

THE PLACE OF HYPNOSIS IN PSYCHIATRY, PART 3: THE APPLICATION TO THE TREATMENT OF EATING DISORDERS

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This paper, the third in the present series, is based on a world-wide search of the literature focusing on the application of hypnotherapy in the treatment of eating disorders. According to DSM-IV (American Psychiatric Association, 1994), eating disorders are broadly divided into two main groups – anorexia nervosa (AN) and bulimia nervosa (BN). There is also an intermediate group where there are components of both anorexia and bulimia present and some authors refer to this as “bulimerexia” (Thiessen, 1983). The authors review a range of treatment procedures which have been shown to be highly effective for the treatment of both anorexia nervosa and bulimia nervosa. Some of these treatments are based on behavioural lines, others are psychodynamically oriented, while a third group involves a combination of these approaches. Detailed accounts of the treatment procedures are given so that hypnotherapy practitioners may incorporate these techniques in clinical practice.

According to the *DSM-IV* classification (American Psychiatric Association, 1994), eating disorders can be divided into two main categories: anorexia nervosa (AN) and bulimia nervosa (BN). In order to establish a diagnosis for anorexia nervosa, there must be a refusal to maintain a minimal body weight and this is associated with a distortion of body image. Before making the diagnosis, it is important to exclude organic illness which may simulate some of the features of anorexia nervosa. Female patients with anorexia nervosa frequently suffer from amenorrhoea and their reluctance to develop into

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a fully grown woman is reflected in their appearance. Anorexia nervosa is subdivided into two main groups:

1. Restricting Type: weight loss associated with dieting, fasting and excessive exercise.
2. Binge Eating/Purging Type: weight loss associated with a bingeing and purging cycle – self-induced vomiting; inappropriate use of laxatives or enemas. This is sometimes referred to as “bulimerexia” (Thiessen, 1983).

The term bulimia nervosa refers to a condition in which the individual has a combination of binge eating associated with compensatory purging – again this is often connected with an obsessive preoccupation with body weight and shape. In order to make the diagnosis, the purging and bingeing cycle, according to *DSM-IV* criteria, must occur at least twice a week for a period of at least three months. Bulimia nervosa is also divided into two main groups:

1. Purging Type: binge eating followed by self-induced vomiting, misuse of laxatives, diuretics or enemas.
2. Non-Purging Type: bingeing followed by fasting or excessive exercise.

DSM-IV also includes the category “Eating Disorders not Otherwise Specified” which is reserved for those patients who do not meet all the necessary criteria for the diagnosis of anorexia nervosa or bulimia nervosa. These are as follows:

1. Females who meet all the criteria for anorexia nervosa but who have regular periods.
2. Patients who starve themselves but maintain a normal body weight.
3. Individuals who meet all the criteria for bulimia nervosa but the binge/purge cycle occurs less than twice a week and for a period of time less than three months.
4. Individuals who binge and purge after eating a small amount of food.
5. Individuals who repeatedly chew, spit out, but do not swallow large amounts of food.
6. Individuals who binge without regular, inappropriate compensatory behaviour.

It is important to note that simple obesity is not classified as an eating disorder in *DSM-IV* because there is no clear association with a psychological disturbance in every instance; however, it is classified in *ICD-10* (World Health Organisation, 2003) as a general medical condition. For the purpose

of this paper, an account will be given of the aetiological factors and the clinical manifestations of anorexia nervosa and bulimia nervosa, focusing on the application of hypnosis in their treatment.

ANOREXIA NERVOSA

The term anorexia nervosa was first used by Charles Lasègue (1873) and then by Gull (1874), who wrongly attributed this condition to hysterical apesia to distinguish this from other causes of weight loss such as tuberculosis and organic gastrointestinal diseases (Chabrol & Corraze, 2001). At the beginning of the twentieth century, the French psychiatrist Pierre Janet gave a detailed account of patients suffering from this condition and he was the first to introduce hypnotherapy to treat what he described as “hysterical anorexia” (Janet, 1924). Janet emphasised the importance of the psychological factors in its aetiology; however, he did not make a clear distinction between anorexia nervosa and what is now known as bulimia nervosa (a condition which now might more accurately be described as “bulimerexia”). He used the expression “*idée(s) fixe*” to describe the patients’ preoccupation with self-starvation and body image, and he used hypnosis to address these problems in a process which he referred to as “mental synthesis” or “*la synthèse mentale*.” Vanderlinden and Vandereycken (1988) pointed out that, perhaps, Janet was one of the first to use a form of cognitive restructuring in the treatment of this condition.

In 2007, an epidemiological study was carried out to determine the incidence of anorexia nervosa in men and women. This research, a population-based study from the National Comorbidity Replication carried out by Harvard Medical School ($N = 9,282$), showed an incidence of anorexia nervosa of 0.9% in women and 0.3% in men. This study was based on a house-to-house survey on a national level using the WHO Composite Diagnostic Interview (Hudson, Hirip, Pope, & Kessler, 2007). These figures indicate that there has been an increase in the number of men with anorexia nervosa; this may be due to a definite increase in the number of men suffering from this condition or, alternatively, that diagnostic tools have improved to such an extent that researchers have been able to locate more men suffering from this condition (ANRED, 2008).

A prominent feature in the aetiology of anorexia nervosa is that the patient is caught up in a highly complex and disturbed family structure; (s)he displays both obsessive and highly perfectionist features, and this is a product of the family’s psychopathology. A major component of anorexia nervosa is that

there are internal hostilities within the family structure, and the food restriction is a function of hostile feelings towards parental figures. This striving for perfectionism pervades the whole of their lives, including the home and work environments; individuals often have an encyclopaedic knowledge of calorie values and the precise constitution of foodstuffs. Some patients exercise excessively each day with the express purpose of losing weight: This has been termed “anorexia athletica” (Segal, 2001). The restriction of food intake can be of such severity that the patient may die of this condition. In order to prevent any weight gain, individuals will go to any length to hide food or lie about the quantity of food they have consumed.

Patients suffering from anorexia nervosa not only reduce their food intake to the point of starvation, but also have a distorted body image, so that they regard themselves as being fat when, in reality, they are already quite thin or even emaciated. A recurring feature in adolescent girls suffering from this condition is that they are unable to deal with their bodily contours in connection with their sexual development. Davis (1961) referred to this phenomenon as “psychological infantilism,” and often they present with a childlike appearance (Yapko, 1986). Similar mechanisms operate with young men who suffer from anorexia nervosa.

Further, these patients are able to suppress their hunger, suffer constipation, and are able to feel full after a small quantity of food (Gross, 1984). One of the very important mechanisms in anorexia nervosa, and a feature which is central to their condition, is that, by eating very small quantities of food they exercise an enormous amount of control; in addition, this has the effect of counteracting feelings of worthlessness or powerlessness in their everyday lives (Sours, 1969).

Patients with anorexia can suffer from a number of physical complications. Some patients suffer from bradycardia (Kollai, Bonyhay, Jokkel, & Szonyi, 1994) and in some cases this may be associated with electrocardiographic changes with an increase in the QT interval (Cooke et al., 1994). These cardiac abnormalities may be associated with hypophosphataemia and delirium (Beumont & Large, 1991). Patients frequently suffer from endocrine disturbances, the commonest of which, in women, is amenorrhoea. In addition, individuals may suffer from osteoporosis which, in turn, may result in an increased fracture risk throughout life (Munoz & Argente, 2002). Adolescent anorexics frequently show stunted growth during their illness, and this can be seen in both male patients (Moses-Modan et al., 2003) and in female patients (Swenne & Thurffjell, 2003). Patients may also develop hypothermia associated

with a thiamine deficiency (Smith, Ovesen, Chu, Sackel, & Howard, 1983). In adolescents suffering from anorexia, this may lead to a zinc deficiency, and supplements of zinc in the diet may be helpful in the recovery process (Katz et al., 1987). Frequently, patients have dry skin, chapped lips, skin pallor and sunken eyes (Gupta & Gupta, 2001); but, more seriously, they may reduce their food intake to such low levels that eventually they become cachectic (Sours, 1974). It is important to remember that anorexia nervosa may lead to sudden death: a meta-analysis has shown that the mortality rate of anorexia nervosa, with causes of death ranging from suicide to sudden death, was 5.9% (Neumaerker, 1997). In a retrospective study carried out in Southern Italy (Signorini et al., 2007), the total mortality rate was 5.25%, which included suicides (1.2%) and AN-unrelated deaths (0.98%). They concluded from this study that the mortality rate for females in Western society was very high.

The following headings have been used to emphasise particular approaches which employ hypnotherapy in the treatment of anorexia nervosa; however, it is important to note that these are not mutually exclusive and therapists may choose to incorporate several of these strategies with the same patient.

Encouraging Increased Food Intake

The authors felt that it was necessary to draw attention to some of the earlier studies which, though dated, still have relevance in the present climate. Kroger and Fezler (1976) recommended a combination of behaviour therapy and hypnosis in order to help patients increase their weight, and this was achieved by the use of post-hypnotic suggestions in which food was associated with pleasant memories. A similar approach was used by Davis (1961), who used post-hypnotic suggestions to promote the fact that food tastes good and that one needs food to stay alive. However, he also used intravenous sodium amylal (amylobarbitone sodium) and ECT, both of which are no longer used in practice. Fourteen years later, Crasilneck and Hall (1975) treated 70 patients with hypnotherapy and they reported that over half of these patients made a good recovery. They gave direct suggestions of increased food intake, and once the patients had succeeded in achieving and stabilising a normal weight they used hypnoanalysis to uncover the psychodynamic conflicts underlying the anorexia nervosa.

An unusual approach was one used by Erickson (Bliss & Erickson-Klein, 1990; Erickson, 1985; Zeig, 1985), who used food as a “punishment.” Erickson gave a detailed account of a 14-year-old girl, Barbie, whose food intake

consisted of one oyster cracker and a glass of ginger ale per day. In a joint consultation with her mother, whenever Erickson asked Barbie a question, the mother replied. He did not deal with this problem straight away, but it was very clear from this one example that her mother was exerting an enormous amount of control over her daughter and interfered with her autonomy. On the third day, the mother complained that she couldn't get to sleep because her daughter had been whimpering all night. The daughter agreed with the therapist that she deserved to be punished for this, which meant having to eat scrambled eggs, and the mother was required to feed them to her. At the same time, Erickson was very critical of the mother, pointing out that she always replied to questions intended for Barbie. It was then that he told the mother to "keep her trap shut" and this had a powerful emotional effect on the daughter who, from then on, was forced to view her mother in a different light. He then used a number of complicated strategies, which included the use of long, elaborate stories and the extended use of metaphors; he also asked Barbie to spy on her mother's eating habits, and that failure to do so would result in further eating punishments. In addition, both mother and daughter gave realistic goals of proposed body weight. This course of treatment was highly successful: Barbie had achieved her desired body weight and was now eating normal meals during the course of the day. A long-term follow-up of 14 years duration showed that she had made an excellent recovery and that she was engaged to be married.

Another behavioural treatment approach was described by Georgiou (1995) in which an important component was the vivid recall of feeling hungry, and this was paired with eating a small delicious meal slowly. Direct suggestions were also given that the patient's appetite and weight would increase and that feelings of comfort and satiation would be a signal to stop eating.

The Nature Approach

Gross (1984) gave a detailed account of a 15-year-old girl whose weight had dropped dramatically from 103 pounds to 50 pounds. On her admission to hospital, her fingers were blue and she fidgeted constantly. She learnt to carry out self-hypnosis for 15 minutes each day, and this had a beneficial effect of reducing her hyperactivity. In the hypnotherapy sessions, she was encouraged to imagine herself in a beautiful setting of her own invention. Having chosen the beach as her ideal setting, this scene was then utilised as a metaphor for the regulation of her bodily functions. For instance, the regularity of the

ebb and flow of the waves was equated to the rhythms of her heart beating, as well as the peristalsis of her gastrointestinal tract (Georgiou, 1995). This treatment approach is very similar to the river approach in the treatment of irritable bowel syndrome which has been used extensively by the Manchester team (Whorwell, 2006). On this system, she gained two pounds each week and eventually reached 100 pounds; and, during this time, she became much calmer and felt that she was able to explore some of the underlying causes for her anorexia.

Esplen (2003) emphasised the importance of using images from nature to provide patients with a soothing and warming environment. Her technique involves the use of guided imagery without attention being paid to the prevailing symptom. Three patients were described and all had a mixture of anorexia and bulimic symptoms. This approach is psychodynamic and differs markedly from the behavioural approaches outlined above. It is a non-directive approach. The great advantage of this form of treatment is that it concentrates solely on the underlying problems responsible for the eating disorder, and this gives the patient a better understanding of her family situation: The symptoms subside without dealing with them directly. Images include the use of meadows, outdoor water, the warmth of the sun and familiar places where the patient has felt safe in the past. The therapist constructs a protective and safe environment and this encourages patients to express their deep-rooted feelings spontaneously.

Correcting Body Image

Gross (1984) also concentrated on changing what he described as, “a notoriously distorted body image.” During the course of the hypnosis, the patient was shown pictures of her emaciated body and it was then suggested that she should imagine a healthier body image. Another component of this approach involved the patient drawing a picture of herself, and it was here that the therapist concentrated on particular areas of distortion. Often, these patients drew over-sized hips. Gross (1984) described a case of a 17-year-old female patient, Cathy, who started losing weight after her boyfriend had commented about the size of her thighs. She had gone from 130 pounds to 80 pounds and was subsequently admitted to hospital. Cathy had a distorted body image: She believed her hips and thighs were huge even though, in reality, they were quite thin. She also was preoccupied with the notion of gaining weight. In the hypnosis, she was instructed to look at the picture of

herself on admission; she was then asked to project herself into the future and to model herself on a favourite film star. Also, the therapist suggested that she should touch her thighs, and gradually she began to view her body in a more realistic light. Concurrently, she started to put on weight and, in a period of four months, she reached 118 pounds; importantly, she was able to stabilise her weight and this was maintained over a three-year period.

Nash and Baker (1993) treated 36 female patients suffering from anorexia nervosa and reported that, at the 6- and 12-month follow-ups, 76% of the patients who had received a combination of hypnotherapy and psychotherapy had a remission of symptoms and had stabilised their weight; this compared favourably with the group who had psychotherapy only, where, the corresponding figure was 53%. Patients were asked to project their distorted body image onto a blackboard or an imaginary screen. Using this dissociative image, an age regression technique was then employed to elucidate the roots of the bodily distortions and then to explore them first during trance and then in the subsequent insight-orientated psychotherapy sessions. Patients were encouraged to erase and then re-draw parts of the body that were particularly distorted; this process often generated a great deal of anxiety, and this was counteracted by suggestions of calm and relaxation.

Approaches to Perfectionism

Patients with anorexia nervosa invariably show powerful perfectionist traits and several authors have paid particular attention to this aspect of the disorder. Yapko (1986) encouraged his patients to make deliberate mistakes in order to show them that this did not lead to world-shattering consequences. He gave examples such as leaving the bed unmade, being late for meetings, and taking wrong turns off the motorway. Patients either comply with the instructions given to them by the therapist which involves making a mistake, or, alternatively, they fail to comply and therefore also make a mistake. Yapko refers to this as a “double bind effect,” where the patient is given the illusion of choice. This phrase differs from the psychoanalytic definition which refers to contradictory messages being given to a patient within the family context. A variant of this technique is to re-frame perfectionism as something which is negative or undesirable.

Correcting Faulty Sexual Maturity

Many patients suffering from anorexia nervosa show a faulty sexual maturation and often have a child-like appearance. One treatment technique is to use

age progression in which the patient is encouraged to imagine herself in the future as a healthy individual. The patient is also given the opportunity to experience the intermediary stages leading to a successful recovery. Yapko used a homework strategy in the treatment of a 20-year-old patient. She was directed to go to the children's section of a department store and to try on the clothes with the express purpose of demonstrating to herself that she was small enough to fit into children's clothes. This had a disturbing effect on the patient because she now had objective proof that she had an abnormal body size. This approach forced her to face the fact that she had been in denial about her bodily contours and she then accepted that she needed to address these problems.

An alternative approach to developing sexual maturity is an Ericksonian-type strategy used by Thiessen (1983), who repeatedly recounted the story of the ugly duckling. He used this metaphor to promote healthy sexual maturation. The realisation that the ugly duckling – in fact, a signet – had been transformed into a really beautiful swan had a powerful effect on the patient. In the hypnosis, the symbol of the swan represented a sequence of important changes relating to the natural development of her adolescent life and becoming an adult woman. It suggested that she was capable of becoming a beautiful swan and that sexual maturity was a desirable outcome. Thiessen described a 22-year-old female patient who showed typical features of anorexia nervosa including perfectionist traits, secrecy, ambivalence to growing up, and a rejection of accepting her female identity. As it is frequently found in these patients, her problems were inextricably interconnected with a highly complex family structure. In addition, she showed bulimic symptoms including bingeing, vomiting, and the use of laxative pills. During the first five or six months of therapy, attention was focused on some of the important psychodynamic factors – namely, her father's excessively high expectations, a bad mother image, and a sexual incident at the age of seven – in the development of her disorder. No doubt, this was effective groundwork for the introduction of the ugly duckling fairytale. By using the story of the ugly duckling in the hypnosis, she was able to restore her normal body weight. At the end of the treatment, she was 118 pounds and had been able to refrain from her bingeing; this weight was maintained at the 6-month follow-up.

Use of the Healthy Voice and the Self-Defeating Voice

Segal (2001) used a multi-faceted treatment approach in the treatment of a 22-year-old male patient who suffered from anorexia nervosa associated

with exercise addition. An important technique which was employed during the course of the therapy was the use of the “healthy voice” and “self-defeating voice”. This approach comes under the general heading of cognitive restructuring. In this treatment paradigm, the patient was encouraged to recount a number of sentences typical of his self-defeating voice (e.g., “I have no control over my exercise routine and diet”) followed by positive and adaptive counter statements of the healthy voice (e.g., “I can control my exercise routine and diet”). Then, in the hypnosis, he was encouraged to repeat silently the statements of the healthy voice.

Sibling Rivalry

Gross (1984) described the role of sibling rivalry in an 18-year-old patient suffering from the purging variety of anorexia nervosa, sometimes referred to as bulimierexia (Thiessen, 1983). He described the onset of the condition following a chance remark from someone who referred to her as “fat,” and this acted as a trigger for her anorexic and bulimic symptoms. Sibling rivalry was an important component of her eating disorder. In the hypnosis, Gross asked her to concentrate on feeling hungry and to respond appropriately by eating small quantities of food to satisfy that need: In the abreaction which ensued, she was able to convey her feelings of jealousy about her younger sister, her constant need for parental approval, and her unconscious desire to be thinner than the sister. The treatment was successful. She reached her goal of 100 pounds and this was maintained at both the 18-month and two-year follow-up.

BULIMIA NERVOSA

While the term bulimia was known as far back as the eighteenth century (Blankaart, 1708), it was Russell (1979) who pointed out that this condition was an “ominous variant” of anorexia nervosa, and intimated that bulimia nervosa could be regarded as a syndrome in its own right. An essential component of bulimia nervosa involves binge eating accompanied by some form of purging behaviour – intentional vomiting, use of laxatives, diuretics and enemas. However, there is also the non-purging variety, and here individuals fast or exercise excessively. Despite episodes of over eating, body weight is normally maintained as a result of these compensatory mechanisms coming into play. Frequently, patients describe their actions during the binge/purging cycle as being, “out of control” or, “as if another person is taking over

my body.” Some patients become so expert at vomiting that they can do this without having to insert fingers into the mouth.

Figures for bulimia seem to have increased over the last 20 years. The Harvard study (Hudson et al., 2007), quoted earlier in connection with anorexia nervosa, showed that the incidence for bulimia in women was 1.5% in the population, while the corresponding figure for men was 0.5%. It was also found that, with binge eating disorder – not included in this paper because it does not satisfy *DSM-IV* requirements for an eating disorder – the equivalent figures are 3.5% in women and 2.0% in men.

Patients suffering for bulimia nervosa frequently experience medical complications to a greater or lesser degree depending on the severity of the condition. One of the complications of bulimia is an electrolyte disturbance – notably, hypokalaemia, with its associated muscle weakness and cardiac arrhythmias. Indeed, some patients who are initially admitted to hospital with an electrolyte disturbance are in fact suffering from bulimia nervosa (Lam & Lee, 2000). Frequent vomiting may also lead to dental carries (Rytömaa, Järvinen, Kanerva, & Heinonen, 1998), lacerations in the mouth (Mendell & Logemann, 2001), gastric reflux and oesophagitis (El-Mallakh & Tasman, 1991), swelling of the salivary glands (Vavrina, Müller, & Gebbers, 1994), schlera haemorrhaging (Gorney, 2000), chronic dehydration (Sagar, 2005) and calcium deficiency causing loss of bone density (Sagar, 2000; Zipfel et al., 2001). In a 12-year longitudinal study of 196 female patients suffering from bulimia nervosa, there was an overall mortality rate of 2% (Fichter & Quadflieg, 2004); it is noteworthy, that the 12-year follow up revealed that 70.1% of these patients no longer showed evidence of an eating disorder as defined by *DSM-IV*. The mortality rate is significantly lower than the previously cited studies on anorexia nervosa (Neumaerker, 1997; Signorini et al., 2007).

A number of researchers have reported a significant correlation between bulimia nervosa and hypnotisability (Barabasz, 1991, 2007; Kranhold, Baumann, & Fichter, 1992; Pettinati, Horne, & Staats, 1985), and while there are slight differences between the various scales of hypnotisability, it has been established that these scales have high reliability and validity (Hutchinson-Phillips, Gow, & Jamieson, 2007). This has an important relevance to the treatment of bulimic patients as they have a high capacity for dissociation. They often experience time distortion, amnesia, and a feeling that the binge/purge cycle is beyond their control. It is argued that bulimic patients have a history of early trauma which cannot be integrated into the self, and both the bingeing and the purging are considered to be a variant of the dissociative state (Covino,

Jimerson, Wolfe, Franko, & Frankel, 1994; Sands, 1986; Vanderlinden, Norre, & Vandereycken, 1989). It is for this reason that ego-state therapy and other dissociative techniques may be particularly valuable for the treatment of bulimic patients.

Vanderlinden and Vandereycken's Three-Phase Treatment Approach

Vanderlinden and Vandereycken (1990) reported a study of 50 young women (mean age = 24; range = 20–30); at the follow-up one and two years after admission, 50% made a complete recovery and a further 30% showed remarkable improvement, while 20% remained bulimic.

The first phase of treatment was aimed at preparing the patient for change. Having taught the patients self-hypnosis and given them a tape to use at home, the patients were asked to keep an accurate diary of their eating behaviour and to record the emotions before, during, and after each meal; due to the chaotic nature of their disorder, patients were encouraged to eat three meals a day at fixed times. In addition, the patients were required to make a list of all the negative consequences of their bulimia as well as the advantages of stopping this behaviour. In the hypnosis, the therapist emphasised both these negative and positive features. This approach can be combined with age progression in which the patient is asked to imagine a future time where they are no longer bulimic and are living a healthy life.

The second phase of treatment involves the exploration of the underlying factors which may have been responsible for the bulimia. Traumatic events in the patient's life might involve incestuous relationships, rape, violence, or abandonment. The authors point out that a useful way of uncovering traumatic events is to address, and negotiate with, the part of the self responsible for the bulimia, with the aim that the patients find more appropriate and adaptive ways of dealing with their problems. In the last phase (phase 3), the authors prepare the patients for this important life transition using age progression and ego-strengthening. They also stressed the importance of aftercare for one, two, and up to five years after admission, and recommend that the therapist should remain available for an extended period of time.

It is important to note that, in order to explore the psychological mechanisms responsible for the bulimia, age regression techniques or the use of the affect bridge may well reveal childhood traumas and other evidence of dysfunctional family dynamics. Before attempting to explore these experiences, the therapist would be well advised to ask permission to do this from the patient using

ideomotor signalling. Clinicians should bear in mind that this technique may produce a violent abreaction. Should this occur, the therapist must handle the situation with sensitivity, providing the patient with the appropriate support and encouragement.

Hypnobeavioural Treatment (HPT)

In this treatment approach, the therapist aims to deal with the problem on behavioural lines associated with hypnosis. Griffiths (1995a) devised an 8-week HBT program consisting of two phases. In the first phase, patients were required to monitor their eating behaviour and were given advice about regulating their food intake and eating three meals a day. Patients were also given nutritional advice. In this stage, patients had three hypnotherapy sessions which focused on behaviour modification following the treatment manual suggested by Fairburn (1985). The second phase involved four weekly sessions during which the patient was encouraged to exercise control over his or her bingeing and purging. In the hypnosis, the therapist gave suggestions to reinforce healthy eating habits, to increase self-esteem, and to encourage more social interaction. Patients were also given suggestions that they would be able to exert control over the antecedent situations which had previously led to a binge/purge episode.

This treatment approach employed by Griffiths focuses solely on behaviour modification and does not pay any attention to the underlying emotional causes responsible for the bulimia. In a two-year follow-up report (Griffiths, 1995b), results showed that there was a significant reduction from pre-treatment to post-treatment bingeing and purging; however, it must be pointed out there was no change as regard to their general health, their psychiatric state, or their depression as measured by Goldberg's (1972) General Health Questionnaire (GHQ), the Eysenck Personality Inventory (EPI; Eysenck & Eysenck, 1963), and the Zung Depression Scale (Zung, 1963) respectively.

Stimulus Control Techniques

This is a behavioural approach to treatment in which the patient is encouraged to take meals at set times of the day to increase the time interval between eating and purging (Kroger & Fezler, 1976). In the hypnosis sessions, guided imagery was used to establish a controlled eating routine; it also gave the patient the opportunity to rehearse eating normal meals (Coman, 1992). Patients were encouraged to enjoy tasting the food and, subsequently, to learn to relax

after the meal by taking a walk or reading a book. This was an important component of this procedure in that it had the effect of interrupting the binge/purge cycle. Other adjuvant techniques include storing a variety of low calorie foods and keeping food out of sight (Singh & Watson, 1986). Coman (1992) recommended that these newly acquired eating patterns should be reinforced during the hypnosis in order to give the patients control over their eating behaviour.

Barabasz (1990) reported three individual case studies in which she emphasised the patients' awareness preceding a binge/purging episode, establishing a new pattern of behaviour in which patients learnt to exercise control over their eating behaviour. Strong post-hypnotic suggestions were given to each patient and the therapist emphasised that the only person to have control over their eating behaviour was them. In this study, two of the three patients benefited considerably from this form of treatment intervention, while the third patient relapsed after a period of six months.

A variant of the behavioural approach towards controlling bouts of binge eating was described by Holgate (1984). In the hypnosis, the patients were asked to imagine walking along a beach or a country scene: These were used for purposes of relaxation as well as a way of controlling binge eating behaviour. The patients were asked to visualise a scene in which they were tempted to binge, and they were encouraged to walk away from this situation. The therapist then encouraged patients to feel proud and a sense of satisfaction that they were able to exercise control over their eating behaviour. In addition, a number of other treatment approaches were incorporated into the program including the use of a dietician, who was present during the course of the second and subsequent sessions, as well as cognitive restructuring. The therapist encouraged the maintenance of healthy eating patterns with the assistance of a record of their eating behaviour. Holgate reported the successful treatment of a 25-year-old schoolteacher with bulimia nervosa using this treatment approach.

Ego-State Therapy

Torem (1986) described two bulimic patients' eating disorder as a manifestation of an underlying dissociative state. In both cases, there was a history of severe childhood abuse; and a dissociative mechanism was put in place to protect them from these traumas. He used a similar strategy for the treatment of both of these patients: With the assistance of hypnoanalysis, he was able to crystallise

the source of the dissociation and to use this effectively in treatment. In the first case, it was established that the ego state responsible for the binge/purge cycle was split off at the age of seven, at a time when her parents separated. It became clear that she had been physically and emotionally abused by both parents: She referred to her ego state as “the angry one.” Later, after a series of abreactions, she was able to work through this material so that her guilt feelings were alleviated; there was a significant reduction in her self-induced vomiting and she had been able to rename her ego state from “the angry one” to “the assertive one”

A similar approach was used in the second case. In the hypnoanalysis, it was revealed that the patient, a 27-year-old married woman with bulimia, had compartmentalised the abuse she had received as a child. Here, the treatment involved a series of abreactions, and also cognitive restructuring. At the time of writing the paper, Torem reported that the patient had been free of bingeing and purging for one month. In this treatment approach, the therapist aims to concentrate on that part of the ego which is responsible for the abnormal eating behaviour. Patients suffering from bulimia frequently experience feelings of helplessness and worthlessness in association with hidden anger and unresolved conflicts; ego state therapy is an effective way of dealing with these underlying, self-punishing mechanisms and feelings of guilt (Torem, 1987).

Torem (1987) reported a case of bulimia nervosa in a 17-year-old schoolgirl. The first stage of the therapy involved keeping a daily diary: She was required to record her eating patterns and her reflections before and after the binge/purge cycle. After 10 days, she noticed a significant change in her handwriting as she became more confused and anxiety-ridden. In one particular diary entry, she described that part of herself which was responsible for her bulimic behaviour and her self-defeating attitude. The author then used a hypnoanalytic technique in which he addressed the part of the ego responsible for the eating disorder: This ego state was then asked to communicate directly with the therapist. Torem stressed the value of this treatment approach for the treatment of patients suffering from bulimia.

Group Therapy Approach

In this model, reported by Degun-Mather (1995), there are groups consisting of five clients and two co-therapists. The programs run for 12 weeks, each session lasting 90 minutes and carried out at weekly intervals. Degun-Mather produced a highly structured program for these clients. In the first session,

clients were given the Eating Disorder Inventory (Garner & Olmsted, 1984) and the Eating Inventory (Stunkard, 1983). Each client was given a few minutes to describe their symptoms, and, following this, they were told that the group would be mutually supportive and that they were no longer alone. In session 2, clients established their own personal goals using the Goal Attainment Evaluation Plan (Vanderlinden, Norre, & Vandereycken, 1989), while in session 3 they were given a chart to monitor their eating behaviour throughout the entire program. Clients were encouraged to eat three meals a day. During sessions 4 to 12, the therapists continued monitoring the clients' behaviour with an emphasis on the triggers which had led to the binge/purge cycle. The co-therapists also gave them assistance with coping strategies. Clients took it in turns to discuss their individual problems, coping strategies, and more complex issues relating to family dynamics. Group hypnosis was used to deal with difficult situations and to control urges to binge. Of note, age progression was employed to enable clients to experience the feeling of having achieved their goals. The treatment results would indicate that 60% of clients treated in this way make a good recovery. In the last session, the clients were told that, should they need further help, they could have individual psychotherapy.

COMMENT

This paper has demonstrated quite clearly that hypnotherapy is a valuable tool in the treatment of eating disorders, a treatment approach which does not require any form of medication.

It has been established that many patients suffering from an eating disorder have a background of abuse in childhood, sexual or otherwise. Patients suffering from eating disorders are frequently enmeshed in a complex family dynamic. For this reason, many therapists (e.g., Nash & Baker, 1993) have used an age regression approach in order to address the negative emotions and body image related to the abuse; this trauma may also be compartmentalised and can then be utilised in ego-state therapy (e.g., Torem, 1986).

Having reviewed the world literature on eating disorders, it was apparent that some authors employed a behavioural approach, such as the regulation of eating times and speed of eating (Vanderlinden & Vandereycken, 1990), and changing patterns of behaviour following mealtime (Coman, 1992). In contrast, Epslen (2003) used a psychodynamically based form of treatment in which she focused on the underlying problems responsible for the symptoms without paying attention to the symptom itself; whereas other authors have

combined hypnoanalysis with a behavioural approach (Crasilneck & Hall, 1975) or with ego-state therapy (Toem, 1987).

The combination of a behavioural and a psychodynamic approach now comes under the heading of integrative psychotherapy, which is a fast evolving treatment approach (Kraft & Kraft, 2007). Hypnotherapy offers a rapid and cost-effective form of treatment for eating disorders, and it is recommended that these procedures are used on their own or in combination.

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