychic wounds. These conditions produce an inner state of fear, hopelessness and despair. The individual begins to identify with these toxic emotions rather than more nurturing, life-sustaining ones. This toxic emotional state gets recorded in the limbic system of the brain promoting a series of physiological changes to occur in the body that adversely affect the immune system and produce disease, including clinical depression.

The Manifestation of Disease
Almost every bodily system suffers under the duress of chronic psychological stress. For some it manifests as sustained suppression of the reproduction system and problems of infertility. For others it manifests as heart disease, hypertension, depression, insomnia and clinical anxiety. For many, chronic stress affecting the body's uptake of sugar produces weight gain, weight loss or the onset of adult diabetes. Suppression of tissue repair caused by stress leads to decalcification of the bones. Chronic stress leads to severe muscle tension, fatigue, migraine headaches, diarrhea, constipation, arthritis, asthma, gastrointestinal disorders, chronic pain and a whole host of immune system disorders.

Similar to the metaphysicians view, the mind/body model sees sickness, produced by psychological stress, as a manifestation of the inner struggle going on between the self-destructive part of the person consumed with toxic emotions and the more nurturing, life supporting part of the person calling for love, life and wholeness.

At Dr. Simonton's world-famous Cancer Counseling and Research Center the following mind/body self-help steps are used in combination with traditional medical treatment. At the counseling center they are prescribed for individuals suffering from "terminal" cancer and they have produced remarkable results. They are also efficacious for treatment of depression and other diseases.

MIND/BODY SELF-HELP STEPS

Make a Mental Decision To Become A Different Kind Of Person
Through psychological counseling the mind/body patient is encouraged to a) make a decision to become a different kind of person who is capable of handling all of life's problems b) decide to identify with the life sustaining, nurturing part of themselves instead of the part that is toxic and self-destructive.

The key to solving your problem lies not in what you do but in what you think. Changing your thinking about the kind of person you are will correct the conditions that have brought about your problem. Your new thinking will enable you to take the action necessary to release you from the anguish of your depression.

Depression is a mental process with which you must stop identifying. To do this you must learn to cultivate what is called in Eastern traditions your inner witness. Ask yourself this question: Is the part of me that notices my depression, depressed? The part of you that can assess your depression is your inner witnesses. It is connected to your higher mind and thrives on love instead of fear. This is the part of yourself with which you want to identify. Why? Because this is the REAL you. You are not your depression. You are not even your body. You are the one using your body. Your body's depressed condition is a response to the

misthoughts of fear created in your mind and projected onto your body.

Think of your body as a learning device.
The chief function of a learning device is to enhance learning. If it does not do this it fails. The way to learn from the body is to recognize that it is a blank slate onto which your fearful thoughts have been projected. Fear presents the concept of lack to the body. The body follows the directives and begins to close down. It cuts off energy, interferes with sleep, appetite, motivation, libido, etc. and begins to manifest diseases such as depression.

All forms of disease are messages manifested to bring the misthoughts of fear into awareness. Fear comes from being in a state of conflict or having a split mind. It occurs whenever we hold grievances, or choose to do what we wholly do not want to do. The way to change the body is to induce the mind to give up the miscreations of fear it has projected onto the body. A Course In Miracles says that this is the only application of creative ability that is truly meaningful. One way to do this is to interpret your bodily symptoms much like you interpret the symbols in a dream so that you can learn from them. In this regard depression can be viewed as symbolic of being immobilized or frozen with fear over some situation that you do not wholly want or some form of fear or unforgiveness that you are holding in your mind.

Forgive
Mind/body patients are counseled to practice forgiveness. Because the venom of resentment produces long-term psychological stress, the mind/body patient is counseled to make a mental decision to let go of all grievances over past hurts and instructed how to use mental imagery to release these grievances.

Every moment of our lives, in every relationship, we are demonstrating either love or fear. Resentment is a product of fear. It is a reflection of deep feelings of self-condemnation, and fear of recrimination. In our relationships, the more we choose to focus on resentment over the faults of others or how we're being treated, the more we end up condemning ourselves. We must recognize that the anxiety produced from our self-condemnation gets projected onto our bodies. Forgiveness withdraws the projections of our ego back into our mind where they can be released and healed. Forgiveness produces inner peace. Inner peace is the greatest boost to our immune system. In Course terminology healing is inner peace.

Visualize Healing
The mind/body patient is guided through deep relaxation exercises and mental images of the body working together with medication to produce health. While deeply relaxed, the individual is also prompted to create mental images of what life will look like when health is restored. Deep relaxation combined with mental imagery is expected to be practiced three times a day, for 15-minutes until well beyond recovery.

The metaphysical healing power of imagery has been understood for centuries. It is based on the principle that the images that we hold in our mind and dwell upon with deep emotion get projected out onto the world. Replacing mental images of despair with images of hope will alter the projections of your unconscious mind and lift the darkness of depression. This is motto suggest that you replace all traditional treatments with visualization. But I am suggesting that you use it in addition to traditional treatment.

This brings me to discuss your desire not to use pills. Look at it this way. The body is not the problem. The mind is. This does not mean that it is wrong to use remedies from outside the body to heal it. The fact is eating, sleeping, drinking water, taking exercise are all remedies outside the body. We don't ask how to overcome our "problem" of hunger or thirst without eating food or taking drink. It is impossible in this world for us not to use these remedies. You may want to begin your forgiveness process by forgiving yourself for needing medication. In the words of the Course, do not despair because of your limitations. It is your function to escape them but not to be without them. Take medication if it helps you to get over the hump of your depression. Just realize that ultimately it is dealing with effects and not cause, which is always some form of fear or unforgiveness held in the mind. Keep working on that to heal the cause.

Set Goals for the Future
The mind/body patient is counseled to engage in goal setting. The writing out of goals is an outward

expression of an inner commitment to decide to take charge of your life. It is the first step in turning thoughts of hope into reality. I would recommend that you write out your goals, and even draw pictures of them, just before falling asleep at night. Then before you fall asleep ask your higher mind to show you the way to remove any obstacles that are preventing you from manifesting them. Keep a journal of your progress toward your goal. Put your focus on the progress you are making. This will further serve to turn despair into hope.

Practice Regular Physical Exercise
One hour of physical exercise three times a week is assigned for mind/body patients to restore balance to the immune system. So important is this step that if exercise is too difficult at first, the individual is encouraged to use mental imagery of exercise to begin to build the expectancy of greater health and physical ease in the near future. Physical exercise is particularly good for depression because it changes physiology by increasing oxygen thereby igniting new levels of energy. It is also a way of demonstrating love and forgiveness of yourself. All of this is a profound medicine for healing depression.

Making a decision to become a new kind of person, not identifying with depression; forgiveness, visualization, goal setting and physical exercise are just some of the mind/body self-help steps for healing. Primarily they produce healing by replacing thoughts of fear, with thoughts of love. When all is said and done, disease can be viewed as the crucible of our redemption when used to learn our lessons of love and forgiveness. Here is a prayer to make this so and to heal the darkness of depression. Dear God, make me an instrument of your peace. Teach me to recognize that the world I am unhappy with is but a mirror reflecting back to me the things that need to be healed in me. When I am withholding love, when I am in steeped in judgment, or lost in despair, please heal my perceptions and help me to see things differently so that I may sow love and forgiveness everywhere and in so doing receive the gift of wholeness that is already mine. Amen.

::front page::

SPOTLIGHT on ISMA-USA MEMBERS

In this section, we want to focus on YOU, our members. We will introduce and welcome new members to our association, and we will report and congratulate members on their achievements and involvements. Please help us to connect with each other and to be informed about the great things you are doing by sending information to the editors either about yourself or another member.

NEW MEMBERS
A warm welcome to these new members who joined ISMA-USA in the past few months.

Stephen E. Hobfal, Ph.D., Kent State University, Kent, Ohio
Jae Kaplin, B.S., Gaithersburg, Maryland.
Karen Krisland, M.S., Providence, Rhode Island
Jana Maas, M.Ed., Charlottesville, Virginia.
Shuen Wai Nicholas Pang, Ph.D., CHC, Hong Kong, China.
Henry Svec, Ph.D. , Chatham, Ontario, Canada.

ANNOUNCEMENTS

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POSITIONS AVAILABLE

VOLUNTEERS NEEDED.

ISMA-USA Web Site Librarian

This person would serve as a contact person for submissions to our on-line library, be a resource person to answer inquiries from visitor to our web site and search for new book titles to add to the existing list.
For further details contact **Betty J. McGuigan**, web site editor.

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