CHAPTER FIFTEEN

The Use of Hypnotherapy in the Treatment of Eating Disorders

Delia Young
Psychologist in private practice

This chapter explores the application of hypnosis to eating disorders, reviewing the research published over the last decade, and goes on to discuss the increasing awareness of the value of hypnosis as an adjunct to therapy, especially in the treatment of bulimia nervosa. The author also considers her own findings using a variety of hypnotic techniques with a number of eating disorder clients treated individually in private practice.

At the turn of the century, the French psychiatrist Pierre Janet described his approach with eating disorder sufferers, making special reference to his work with anorexics, whom he treated with hypnotherapy (Janet, 1907). It was not until the 1970s, however, that interest in the value of hypnosis with eating disorders started to grow. In 1975, Crasilneck and Hall reported the results of their research with 70 cases of anorexia nervosa in which treatment consisted of direct suggestions for increased food intake and they further recommended hypnoanalytic techniques for exploring and uncovering the psychodynamic conflicts underlying the anorexic symptoms. Their results showed a marked improvement in more than half the cases. Kroger and Fezler (1976) and Kroger (1977) promoted the combination of a behaviour modification programme and hypnosis with anorexia sufferers. In their work, hypnosis was used to increase food intake by means of post-hypnotic suggestions, which associated food with pleasant memories, and by presenting images to the client that enhanced feelings of hunger or emptiness in the stomach. Spiegel and Spiegel (1978) similarly stressed the importance of hypnosis for both diagnostic and therapeutic purposes in anorexia nervosa and Erickson described the case of a 14-year-old anorexic girl whom he treated with a combination of indirect and paradoxical strategies (Erickson & Rossi, 1979).

Since 1980, an increased interest in the hypnotherapeutic treatment of bulimia nervosa has emerged. Channon (1981) reported the use of

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the affect-bridge technique, and Lankton and Lankton (1983) mention a successful outcome in one case using hypnotherapy, in which they combined suggestions of self-control with indirect suggestions for attitude restructuring and completion of blocked developmental tasks. Griffiths (1989) described using imagery training and direct suggestion, whereas Calof (1986) suggested obtaining a dissociative state under hypnosis in order to access the client's unconscious mind. Similarly, instead of openly discussing the client's ambivalent attitude with regard to change, the therapist can explore these in hypnosis via an unconscious route by using ideomotor questioning and finger signalling with the seven questions of Le Cron (Cheek & Le Cron, 1968).

The importance of the ego-dissociation mechanism in the onset of abnormal eating behaviour has been frequently noted. Bulimia sufferers often state that they switch into a different personality when bingeing and vomiting and sometimes there is amnesia for what happened during the binge. Torem (1986, 1987), in his studies with 30 subjects with eating disorders, discovered dissociated ego states that were in disharmony with one another. He underlined the importance of incorporating hypnosis and hypnoanalytic explorative techniques as a routine part of the diagnosis with eating disorder clients. His treatment consists mainly of the identification of the dissociated ego state and the accomplishment of a negotiation between this ego state and the other part of the personality. The final objective is a better and more adequate integration of the dissociated ego state into the total personality. Interestingly in this context, Pettinati, Horne, and Staats (1982, 1985) found that bulimic subjects were highly hypnotisable, significantly more so than subjects with anorexia nervosa and normal age-matched controls. They also noted a trend for the purging subgroup of anorexics to have higher hypnotic capacity than abstaining anorexics.

Ego-strengthening suggestions as described by Hartland (see Waxman, 1989) and elaborated on by Stanton (1975, 1979, 1989) can be used to promote healing, strength, and well-being. They are designed to increase the client's self-confidence and ability to cope. It is useful to introduce both direct and indirect suggestions relating to healthy eating and improvement in the client's body image. However, this needs to be done with great caution because it may be met with resistance from the client. As Michael Yapko points out in Chapter Nineteen, the more resistant the client, the less effective direct

suggestions are. This is especially true in clients with anorexia and with adolescents in general. Many adolescents use their eating disorder as a means by which they communicate their dissatisfaction with the family setting or their dissociation from an unacceptable introjected parental objection. Their purging may be seen as a metaphor for rejecting the parent's value system and ideas, and for declaring their separateness in finding their own identity. Indirect suggestions for healing can be helpful when constructed in a way that allows the client a choice of whether to continue to cope with the family dynamics in the old "bulimic" or "anorexic" way, or whether to be creative and find new ways to deal with their predicament.

To deal with these issues, Theissen (1983) suggested an Ericksonian approach, using fairy tales in hypnotherapy, in a similar way to that described above. Holgate (1984) offers a short-term eclectic approach, including various hypnotic, behavioural, and cognitive techniques. She advocates guided imagery exercises for self-control of bingeing and vomiting, for strengthening stimulus control techniques, and for ego-enhancement. Yapko (Chapter Nineteen) promotes the use of indirect hypnotic suggestion to challenge the four dynamics most commonly associated with anorexia nervosa, i.e., family enmeshment, delay of maturity, poor self-esteem, and distorted body image. His approach consists of indirect hypnotic suggestions (given as metaphors), behaviour prescriptions (mostly paradoxical), and cognitive reframing.

Age regression, abreactions, and catharsis have been found to be useful with clients in whom the underlying dynamic for the eating disorder appears to be related to past traumas. The relevant trauma may be identified by using such techniques as the affect bridge, originated by Watkins (1971, 1978) and also described by Channon (1981), with the assistance of ideomotor signalling, as offered by Cheek and Le Cron (1968), Barnett (1981), and Brown and Fromm (1986). The client can then be led by the use of age regression to the original trauma to which the eating disorder appears to be related. The client will then often fully abreact emotions attached to the original trauma. The emotional catharsis in the abreaction may in itself produce relief, and significant improvements have been reported using this approach (Watkins, 1980). Other techniques that can be applied in dealing with a traumatic event are implosive desensitisation and silent abreaction (Edelstein, 1982). Implosive desensitisation is a benign progressive flooding technique in which the client re-experiences time and again,

feelings about the traumatic event, with interruptions, until the feelings have sufficiently decreased in strength. The therapist then applies the affect bridge technique to help the client re-experience these feelings until the next pause is reached in the story. The confrontation is repeated until the tension gradually decreases to a level that is tolerable for the client.

In my experience of using hypnosis with eating disorder clients, an eye fixation technique (choosing a focus) has been found to be an appropriate induction, continuing with a few deepening procedures (breathing, descending steps or an escalator, arm levitation, etc.) and concluding with a short future-oriented fantasy. In the fantasy, clients attempt to imagine finding themselves in a place where they can feel peaceful, safe, and protected, can recover for a while, and then gradually enable themselves to relax. If clients resist this approach, a non-directive (Ericksonian) induction may be the best way forward, although this seldom occurs in the case of bulimic clients as they often prefer a distinctly structured hypnosis induction. As an example of an indirect approach, in one of my own cases, an Ericksonian fairy tale technique was adopted (Theissen, 1983) based on the story *Up the Far Away Tree* by Enid Blyton. The fantasy involved a hollow tree, inside which was a chair lift that stopped at different future images representing the client's full recovery and reaching an ideal stage in terms of personal goals, body image, and state of healthy living. "Back from the future" is a modification of this strategy in which the client brings back from their trip into the future, all the images of accomplished life goals.

I have also successfully used another of Torem's ideas, wherein the client remodels and redecorates their own room, which is analogous to their body: first, imagining living in an old room with which they feel dissatisfied; then using imagery to visualise remodelling, and redecorating their room to meet their needs. Emphasis is put on the client's choice of colours, materials, furniture, curtains, and pictures (Torem, 1992). Another effective image is that of the client adopting a pet, perhaps a sick one from an animal shelter of the local community. The client is encouraged to imagine the pet being nursed into full health through their commitment and dedication. The sick pet is naturally a metaphor for the client's unhealthy body which they make a commitment to heal and nurse back to health. A self-hypnosis tape can be recorded on an audio-cassette with ego-strengthening for their individual problem and this can be practised every day at home, either before and after meals, or at the end of the day.

With eating disorder clients, it is also important in the induction or deepening procedures not to use the phrase "getting heavier and heavier" because many clients react badly to this choice of words. In the case of an anorexic client, an additional method of refraining can be utilised in which discussion focuses on gaining strength units instead of gaining weight. The client may be told that each strength unit is equal to one pound of body weight. Most anorexic clients get very tired and feel physically weak and they are more willing to accept the idea of gaining strength than of gaining weight. With these and similar cautions in mind, a treatment plan can usually be formulated that will be accepted by the client with the minimum of resistance.

Vanderlinden and Vandereycken (1990) and Torem (1992) carried out a wide range of different hypnotic interventions, including general relaxation and calmness, guided imagery, teaching self-hypnosis, ego-strengthening, imaginal rehearsal of appropriate eating, planned reduction of binges, direct and indirect suggestions for healing and recovery, cognitive restructuring and refraining, symbolic guided imagery, age progression ("Back from the future" technique), metaphorical prescriptions, affect bridge to traumas, age regression and abreactions, together with ego state therapy. These provide symptom relief and behaviour changes as well as improvement in self-esteem and body image. In the case of my client mentioned earlier, a severe bulimic woman of 19 years, most of the above techniques were incorporated into a six-month programme. The therapy was initially weekly for one hour, and after three months progressed to fortnightly visits until the conclusion of the treatment. In my experience, an individual approach is preferable with anorexia and bulimia sufferers as these clients have often suffered from a lack of bonding in relationships. A trusting, safe environment in therapy helps to redress this imbalance.

There is however, an awareness that the cost of long-term therapy often precludes its choice by many sufferers. A new programme of brief therapy, therefore, is being adopted by the author in line with previous research by Barabasz (1990). This approach involves an initial two-hour session, which emphasises person-centered interviewing techniques, to build maximum rapport, and hypnosis is introduced using the induction instructions taken verbatim from the Stanford Hypnotic Clinical Scale (SCHS) of Morgan and Hilgard (1959). Following the induction, post-hypnotic suggestions targeting bulimic behaviours are administered. There is a one-hour follow-up session at

one month, three months, six months, and one year. Barabasz's report (1990) indicates this intervention was effective in two out of the three cases presented. With such a small sample, it is difficult to assess the programme's true success and, therefore, a larger scale study is planned, which, it is hoped, will lead to the identification of a reliably successful, low-cost treatment for clients with eating disorders.

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