Chapter 28

Eating Disorders

David Kraft
Professor Peter J. Hawkins

with contributions from
Dr Duncan Shrewsbury
Dr Adrian Hamill
Dr Lucy Coffin

Introduction

Eating Disorders in DSM IV are divided into Bulimia Nervosa (BN) and Anorexia Nervosa (AN) as well as the category 'Eating Disorders not Otherwise Specified' (EDNOS) which is reserved for those patients who do not meet all the necessary criteria for the diagnosis of anorexia nervosa or bulimia nervosa.

AN is a condition of compulsive restriction of intake and weight loss, BN is characterised by episodes of uncontrollable binge eating interspersed with tightly controlled and restricted intake. Both are also characterised by a dysmorphic sense of appearance and a desire to lose weight.

It is thought that females are more often affected then males. However, whilst this may be true, the extent to which males are affected may be severely underestimated. Diagnostic criteria for AN and BN are strict thus many patients with even moderately severe eating problems do not fulfil criteria for treatment in the National Health Service and therefore cannot access help and services.

Anorexia Nervosa

The lifetime prevalence of AN among adult women has been reported as 0.5% to 0.6% in two large population-based surveys in the United States (Walters & Kendler 1995) and Canada (Garfinkel et al 1996).

An epidemiological study in 2007 showed an incidence of 0.9% in women and 0.3% in men. This later population-based study was based on a house-to-house survey on a national level, carried out by the Harvard Medical School (n=9,282). The results of this study showed that there has been an increase in the number of men suffering from this condition or, alternatively, that the diagnostic tools have developed to the extent to where more men fit the criteria for AN (Hudson et al 2007).

Most often diagnosed in females (up to 90%), anorexia is characterized by failure to maintain body weight of at least 85% of what is expected, fear of losing control over their weight and of becoming 'fat.'

Much research has been completed on this disorder, and results indicate a strong familial undercurrent. Many individuals with Anorexia come from over controlling families where nurturance is lacking. Studies suggest that sexual abuse survivors are more prone to the disorder, as are fraternal twins and first degree relatives of those who have anorexia, the latter suggesting a biological component as well (Walters and Kendler 1995). A frequent finding in anorexic patients is that they are often caught up in a highly complex, emotionally-charged and disturbed family environment. Anorexics are often high achievers, obsessional and perfectionist. In many cases, anorexics have internal hostilities that present themselves in the form of starvation: these feelings of hostility are directed towards parental figures, usually the mother.

Individuals with anorexia want to lose weight despite their actions compromising their health, and are often already seriously underweight. This irrational desire may start from the current cultural belief that glamorises thinness so that dieting starts to become a way of life. There is typically a distorted body image, where the individual sees themselves as overweight despite overwhelming evidence to the contrary. Often the anorexic will rationalise why they are not eating; maybe they do not like the food, feel ill or have already eaten elsewhere. They may obsessively read food labels and know exactly how much sugar and fat is in their food. When they do eat they may induce vomiting, which over time leads to dental problems; over exercise compulsively; or take laxatives to excess. The anorexic takes control over the only activity they perceive that they can – their dietary intake. It must be remembered that this is often at an unconscious rather than conscious level of awareness.

Fundamentally, eating disorders can be considered a serious form of self-harm. Sufferers tend to have experienced a history of domestic violence, mental illness or catastrophe. The destructive behaviour can be triggered, or exacerbated, by psychological stressors and is directly related to a sense of fear and control. The fear is related to perceived inadequacy of their physical form or appearance, the sense of control is often related to an underlying need for the individual to establish and (secretly) maintain control over a specific aspect of their lives. Sufferers tend to have low confidence and a very low belief in their own worth and abilities, which can significantly affect treatment.

It is in the nature of sufferers to keep the disorder hidden, and therefore they develop many strategies to hide, cope and mask both the physical and psychological aspects of the condition. The most significant is the denial that there is a problem, which is also the greatest barrier to recovery. Whilst eating disorders can occur on a spectrum of severity, it is important to be aware of the cues to involve more specialist help. All severe cases of established Anorexia and Bulimia Nervosa should be under the care of a psychiatrist and their treatment should be approached from a multi-disciplinary angle.

Anxiety states and other emotional problems are often found alongside the AN (O'Brien & Vincent 2003). AN is treatable, especially if caught early, but often the anorexic denies that there is a problem, sometimes until their weight is such that they become seriously ill and end up in hospital.

Treatment has to start with gaining rapport and this can be difficult if someone else has insisted that the patient come for therapy. Interim goals need to be agreed and creative ways of helping the patient start to achieve better health and self esteem generated. Their cognitive distortions need addressing but experiential learning is much more effective than just being told, so experiments may need to be devised to help the patient address these.

There is little or no RCT evidence for the use of hypnosis in anorexia but numerous case studies indicate that hypnosis can be a useful therapeutic tool in resolving underlying issues and giving the anorexic self hypnotic tools that can give them feelings of greater control (Vanderlinden & Vandereycken 2006, Gross 1984, Nash & Baker 1993, Yapko 1986).

Treatment of a case of anorexia is outlined below by courtesy of Dr D Shrewsbury.

Helen was under the care of a team, which included a consultant psychiatrist and a senior clinical psychologist. She had acknowledged her problem and had begun to engage in the treatment. Of significance, it was the thought of getting better, and not retaining the level of control over her eating that triggered anxiety.

She had a background of family violence with a very controlling mother who actively encouraged her to lose weight (even though her BMI was less than fifteen by the time she was seen in clinic) on the premise that thin women were more successful in life. Helen had originally been able to ignore such comments and influences, but as the family situation deteriorated and the divorce of her parents approached, her psychological wellbeing deteriorated, culminating in a sense of being out of control. In order to cope with this, she had developed a habit of fastidiously controlling the number of calories that she consumed each day, and exercised in excess of two hours a day.

Having liaised with the psychiatrist and psychologist, the girl was seen for an hour and a half session, during which time a good level of rapport and trust was established. The main aim of the treatment was to build her confidence and the belief that she was: worthy of a long, good-quality life; capable of controlling many aspects of her life, to accept that everyone is unable to control all aspects of their lives; strong and capable of successfully taking control of her life, and not allowing her condition and perceived control to dictate her health and wellbeing.

Treatment was divided into three elements, which could be considered as questions aimed at the condition.

The first question was regarding what learnings, beliefs or events from Helen's past underpinned her choice of behaviour. Using trance and guided imagery her 'safe place' was enhanced and ego strengthening was employed to prepare her to explore this. The psychologist had previously alluded to much of what was revealed in trance; however, it was important for Helen to recognise the underlying factors for herself and come to her own conclusions. Once a root cause was established, it was possible to go back along her timeline to help resolve her negative perceptions and emotions regarding these events.

Secondly enquiry was made concerning how choosing this behaviour related to the way she was feeling and the way she wanted to feel; what did it gain for her? In this step, it is important to identify and manage specific fears in a sensitive manner. Helen experienced fear of losing control; becoming unacceptable and being rejected. These fears were so severe it was, and often is, sensible to treat them as phobias. Treatment consisted of a combination of guided imagery and ego strengthening, establishing an anchor for her safe place and generating a strong feeling of safety, comfort and confidence (note, the exact combination of feelings are unique to the individual and can be tailored to fit what they feel they need most).

At this stage it is wise to confront, and provide a means of dealing with triggers. By far the simplest, and probably most effective, way of doing this is stacking anchors (see page x) and using a Swish Pattern technique (Bandler 1985) to change the behavioural responses to the trigger situations using visualisation (see page x).

Finally it was important to connect Helen with her desired future by asking her what her future would be like if she was able to choose different behaviours. It is important to approach this situation last as the 'Future Pacing' of the individual, and the success of the whole process, is influenced by the altered perception of their triggers.

Bulimia Nervosa

The lifetime prevalence of bulimia nervosa in adult women has been estimated as 1.1% – 2.8% in three large population based surveys in New Zealand (Bushnell et al 1990), the United States (Kendler et al 1991), and Canada (Garfinkel et al 1995). The incidence of BN for women in the 2007 Harvard study was 1.5% for women and 0.5% for men (Hudson et al 2007).

BN refers to a condition in which the patient has a combination of binge eating and purging; again, patients have an obsession with body weight and size. To make the diagnosis, the purging and bingeing cycle must occur at least twice a week for at least three months.

The features of bulimia include episodic eating patterns involving rapid consumption of large quantities of food in a discrete period of time, usually less than two hours; awareness that this eating pattern is abnormal; fear of being unable to stop eating voluntarily; and depressed mood and self-deprecating thoughts following the eating binges. The eating binges usually happen in private, and are often followed by purging (elimination of the food through artificial means such as forced vomiting, excessive use of laxatives, periods of fasting, or excessive exercise). (APA 1994).

Bulimics often have a history of unresolved early trauma: a common feature is that patients feel that it is someone else who is binge eating and purging, and that they are out of control (Covino et al 1994). It has also been shown that patients with bulimia are more highly hypnotisable than the norm

(Pettinati et al 1985, Barabasz 1990) although a study done in 1995 failed to demonstrate any association between hypnotisablity and outcome (Griffiths et al 1995a).

The average bulimic can be characterised as a white, single, college educated woman from an upper or middle-class family (Fairburn & Cooper 1982). The age of onset is usually in the late teens, with a duration of about four to five years before the woman first seeks treatment (Johnson et al 1982, Fairburn & Cooper, 1982). In almost every case the women are struggling to obtain a below normal ideal weight (Katzman & Wolchik, 1984). The frequency of binge eating episodes varies widely across studies; however approximately 50% of the bulimic women in treatment report binge eating at least daily, whilst some women only binge twice a month or even less often (Johnson et al 1982).

There seems to be a number of factors which may precipitate an eating binge in a susceptible person. Most women say that before a binge they are unduly tense, and that loneliness or boredom precipitates a binge (Leon et al 1985). Constant thoughts of foods and a craving to eat, which they are eventually unable to control, are also factors. Bulimics are constantly concerned about their body image and usually perceive themselves as fat and ugly.

The disturbed eating pattern of a bulimic can have serious effects on their physical health as well as their social relationships. Treatment has included hospitalisation, pharmacological approaches using anticonvulsants or depressants, behaviour therapy, cognitive behavioural treatment, group therapy and family therapy. Weiss et al (1985) have developed a treatment programme for bulimia based on research findings that bulimic women suffer from depression, low self-esteem, poor body image, perfectionist tendencies, and a high need for approval, as well as difficulties in handling negative emotional states such as anger and anxiety, and the setting of unrealistic goals for thinness. They also suggest that bulimic women need to refine their existing coping styles and to develop competencies.

Barabasz (2007) reviewed the evidence base for hypnosis and reported that many of the studies available provide insufficient information regarding the specifics of the hypnotic intervention to facilitate replication and clinical implementation. Therefore, only studies with replicable methodological descriptions were included (Coman 1992, Griffiths et al 1998). This need for standardisation to eliminate variables is not applicable to the clinical context, where the interventions are tailored to the individual. As has been stated elsewhere in this book this is very likely to undervalue hypnotic intervention. Further studies can be found in (Kraft & Kraft 2009, Griffiths 1995b, Degun-Mather 1995, Griffiths 1995c).

It may often be helpful to disrupt the patterns around the binging as in the case example from Dr A Williamson below

Sue, a single woman of 23 years who lived alone in her own flat, presented with binge eating often followed by self induced vomiting. At the first session the pattern of her binging was established as she would start feeling ‘fed up’, and then begin to think about food. After a little while Sue would go down to the kitchen and stand in front of the refrigerator eating whatever she could find. It was suggested to her that she might find it useful to disrupt the pattern in some way and she decided that she would, instead of standing up eating in the kitchen, go and lay a place setting on the dining room table and take the food out from the refrigerator and eat at the table. Work was done in later sessions to devise ways she could interrupt and maybe resolve the ‘fed up’ feeling and stop using food as a way of self soothing when distressed and feeling lonely. By teaching her various hypnotic tools such as self hypnosis, ways of discarding negative feelings and replacing them with positive ones, anchoring and goal setting she began to feel more in control and more confident. This led to increasing social activity which in turn boosted her self esteem. After four sessions (in one of which we used the time road metaphor to improve her feelings of self esteem, see page x) she decided that

she had improved to the point when she stop therapy and follow up six months later showed continuing improvement.

Bulimia may vary along a continuum of severity with many patients not reaching the diagnostic criteria as such but suffering intermittent symptoms depending on their circumstances at the time.

The case history that follows demonstrates an integrative hypnotic treatment approach embracing psychodynamic, behaviourist and phenomenological paradigms; where hypnosis (both 'formal' and 'naturalistic') is used to enhance the therapeutic process. The approaches used include ego strengthening, dealing with negative emotions, assertiveness training, relaxation, reframing, hypno-analysis, goal setting, action planning, and stress management.

Case study of a woman with bulimia
Katherine was a 16 year old female who was referred to the author (PH) by a local general practitioner. She was asked to provide an autobiographical account of her eating problems prior to the first therapy session. The account written by Katherine illustrated many of the behavioural and psychological conditions of bulimia. These included preoccupation with weight and thinking 'thin', excessive exercise, depression, tiredness, attempts at concealment from the family, vomiting, poor self-image and distorted body-image, feelings of guilt and shame following a 'binge', and suicidal thoughts.

Statements made by Katherine included the following:
"I had always admired skinny people, and at thirteen I still disliked myself because I felt fat. So I ate less and less because I wanted to be skinny because to me that meant beautiful, and I wanted people to look at me and be jealous because I had the best figure….I did one and a half hours exercise in the morning and the evening. Purposefully forgot to bring things from upstairs just so I could run up and down again to stay thin…..I was happy with my body when I was anorexic. I was somewhere between five and five and a half stone…..I started to miss school a bit because I was so depressed and tired but I liked myself because I was thin…..I was still obsessed about exercising and my weight; even when brushing my teeth I would be doing some kind of exercise to help burn off the calories….One night after eating too much chocolate and feeling guilty because I was still trying to get a flat stomach, I tried to be sick but could not manage to do it".

"The only enjoyable thing left seemed to be eating and vomiting afterwards; about twice every two weeks……The thought of dieting bored me. I hated my size but I had lost control and tried to commit suicide…..I concealed what I was doing for weeks and told mum I was improving, until she found evidence in the bathroom, and buckets under my bed"

"I couldn't sleep some nights if the following day I had a binge planned because it excited me so much…..I took no pride in my appearance and made no friends."

"My wages were spent on food, and all the money saved in the building society was withdrawn to buy more food … If my mum was out for the evening that was wonderful for me, but if she was in I would pretend that I was working, but I was eating and being sick in my bedroom, playing the radio to disguise the noise."

Session 1: Preliminary Interview
Katherine attended this first session with her mother. Confidentiality was briefly discussed and agreed. A brief history of Katherine's problem was obtained, including when the problem began, the course of the problem, any treatment received or ongoing, the current position, and related problems. A brief description of the therapy approach was provided, and it was agreed that Katherine would come for five one-hour sessions. The General Health Questionnaire (Goldberg &

Williams 1988), and The Eating Disorders Inventory (Garner & Olmsted 1987) were administered to provide additional information. Katherine was given an ego-strengthening tape and asked to listen to it at least once a day. It was explained that this was to help her relax in order to 'de-stress' her mind and body to counteract anxiety and depression, and to increase her confidence in herself and her ability to control her own destiny.

Session 2: Ego-Strengthening; Self-Hypnosis for Eating

Katherine was asked to share anything that was good about her life over the past week. She described a new job that she had just started.

Katherine was then taught self-hypnosis by Spiegel's eye roll followed by arm levitation (Spiegel & Spiegel 1978). In hypnosis she was asked to repeat three phrases: "*For my body nourishment is essential*", "*I need my body to live*", "*I owe my body this respect and attention*" and to repeat this exercise at least ten times a day over the next week.

Katherine was asked to imagine that she had a photograph album on her knee. She was asked to experience 'good' events from her past, and to 'carry' the good feelings into a future experience (goal-setting). This also was to be repeated daily.

Session 3: Developing Alternative Coping Strategies

As Katherine acknowledged that she used to binge when she was anxious and upset this session was devoted to helping her 'construct' alternative coping strategies for the management of anxiety. The mirror exercise (see page x) was used to help Katherine connect with her desired state and various metaphors for change were used (Graham 1988).

Katherine was invited to consider alternative ways in which she could 'treat' or nourish herself apart from food. In the context of relaxation she came up with the following: taking a bath, playing her clarinet, making a cup of coffee, buying a magazine and reading it, telephoning a friend, relaxing, and watching television. She was asked to imagine herself doing these things and feeling good and positive about doing so. Katherine was asked to write these down, and whenever she felt depressed or anxious to choose one of them instead of eating. She was also asked to continue with the ego strengthening tape and the exercises.

Considerable emphasis was put on the use of such homework assignments, not only for the intrinsic value of the exercises themselves, but also for building up Katherine's autonomy and mastery of her own life.

Session 4: Hypnoanalysis

It was explained that it would be valuable to examine some of the causes of her problem. It was proposed to use a hypnotic technique called ego-state therapy (Karle & Boys 1987). In this session Katherine used the self-hypnosis technique that she had learnt earlier. In trance she was asked to 'go inside her mind and find that part that thinks thin'. This procedure was carried out using ideodynamic finger responses, and Gestalt techniques, in particular the 'negotiation of parts', were employed to work through various conflicts.

Afterwards Katherine reported that 'the part of her mind that thinks thin' would help her by 'stopping her from being fat'. She said that the 'thin' part had agreed to be active only when she reached a weight of more than seven and a half stones. In other words she could use this 'negative programme' as a resource (or friend) to manage her eating behaviour. It was also established during this session that the negative programme had developed when she was about ten years old and for a number of reasons: family relationships, self-concept, and messages about 'thinness' from family, television and advertisements.

Further work was done using ideodynamic finger signalling. This essentially followed the approach described in (Rossi & Cheek 1994) as the 'retrospective approach to ideodynamic signalling', but with the addition of future pacing.

Session 5: Anger and Assertiveness

It has already been indicated that eating is often precipitated by a difficulty in handling negative emotional states such as anger and anxiety (the latter has already been examined with respect to treatment strategies.) Many bulimic women appear to have difficulty expressing their emotions directly or assertively.

In this session it was explained that anger is a normal and healthy emotion, that repressing it is unhealthy and can lead to a number of psychosomatic problems, including anorexia and bulimia. Katherine was invited to participate in an exercise which would involve her experiencing any angry feelings she had at the time when her problems commenced. During trance she was asked to participate in a guided imagery sequence which involved the evocation of anger. She was encouraged to ventilate her feelings somatically. Research has demonstrated that somatic-emotional discharge of feelings is of greater therapeutic benefit than cognitive-emotional catharsis (Hawkins 1986).

Katherine was then asked whether there was anything in her current life that made her angry. She said that her boss did although it would be inappropriate to express it. She was encouraged to express her anger towards him using the Gestalt empty chair technique. Afterwards she said that she felt a lot more relaxed and confident.

This session helped Katherine express her anger that had been 'bottled-up'. In this way it was hoped that the repressed dynamic underlying her problems could be dissolved, and that she could become more assertive and in control of her current life. It was therefore an ego strengthening technique as well as one aimed at dynamic resolution.

Session 6: Inner Guide

In this session Katherine was asked to close her eyes and imagine that she was in her favourite outdoor place. A guided imagery approach was used and she was asked to meet a 'friendly animal' with whom she could share her problems and who could give her advice (Jaffe & Bresler 1980). Katherine imagined a dog that she had as a pet when she was a child. The dog (whose name was Fudge) advised her to look after herself and to respect her body. Katherine later said that this exercise was the most significant of the treatment sessions.

She was also encouraged to examine aspects of her body image, using the Body Mirror Exercise described in (Weiss et al 1985). This concentrates on helping the individual experience himself or herself more positively. Katherine experienced no problems in doing this.

This was the final contracted session and considerable progress had been made over the three months. Katherine was feeling more positive about herself with respect to her body, her sexuality, and her life. She no longer had problems concerning food, relationships had improved, she had menstruated for the first time, and she was generally enjoying life. One year later there had been no remission of the symptoms.

Conclusions

The therapeutic style adopted, reflects a balance between directive and non-directive approaches, and was clearly patient-centred. The non-directive aspect was essentially implicit, in that it was not part of a formally adopted model. Respect, empathy, unconditional positive regard and genuineness

were important core conditions of the approach. Katherine was invited to participate in a way which allowed her to assume responsibility for herself.

Obesity

Obesity and being overweight is becoming a huge problem both in the USA and increasingly in the UK. Many people know that they should eat healthily and take more exercise but because of perceived time or financial constraints fail to do so. Large numbers of patients ask for help in losing weight and the media bombards people with 'get thin quick' diets and pills.

Many people suffering from stress and anxiety resort to 'comfort eating', with a preference for sweet foods such as cakes, biscuits, chocolate, and junk food rather than healthy options such as vegetables and fruit. This may become a habitual pattern and the resulting weight gain leads in turn to other health problems such as diabetes and high blood pressure.

Outcomes have been shown to be greatly improved when hypnosis is combined with a CBT weight loss programme compared with CBT alone (Kirsch 1996) in 78% of patients and this actually increased over time. Hypnosis and imagery have been shown to be effective in improving the self regulation of eating behaviour in a study of eighty students (Hutchinson-Phillips et al 2005). For a more comprehensive look at weight management and the role of hypnosis see Evans et al (1997).

Hypnosis can help with connecting the patient to their desired goals but it may be useful to have the patient consider re directing their goal to the positive one of being healthy rather than to a somewhat negative one of weight loss. Cravings for various foods or for sweet things at various times can be treated with re-framing (see page x). Occasionally a negative anchor can be used as in the example below.

Paula was somewhat overweight at twelve stone and stated that she could not pass the biscuits, cakes and sweets shelves in the local supermarket without buying a considerable quantity which she would consume later leading to an unpleasant feeling of bloating and sluggishness. One intervention that she found effective was to anchor this uncomfortable feeling to pressing her left finger and thumb together and to fire this anchor when she approached the tempting foodstuffs. This she found helped her not to feel compelled to buy them.

Often, including in the example above, work needs to be done on improving self esteem (see page x), dealing with past underlying events (see page x) and goal setting (see page x). Exploration of the 'meaning' of food to the overweight patient can lead to the discovery and subsequent resolution of imprints, fears and emotional difficulties. Work with the obese patient, in the author's (AW) opinion, needs to be directed both to the present behaviours and the future goals, whilst taking note and helping to resolve past emotional events that may have contributed to the current problem.

There follows a case study courtesy of Dr A Hamill which demonstrates how the presenting problem (overweight) may be resolved by tackling the underpinning emotional difficulties (grief, in this case).

Sheila was a music teacher who attended the author's (AH) practice (who was known to use hypnosis) and asked the nurse if he could help her with weight loss as she had put on three stone since her husband, Paul, had died two years previously.

The author (AH) already knew a lot of her background and her medical and social history, so at the first session hypnosis was explained. It was stressed that she would always be in control, and that this light trance would allow her creative, emotional side to help her at what was a very emotional time.

Sheila was asked to say in her own words how she saw the problem. She immediately stated that 15 months before her husband died (some five months before Paul's diagnosis), her stepson had committed suicide.

Paul had left his first wife and young son to marry her and although he had kept in touch and supported his first family financially and emotionally, there was always guilt associated with this. The son had never really accepted the situation, which had been made worse when their own child was born. Paul and Sheila had given the stepson lots of support, but he always had issues. Paul had helped him financially with a deposit to run a pub, but this had failed and alcohol became a problem. When his son committed suicide Paul found him. They had never really discussed all this because, just when things were starting to settle, Paul was diagnosed with cancer and died eight months later.

They had had one big argument six weeks before he had died over pain control when he wanted to downplay it and she felt very guilty about this. She then added that she had not felt a moment of calm or peace since Paul had died even though her GP had prescribed anti depressants. She had not continued taking them as she did not like taking pills.

It was suggested that with all this turmoil, grief and emotional storm ongoing it was no wonder she had turned to eating as her comfort; "Exactly" was her reply. She now felt fat and knew her health was at risk, at over fifteen stone and five foot two inches tall.

It was decided to firstly assess her hypnotisability, to teach her self-hypnosis, and to give her a sense of peace and refuge from the 'storm' in her own special safe place.

The author (AH) uses the 'Is it possible?' technique (Margolin 1992) to introduce the patient to hypnosis and to enable tailoring of any further induction to their answers.

Sheila was then taught a simple self hypnotic exercise and this was repeated (fractionating).

She achieved peace and serenity and whilst in that state the author (AH) gave her a metaphor about grief, the cycles of time and the seasons, and where Sheila's responsibilities lay with decisions regarding how Paul experienced his last days. The boat metaphor and Ararvind's hand technique for grief were then employed (see page x).

On re-alerting, she reported that this was the first time that she had felt calm since Paul's death. A suggestion was given that she would continue to improve on this feeling each time she practiced her self-hypnosis. This immediate post hypnotic phase is a great time to make suggestions as it bridges and cements conscious and unconscious communications in place.

On the second session she reported feeling improved and it was decided that we deal with her remaining feelings of guilt. We talked about responsibility; how we all need to be responsible for our own thoughts and feelings, not to blame others or to accept blame from others.

Sheila then stated that she had felt guilty about being alive when Paul was dead. She now hardly did anything that she and Paul had previously done together as she felt disloyal. This was reframed by suggesting she could keep Paul's memory more alive if she did some of the things they had shared as a celebration of their love and good times together. She really liked that idea!

Having induced hypnosis it was suggested that she had a rucksack on and was walking across to a hot air balloon tethered in a field. She was asked to empty her rucksack, looking at each object as she pulled it out. Each object represented a problem or an unresolved grief or guilt. As she looked at them again in a new light she was to ask herself if she still needed to carry them around all the time or had she learnt all she needed from them. If she had no more need for them, she was to place them

in the balloon. If she was not sure or still felt more work was needed on them, she was to put them back in the sack.

When this was accomplished she was to untie the balloon and watch it soar away; and as it soared away it could take any associated pain with it, far away until it disappeared.

It was then suggested that she continue to walk until she came to a stream. A metaphor was used describing how a stream meets obstacles in its path but uses many ways to get around them, under them or over them! As she walked up the stream she would come to a rock pool which she could bath in, a refreshing pool of new or old resources re-found, re-energised. It was suggested that she might like to incorporate this pool into her special place and find new or different ways of meeting her problems. Before returning to the here and now she was asked if there were any other issues concerning her now that she needed to look at. Sheila shook her head and said she felt confident and good.

It was then suggested that we could finish now as she already knew all about how to diet. She said she certainly did. She was asked to contact the author (AH) if she needed any more help and to let him know how she was getting on. Ten weeks later the author received a thank you note, saying she still missed Paul but she was getting there, and had lost just over two stone.

Emma - a woman with PCOS courtesy of Dr Lucy Coffin

Emma was a 29 year old with no significant past medical history apart from Polycystic Ovarian Syndrome (PCOS). She had been trying to conceive for four years and was obese with a BMI of thirty. She also had anovulatory cycles, excess body and facial hair, and acne. Emma reported that she never ate breakfast, she had a late morning snack, lunch, snacks, and then supper. She ate a lot of processed foods, caffeine, junk food and usually had ready-meals in the evenings.

A long discussion prior to induction indicated she would like to stop craving these foods and instead wanted to make more healthy choices. We also talked about the benefits of regulating blood sugar levels and raising metabolism by eating regularly, particularly including breakfast. Emma wanted to change the way she saw junk food so that it would lose its appeal. Our treatment plan consisted of using hypnotic relaxation to help induce homeostasis; to help lose weight by changing her eating behaviour and focus for exercise; to use dynamic imagery to assist Emma's body into more regular menstrual cycles and to reduce her symptoms.

Emma was initially very nervous about hypnotherapy and required a lot of reassurance together with in depth explanations of how the process could work. A permissive approach suited her well as she was invited to gently relax and be in control. She established, with guidance, a 'safe place' where she could always return in order to feel comfortable and secure. She also developed a 'waste disposal' system so she could get rid of any unwanted beliefs or baggage she came across.

She wanted to tackle the weight issue first. Emma was asked how she sees the food at the moment and she described how it smelt amazing and tasted great, licking her lips and laughing as she thought the image of eating chocolate and crisps felt so real in imagery. She was then asked how the food is broken down and what benefit it gives to her body. She replied by stating that she likes the taste of it but that was all, as it only caused a build up of fat in her body. We explored what she would gain by losing weight, things she could not do whilst continuing to over indulge on junk food. She was then asked which was more important to her, the achievement of her goals or the experience of tasting the food. She picked the former.

She was gently facilitated into thinking about how she could detach herself from wanting these foods so badly and she went on to decide she would like to start to see the food differently. With that she began to talk about how the food breaks down into fat in her body. Emma was asked if she

would like to really not fancy the food she had formerly loved and she expressed a wish to be almost repulsed by it and to crave healthy foods to bring nutrition to her body. We agreed it should be a positive outcome if she had the confidence and self esteem to recognise that she deserved to have the best thing in her body to be as healthy as she could. We also added in the motivation of preparing her body for pregnancy.

She started to see the items of food as lumps of gelatine which she did not want to eat. She imagined various scenarios, including a trip around the supermarket, where she easily saw herself moving past the junk food aisles and opting instead to fill her basket with fresh fruit and vegetables. Emma was asked if she would like to accept a suggestion that she would no longer feel drawn to these junk foods and would automatically think of the gelatine and the negative impact on her body. She readily agreed and this direct suggestion was given.

Emma also did imagery work on her metabolism which she saw as a slow sausage with the sluggish contents stuck in places. Once empowered she was able to locate a switch to get it moving and a lever to speed it up. We checked in on this in subsequent sessions and it was gradually getting faster. Emma had also learnt self hypnosis and was able to check in on this at home too.

The result has been a steady weight loss around one pound per week, and she genuinely does not want to eat junk food and is almost nauseous at the prospect. She is really happy with this and is now creating a new lifestyle of eating regularly and putting nutritious healthy foods into her body which she feels really positive about.

We went on in subsequent sessions to use dynamic imagery to help her body reach homeostasis and she has found that her menstrual cycles are greatly improved with obvious signs of ovulation

Thus it can be seen that hypnosis can facilitate treatment with obesity and eating disorders by connecting the patient with their inner resources, helping to resolve underlying emotional difficulties and encouraging them to focus on desired behaviours and goals.

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