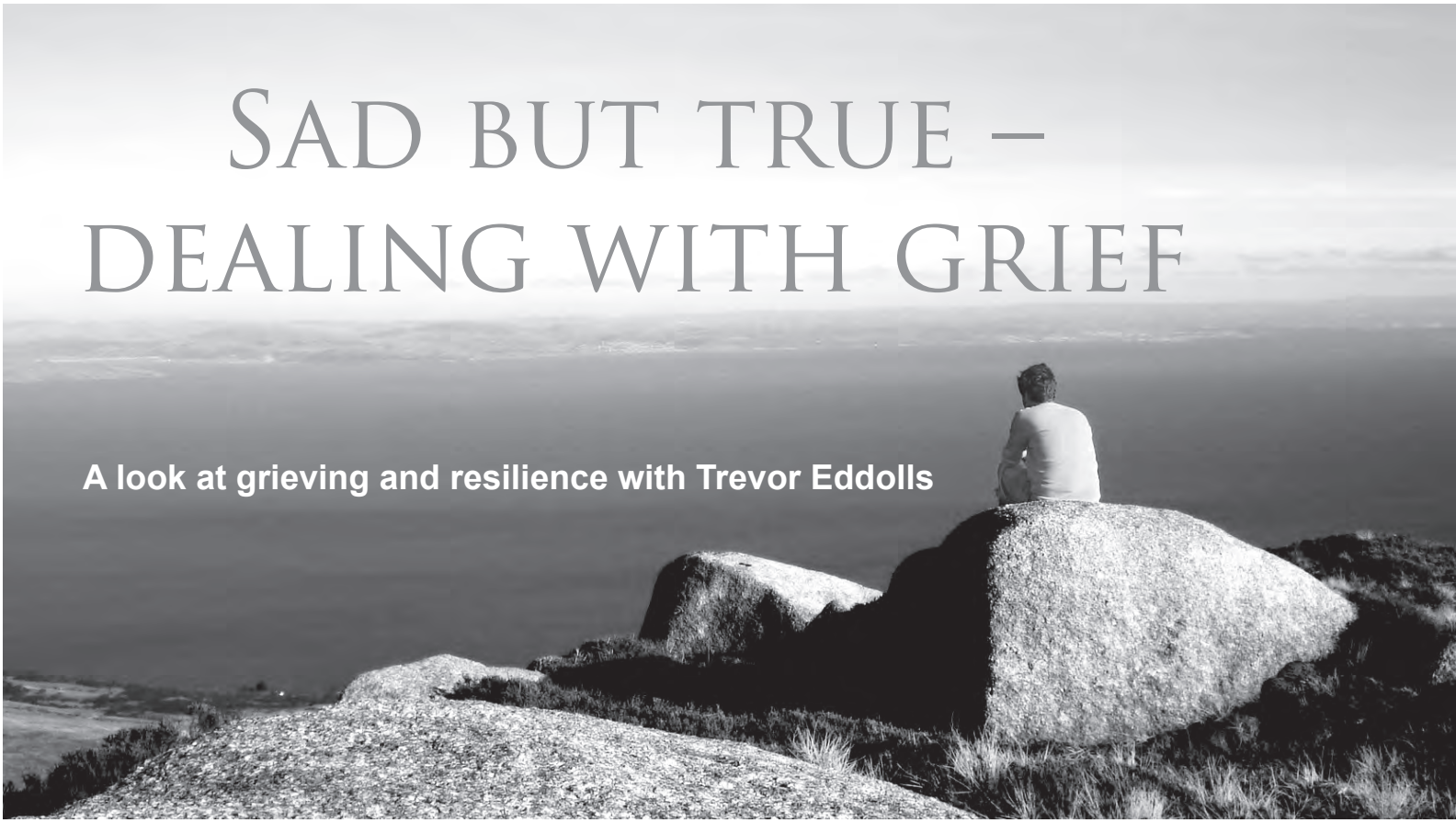
Sad but true – dealing with grief



A look at grieving and resilience with Trevor Eddolls

The first time I had a client with grief issues, I wasn't quite sure what to do. I knew they needed to get into their control brain and out of their emotional brain, but I wasn't sure what stages of grief they had to go through or whether my experiences of loss were of any value in this situation.

Grief usually follows a loss. A person can grieve for a dead family member, and they can also grieve for lost friends, a lost home, a job, even a country. Whatever form the loss takes, a person can experience grief.

Watching TV programmes and films, you'd think everyone went through the five stages of grief that were first specified by Elisabeth Kübler-Ross in her book On Death and Dying. The stages are:

- Denial – "I feel fine"; "This can't be happening to me".
- Anger – "Why me? It's not fair!"; "How can this happen to me?"; "Who is to blame?". People can be angry with themselves, or with others.
- Bargaining – "I'll do anything for a few more years"; "I will give my life savings if..."
- Depression – "I'm so sad, why bother with anything?"; "I'm going to die soon so what's the point?"; "I miss my loved one, why go on?"
- Acceptance – "It'll be OK"; "I can't fight it, I may as well prepare for it".

But these stages were only what Kübler-Ross had observed and were not meant to be prescriptive, only descriptive. Other researchers have not observed people moving through these stages.

So, if people aren't working their way through the five stages of grief, what are they doing?

George Bonanno suggested that a natural resilience is the main component of grief and trauma reactions. He came up with, what he called, four trajectories of grief. He even showed that the absence of grief or trauma symptoms is a healthy outcome. He found that grief responses can include laughter, celebration, and bawdiness, as well as sadness (which is what you'd expect). He called these counter-intuitive strategies "coping ugly". He also found that resilience is normal for people.

His four trajectories are:

- Resilience – the ability to maintain relatively stable, healthy levels of psychological and physical functioning.
- Recovery – following Post-Traumatic Stress Disorder (PTSD) episodes.
- Chronic dysfunction – prolonged suffering and inability to function.
- Delayed grief or trauma – when adjustment seems normal but distress increases months later.

Continued over...

GRIEF

Charles A Corr suggested that individuals may try out different coping strategies only to reject them. He also thought that a person may pursue several strategies at the same time, even if they are not compatible.

According to the Changing Minds Web site, "we are not always able to cope with the difficulties that we face. As a result, we are subject to feelings of tension and stress, for example the cognitive dissonance and potential shame of doing something outside our values. To handle this discomfort we use various coping methods." They go on to suggest a number of types of coping mechanisms:

- Adaptive mechanisms – that offer positive help.
- Attack mechanisms – that push discomfort onto others.
- Avoidance mechanisms – that avoid the issue.
- Behavioural mechanisms – that change what we do.
- Cognitive mechanisms – that change what we think.
- Conversion mechanisms – that change one thing into another.
- Defence mechanisms – Freud's original set.
- Self-harm mechanisms – that hurt ourselves.

Hypnotherapy can help clients to manage their internal experiences, so that they can move from feelings of pain and sadness to those of acceptance and calm. Hypnotherapy can help make the process of bereavement and mourning less painful and more manageable by:

- Helping people come to terms with their loss
- Visualizing a positive future and setting goals
- Lowering emotional responses of fear and loneliness
- Increasing levels of self-esteem
- Overcoming temporary responses such as poor eating, lack of exercise, etc
- Dealing with unresolved issues with the deceased
- Celebrating the life of the deceased.

Clients may need help before the funeral. They may also need help to get through the funeral. And they will probably need help for a period of time after the funeral. The funeral doesn't mark the end of their feelings of grief.

People who come to see you about grief and bereavement issues may be experiencing shock and disbelief at their loss. They will probably be feeling very sad and may cry a lot. Some people may be feeling guilty about the things they said or didn't say. Or they may feel guilty at their feelings of relief (for example after a long illness). They may be feeling angry at the world for taking away their loved one, or they may feel angry with themselves. They may be feeling fear because they have been left alone to cope or because they realize their own mortality. And they may be experiencing physical symptoms such as fatigue, nausea, insomnia, aches and pains.

It's important to tell clients they have permission to express their feelings (not just during a session) and they can do this by talking to an empty chair (a Gestalt technique), or writing a letter to the deceased. They need to understand that they don't need to 'move on' or 'get over it' until they are ready. Grief is a natural process, it won't last forever, and the client will be able to move on when they're ready. You can plan ahead with the client for occasions that will trigger their sad feelings, for example anniversaries, or visiting places they associate with the deceased, etc. Let them know that they are allowed to cry when they're with you – and they're also allowed to laugh – whatever feels right for them. And be prepared to hear the same story over again. The client is processing and accepting the death, and repeating the story helps to lessen the pain of the loss for them. Of course, it's never good to start sentences with "you should", when suggesting things your client might do, and it's worth avoiding platitudes, such as saying "it's all part of God's plan".

Prolonged Grief Disorder (PGD), also called complicated grief, presents as long-term and severe grief symptoms. Most people are resilient and start to move on with their life. However the Helpguide.org site suggests that after two months there are warning signs to look out for indicating that people need help. These are:

- Difficulty functioning in daily life
- Extreme focus on the death
- Excessive bitterness, anger, or guilt
- Neglecting personal hygiene
- Alcohol or drug abuse
- Inability to enjoy life
- Hallucinations
- Withdrawing from others
- Constant feelings of hopelessness
- Talking about dying or suicide.

You may well see people experiencing some of these difficulties following bereavement.

Going back to resilience, which is sometimes called hardiness, mental toughness, or resourcefulness, but whatever term is used, it is refers to an individual's ability to cope with stress and adversity. For people who have suffered a loss, it's their ability to cope with their grief. Fredrickson in 2003 identified more-resilient people as those who noticed positive meanings in the problem they faced, experienced fewer depressive symptoms, and experienced more positive emotions than less resilient people. Ong found low-resilient people had difficulties regulating negative emotions and over-reacted to normal daily events. As hypnotherapists, we need to help clients to be more positive about aspects of their life and recognize good things in their lives (which, I guess, we're all doing with our clients anyway) ■

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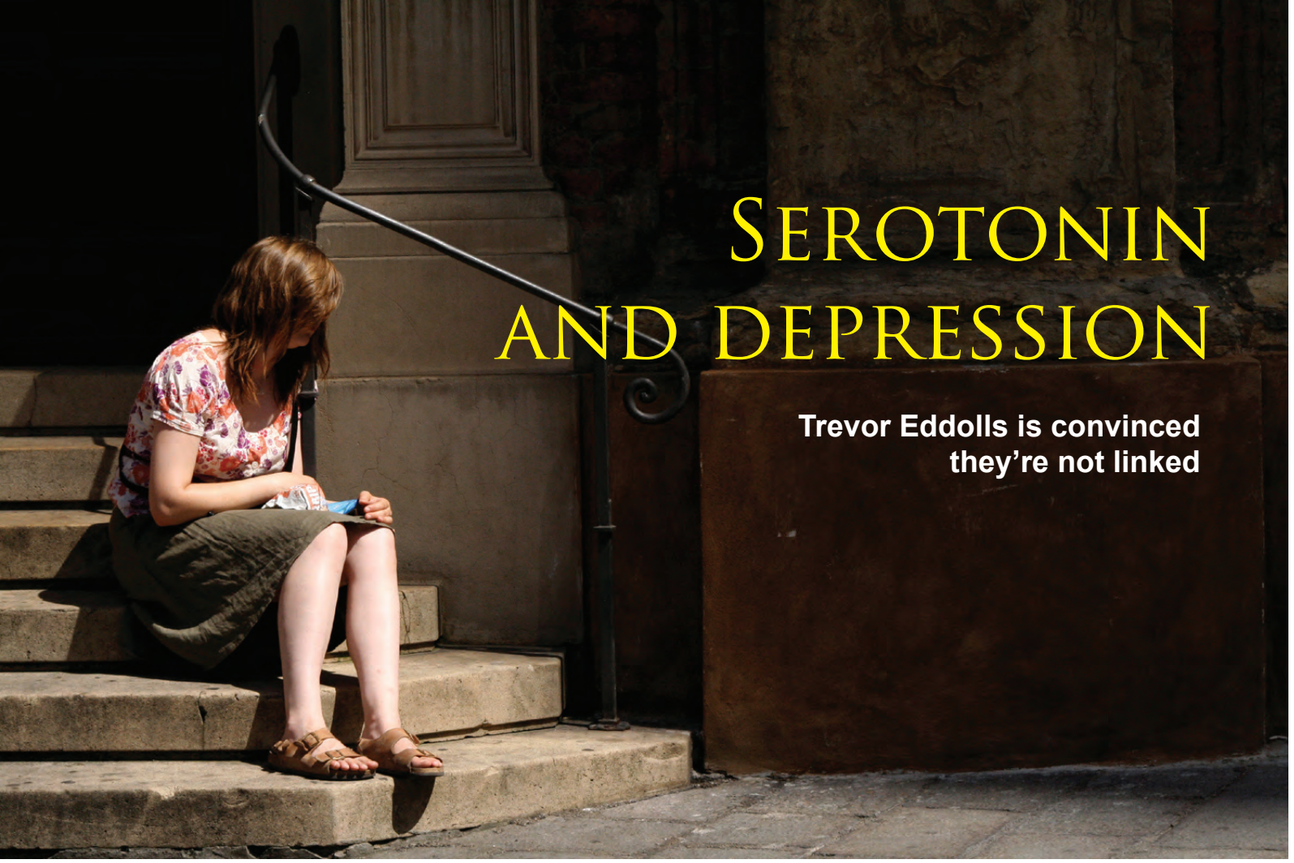

Serotonin and depression

Trevor Eddolls is convinced they're not linked

Research shows that serotonin and depression are not directly linked.

Everyone knows that low serotonin levels cause depression – in much the same way that everyone used to know that the Earth was flat! Everyone knows depression is caused by low serotonin levels – in the same way that everyone knows that headaches are caused by a lack of paracetamol or aspirin.

The blood-brain barrier separates Brain ExtraCellular Fluid (BECF) from circulating blood. It consists of endothelial cells that restrict the diffusion of microscopic objects and large or hydrophilic molecules, but allow the diffusion of small hydrophobic molecules (O2, CO2, hormones). Glucose and specific proteins are actively transported across the barrier.

The trouble is that many people believe there is a direct link between neurotransmitter serotonin levels and depression, and many hypnotherapists are saying this to their clients. According to Ben Goldacre in Bad Pharma: "The 'serotonin hypothesis' for depression, as it is known, was always shaky, and the evidence now is hugely contradictory".

Most drugs used for depression are SSRIs – selective serotonin reuptake inhibitors – yet Goldacre informs us that tianeptin is equally effective, and it is a selective serotonin reuptake ENHANCER. It should have quite the reverse effect, if the theory held water.

Why is it so hard to prove this one way or another – either serotonin levels effect depression or they don't. It's hard because scientists would have to work on living brains, and not many people would agree to have part of their brain mashed up for science (and those darn ethics committees wouldn't be very happy either!). The only way the science can be done is by measuring serotonin levels in blood. You can see the problem. Serotonin is a neurotransmitter, it exists in the synapses between neurons. There's a blood-brain barrier that stops large molecules diffusing in or out. And serotonin is made in other parts of the body too. It seems that about 90% of the serotonin in our bodies is in what are called enterochromaffin cells. These can be found in the gut and are used to regulate intestinal movements.

Even allowing for these difficulties, scientists made an estimate of the serotonin levels in the brains of depressed people - and they found that they were pretty much the same as the rest of us.

So, scientists tried another experiment. They took normal healthy people and reduced their serotonin levels. (It's done by messing about with tryptophan, a serotonin precursor.) And guess what? The subjects didn't become depressed.

Other scientists even came to the conclusion that too much serotonin causes depression – and suggested this as a reason for the side-effects of SSRIs.

But there's another issue here. Does a low (or high) serotonin level cause depression, or does depression cause a change in serotonin level?

Let's take a more detailed look at the arguments against serotonin causing depression. Firstly, how come it takes a month of taking SSRIs before there are any noticeable effects? Wouldn't raising the serotonin level kick in pretty quickly if the theory was correct? Isn't that what people argue as they tuck into a bar of chocolate. The evidence from medication would suggest that you should eat chocolate for a month before you felt happier!! Secondly, SSRIs would work on everyone in the same way. Yet the evidence suggests SSRIs work on only 60% of people.

SSRIs obviously work – albeit slowly and on just over half the population – so how are they working? It looks like they also increase neurogenesis – the birth of new brain cells in the hippocampus. Experiments on animals (those ethics committees again) show the animals eat more tasty food and move around more when treated with antidepressants. And if you depress them, they do less of it – and neurogenesis is reduced as well.

So, it looks like (it could well be that) increasing serotonin levels in the brain increases neurogenesis, which reduces depression. That would explain the three to four week delay before the effects of the SSRI medication can be felt.

Or, of course, it could be something else entirely! ■

It's like that part in the television programme QI: the screen has gone black and is flashing because Alan Davies has just said something that most people believe, and Stephen Fry is gloating over the error and showing his superior knowledge. We've all been Alan Davies, shortly (and without the gloating) we'll become Stephen Fry!

ANTI-DEPRESSANT MEDICATIONS

Selective Serotonin Reuptake Inhibitors (SSRIs):
- Fluoxetine (Prozac).
- Citalopram (Cipramil)
- Paroxetine (Seroxat)
- Sertraline (Lustral)

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
- Duloxetine (Cymbalta and Yentreve)
- Venlafaxine (Efexor)

TriCyclic Antidepressants (TCAs):
- Amitriptyline (Tryptizol)
- Clomipramine (Anafranil)
- Imipramine (Tofranil)
- Lofepramine (Gamanil)
- Nortriptyline (Allegron)

MonoAmine Oxidase Inhibitors (MAOIs):
- Moclobemide (Manerix)
- Phenelzine (Nardil)

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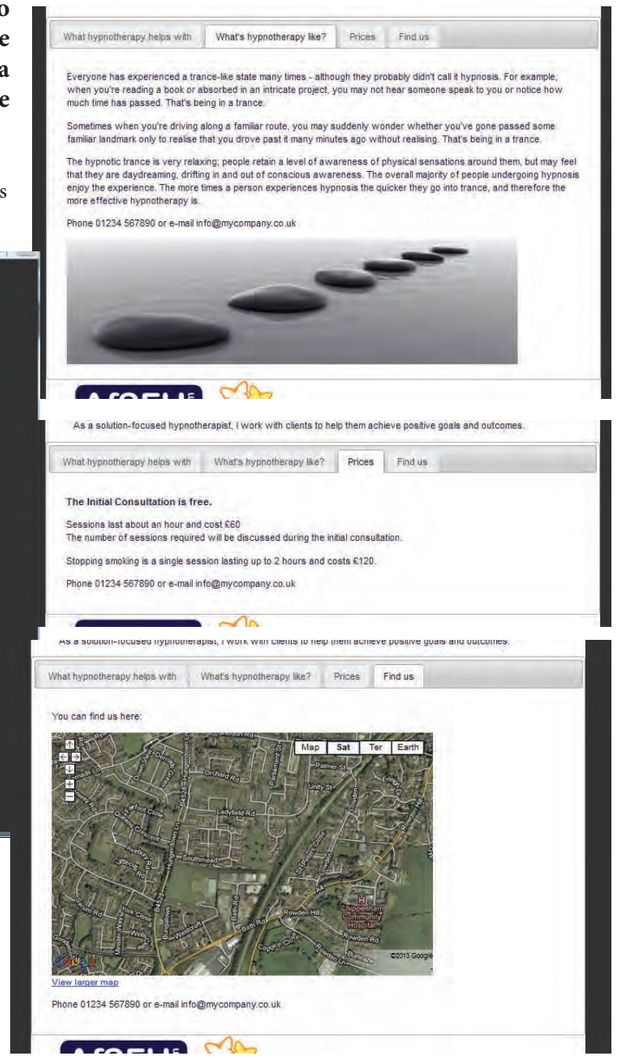
FREE WEB SITE

Trevor Eddolls explains the latest offer for AfSFH members.

Starting out with a new hypnotherapy business can be a daunting task. You need to make sure you know your stuff. You need to find somewhere to practice, and you need to get clients coming to see you. One of the best ways to be found by potential clients is to have a website – but how do you do that when you have so much else to think of? The AfSFH has prepared a basic website that you can personalise and use pretty much straight away.

The site is at http://afsfh.zxq.net. It looks like this



You can change the banner across the top to include your logo and any images you would like, as well as putting the name of your business and contact information (phone, e-mail, etc). The existing graphic is 800 pixels wide by 200 pixels high.

At the bottom of the page are the AfSFH logo and the trained at CPHT logo. You can add any other logos you want. So, if you're a member of the GHR, NCP, NCH, etc, you can add their logos too.

In the middle section are four tabs. This is an easy way to put lots of information into a limited amount of space. Again, you can change these, and you can change the text and graphic under each tab. The tabs are "What hypnotherapy helps with", "What's hypnotherapy like?", "Prices", and "Find us".

So let's get technical for a moment. If you don't have drawing software to create and modify graphics, a really good free program is called Paint.Net. GIMP is another great graphic tool. If you have a 'Save for Web' option with your drawing program, use it. Web graphics don't need so many bits as printed graphics. They also load faster if they are smaller.

The next thing you need is some way to edit the HTML – that's the code that displays the text on the page. You can read the code by right-clicking on the Web page and selecting "View Page Source". You can select all the text that appears, copy it, and then paste into Notepad – the software that comes free with Windows. Under "Edit" there's "Find". That allows you to find a piece of text that you want to change – like changing contact details to your own. Next, you want to "Save" your file. I'd create a directory called 'website' and "Save as" into that. The name for your file is 'index.htm'. As long as the extension is htm or html, you can view the contents as a Web page – that means it will show up in your browser (Firefox, Internet Explorer, etc). Any graphics you create can go in the same directory (the one we called website).

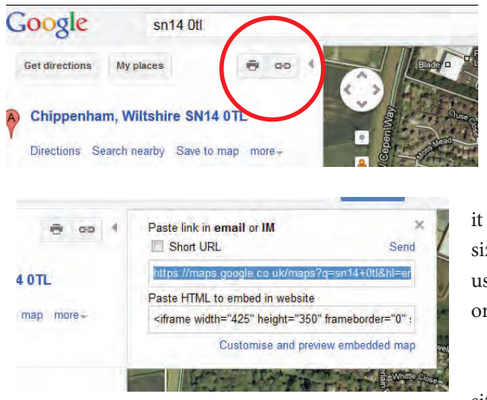
One word of caution: don't change anything inside the angle brackets – eg <p> – unless you know what you're doing. This is the HTML code that tells the browser what the page should look like.

Near the very top of the HTML it says:

```
<title>AfSFH site for members
</title>
```

You can delete "AfSFH site for members" and insert the name of your hypnotherapy company.

The clever part is on that fourth tab where I've put a Google map showing where your business is located. How can you do that? Go to https://maps.google.co.uk/, put your post code in the box at the top – your local map will appear. Zoom in. Then click on the icon that looks like chain links (in the red circle in the diagram):



Underneath where it says "Paste HTML to embed in website", select that code and paste it over the top of the existing code on the page:

```
<div id="tabs-4">
<p>You can find us here:</p>
    <p style="font-size: 13px;">
      <iframe style="font-size: 13px;" src="http://maps.google.co.uk/maps?f=q&amp;source=s_q&amp;hl=en&
      <br style="font-size: 13px;" />
```

It just over writes that one line – and now your location will show up in that fourth tab.

One final technical bit - the logos at the bottom of the page are hyperlinked to the AfSFH Web site and CPHT.. Were you to add an NCP logo, you'd want to hyperlink that too. Here's how:.

```
<a href="http://www.ncphq.
co.uk/" target="_blank">
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width="100" height="98"
style="border: 0px;"
alt="LNCP" title="National
Council of Psychotherapy"/>
</a>
```

That top line has the Web address for the NCP. You could change this for any other organization. The next two lines have information about the graphic – giving information about where it is, what size it is, and that 'title' tag creates text that will pop-up when people move their mouse over the graphic. The last line simply closes everything. You can repeat this for more logos.

How do you get a graphic for the Hypnotherapy organizations? If they don't have them on their website, search Google images. Once you have a logo, you'll probably want to resize it (make it smaller so it's much the same size as the existing logos). You can do that using your drawing software (Photoshop or Paint.NET, etc).

You now have a personalised website sitting on your computer. What next? You need to get your website out there so people can find it. And that means two things – you need Web hosting and you need a domain name. Now, because these are early days in your business, you don't have much budget left after arranging consulting rooms etc. You can get free hosting from a number of companies (a Google search will help). I used zymic.com for the afsfh.zxq.net site. You control the first part of the name, so you can personalise it – myhypno.zxq.net or tranceformer.zxq.net, or anything-that-someone-else-hasn't-already-thought-of.zxq.net.

Lastly, you need to get your files to the domain. Some free hosting sites offer file uploading mechanisms. Internet Explorer has a convoluted way of loading files. Or you can download software that makes it easy – things like Filezilla. Once you've uploaded your index.htm file and your graphics, your website will be online. You can modify your Web page on your computer, look at it, decide you like it, and then upload the new version. And you can do that as often as you like.

You now have your own website with as little effort as possible! ■

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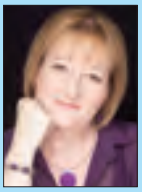

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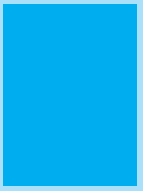

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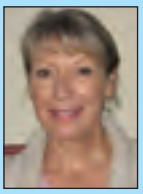

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Don't Forget!

If you are a member of the NCH, then you can register your details of your supervisor (If they have been accredited by the NCH) with them - online. www.hypnotherapists.org

Committee Members

Chairman and Trustee: David Newton

David Newton founded the AfSFH and is an avid supporter of getting the word out to the public of what Solution Focused Hypnotherapy is all about. His inspiration brought the Association to life and has allowed us to flourish rapidly in our early days. His support of all that we do is greatly appreciated.

Company Secretary and Trustee: Nicola Griffiths

Nicola chairs and tries to keep control of our Executive meetings! She works closely with the Executive in order to push the Association forward. The bee in her bonnet is to support both newly qualified and experienced Hypnotherapists in their careers, so she comes up with many of the initiatives that help our members improve their businesses.

Trustee: Susan Rodrigues

Susan is our mainstay who oversees our Executive meetings to ensure we're on the right track! Her knowledge ensures that our brain waves keep to the ideals (and regulations) of the solution focused world.

Assistant Company Secretary: Sharon Dyke

Not content to be Nicola's Deputy, Sharon has taken on the role of Risk Assessor AND taken charge of long term planning for the Association. So we now have a vision for the future – all she needs to do now is keep us focused towards our goal!!

Journal Editor: Penny Ling

Luckily for us, Penny was in publishing before she became a full-time Hypnotherapist. Working with a team of volunteers who submit articles, Penny (amidst occasional tearing out of hair) writes, designs and produces our amazing Journal which has received unprompted and excellent feedback.

Communications manager: Debbie Pearce

Having decades of experience in PR, Debbie is in charge of national publicity. She also works hard behind the scenes establishing relations with publications and organisations that will benefit the AfSFH as we move forward. She also brings a large dose of energy to the Executive which keeps us motivated!

Member Benefits Officer: Andrew Workman

Andy is responsible for obtaining discounts on products and services that you find on the Member Benefits page of our website. He approaches many many companies using his persuasive powers to encourage them to offer these discounts! We don't like to ask how he does it, we just leave him to it…..

Marketing Officer: Su Brampton

Su has joined the Committee to help Debbie with Marketing and she now has responsibility for our press releases and those lovely e-newsletters you receive!

Treasurer and Events Co-ordinator: Denise Barkham

Not content to organise our Events, Denise also has the responsibility of keeping us in line when it comes to spending money, keeping a tight hold of the purse strings and balancing our books!

Website Officer: Trevor Eddolls

Trevor, for his sins, is charged with updating the website and inspiring us with ideas to further progress the site. A challenging and key role as we grow bigger!

Assistant Journal Editor: Kim Dyke

Kim has thankfully come to the rescue of Penny who was drowning under a mass of admin and chasing up copy so Kim will be the liaison between writers and the editor in the future.

Administrative Secretary: Shelley Sanders

Shelley is our lovely new Administrator who deals with all your queries and those of the public whilst Claire is looking after her new baby. Shelley has already had to keep up the pace during the last association meeting and AGM with all the minute taking - so thrown in the deep end already!