

Student and Alumni Guild E-Journal



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Feelings: The Door Into the Client's Issue

Conference keynote speaker Tom Nicoli shares his insight on success with clients

This approach is to offer any professional using hypnosis, when working with a client for relief of issues and personal goal achievement, an alternative to what is traditionally taught as a way of inducing the "hypnotic state." It is also a way to get to the motivators (feelings) of unhealthy behaviours quicker and easier for both the client's and facilitator's success.

Inductions

A formal "induction" is what hypnotherapists generally assume to be the way to direct a client into the hypnotic state, in which to then engage the subconscious mind to assist the client with the presenting issue. But what do we really mean when we use the word "induction"? The intent is to "induce" the hypnotic state. When looking at the word induce in Merriam Webster dictionary we see:

- 1 a: to move by persuasion or influence b: to call forth or bring about by influence or stimulation
- 2 a: effect, cause b: to cause the formation of c: to produce (as an electric current) by induction
- 3: to determine by induction ; specifically : to infer from particulars

What we do in a hypnosis session with a client would be definition 1; to move by persuasion or influence; to call forth or bring about by influence or stimulation. This is what happens when using a traditional or formal "induction" with a client to achieve the hypnotic state in which to do the work we do. We know there are long, drawn out inductions such as a Progressive Relaxation and Guided Imagery and more rapid types of inductions such as the Hand Drop or Handshake inductions. And though it is more beneficial regarding



Tom Nicoli

use of time and as a "convincer" to the client that something happened during the session (for the client to actually believe they may have been hypnotized) a rapid induction like the aforementioned is avoided by many hypnotherapists for it is more of an authoritative and sometimes uncomfortable approach. So let us look at yet another "rapid" way to direct the client into a hypnotic state, in a much different way than traditionally taught, which is

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Welcome to the E-journal

Hi and welcome to the Autumn edition of the E-Journal for members of the NCHPSAG.

I hope you enjoyed the first edition, however if you missed it remember you can download it from the SAG website at <http://www.hypno-psychotherapy.net/>

My thanks go to this edi-

tions contributors, including Conference keynote speaker Tom Nicoli, Liz Taylor, Jo Goss, Simone-Davis, Sharon Mustard and Grahame Milton-Jones.

This quarter has seen the foundation of a committee of volunteers, dedicated to making SAG the organization we all deserve—more on page 18.

Remember, this is your journal and we welcome letters, comments, articles and (almost) anything you would like to share with other members.

Happy reading *Su*

Next E-Journal Submission Deadline
15th December 2009

Psychopaths have Faulty Brain Connections Research synopsis provided by Jo Goss

Scientists at the Institute of Psychiatry at London King's College Hospital have discovered that violent psychopaths may have faulty connections in those areas of the brain that control impulses and decision-making.

The study, which made use of a new brain imaging technology called diffusion tensor magnetic resonance imaging (DT-MRI), followed on from earlier studies that had shown that the amygdala, which processes emotions, and the orbitofrontal cortex, which handles impulses and decision-making, are both structurally and functionally different in psychopaths. This new technology allowed the researchers to study the white matter tract that links those two key areas

of the brain.

The researchers used DT-MRI to scan the brains of a group of nine psychopaths, all of whom were serious offenders (having committed crimes of violence such as murder, manslaughter, multiple rape or strangulation). They compared the results with scans from a control group of nine people who did not suffer from the condition. They found that in the psychopathic group there were 'roads' linking the two brain areas that were filled with 'potholes', whilst the 'roads' in brains of the non-psychopathic group were in good condition. They also found that the degree of abnormality was significantly linked to the degree of psychopathy.

It was noted as significant that none of the members of the psychopathic group had any other form of mental illness.

The findings to date have not established how, when or why the brain links became damaged, and for this reason the researchers consider that the technique could not be used for the screening of potential psychopaths before they had committed any offence. This is an area that requires further research.

The researchers also acknowledge that the study was carried out on a very small scale, largely because of the difficulty in finding sufficient people in this category who were willing

to take part in such research. Indeed they stress that 'the important thing it raises is that more research needs to be done'.

Source: 'Psychopaths have faulty brain connections, scientists find'. Reuters, Friday August 7th 2009.



Jo Goss, NCSAG Research Coordinator

Assignments—Assessor Hints and Tips

Some say the reason that assessor's identities are kept confidential is to maintain the integrity and objectivity of the marking system, others believe that in reality they all have scales hidden beneath their clothes.

Regardless of this speculation, we can in fact confirm that assessors are indeed real human beings and to prove it, here are a selection of hints and tips to help you in the completion of your assignments.

Dissertations

- use a wide range of sources (and reference these) try to have a range of historical and recent research (if appropriate) always try to give a balanced view and look for the alternative viewpoint to your own to aid evaluation choose a dissertation topic you have a real personal

interest in .. it shows.

- use a spell/grammar check to improve professionalism

Essays

- Read the question thoroughly.
- Begin the essay by demonstrating that you understand the question by explaining how you will answer it. For example, 'I will begin by explaining what xxx means, where it originated and how it developed. I will then describe how I used xxx with my clients, and finally I will conclude by analysing and reflecting on the results'.
- Read around the subject. Quotes should be correctly referenced, and a bibliography shows the extent of your research.
- Ensure you write in the correct style. An essay is a

formal piece of writing, so try to avoid overuse of lists, charts and graphs in the main body of the work, instead add them as an appendix.

- Keep to the word count, + or - 10%.
- Double line space your work, number pages and show the word count.
- Keep to the subject, any of your own conclusions drawn should be expressed as such, for example, 'during my session with Client A, I noted' or 'I observed the client displayed XYZ'.
- Spell check your work to avoid unnecessary errors.

Referencing

- Remember to quote the source from which YOU acquired the information, rather than original sources

which might be quoted within the text.

- Even if the source material seems to sum up exactly what you would like to say about the subject matter it is important that you summarise and discuss the information in your own words to demonstrate that you understand the content.

“Keep Word Counts to Plus or Minus 10%”

- Run your work through a plagiarism software programme to ensure that quotes and sources are correctly formatted—the Viper Plagiarism Scanner is available free of charge from www.scanmyessay.com/

Focus On S3C—Simone-Davis

Foreword by Harry Brownrigg

This issue we take a closer look at the excellent new internet forum based tutorial system for NCHP students, launched by the college in January. These collaborations run in tandem with the existing classroom based teaching, and give students a no-cost opportunity to deepen and broaden their learning, preparing them for eventual UKCP accreditation.

Free education? Sounds good doesn't it!

There are three sorts of National College student at the moment,

- those who know what an S3C is and who actively participate, albeit with lousy spelling but a willingness to give it a go, (these bizarre creatures are currently as rare as hens' teeth);
- lurkers, who know what a S3C is and even where to find one, but haven't quite got round to actively participating in them regularly, though they might take a look at what others have written, (the number of these is unknown but perhaps growing); and
- those who may have heard or read the term S3C but quickly put it out of mind, secure in the knowledge that they will get around to it some day, but not just yet.

Which one are you?

The S3C is essentially an online seminar that replaces a classroom based experience and can be attended by anyone anywhere who has a suitable internet connection. Held weekly, on a theme set in advance, they consist of a

week's worth of messages on a message board followed by an hour in a real-time online chatroom. Being virtual, these seminars allow the college to provide a large number of additional hours of education to every member, wherever they live, at very low cost.

The main reason for introducing them appears to be that, under UKCP rules, we needed to increase the number of hours in the qualification, in order to permit registration with UKCP upon completion of level 4. In order to meet the requirement, the college could either add another 14 classroom-based weekends (and just think how much that would cost us) or make use of virtual interfaces and spread it out over the training period and not add to the cost. Now it may be just that I am stingy and I like my lie in at the weekends but for me it is a no-brainer; I started doing S3Cs three months ago when I started back with the college (I took a bit of break in the middle there) and so far have done 10.

The idea of using online forums and chat rooms might seem unusual to those of us who can remember when mobile phones really were the size of a brick, but it is definitely the way that education is going in the 21st century. The evidence, such as it is,

suggests that properly engaged groups, who do the research and get involved in the debates, gain substantially from the online method of teaching and that it is as valid as any other educative process. These days you can get entire degrees online from reputable institutions such as Open University, so doing just a portion of our learning this way in no way degrades the quality of our education – not if it is done properly, anyway.

If you show up for the forums, make three or four posts that show you have considered the topic and what the other people on the forum have said, come to some justified conclusions and then participate in the chatroom you should pass. Total time taken is supposed to be at least two hours, but if you can't make the chatroom then just let the tutor know in advance, do a little more on the forum to take it up to two hours and you will still pass. If you don't contribute enough (by only making one or two short posts) or your contributions showed that you weren't really thinking about the issue or taking on what others have said then you might get a defer, but that isn't the same as a fail and is nothing to be ashamed of. You just keep turning up and contributing and eventually you will get

there.

Some people have said to me "I'm only on stage one; I feel that I don't know enough." or "It says S3 – it's only for stage three students and above".

Well, knowing is what you end up doing once you've gone through the education process, there isn't much point if you know it all before hand, is there? The whole point is to engage, to think and to discuss with your peers and colleagues. There is no shame in not understanding or not having experience – the forum is a safe place to explore ideas and to learn from other people. The good thing about the forums is that if they get sidetracked and/or too theoretical then all it takes is a someone to ask "Yes, but what does it mean to the practicing therapist?" and we can all get back on topic and bat around the pragmatics of turning what we learn into what we do.

Speaking to people, I suspect that many put it off until they have done stage three and written up their dissertation. If you do the numbers, though, you may find that this is potentially quite damaging to your prospects as a therapist. On the assumption that all current students eventually intend to register with UKCP, you might want to bear the

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Focus on SC3 continued

(Continued from page 3)

following in mind.

It takes a minimum of four years start to finish qualifying for UKCP registration. In order to meet the qualifying teaching and learning hours requirement, this year's stage one students will need to complete 100 collaborations.

If you only start collaborations after you pass stage three, it will take at least two further years to qualify for UKCP registration, and that assumes that you turn up every week and pass every one you attempt. (In fact, regulars have found they might make 80% of collaborations, as other commitments impact on their ability to participate). If, on the other hand, you started straight away then you could spread them out a bit and still be ready for registration just as soon as you finish all the other requirements – no extra time at all.

The learning is part of becoming a good therapist and the real life information and how it applies to the practicing therapist is useful – often more so than say the theoretical difference between say Freud and Klein.

If everyone puts it off there will be insufficient people on the forums to make it worth while continuing with them. The tutors (who don't charge for the service) will become disillusioned if there are only a few people, and consequently might stop the service and switch instead to classroom-based learning instead. If that happens then we will all be considerably out of pocket and will also have much less free time, since we will be spending all our weekends in classrooms instead of spending 10 – 15 minutes a day online.

Someone asked me how I go about preparing for a S3C so here it is; Simone's patented method for getting through these as painlessly and productively as possible.

First, get the title and whatever pointer the administrator gives at the beginning.

Then hunt around your bookshelves and the internet (I love Google – how did we do research without it?) looking for relevant material and put together a post - just one long paragraph will do.

If you have more to say then consider splitting it up, so you can post over the course of three or four days – after all

you have to do multiple contributions but they don't all have to be huge and anyway you will need to respond to what the other people say.

Read what others put in their posts and think – respond, ask questions, agree, disagree, offer your own practical experience. That's really all there is to it.

Go on, give it a go. The people already there will genuinely welcome you, and you will almost certainly learn something and help others in their learning. You might even enjoy it after a while, since they can become just a teeny bit addictive. One stage one student with an amazing 25 contributions to his credit already says he finds them "fascinating" because they force him to think in depth about issues he had previously considered obvious. He often changes his mind on something and considers the collaborations as time well spent. For myself, I like them because I enjoy a good debate and the challenge you get from other people, while trying to understand their differing viewpoints is usually more stimulating than just reading a book. I also have to acknowledge I'm keeping my eye on the main objective; I

know the extra time is a hoop I have to jump through in order to get registration, so I figure I may as well get through it as quickly as I can.

Anyway that's enough for now. It's your call, but I do believe that you should at least give it a go and take advantage of the service we are being offered, and which students at other training organisations might even envy.

Hope to see you at the next one.

Simone-Davis

Simone-Davis is a stage three student currently awaiting the exam results while plodding on with the dissertation and simultaneously (and slowly) setting up a practice in North London and Essex.

You can join the S3C process by logging on at the College forum, a closed web based discussion board accessible only to college members. If you haven't already done so, please register - admin will approve your membership.

<http://nationalcollege.freeforumit.com/index.php>

Some of the exciting forthcoming weekly study topics for 2010 include –

The ethics of when to regress, Goals, Projection, Smoking, Defence Mechanisms, Working with GP's, Ontic/Ontological Anxiety, several case studies, Stress and coping resources, The pro's and con's of legislation and many, many more!

Download the full list here and discover which you'd like to participate in:

http://www.hypnotherapyuk.net/_system/uploaded_docs/S3Cs.pdf

Congratulations! Join us in celebrating the achievements of the following students:



Certificate in Hypno-Psychotherapy
CHP(NC)

- *Darren Hall*
- *Stephanie Lewis-Vivas*
- *Douglas Randall*
- *Michael Odell*

Diploma in Hypno-Psychotherapy

- *Sharon Mustard*
- *Julia Robinson*
- *Becky Verinder*
- *Sue Blatcher*
- *Joy Roskilly*
- *Evie Bentley*

Advanced Diploma in Hypno-Psychotherapy

- *Su Ricks-McPherson*
- *Karen Hodgson*

***2nd Annual International
Hypno-Psychotherapy
Conference***

*11-13 June 2010, Grand Hotel,
Leicester*

Speakers Include

- *Fiona Biddle—
Weight Management*
- *Hilary Norris-Evans-
Gambling Addiction*
- *John Monk Steel-
Transactional Analysis*
- *Ann Williamson-
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- *David Collingwood Bell-
Tinnitus*

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presentations from experts in
the field of*

hypno-psychotherapy.

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*For details or **Email Us Now** for an
application form—
enquiries@nchp.org.uk*

Message from the Commissioning Editor

Greetings fellow students, alumni and readers in general – I'm Harry Brownrigg, a student here at the NCHP.

To redeem my many and varied sins (which include destroying the curtains in one of Su's lectures – sorry Boss) I recently volunteered as Commissioning Editor. Put simply, it's my job to appear from nowhere when you least expect it, and attempt to persuade you to contribute something for us to print in this august and stately tome. Well, perhaps it hasn't reached such epic proportions just yet, but these are early days and we do

have plans to evolve. Bringing order, wisdom and direction to the jumble of material I send in is Su Ricks-McPherson - your Editor and the person I report to.

It's my belief that this journal provides a great opportunity for all those connected with the NCHP – students, lecturers and alumni alike - to come together and share their wealth of experience and knowledge, for the benefit of us all. A place for news, research, views, tips and advice that keeps us in touch with the world of hypno-psychotherapy and life within our College.

Ultimately this is your journal – I see my role as helping to find contents that reflect what you actually want to read. So, your feedback and suggestions are always very welcome.

These are humble beginnings, but we can all go a long way in helping grow both the NCSAG and the Journal into a valuable resource, simply by making an effort to contribute.

Enormous thanks go out to all those who submitted material for this issue.

I hope you find it interesting – there's much to come in future. *Harry*

Submissions:

Please email your research articles, news stories, events listings, letters and anything else of interest to me at: harry.brownrigg@hypno-psychotherapy.net

Submission deadline for Issue 3, Winter 2010 is 15th December 2009



Harry Brownrigg

Comment On The News—Copy and paste the blue links into your web browser for the full articles



Please send us any interesting articles you find remembering to add your comments too

The Observer, Sunday 9 August 2009

A rather cynical discussion on the potential **impact of regulation upon psychotherapists and counsellors**. What are your views on this article? If you are a counsellor as well as a psychotherapist, how do you think your practice will be affected?

<http://www.guardian.co.uk/society/2009/aug/09/counsellings-psychotherapy-hpc-regulation>

Mail Online, 29 July 2009

A thought provoking article about **a woman who claims she is unable to eat healthily as she is living on benefits**. Having lost around 13 Stones in weight through will power and gastric band surgery, she is now gaining weight due to depression as her benefits have been cut.

<http://www.dailymail.co.uk/fe-mail/article-1202767/>

What are your views on this article? Is she being harshly punished or being encouraged to take responsibility for her health and well being in general? How does this fit with the concept of the **post hypnotic suggestion of having a gastric band** discussed in the article below? Is this a severe case of secondary gain, or an indication of what may happen when medical intervention inadvertently impacts on the persons concept of the self?

Telegraph.co.uk, 20 May 2009

<http://www.telegraph.co.uk/news/uknews/5357013/Woman-lost-4st-after-hypnotist-convinced-her-of-gastric-band-fitting.html>

The Independent, 28 July 2009

An article outlining **research**

carried out by the Harvard Medical School which suggests that **people who practice relaxation** on a regular basis are likely to be more resilient than those who do not, and **are less likely to contract a range of physical conditions**. I guess this is something that many have believed for a long time—I'd like to get a look at the raw data though!
<http://www.independent.co.uk/life-style/health-and-families/features/relax-your-way-to-perfect-health-1763109.html>

BBC News, August 2009

A call for widespread use of **CBT therapy provided online**. So is this an innovative approach which will improve accessibility to talking therapy, or devaluing the role of the therapist to that of a process operator?
<http://news.bbc.co.uk/1/hi/health/8225567.stm>

Tinnitus – Turning Off the Phone—Grahame Milton-Jones

Imagine sitting in a room with the phone ringing and you unable to answer it or turn it off. After a while, it would become so annoying that you would cheerfully rip the phone off the wall and throw it through a window. This gives you some indication of the level of annoyance that some people have to put up with when they have tinnitus.

Approximately 17% of the population suffer with tinnitus to the extent that they seek medical advice. The sounds that they hear may not be ringing; it may be a popping sound, the sound of a waterfall, or any other noise that refuses to go away. At times it may reduce to a level that is bearable, at others, and usually when the sufferer wants to sleep, it can be so loud that sleep is not possible until they are exhausted.

Due to the level of sound, the tinnitus noise may reduce the person's ability to hear other sounds. They may even be partially deaf but hear the tinnitus clearly. The sound may be in one ear or in both. It seems to vary with the individual.

In many ways, tinnitus is like false leg syndrome; this is where people can still feel the presence of a leg even though it has been amputated. The sound is there but there is nothing to cause it. The similarity is more appropriate than at first sight because both tinnitus and false leg syndrome relate to sensations where no physical manifestation is present.

There are many causes of tinnitus. Most arise from a physical event such as a head blow or repeated loud noises. Meniere's disease is also a cause; this is where there is fluid in the inner ear. There may also be hair loss in the cochlea which gives rise to a false sound. The effect of persistent and loud noise pollution is underestimated. Even high blood pressure can cause tinnitus

In essence, tinnitus is the perception of a sound where no sound can be detected by any instrument. It is a false sound that refuses to reduce or go away no matter what the person does.

Strangely, the problem lies within the mind rather than within the ears. Everyone hears large amounts of sound at every moment of the day and night. The unconscious mind has the responsibility of selecting which sounds the person (conscious mind) should listen to and which should be filtered out. It is the unconscious mind's incorrect decision which allows the tinnitus noise to be heard. Instead of filtering out the sound, it allows the person to hear it.

People who live near a railway line, an airport or a motorway know that after a few days, they cannot hear the constant sound that their visitors hear. Their unconscious mind learns that the sound is not necessary and filters it out. It is the filtering process that fails with tinnitus sufferers.

There are no medical solutions to tinnitus. There are ways of reducing the sound and ways of reducing the anxiety caused by tinnitus, but no cure. A common way of dealing with it is to mask the sound. By using a device similar to a hearing aid that produces white noise, the tinnitus noise is overwhelmed and becomes less annoying. Anti-depressants may also be prescribed but these do not attack the sound, simply the anxiety that comes with it.

There is a solution, but it deals with the unconscious mind rather than the ears. In essence, it is the method by which the unconscious mind is asked to listen to the noise, recognise it for what it is and then told that this sound is meaningless and it can safely filter it out.

The method is similar to a spam filter on the computer. People receive emails that suggest (for example) they need luminous socks so that they can get dressed in the dark; this is called spam. When their computer system is told that this is spam, it filters out all similar messages in the future.

Telling the unconscious mind to filter out the sound is not difficult; some people can do it themselves whilst others need someone to do it for them. A hypnotherapist can use hypnosis to contact the unconscious mind and make the necessary changes. It is not complicated and there are no risks attached to the procedure. Most people experience complete relief from

tinnitus, but all experience a substantial reduction.

Now at last there is a way of turning off the phone other than by ripping it off the wall.



“People who live near a railway line, an airport or a motorway know that after a few days, they cannot hear the constant sound that their visitors hear.”

If you are interested in working with tinnitus, **David Collingwood Bell** is presenting on this at the **2nd Annual International Hypno-Psychotherapy Conference**

11-13 June 2010, Grand Hotel, Leicester

See www.hypnotherapyuk.net/Courses/CPD.htm

For details

Feelings: The Door Into the Client's Issue continued



Tom Nicoli

“He is an expert in his field. Nicoli deals in a straightforward and honest manner. His presentation was thought provoking, stimulating and made a large impression “Harvard Medical School”

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passive and untraditional.

Don't Think – Feel

In a matter of seconds a person can be guided away from the thinking mind and into their feelings. Once a person is in the feelings associated to an experience they are no longer analytically involved but have entered that inner place where we can begin reframing, releasing and directing change for the relief of an issue. I explain to clients that feelings are like the fog. We cannot go over or under it, we must go through it in order to get to the clearing. However, most people avoid their painful feelings by being distracted by behaviours, sometimes healthy but usually unhealthy. Until we face the repressed and avoided uncomfortable feelings they will persist and continue to cause problems. “What we see disappears and what we resist persists.”

I feel it is very important to explain to the client, before the session begins, that this is what needs to happen. To prepare them to allow themselves to enter the feelings that arise (or what they already know they repress and avoid) so the issue can once and for all come to an end. Once they are in agreement the work can begin, though that doesn't mean you will have an easy go of it for you never know what may come up during the session.

Once the session begins it is important to guide the client back into the feelings whenever you see they may be thinking. A simple sentence such as, “It's okay... don't think... simply allow yourself to feel whatever it is.”

Time to Begin

At the start the process is rather simple. A dialogue

something like this can be used:

“I'd like you to take a few deep breaths... and you will begin to feel more comfortable... and relaxed... in your body and in your thoughts. That's it... deep breaths that automatically bring that comfort... and safe and secure feeling. As you now feel more comfortable with each breath... you will begin to feel your eyelids heavier... feeling them heavier and wanting... needing to close... and you can let them close now as you begin to focus on your inner self... your feelings that come to you now... as I talk to you.”

(From this point we can begin guiding the client into their feelings and begin the work)

“As you feel more comfortable now... and more focused on your more personal inner world... leaving the outside world behind... I want you to focus on (insert presented issue) that you came here for. Let yourself be that casual observer as you feel whatever it is. Notice what you see... what you feel ... about _____ . Focus on the feeling that is there now... that's it. And you have been waiting to have the last word on this issue. Tell me... what do you feel now?”

From this point it's a matter of continuing to direct the client into a feeling and then allowing them to witness / observe whatever it is they gather from this experience about the issue. Direct them to release these feelings in any of a variety of ways... sometimes it's verbal, crying, pillow pounding, etc. Meanwhile, use reframing techniques, metaphors, indirect suggestion, regression, etc. as you feel appropriate at the time with that specific client. In my experience and belief it is not for me to set the

format for we do not follow a 'one size fits all' system with our clients.

The intention of this information is to explain how in a very short period of time a client can be guided into a deep, personal, inner place by engaging the feelings associated to their issue, which in my opinion is a fast track opposed to longer traditional approaches to direct the client inward using a variety of techniques. It's not what we do but why we do it and the why is emotionally driven in some way for as we know the subconscious directs us away from “pain” while seeking pleasure. The two basic emotions from which all others derive.

Tom Nicoli is a published author, speaker, trainer, life coach and consultant to practicing hypnotists. He is a Board Certified Hypnotist with the National Guild of Hypnotists, an NGH Certified Instructor, Certified Instructor Coach, NGH Advisory Board Member, Order of Braid Council Member and adjunct faculty member. He is also the Chairman of World Hypnotism Day. World Hypnotism Day, January 4, is when professional hypnotists around the world enlighten the general public of the benefits and truths of hypnotism, while dispelling myths and misconceptions.

Tom has been involved in the study of hypnotism for 20 years, is the President of A Better You Hypnosis, Inc. and the founder and Principal Instructor of New England Institute of Hypnosis in Woburn, MA, both located just north of Boston, MA.

Psychotherapy and Hypnotherapy in the Management of the Irritable Bowel Syndrome - E.E. Taylor M Med Sci, UKCP

Introduction

Functional Gastrointestinal Disorders (FGID) are frequently presented in primary care and account for approximately 50% of the Gastroenterologists workload (Thompson, 2006). Irritable bowel syndrome (IBS) and functional dyspepsia make up the largest group of FGID. Patients frequently present with both upper and lower gastrointestinal (GI) symptoms and, for referral purposes, tend to be categorised under the umbrella term of IBS. Research over the last three decades has indicated that the pathophysiology of IBS is multifactorial, with environmental issues, gender, visceral sensitivity, and psychosocial stressors all playing a part (Jones et al, 2007). Symptoms are thought to be associated with altered 5-HT transmission and central processing of noxious stimuli (Jones et al, 2007; Clark and DeLege, 2008). Providing there are no 'alarm' symptoms indicative of organic disease (Spiller, 2005), IBS can be reliably diagnosed using the Rome criteria (c.f. Thompson, 2006). Treatment, however, can only be effective if the complex relationship between biological, psychological and environmental factors is acknowledged and addressed (Jones et al, 2007). Assessment and treatment, therefore needs to integrate gut function with psychosocial issues (Levy et al, 2006). Research into dynamic psychotherapy, cognitive-behaviour therapy and hypnotherapy has provided ample evidence of lasting efficacy in IBS (Creed et al, 2003; Drossman, 2003; Barabasz et al, 2006) suggesting that psychosocial interventions should be routinely available for this patient population. Benefits to the economy have also been

demonstrated. Patients who received hypnotherapy visited their doctors less frequently. Some returned to or obtained work thus reducing sickness benefit claims (Houghton et al, 1996; Gonsalkorale et al, 2003). Reduced medication following hypnotherapy has also been reported (Koutsomanis, 1997; Gonsalkorale et al, 2003).

This report presents an evaluation of psychological therapies for sufferers of IBS. Twenty-nine patients completed the intervention and symptom monitoring revealed that 100% were either symptom free or their symptoms were substantially reduced after a course of treatment. A satisfaction survey indicated that patients valued the intervention. Cost effective service provision is discussed.

Methods

Setting

Holistic Resources is a not for profit social enterprise, providing psychological services across Lancashire. The centre works closely with health professionals with the aim of providing an integrated service.

Referral Procedures

Referrals were accepted from Consultants across East Lancashire and approved by East Lancashire and Blackburn with Darwen Primary Care Trusts. Inclusion criteria were diagnosis of IBS and sufficient command of the English language for patients to work with the therapist. Exclusion criteria were substance misuse and unstable psychotic illness.

Patients

Over the 12-month period a total of 44 patients were referred for treatment. Of these

4 failed to attend the assessment appointment and 11 withdrew from the programme after attending an average of 2 sessions (range 1-5). Reasons for early withdrawal included illness, undergoing further investigation, work/training commitments, too far to travel, misconceptions about hypnotherapy, diagnosed with cancer, felt claustrophobic in the small consulting room and no reason given. Two patients cancelled assessment appointments within the agreed timescale with no cost to the PCT.

Twenty-nine patients (4 males, 25 females) completed treatment in an average of 9 sessions (range 3-12). The average age was 41 and all patients were of white European origin.

Assessment and Intervention

Assessment included a detailed history of gastrointestinal and psychosocial symptomatology, motivation for change and commitment to regular attendance. A detailed explanation of IBS was given and the treatment programme explained. Patients were aware that they might be encouraged to discuss issues of a psychological nature (as well as GI symptoms) which could elicit emotional distress. Informed consent was obtained and the patient's Consultant and GP notified of treatment and outcome. Therapy was tailored to individual need with a treatment programme selected from: Psychodynamic Therapy (facilitation of self-understanding by means of therapeutic regression); Cognitive-Behaviour Therapy (exploration of the relationship between thoughts, feelings,

(Continued on page 10)

Treatment can only be effective if the complex relationship between biological, psychological and environmental factors is acknowledged and addressed



environmental issues, gender, visceral sensitivity, and psychosocial stressors all play a part

Psychotherapy and Hypnotherapy in the Management of the Irritable Bowel Syndrome Continued

(Continued from page 9)

behaviours and GI symptoms); Hypnotherapy (altered state of conscious awareness used to treat a variety of physical and psychological problems); Neuro-Linguistic Programming (NLP) a derivative of hypnotherapy. All patients received Gut-Directed Hypnotherapy – which is hypnotherapy targeted towards the gut.

Treatment Outcome Monitoring

Patient-reported symptoms were rated on a scale of 3=severe symptoms, 2=moderate symptoms, 1=mild symptoms, 0=no symptoms. Overall well-being was monitored on a scale of 0% =feeling unwell to 100% =feeling well. These measures were completed each time the patient saw the therapist.

Service Satisfaction

On completion of treatment patients were asked to complete an anonymous service satisfaction questionnaire that was returned by post. Respondents were asked to indicate on a Likert scale to what extent their symptoms had been relieved from Not at all, Par-

tially, Mostly to Completely. Space was available for written comments.

Results

Treatment Outcome

Reported symptoms, pre-treatment and post treatment scores are presented in table one.

For Rome criteria see appendix one

Patients who fail to attend and those who cancel appointments with less than 24hrs notice are charged to the PCT.

Table 1 indicates that almost all participants suffered from anxiety. The vast majority had the 3 classical symptoms of IBS (abdominal pain, bloating and bowel habit disturbance). A substantial number suffered from depression and approximately half of the sample reported indigestion, nausea and heartburn. Gastroesophageal reflux was reported by approximately one third of participants with a small number actually vomiting. Non-gastrointestinal symptoms and emotional issues other than anxiety and depression were re-

Table 1

Symptoms	Number of patients reporting symptoms	Pre-treat mean	Post-treat mean
Anxiety	27 (93%)	2.70	0.74
Abdominal pain	25 (86%)	2.38	0.90
Bloating	24 (83%)	2.60	1.10
Bowel disturbance	24 (83%)	2.65	1.10
Depression	22 (79%)	2.38	0.80
Indigestion	14 (48%)	2.17	0.69
Nausea	14 (48%)	2.00	0.50
Heartburn	13 (45%)	1.88	0.40
Reflux	11 (38%)	2.09	0.50
Other physical *	11 (38%)	2.27	1.04
Vomiting	5 (17%)	2.40	0.20
Other Emotional**	4 (14%)	2.62	1.00

Figure 1

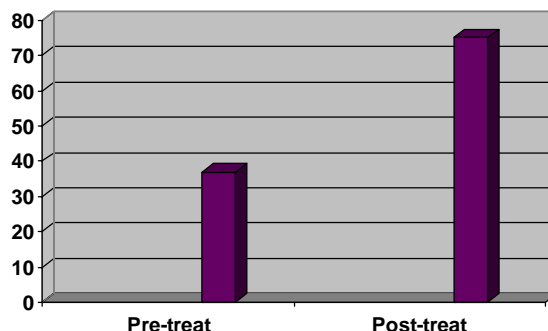


Figure 1 demonstrates improvement in average well-being, from 37% at initial assessment to 75% at treatment completion

corded. With the exception of heartburn which was mild to moderate, all symptoms were moderate to severe before the intervention. On completion of treatment, symptoms were reported between zero and mild for the vast majority and mild for the remainder.

Satisfaction Survey

Fifteen satisfaction surveys were returned and the findings are presented below.

ments included:

Comments from the service satisfaction questionnaire

The therapy has been very beneficial both for my IBS and other attendant anxiety-related problems. Although the condition has not completely disappeared, I have noticed much improvement both with the

Table 2	Symptom free	Mostly improved	Partially improved	No improvement	NA
GI symptoms	25%	75%			
Emotional problems	25%	75%			
Non-GI symptoms	38%	49%			13%

Table 2 demonstrates a reduction in gastrointestinal symptoms and emotional problems for all participants. Patients with additional non-gastrointestinal symptoms reported similar benefits. Patients particularly appreciated the provision of an environment conducive to personal disclosure, time for effective communication, anxiety management and techniques to improve quality of life. Com-

symptoms and my ability to cope with them.

I am much more positive in outlook and far less fatigued. Life is now an opportunity rather than a burden.

[Named therapist] was the first person to note that hyperventilation was causing my problems, a fact that I will always be grateful for.

(Continued on page 11)

*Back pain, headache, chest pain, lethargy, fibromyalgia and muscle tremor

**Anger, stress and guilt

Psychotherapy and Hypnotherapy in the Management of the Irritable Bowel Syndrome Continued

(Continued from page 10)

It was such a relief to feel understood. I now feel able to move forward

I looked forward to my appointments because [named therapist] was so easy to talk to. I could tell her anything and she always found ways to help me

It's made such a difference knowing what causes my symptoms and techniques to stop them happening

As well as my IBS, I was helped in many other ways. I also suffer from panic attacks and stress and the therapy has helped me to manage them better

Very satisfied with the whole treatment. I have learned to pace myself and to take gentle exercise. I no longer let my IBS and back pain ruin my life

Enjoyed being able to talk. I am much more confident and happy in myself

Discussion

The findings show a beneficial effect for all symptoms monitored. One hundred per cent of patients who completed the intervention were symptom-free or their symptoms were substantially reduced on completion of treatment. Quantitative measures were supported by the satisfaction survey data. These findings suggest that the combination of therapies provide advanced coping skills for sufferers of IBS and functional dyspepsia, and the low attrition rate (10%) suggests good patient acceptability. Additional benefits, such as improved emotional adjustment, were observed. The majority of patients received gut-directed hypnotherapy, which was valued for relaxa-

tion and exerting control over gut function. Patients were able to relate to psychological issues and not only appreciated the intervention but also valued the therapists themselves. This is congruent with research demonstrating that the therapeutic alliance is an important variable in treatment outcome.

Although IBS is increasingly accepted as a psychosomatic disorder, some patients still expect and undergo exhaustive medical enquiry. Repeated medical investigations serve to increase patient anxiety leading to further treatment seeking behaviour and disproportionate utilisation of healthcare resources (Toner, 2005; Jones, 2007). Such patients can be considered challenging by doctors, which is not surprising as FGID is characterised by multiple recurring physical symptoms in the absence of known structural or biochemical cause. Reliable diagnostic criteria exist (Thompson, 2006). Therefore, in the absence of symptoms indicative of organic disease; it would serve both the patient and those responsible for health care budgets far better to provide education and effective psychological therapies (Jones, 2007). Sensitive explanation regarding the nature of FGID does much to reduce the stigma associated with psychology and with misconceptions about hypnotherapy. Time constraints on Physicians may prevent detailed explanation, particularly about emotional issues but an explanatory leaflet could do much to help the patient feel understood and be more accepting of psychological interventions (see attached).

FGID are common, affecting up to 20% of western populations (Sandler, 1990; Drossman et al, 1993). Robust evidence over the last thirty years has demonstrated the lasting efficacy of psychological therapies for these conditions. It is therefore surprising that only three centres dedicated to the provision of psychological therapies for FGID exist in England (London, South Manchester and East Lancashire). The latter, ELIHC, receives PCT funding but patients can only be referred from Consultants which is a bone of contention for GPs. Although hypnotherapy is now recommended by NICE (DH, 2008), all referrals must be individually approved by the appropriate PCT. This referral pathway perpetuates the diagnosis of exclusion, excessive treatment-seeking behaviour, increased health care costs and an erosion of confidence in the medical profession. From April 2009, rather than relying on self-report, Holistic Resources will measure outcomes using a validated psychometric measure specifically designed for IBS (Patrick, 2002). As many patients take time off work or are unable to work because of IBS, employment/worklessness status will also be reported before and after treatment. Post-treatment questionnaires will be mailed to those patients who do not complete therapy. Any returned data will be included in the analysis to avoid skewed results as far as possible. However, experience suggests that those patients who fail to complete treatment without explanation are unlikely to return data.

Subject to funding, it would be useful to conduct an interview

study that addresses patients' experiences of the service including those who complete, withdraw or do not attend. It would also be beneficial to compare frequency of attendance in primary and secondary care for completers, non-completers and those who fail to attend. This information could do much to improve cost effectiveness thus encouraging appropriate referrals, improved health care and greater patient satisfaction.

Costs could further be reduced by the provision of group therapy for appropriately selected patients. Subject to funding, an evidence-based, 8-session group programme is available (Taylor et al, 2004; Taylor, 2009). The latter includes education, CBT and hypnotherapy. Details are available on request.

Acknowledgements

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Appendix one

Classification of Functional Gastrointestinal and Bowel Disorders: Excerpts from The Rome II Criteria

1. Gastrointestinal disorders

Functional dyspepsia

Dysmotility-like dyspepsia

Unspecified (non-specific) dyspepsia

2. Aerophagia

3. Functional vomiting

II. Bowel Disorders

Irritable bowel syndrome (IBS)

Functional abdominal bloating

Functional constipation

Functional diarrhoea

Unspecified functional bowel disorder

Diagnostic criteria for IBS

At least 12 weeks, which need not be consecutive, in the preceding 12 months, of abdominal discomfort or pain that has 2 or 3 features:

Pain relieved with defecation; and/or

Onset associated with a change in frequency or stool; and/or

Onset associated with a change in form (appearance) of stool

Diagnostic criteria for Functional Dyspepsia

At least 12 weeks, which need not be consecutive, in the preceding 12 months, of:

Persistent or recurrent dyspepsia (pain or discomfort centred in the upper abdomen); and

No evidence of organic disease (including at upper endoscopy) that is likely to explain the symptoms and

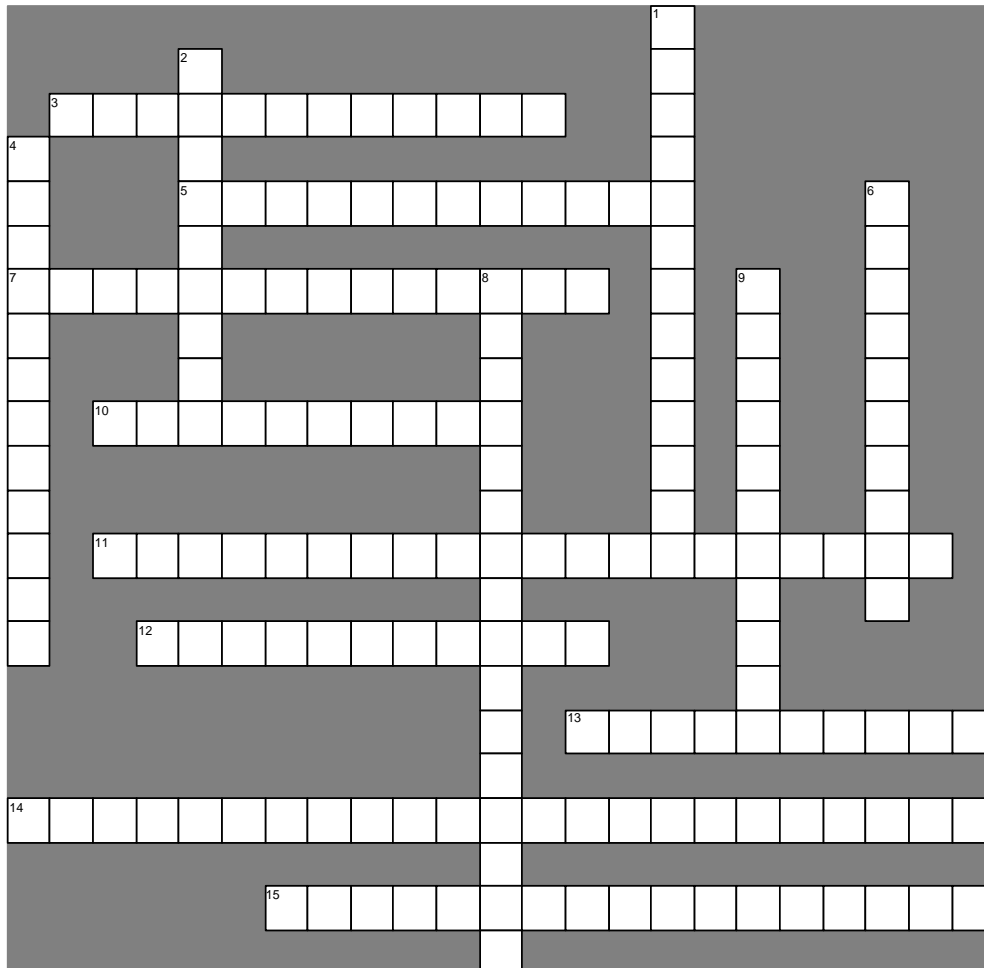
No evidence that dyspepsia is exclusively relieved by defecation or associated with the onset of a change in stool frequency or stool form i.e. not IBS.

The classification scheme for functional gastrointestinal and bowel disorders (FGID) are shown. Diagnostic criteria for IBS and functional dyspepsia, the 2 most common FGID are also listed.

Cited in Jones et al (2007)

Therapeutic Puzzle—Win £20 off of your conference booking fee or a Brookhouse & Biddle book!

All the words, phrases, names in the puzzle below relate to subject matter covered within the NCHP training programme although they are made slightly cryptic by the often peculiar workings of Su's mind!



www.CrosswordWeaver.com

ACROSS

- 3 Maybe easy for you to say, but not in front of an audience (Phobia)
- 5 A big bang, the fear began. Then he was gone John (6,6)
- 7 Envious? It's a girl thing (7,7)
- 10 The place to be in June, and not a day too soon
- 11 Best things in life free? Not Fromm these people (9,11)
- 12 A testing time for Erikson
- 13 Right to the core, what you see is what you get (Humanistic)
- 14 What we all know and share concerning the world around us (10,13)
- 15 The lady doth protest too much methinks (8,9) (Defence mechanism)

DOWN

- 1 Open and close and go deeper and deeper and deeper and deeper
- 2 Dark humour, so defensive
- 4 Whether the ground covered is black, white or grey, this is a path from which you must not stray (4,2,6)
- 6 Pussycat, pussycat, where have you been and did it push any buttons for you? (7,3) (Behaviourism)
- 8 Strip off for an explosive experience (6,2,8) (Gestalt)
- 9 A bright star or inferior within the constellation? (6,5) (Name)

REMEMBER!

The benefits of membership of the Students & Alumni Guild include;

- A listing on the online directory of qualified hypno-psychotherapists at www.hypno-psychotherapy.net
- Preferable rates for Professional Indemnity Insurance from Towergate Professional Risks—call 0113 391 9595 or go to towergateprofessionalrisks.co.uk for details
- Regular CPD opportunities
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Email your answers to su.ricks@nchp.org.uk listing the clue orientation, the number and the answer e.g. Across, 21, Elephant
The solution will be published in the next edition

Understanding Tokophobia: it's prevalence, aetiology & relationship to general phobias—Sharon Mustard

Introduction

Tokophobia is a pathological dread and avoidance of childbirth. An article published in the British Journal of Psychiatry (Hofberg & Brockington, 2000) described the fear of childbirth as a psychological disorder, when it had previously received little to no attention as such, in addition to introducing the term tokophobia (from the Greek tokos, meaning childbirth and phobos, meaning fear). It is a distressing condition which can often be overlooked by medical professionals; as well as specific phobia and anxiety disorders, tokophobia may be associated with depression and post-traumatic stress disorder (PTSD). Phobia of childbirth, as with any phobia, can manifest through a number of symptoms including nightmares, difficulty in concentrating on work or on family activities, panic attacks and psychosomatic complaints.

Since the pioneering work by Grantly Dick-Read (2004, first published 1942), an obstetrician who dedicated his life to promoting natural childbirth, hypno-psychotherapists throughout the world have been developing effective treatments into many of the anxiety disorders associated with childbirth—including the extreme fear characterised within tokophobic sufferers.

Definition and prevalence of Tokophobia

The disorder has been classified into Primary and Secondary tokophobia:

(a) Primary tokophobia is the fear of childbirth which pre-dates pregnancy and can start

in adolescence and extend well beyond menopause.

(b) Secondary tokophobia is due to a previous negative experience regarding traumatic birth, poor obstetric practice or medical attention, postpartum depression or other such upsetting events. Although most typically this is after a 'traumatic' delivery, it could also occur after an obstetrically normal delivery, a miscarriage, a stillbirth, or a termination of pregnancy.

Fear of childbirth is common and more intense in pregnant nulliparous women (i.e. those not having previous experience of childbirth) than in parous women. (Areskog et al, 1981; Searle, 1996). Over 20% of pregnant women report fear and 6% describe a fear that is disabling. (Hofberg & Brockington, 2001; Hofberg & Ward, 2003). Altogether 13% of non-gravid women report fear of childbirth sufficient to postpone or avoid pregnancy (Sjogren, 1997).

What is it about birth that tokophobic individuals are afraid of?

Women can still suffer from a fear of death during delivery (Areskog, 1982).

More recently, pregnant women fearful of childbirth reported a lack of trust in the obstetric team, fear of their own incompetence and fear of dying (Szeverenyi et al, 1998). Other studies have suggested the biggest fear was of delivering a physically damaged or congenitally malformed child. (Ward, 2001; Mongan, 2005).

Women who have suffered

childhood sexual abuse or rape fear the experience of childbirth will revisit the distress and helplessness of abuse. Women who have already suffered trauma during childbirth are afraid of re-traumatisation (Wessell, 1994). The repertoire of fears can extend to fear of pain, long labour, complications, medical intervention. There may be secondary phobias present such as irrational fears of hospitals or of needles.

In many cases the fear is so profound that it can lead to a complete avoidance of pregnancy, even though many sufferers admit they would dearly love children. Others, either intentionally or not, find themselves pregnant and living in abject fear of facing the phobic situation in 40 weeks time.

Aetiology of Tokophobia & Relationship to general phobias

In line with the profile we often see with phobias in general, tokophobic individuals often talk incessantly/nervously about their fears. The avoidance of the phobic situation and even discussions about birth is less likely to be accompanied by an avoidance of thinking about it. This pre-occupation, rather than relieving tension instead has the effect of turning the screw of anxious expectation. A woman who is pregnant and frightened of birth will have recounted her fears to many people. If these people have had traumatic birth experiences, they may feel inclined to empathise with her that

(Continued on page 15)



Grantly Dick-Read Pioneering Author of *Childbirth Without Fear*

“Altogether 13% of non-gravid women report fear of childbirth sufficient to postpone or avoid pregnancy”

Understanding Tokophobia: it's prevalence, aetiology & relationship to general phobias—cont

(Continued from page 14)

they know the ordeal she describes-inadvertently providing evidence to support her fears.

There are, of course, many theories from difficult schools of thought about the origins and development of phobias in general, mirroring the root cause and progression of tokophobia;

(a) Psychoanalytic theory; Freud believed that the supposed chain of causality was little more than an illusion. By questioning the equation between 'stimulus' and 'response' he uncovered the influence of the unconscious factors in the mind (Ward, 2001).

AUTHOR'S CASE STUDY #1: Michaela was 20 weeks into an unplanned pregnancy and described herself as petrified of giving birth. She said she had always wanted a family but had previously agreed with her long-term partner that adoption was the only way forward due to her fears. Now unexpectedly pregnant, an abortion had been considered even though she felt it was the right time for her to become a parent. With use of regression techniques, we discovered that it was not birth itself that she was actually terrified of. She has repressed memories of her younger brother having been rushed to hospital when he was only a few months old. He had a virus so was moved to a specialist hospital some distance away. Michaela didn't see him for 6 weeks, during which time she witnessed her mother in a highly anxious state, unable to give the attention her 3 year old daughter

needed. She disappeared for days at a time (to stay with her baby), but Michaela was too young to process this information and instead believed that not only her baby brother had been taken away from her, but also her mother. Her fear of abandonment during her early formative years lead to blaming her brother, remembering telling an aunt that she "wished he had never been born". In later years this had transformed into a fear of birth and of hospitals; as an adult she had displaced her feelings of hatred towards him, as she couldn't consciously 'permit' herself to have them. Michaela went on to give birth in hospital at her own choosing and described the birth as "an extraordinary, natural, humbling experience. Something I am very proud of and can't wait to tell my daughter about!"

(b) Biological theory; Phobias are left over from our evolutionary past and refer to real dangers faced by our ancestors. Freud, in his 1917 'Introductory Lectures on Psychoanalysis' (Ward, 2001) spoke of Darwin's feeling real fear in an encounter with a snake who struck at him, even though it was safety on the other side of a thick sheet of glass. Freud believed that a snake phobia is a universal human characteristic.

Carl Jung's talked of a 'collective unconscious' whereby we have an objective psyche which is common to everyone, instincts and knowledge being cross-cultural and cross-generation (aka "the reservoir of our species"). Jung's ideas seem to add

weight to the biological theory. However we know that throughout history, women have not always feared childbirth in the way they do now. Mongan (2005) states that towards the end of 200AD, childbirth turned from something to celebrate to something to fear.

In 3000 B.C. –women, revered as the givers of life, tended to have their babies naturally and with a minimum of discomfort.

In 200 A.D, pregnancy became considered a 'carnal sin'. Birthing women left isolated and without support, even in the event of complications, and were 'expected' to groan to atone their sin.

The 'curse of Eve' is seen in biblical translations for first time i.e. that all women will suffer pain in childbirth. In the late

1800's, Queen Victoria insisted on chloroform during her birthing. There was a subsequent move from birthing in home to birthing in hospital, for purpose of administering anaesthesia more safely.

Early 1900's, women were regularly dying in childbirth due to poor sanitation in hospitals. (Wessell, 1994)

Societal influences of the early centuries caused birthing to go awry and left us with a legacy of fearing inevitable pain during labour and even death. With the move to hospital, childbirth was perceived as a medical condition.

Queen Victoria insisted on chloroform during her birthing, heralding a move from home to hospital birthing for the safe administration of anaesthesia



(Continued on page 16)

Understanding Tokophobia: it's prevalence, aetiology & relationship to general phobias—cont

(Continued from page 15)

sex education videos shown to teenagers often had the primary function of showing the consequences and creating an aversion-so childbirth was often intentionally presented in a traumatic way



Dame Helen Mirren—"I haven't had children and now I can't look at anything to do with childbirth. It absolutely disgusts me"

c) Trauma theory whereby the phobia is a conditioned response to a traumatic experience.

With childbirth, tokophobia can certainly be rooted in first hand experience of a previous traumatic birth. An emergency caesarean section or instrumental vaginal delivery increases fear of childbirth in a subsequent pregnancy (Areskog et al, 1983).

AUTHOR'S CASE STUDY #2
(Woman's email): "I am currently expecting my second child at the end of November, and am finding myself being already scared at the thought of giving birth. My first child was born November 2004 [Email sent in April 2007] and I found the labour quite traumatic. It lasted 30 hours and my son was born by ventouse and also had an episiotomy which took an awfully long time to heal. I suffered from insomnia for 6 months after the birth which I believe was due in part to the trauma. As a result I am most anxious to ensure the second birth does not go the same way."

The seminal work in this area by Bydlowski and Raoul-Duval (1978) described 10 cases of PTSD in women who had endured long, painful deliveries. Recognition of tokophobia and close liaison with obstetricians or other medical specialists can help to reduce the severity of tokophobia and ensure efficient treatment. Hofberg and Ward (2003) and the Birth Trauma Association both acknowledge that following witnessing a traumatic birth, men can also develop tokophobia.

The trauma may not be from a first hand experience at all but instead a result of vicarious learning; Nicholas (2007) wrote an article on Tokophobia for the Daily Mail. It reported that Dame Helen Mirren had recently admitted to suffering from tokophobia. She blamed a graphic video of childbirth shown to her as a 13-year-old schoolgirl for her childlessness ever since. "I swear it traumatised me to this day," she said. "I haven't had children and now I can't look at anything to do with childbirth. It absolutely disgusts me."

It is important to remember that just 2-3 decades ago, sex education videos shown to teenagers often had the primary function of showing the consequences and creating an aversion-so childbirth was often intentionally presented in a traumatic way. Unfortunately the aversion can stay even when the woman is emotionally mature enough to have a child herself.

Nicholas (2007) wrote also of Rachel, whose fears stemmed from her childhood. "I was three years old and my mother had just returned home from hospital with my new baby sister," she says. "I overheard her talking to a friend on the phone, telling her it had been an 'horrific' birth, and that she was cut to ribbons. She went on to describe how she'd inspected herself using a mirror and counted 24 stitches. Mum was clearly deeply upset about the whole experience and it has stayed with me my whole life. Despite her desire to find a way to have children, Rachel has been labelled "cold-hearted" and a "babyhater" by

some friends she has discussed her fears with. "Because there is the reward of a baby at the end of childbirth, it seems most people think that women should just stop whinging and get on with it," she says. "In fact, plenty of mothers wear their stories of horrific deliveries like a badge of honour."

The purpose of the tokophobia can be as a defence mechanism e.g. the woman so traumatised following a miscarriage, termination or previous delivery that they avoid a further pregnancy even when a baby is desperately wanted.

In conclusion, no single theory seems to be sufficient to explain the multitude of phobias we encounter. The kaleidoscope of causes within tokophobia echoes this. A hypnotherapist must pay special attention to the uncovering the aetiology before advancing on a course of treatment.

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Sharon Mustard
www.mustardhypnotherapy.co.uk

Sharon Mustard has been working as a qualified Psychotherapist and Hypnotherapist since 2000. She has a full-time practice in Salisbury, Wiltshire seeing one-to-one clients.

In addition Sharon runs Hypnosis for Childbirth courses privately and as part of a contract within the nhs. The training is aimed at empowering mums-to-be and their partners to eliminate anxiety which could otherwise hinder the birthing process and their ability to adjust to parenthood.

In conjunction with the National College CPD programme, she also trains practitioners throughout the UK to specialise in the area of 'Hypnosis for Childbirth'. Scheduled courses:

21st & 22nd November 2009 FULLY BOOKED

23rd & 24th January 2010 in London

26th & 27th June 2010 in Manchester

13th & 14th November 2010 in Bristol

You can contact Sharon on 01980 623089 or visit www.mustardhypnotherapy.co.uk

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S.A.G Member Ads

Members can advertise here using the formats detailed below. The submission deadline is the 15th day of the month of publication; March, June, September & December.

A standard advertisement might look something like this;

Classified Text Only Advertisements

An ad consisting of up to 50 words including your contact details will cost £5 per edition.

Remember to include prices and postage / packaging where appropriate as well as your contact information including a telephone number and email address if possible.

Remember many of the old books collecting dust on your shelves could help new and future students on their journey into the world of therapy and could also help fund your investment in new publications.

Perhaps you have a consulting room which is not fully utilized; offering a room share could help out a fellow therapist and spread your costs.

If you are a supervisor, or run peer support groups in your area, remember to tell other members of SAG about it here—In fact if there is anything you would like to advertise which would be of interest to other members, can be added here for just a small administration fee.

Message From The Chair—Fiona Biddle

Thank you for all the feedback following the first edition of the NCSAG e-journal! And thank you too to the volunteers who have formed our first committee.

There is much enthusiasm for making our organisation as effective as it can be, with you, the members, always at the forefront of our minds. There is no point in creating the SAG unless it provides for you... if you have ideas of services that you would like us to offer, please let us know.

Shaun and I have just returned from a productive visit to Australia where Shaun keynoted at the Australian Hypnotherapy Association conference. His keynote on the Future of the Profession (audio) is available from the office and will be routinely given to all stage two students. It is a tad controversial ! NB: the content is Shaun's opinion and may or may not be shared by the AHA. Shaun also gave a three hour workshop on anxiety which was hilarious and educational at

the same time. It was one of those occasions where the audience got really involved and it was a great experience for all.

We have several new courses starting this autumn, so a warm welcome to all new readers of the e-journal. If you are a new student remember to register on the NCSAG website!

Enjoy the journal



Fiona Biddle—Chair, NC Students & Alumni Guild