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EDITORIAL

With this first edition for what I hope will be a productive year for the *Australian Journal of Clinical and Experimental Hypnosis*, I have an unhappy duty to perform. Dr J. Arthur Jackson has been forced by ill health to retire from the Society and from his position as Associate Editor with the journal. Arthur has been associated with the Society and the journal for many years and the journal, in particular, will miss his contributions and the role he has played as Associate Editor. He also made an outstanding contribution to the first of the anthologies published by the journal, with his chapter detailing the anxiety disorders and their treatment.

This edition includes a special Case Note from Arthur and Dr Lorna Channon-Little, which provides a fitting summary of his approach to hypnosis in therapy. On behalf of the journal and its staff, I wish him all the best for his retirement.

Clinical Update Papers

This year will see the introduction of another new feature to the journal. To increase its interest and usefulness to members, the journal will regularly publish Clinical Update Papers in areas of psychology, psychopathology, and general medicine. Working in clinical practice, it is often difficult to keep abreast of clinical and experimental developments in these fields and the focus of Clinical Updates will be to review current developments in the areas under consideration, to provide a quick summary of new trends and research.

The first of these Clinical Update Papers is published in this number of the journal. This is the article by Greg J. Coman and Barry J. Evans: "Clinical Update on Eating Disorders and Obesity: Implications for Treatment With Hypnosis."

Researchers and clinicians, within and outside the Society, will be asked to write Clinical Update Papers on their areas of expertise over the next twelve months.

Journal Anthology Series

By now you will be aware of and, I hope, will have purchased the first two anthologies in the series currently being published by the journal. Work is under way on the next two anthologies in the series.

By the end of 1995, the journal will have published *Hypnosis in the Treatment of Sexual Dysfunction* and *Hypnosis in the Treatment of Habit Disorders*. Treatment of a range of habit disorders is the major reason for referrals to members of the Society in the various states and sexual dysfunction remains a serious and widespread problem. I hope these two additions to the journal's collection will be of interest and value to you and will be supported in the way the first two anthologies have been.

Special Section: Hypnosis in the Management of Obesity and Eating Disorders

This edition of the journal features a special section devoted to an examination of the role to be played by hypnosis as an adjunct for treatment of obesity and eating disorders. It features three articles specially written for the *Australian Journal of Clinical and Experimental Hypnosis.*

Greg J. Coman and Barry J. Evans provide a review of the current literature on the eating disorders of anorexia nervosa and bulimia. The diagnostic criteria for both in the new *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM IV, 1994) are discussed, together with aetiological views for both disorders. Personality characteristics associated with both disorders are also discussed. The current literature on the epidemiology of obesity is presented and the finding that many of the so-called normal community have disordered eating attitudes and behaviours is reported. The article concludes with some general treatment issues with hypnosis when counselling those interested in weight management.

Elizabeth Georgiou presents an interesting case of anorexia tardive in a 29-year-old woman, successfully treated using a multi-disciplinary approach to therapy, with hypnosis as an adjunct. This case illustrates that anorexia may be successfully treated using hypnosis, despite the reportedly lower hypnotisability of sufferers of anorexia.

In the final article in this special section, Rosalyn Griffiths presents her hypnobehavioural treatment program for bulimia. This is a detailed treatment regime, combining behavioural and hypnotic techniques, which has demonstrated effectiveness for the eating disorder, and which may have implications for therapy in almost all cases of weight counselling.

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CLINICAL UPDATE ON EATING DISORDERS AND OBESITY: IMPLICATIONS FOR TREATMENT WITH HYPNOSIS

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This paper reviews the clinical and research literature on the epidemiology and aetiology of the eating disorders bulimia nervosa and anorexia nervosa and discusses the personality characteristics descriptive of sufferers of these disorders. The evidence suggests that disordered eating attitudes and behaviours are increasingly a characteristic of a far wider proportion of the population than was previously the case and practitioners treating obesity and weight-control clients need to be aware of these social trends. The implications of the research and clinical evidence available on eating disorders and obesity when considering hypnosis as a treatment of choice for these clients are then discussed.

ANOREXIA NERVOSA

Epidemiology and description

DSM-IV (American Psychiatric Association, 1994) reports a frequency of 0.5% to 1.0% for anorexia nervosa. The condition is reported primarily in females, with 85% of sufferers in this category. Onset is generally between the ages of 10 and 25, and the condition rarely develops after age 30. While the formal diagnosis of anorexia may apply to only a small percentage of the population, at the sub-clinical level, the research and clinical evidence would suggest that many adolescents and young women (with a lesser, but increasing, number of males) suffer from distortions of body image and misperceptions of being overweight or obese and indulge in unhealthy eating and dietary practices.

We express our appreciation to Brian Jacka, Diane McGreal, and Susan Hook, Melbourne clinical psychologists, for their contribution to this paper, which was presented at the ASH Queensland Branch Annual Conference, Binna Burra, Queensland, 22–23 October 1994.

Requests for reprints should be sent to Greg J. Coman, Behavioural Medicine Unit, Austin Hospital, Heidelberg, Victoria 3084.

Researchers have argued that the incidence of anorexia has been increasing, with some estimates running as high as 7% of the young female population in an Australian study and over 20% in an American college female study (Garner & Garfinkel, 1985; Touyz & Beaumont, 1985). The challenge for the practitioner is to identify when such attitudes and behaviours exist, understand why they occur in any given individual, and develop an appropriate and effective management program.

The diagnostic criteria for anorexia contained in DSM-IV give the impression of an individual with an intense fear of becoming obese and a determination not to eat, to avoid putting on weight. The person will generally report disturbances of body image, usually claiming to "feel fat" and refusing to maintain a normal body/weight ratio, with no known physical illness to explain the condition. The distinguishing feature in all cases is the patient's determination not to eat, rather than the behaviours that result from the choice not to eat. Sufferers can exhibit bizarre eating habits, show preoccupation with thoughts of food, irritability, depressive episodes, sleep disturbances, and sexual disinterest (Button, 1993).

The prognosis is rather poor, with fewer than 35% eating normally after five years of onset. While the condition itself is not necessarily life-threatening, patients may suffer from a range of physical and psychological problems as a result of the illness (DSM-IV, 1994; Hsu, 1980; Singh & Watson, 1986; Swift, 1982).

The diagnostic criteria in DSM-IV also highlight the two categories of anorexic behaviours, consistently argued for by Russell (1979) and Garner and Garfinkel (1985). The first type of patients are termed "restrictors" — patients who show a determination not to eat and who use strict dieting and exercise to lose weight and to maintain a low height/weight ratio. The second type are termed "binge eating/purging" patients, who binge eat and then purge, using induced vomiting and/or laxatives. This distinction is an important one, as researchers have found different personality characteristics associated with the two types of patients, their eating behaviours are quite different, and treatment considerations may differ.

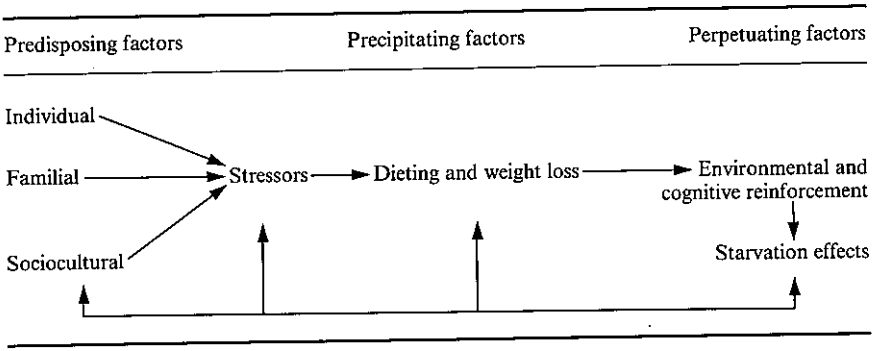
Aetiology

The research and clinical evidence suggests that anorexia develops from multiple causes, with a number of predisposing, precipitating, and perpetuating factors (Garner & Garfinkel, 1985; Singh & Watson, 1986).

Predisposing factors encompass a range of individual and familial issues. Individual factors include such personality characteristics as obsessiveness, need for control, and feelings of personal inadequacy; perceptual-cognitive disturbances; early maturity; and tendency to obesity. Familial factors include parental personality features; parental attitudes; and the family's interaction patterns. The research and clinical evidence strongly suggests that family dysfunctioning is a factor in most cases of anorexia.

Precipitating factors may include interpersonal separation and loss experiences; sexual conflicts; or any event which produces the belief that weight loss is necessary. Dieting and weight loss may then be reinforced by environmental and/or cognitive perpetuating factors. The resulting starvation outcomes have a feedback effect, creating a self-perpetuating cycle. Figure 1 shows how these variables operate in conjunction to produce and maintain anorexic behaviours. A number of frameworks have been suggested in order to explain anorexia nervosa.

Figure 1. Relationship Between Factors in the Aetiology of Anorexia (from Garner & Garfinkel, 1985).



Some theorists have argued that anorexia represents the outcome from a struggle by the individual to gain a sense of identity and respect through perfect control over one's body (Beattie, 1988; Bruch, 1973, 1978; Minuchin, Rosman, & Baker, 1978). This develops largely through inappropriate parenting through the child's developmental stages, compounded by social pressures on the young female to be slim and attractive. Certainly, an important dimension in the aetiology and maintenance of anorexia appears to be the nature of the family setting in which the anorexic subject lives. Researchers and clinicians have stressed the typically enmeshed anorexic family, which is intrusively overconcerned with the anorexic child (Vanderlinden & Vandereycken, 1988, 1989).

Crisp (1980) argued that anorexia is phobic avoidance behaviour, in which the individual fears puberty and avoids biological development and consequent sexual and psychosocial experiences by dramatic weight loss, which provides a false sense of control.

These theoretical positions are not mutually exclusive and the clinical literature demonstrates how these processes may work together in the development and maintenance of anorexic behaviours. In the words of Button (1993), although the precise aetiology of anorexia is unknown, the condition is more likely to develop in adolescent and young females who have poor

self-esteem and ineffective social and interpersonal relationships. These derive from the sufferer's biological and familial experiences and, when the individual's coping mechanisms are challenged in adolescence or adulthood, eating disorder symptomatology develops in an attempt to deal with the situation.

Whatever the aetiology, researchers and clinicians have suggested a number of personality and attitudinal traits that may be symptomatic of anorexia nervosa sufferers, relative to the particular way in which the condition is displayed. These include:

1. A marked degree of distortion of body image and distorted perceptions as to how thin one is, or should be;
2. A high external locus of control;
3. High generalised anxiety, with associated social anxiety and generalised deficits in self-esteem, social skills, and assertiveness;
4. Feelings of ineffectiveness, with subjects feeling they are not autonomous or in control of their lives; and
5. A constant debilitating concern about weight control and determination not to put on weight. This results from the perception that weight control and thinness contribute to the subject's autonomy and personal control.

Those anorexic patients who binge then purge are more extroverted and more likely to be suffering depression, guilt, and anxiety than abstaining anorexics. They are also known to be more highly hypnotisable than abstaining anorexics.

BULIMIA NERVOSA

Epidemiology and Description

DSM-IV (1994) suggests the frequency for bulimia is approximately 1–3%, but studies suggest that the figure may be far higher, as many individuals binge and purge in secrecy. Researchers have suggested prevalence rates of around 6% in female high school students, and ranges of 4% to 23%, depending on the population being studied (Button, 1993; Touyz & Beaumont, 1985).

Bulimia is an eating disorder characterised by uncontrolled, recurrent episodes of binge eating followed by self-induced vomiting or purging. Typically, sufferers are female, aged over 15 years, with the majority in their twenties. Most are within their weight range or are slightly overweight for their age and height. The frequency of binge eating by sufferers may vary from many times each day to once every other week, followed by episodes of purging. The most common means of purging is vomiting, followed by ingestion of laxatives and use of diuretics. Most sufferers frequently report becoming depressed soon after their bingeing episodes and generally have a personal awareness that their eating patterns are abnormal. It is estimated that up to 7 out of every 10 bulimics experience depressive symptoms so severe as to be classifiable as suffering from an affective disorder.

The general description of a bulimic person is that of a perfectionistic personality, obsessively concerned with food and body proportions and excessively preoccupied with pleasing others, who:

1. Suffers from some degree of distorted body image.
2. Shows high levels of immaturity, both in their understanding of self and in their relationships with others. In treatment, they will often show a reluctance or inability to talk about their feelings and perceptions of themselves and others, usually because of feelings of shame and self-criticism. Many are said to be alexythymic, that is, unable to articulate their feelings about self and their interpersonal relationships.
3. Shows the traits of impulsivity and displays a tendency to seek immediate gratification of needs, rather than being able to control their behaviour.
4. May be separated from their internal emotional and cognitive experiences, so that a major therapeutic aim in treatment will be to help them become aware of and integrate their experiences.

Aetiology

There is still little consensus as to the aetiology of bulimia. Some researchers have argued that the condition is an addictive disorder, with food being used for tension release, while the individual purges to avoid the problems associated with obesity (Johnson & Larson, 1982). Adopting a more psychophysiological perspective, some researchers consider the condition to be a combination of psychological disorder (overeating) and physical disorder (hypothalamic). The sufferer rejects her "healthy" weight, which leads to a reduced food intake and consequent loss of weight. Binge eating is a hypothalamic response to the individual's suboptimal weight (Russell, 1979).

DSM-IV makes the observation that anorexia and bulimia are apparently related disorders, typically beginning in adolescence or early adult life. In anorexia, there is severe weight loss, but in bulimia the weight fluctuations are rarely so extreme as to be life-threatening. There are clinically significant differences between bulimic and anorexic patients, in terms of biological and psychological profiles and their prognostic implications. At the same time, we know that approximately 57% of patients over the course of their illness display both bulimic and anorexic symptomatology (Russell, 1979).

OBESITY

Obesity is a major problem in the Australian community. According to the National Heart Foundation's recent risk-factor prevalence study (Hetzel & McMichael, 1989), 17.5% of females aged between 20 and 24 are overweight or obese and 25% of males in the same age range are similarly overweight or obese. By age 39, 35% of females and 42% of males are overweight or obese. By age 69, 56.9% of females and 60% of males are overweight or

obese. Obesity is a causal factor in the onset and maintenance of many illnesses, including diabetes, hypertension, pulmonary respiratory diseases, gall bladder disease, and heart conditions.

Although not classified as an eating disorder by DSM-IV, the obese client shares many of the personality characteristics identified in eating disordered patients, particularly feelings of body dissatisfaction, preoccupation with weight, and distorted body image (Button, 1993; Garner, Olmstead, & Polivy, 1983).

Virtually all the clinical research has focused on the personality characteristics of obese women, comparing these to so-called "normal" college females. The research suggests that obese subjects have lower self-esteem than normal subjects and have greater body dissatisfaction and drive for thinness than normal subjects. Their scores on measures of body dissatisfaction and perceptions of self suggest they see themselves in the same negative light as do bulimic and anorexic patient groups, but not to the same extent.

Although the data reported in the literature are not consistent, it appears that locus of control may discriminate categories of eating disordered and obese subjects. Overweight and obese subjects who have demonstrated successful weight management reportedly have a higher internal locus of control than obese subjects who have not been effective in their weight management. Although the causality is not clear, it may be that subjects who have been able to lose weight or maintain a dietary regime see themselves as more in effective control than subjects who have not been successful or who, having a higher external locus of control, do not attempt to lose weight, believing it is beyond their control.

Studies have also found that bingeing behaviour is often associated with obesity, with at least one study finding that almost half the female subjects in a weight-control program reported bingeing behaviour during the program. The incidence of bingeing behaviours among obese subjects has been widely reported in the clinical literature (Button, 1993; DSM-IV, 1994; Garner et al., 1983; Russell, 1979).

Much of the recent literature on eating disorders and obesity reflects a disturbing trend in the incidence of distorted body image and obsessions about weight and weight control in the so-called normal population. Some of these research findings are distressing. Studies of college females have found that over 10% are pathologically weight preoccupied; many skip meals and have a reduced caloric intake; and that, while over 26% perceive themselves to be overweight, less than 5% actually are obese. Numerous studies have suggested that eating disorder symptomatology, weight preoccupation, and body dissatisfaction within school and college students appears to be increasing, to the extent that some researchers have argued that these preoccupations and distortions should be considered normative. The impact of these findings for the practitioner is clear — the likelihood is that the majority of clients who present for weight-management counselling or disordered eating attitudes and/or behaviours will be likely to have significant body dissatisfaction; a

distorted picture of themselves, relative to their "true" height to weight ratio; and misperceptions regarding the most appropriate and effective means of weight management.

DISSOCIATION IN BULIMIA, BINGE/PURGING ANOREXIA, AND OBESITY

Research has generally demonstrated that bulimic clients score significantly more highly on measures of hypnotisability than do restrictor anorexics and control subjects. Studies have also shown that higher hypnotisability may also be a characteristic of individuals in the general population who are preoccupied with dieting and obesity concerns. Theorists have argued that dysfunctional eating behaviours such as binge eating may be related to trance-like states and that the experience of binge eating may be akin to being in a dissociative state (Groth-Marnat & Schumaker, 1990; Torem, 1986, 1987). Bulimics often describe themselves as becoming someone else when bingeing and they report feeling dissociated from their affective and cognitive internal experiences. Moshe Torem (1986, 1987) argued that patients with bulimic eating patterns or with excessive concerns about eating behaviours have at least one dissociated ego state or part of their personality split off from consciousness. This dysfunctional eating ego state functions at cross-purposes from the rest of the individual's personality, causing intrapersonal conflict which the individual attempts to control by binge eating.

What explains the higher hypnotisability of bulimic patients, anorexics who binge then purge, and normal females with a weight preoccupation, compared with the supposedly low hypnotisability of restrictor anorexic subjects? David Spiegel's recently articulated approach to understanding the factors in hypnotisability may provide some clues. Spiegel (1986) has argued that an individual's level of hypnotisability reflects that individual's attentional capacity, suggestibility, and ability to dissociate. Suggestibility is a measure of the individual's psychological responsiveness to input, while dissociative capacity is a function of the individual's biological make-up.

Lower hypnotisability is reflected in low dissociative capacity, low suggestibility, and the individual's inability or unwillingness to focus their attention on the therapist's input. On the other hand, higher hypnotisability is reflected in high suggestibility, high dissociative capacity, and the ability and willingness on the part of the client to focus attention.

In bulimia, in the bingeing behaviour of anorexics, and in the eating preoccupation of so-called normal subjects, their higher hypnotisability reflects their capacity for becoming absorbed in the focal experience of overeating and purging as a means of meeting the needs of the dissociated bulimic ego state. Spiegel (1986) has argued that dissociative capacity is used as a means of defence and coping by individuals, in this case, to help the eating disordered individual regain a sense of control over feelings of inadequacy and helplessness.

Unfortunately, for many sufferers, the disordered eating is followed by feelings of shame and depression, contributing to even greater feelings of loss of control and ineffectiveness.

Spiegel's model may also explain why anorexics who abstain are reportedly typically low on measures of hypnotisability. Given the importance of control in the anorexic's lifestyle, they may lack the motivation to focus closely on the therapist's input or actively resist the therapist's suggestions, fearing loss of control if they do attend. As their anorexic behaviour pattern develops, sufferers typically show attentional and cognitive deficits associated with their weight loss and nutritional deficiencies. They may then lack the ability to attend to the therapist and their suggestions. This viewpoint is not inconsistent with that suggested by Pettinati, Horne, and Staats (1985), who empirically supported the hypothesis that bingeing anorexics, who manifest the dissociative-like bulimic behaviour in common with those classified as bulimics, would be more hypnotisable than restricting anorexics. They concluded that eating to excess, then purging, and the ability to go into trance may involve the same dissociative mechanisms. The restricting anorexic does not utilise this dissociative technique for dealing with the world and resists any direct suggestions for trance from the therapist.

The capacity of eating disordered clients to enter the trance state will clearly have implications for treatment using hypnosis.

IMPLICATIONS FOR TREATMENT WITH HYPNOSIS

Obesity and Weight Management

A range of cognitive and behavioural techniques to help clients manage their weight problems are described in the literature and a full description is not possible in this paper. In general terms, researchers and clinicians describe the following approach to weight counselling:

1. Collect data on the eating problem and possible contributing factors (over-eating, lack of exercise; where and when eating occurs; inadequate nutrition; lifestyle issues). Many clinicians ask the client to maintain an eating diary, to identify eating problems or the triggers which cause eating problems.
2. Provide information about nutrition, exercise, and the probability of relapse. Help the client prepare for relapses, using hypnotic projection and giving suggestions in trance.
3. Help the client set realistic weight-loss goals. A healthy and realistic figure is between 500 g and 1 kg per week.
4. Help the client identify antecedents to eating (availability of food; social pressures; relief from bad feelings or depression) and consequences (intrinsic reward of the food; temporary relief from bad feelings). Work to change antecedents and consequences which contribute to eating problems.
5. Help the client identify stimulus control difficulties and teach new strategies for control. For example, the client should eat only in one room;

not associate activities with eating (e.g., watching TV); and shop from a list, rather than impulse buying. Similarly, help the client identify and modify response control problems. For example, control the act of eating by chewing food a set number of times; or putting utensils down for a specified time between mouthfuls.

6. Help the client identify and restructure their faulty cognitions related to eating and weight management. Typically, these relate to the probability of weight loss; ability to lose weight; setting and achieving realistic goals; controlling obtrusive food thoughts; and making excuses for lack of action.

Hypnosis works effectively for each of these therapy goals, being used by the practitioner to enhance the efficacy of cognitive and behavioural techniques.

Eating Disordered Clients

Clinicians have long pointed out that many eating disordered clients are resistant to therapy, deny the nature of their eating problem, and have highly developed skills for maintaining their sense of so-called control. It is therefore necessary to develop an eclectic approach to treatment, selecting from a range of techniques those which may be appropriate for individual patients (Button, 1993; Coman, 1992; Vanderlinden & Vandereycken, 1990; Wooley & Kearney-Cooke, 1986). These writers have suggested that behavioural and cognitive-behavioural techniques appear to be relatively effective with bulimia sufferers, but clinical outcomes for anorexia sufferers are generally poor irrespective of the therapy.

Given the probable high hypnotisability of most eating-disorder patients and the fact that extreme weight control behaviours may be similar to hypnotic-like behaviours, it seems that hypnosis as an adjunct to other therapeutic techniques should be most appropriate. Such a view has many proponents in the research and clinical literature (Coman, 1992; Griffiths, 1989; Groth-Marnat & Schumaker, 1990; Holgate, 1984; Pettinati, 1986; Pettinati, Kogan, Margolis, Shrier, & Wade, 1989; Yapko, 1986). The hypothesised "dissociated ego state" (Torem, 1986, 1987) responsible for many of clients' disordered eating attitudes and behaviours can be accessed in hypnosis to reveal the source of the pathology. This aids the understanding of both the therapist and, more importantly, the subject, helping both to appreciate the reasons behind the binge/purge behaviours, the body-image distortion, and phobias related to food and eating. With this understanding the therapist can use the controlled trance state to help the client change faulty cognitions and emotions to restructure thinking (Torem, 1986). Hypnosis may also be used to help the client develop more appropriate feelings of control, with specific suggestions for mastery and control, even when previously obtrusive and uncontrolled thoughts about food or eating occur.

At all levels of therapy, the clinician can use hypnosis to help the subject change perceptions and cognitions related to their body image, to create positive imagery, and to help the subject visualise becoming stronger over time and,

thus, develop control over eating behaviours (Coman, 1992). All cognitive and behavioural techniques for weight management, stimulus response, and stimulus control have increased efficacy when used in conjunction with hypnotic techniques for ego-strengthening, imagery, systematic desensitisation, and cognitive restructuring (Coman, 1992; Griffiths, 1989; Groth-Marnat & Schumaker, 1990; Holgate, 1984; Vanderlinden & Vandereycken, 1990; Yapko, 1986).

The suggestion from clinicians in this field of practice is that, for many disordered eating clients, indirect and permissive suggestions for trance are far more effective than more direct methods of induction and trancework (Coman, 1992). These permissive methods enhance, rather than cut across, clients' need for control. This aspect to treatment is discussed more fully in Coman (1992), which provides a review of the literature dealing with the use of hypnosis as an adjunct in the treatment of bulimia.

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HYPNOTHERAPY IN THE TREATMENT OF ANOREXIA TARDIVE

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This case study involves the treatment of a 29-year-old female diagnosed with anorexia tardive, that is, delayed-onset anorexia nervosa. She displayed purging anorexic symptomatology and was referred by her GP as psychiatric management had proven unsuccessful. She was successfully treated, using a multidisciplinary approach to therapy, with hypnosis as an adjunct. The case demonstrates that hypnosis may be successfully used in treatment of this disorder.

PRESENTING PROBLEM

Debbie was a 29-year-old legal secretary with a three-year-old son, referred by her GP for "counselling" for her disordered eating behaviour. The referral note stated that "she appears to be coming to terms with the problem." Debbie had been referred by him for psychiatric assessment and management five months earlier, but she had terminated contact after four sessions, claiming lack of rapport, and at her lowest weight of 38 kg.

She dated the onset of her disordered eating from cessation of breast feeding of her son. At that time her weight was approximately 60 kg. During her twenties, Debbie's weight had fluctuated between 58 and 65 kg, and periodic, apparently appropriate, dietary restriction was utilised regularly. No previous history of eating-disordered behaviour was reported. Debbie's food intake had become progressively more restrictive and ritualised and, in addition, she was exercising for half an hour twice per day. In response to my probing, Debbie also admitted to self-induced vomiting, up to twice daily, but denied use of purgatives. Vomiting was preceded by out-of-control "nibbling" rather then a full-scale binge, during which she claimed to be "in a daze" and unable to remember what she had eaten, suggestive of a dissociative state. Feelings of tension and depersonalisation, as well as bloating and abdominal pain, were relieved by vomiting, following which feelings of calmness and relaxation were reported. She had been amenorrhoeal for approximately two years.

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HISTORY

Debbie is the youngest of three children. Her brother is a consultant civil engineer, who is reportedly aloof from other family members. Debbie is close to her sister, whom she feels has become a highly successful mother (six children), following her recovery from drug addiction and Moonie cult membership. Debbie recalls her parents' marriage as being stable and happy and her own experiences within the nuclear and extended family, who live next door, as secure. Her father, whom she revered, died suddenly when she was 16. At that time, there seems to have been an absence of appropriate grieving, or communication among siblings and her mother, who evidenced a tendency to "get on with things as though nothing had happened." Debbie's grandmother had died giving birth to Debbie's mother and this became an issue later in therapy.

Debbie is close to, but ambivalent towards her mother. She reported feelings of inadequacy and worthlessness in her attempts to emulate the high standards of domestic role performance of her mother.

Debbie developed severe asthma at the age of four, apparently precluding her attendance at preschool. She evidenced separation anxiety at commencement of primary school and spent lengthy periods in the following years at home in bed, being attended by her mother and plied with "special little nibbles" (her words). She associated these memories with feelings of being "special" and loved.

From the age of 13 years her asthma was deemed sufficiently severe to complete her studies by correspondence. She completed Year 11, did a year's business college studies, and became a junior legal secretary, which she enjoyed. The asthma progressively remitted and she now requires medication relatively rarely.

It is tempting to speculate upon the mother's investment in keeping her youngest child bound to her. Certainly, developmental deficits have resulted, notably lack of opportunity to develop appropriate social skills in relation to peer contacts outside the extended family and to achieve self-individuation. At the time she commenced sessions with me, she was visiting her mother's home daily.

Debbie had been married for six years to a second-generation Maltese man. Both had no previous history of emotional involvements or sexual relationships prior to marriage. The husband evidences a significant level of anxiety and obsessionality. He has a highly developed need for control, which in conjunction with Debbie's lack of assertiveness and feelings of inadequacy, form the basis for chronic discord within the marriage. They lived with her mother until late in Debbie's pregnancy.

The couple's only child was born severely distressed and took some time to revive. The husband was reported to have been so badly affected that he decided summarily to have no further children and had a vasectomy shortly thereafter. Debbie signed the forms at the time, but now expresses great difficulty in coming to terms with her perceived loss of future pregnancies.

She bonded well with her son, but expressed consistent self-doubt as to whether she was a "good mother," especially since she had returned to work part-time while her mother looked after him. Both her mother and husband contributed to Debbie's intense feelings of conflict by giving mixed messages to the effect that while it was necessary financially to work, it was a "shame" that she was not able or prepared to be a full-time mother.

The aim of a detailed history-taking was to identify the multiple factors contributing to the onset of the disorder at this particular age and stage in the life cycle, compared with the more typical adolescent onset.

The seeds of its development lie in Debbie's failure to resolve developmental and other conflicts, and to develop autonomy and self-individuation within her family of origin. This in turn influenced her choice of a husband, whose personality essentially mirrored her own (controlled, anxious, depressive, dependent). Having separated from her mother physically only just prior to the baby's birth, and experiencing this as a source of anxiety, Debbie hoped that the birth would cement the marital relationship and allow her to experience the closeness she craved.

Becoming a mother, though highly desired, aroused feelings of inadequacy, which were partially compensated for by success in breast feeding. When this ceased, feelings of aloneness, dissatisfaction, and anger with the marriage surfaced. Her perceived loss of control in the decision about having more children and thus having further opportunities to get the "good mother" aspect of her identity right became acute.

Debbie's low self-esteem was intensified by her husband's anxiety in relation to management of the child and her mother's covert criticism of her role performance and personal adequacy.

It seems, then, that Debbie, with her inability to tolerate the conflicting emotions generated, chose this maladaptive solution to the threat of losing control of her emotions. Restrictive food intake allowed Debbie to salvage an illusion of personal control and self-esteem. As a by-product, the prepubertal shape and amenorrhoea created a more personally acceptable, though largely unconscious, reason for her inability to become pregnant.

ASSESSMENT

The first two sessions were spent building up a detailed history and obtaining baseline data on Debbie's currently disordered eating behaviours. She was asked to keep a record of food consumed, content of binges, timing of vomiting episodes, as well as her recollections of emotions experienced, and antecedent events. She was given a detailed questionnaire, which I use with all clients, to take home and complete.

In the third session, objective assessment of depression, anxiety, and psychological components of the eating disorder was undertaken as an adjunct to clinical impressions.

The IPAT Anxiety Scale placed Debbie on the 77th percentile on norms for a non-clinical female population; that is, only 13% of such a population would be considered to exhibit a greater degree of anxiety (Krug, Scheir, & Cattell, 1976).

Depression was assessed by the Beck Depression Inventory (1987), on which Debbie scored 19, with an interpretation of "borderline clinical depression." In view of the clinical indicators of depression obtained in the history, it seems surprising that she did not fall into at least the moderately to severe range on an objective measure. However, physiological concomitants of prolonged starvation per se may have accounted for the reported changes in sleep patterns, activity, and shift of interest away from previously enjoyed activities to food-related issues.

The Eating Disorder Inventory (Garner & Olmsted, 1984), with subscales tapping psychological and behavioural traits common in anorexia and bulimia, yielded useful idiosyncratic information on which to base aspects of the treatment plan. For example, Debbie's scores on Body Dissatisfaction and Perfectionism were lower than those of typical anorexics, confirming clinical impressions that her appraisal of body image was more congruent with reality than the typical anorexic. However, her score on Interoceptive Awareness was elevated beyond the upper level of the range for anorexics, confirming her marked inability to recognise and accurately identify emotions and visceral sensations. Her score on the Ineffectiveness scale was similarly elevated, indicating negative self-evaluation and feelings of being out of control. Her high score on Maturity Fears was suggestive of the critical importance of the separation difficulties inherent in Debbie's clinical picture. Debbie's symptoms fulfilled all of the DSMIII-R's (American Psychiatric Association, 1987) diagnostic criteria for anorexia nervosa.

It became evident by the third session that hypnosis could be a useful adjunctive technique in all phases of the treatment strategy. This was put to Debbie, and explained in detail with an emphasis upon the control by the subject rather than the therapist. Her refusal to accept medication would also indicate a need to internalise control. Debbie appeared well motivated, partly, I think, because her brother-in-law had experienced successful hypnotherapy.

In the fourth session, the Stanford Hypnotic Clinical Scale (Morgan & Hilgard, 1979) was administered, with Debbie proving to be highly hypnotisable, scoring a 4, plus partial response for post-hypnotic suggestion. Her subjective report and her observed responses during administration of the SHCS suggest that visual imagery, dissociation, regression, and post-hypnotic suggestion could be utilised appropriately in therapy.

GOALS OF THERAPY AND TREATMENT PLAN

The goals of therapy with Debbie involved addressing both the symptom behaviours and the underlying psychological issues contributing to the development and maintenance of her condition.

While acknowledging the appropriate nature of the underlying goal of her behaviour, (i.e., to be in charge of her life and to feel competent) I aimed to use the therapeutic alliance to develop with her more constructive and effective behavioural alternatives. The fact that Debbie sought therapy of her own volition and appeared overtly well motivated meant that she implicitly acknowledged that what had been a solution to her difficulties initially had now become a problem in itself (Gross, 1984).

I aimed to use her strengths (motivation, rapport, and her hypnotic responsivity) in teaching specific coping skills to deal with stress in her everyday living, and to enhance mastery and control over her feelings and symptom behaviours. Once a greater sense of effectiveness had been established, the underlying chronic unresolved issues could be tackled, specifically utilising hypnotherapeutic strategies.

The treatment plan had to be flexible and multifocused, with scope to be re-evaluated and redirected in response to Debbie's progress and wishes, given her highly developed need for control. For example, at the outset a multidisciplinary approach to her treatment was recommended, but characteristically, she made the choices. She agreed to continue to see the dietitian and her GP periodically, but refused marital therapy, group therapy, or a psychiatric second opinion. I contracted with her that we would continue on this basis provided she gained weight and decreased her vomiting and that her depression did not become more severe, in which case prompt psychiatric referral would ensue.

The initial aim of the treatment plan was weight restoration and reduction of vomiting. Consensus exists among clinicians that cognitive and perceptual distortions due to starvation effects render any of the insight-oriented psychotherapeutic approaches useless, until this has been achieved.

Methods to achieve this initial aim included an education program, behavioural techniques (record-keeping, stimulus control techniques) and hypnosis (both hetero- and self-) for relaxation and tension reduction, ego-enhancement and desensitisation of anxiety towards food and weight.

As weight was gained, appraisal-focused coping and cognitive restructuring techniques were to be introduced to supplement coping deficits and to restructure her attitudes. Hypnosis would be used to potentiate these techniques and also to enhance self-esteem and ability to use more effectively the skills and personal resources she already possessed.

Distortions in perception of internal sensations would be addressed in hypnosis, utilising her considerable ability to dissociate, in order to shift her perceptions closer to reality, as well as increasing her awareness of bodily sensations. By demonstrating her hypnotic ability and its effectiveness in achieving control on both behavioural and emotional levels, it was hoped that increased mastery and positive expectations for behavioural success would be reinforced.

Once a shift towards normality was observed in eating and purging behaviours and associated bodily perceptions, the core issues of her marital problems,

separation difficulties from her mother, and the secondary gain issues involved in maintenance of the illness could be tackled.

Hypnosis was envisaged as being relevant to all phases of treatment as well as giving Debbie lifelong skills to master stress which could predispose her to a recurrence of the symptomatology, as well as to enhance the quality of her life generally.

OUTLINE OF SESSIONS

As therapy has involved sessions on a more or less regular basis for an extended period, this case description outlines major phases of treatment with selected examples of hypnotherapeutic interventions, rather than providing a session by session account.

By the fourth session, an agreement to slowly gain weight (not more than 1 kg per week) by increasing quantities and content of food, was reached. Debbie agreed to continue record-keeping between sessions.

In all sessions, hypnosis was induced using a permissive eye-fixation technique, with progressive relaxation. Debbie chose to use imagery associated with a cruise she had undertaken in the Whitsundays some years previously. The deepening technique involved seeing the shoreline slowly float by as I counted from 10 to 1. She was asked to pay attention to the rhythm of her breathing and feel the tension floating away with each exhalation. Guided imagery was used in a number of ways; as a method of relaxation and reduction of anxiety and to introduce greater awareness of body sensations. Vivid recall of feeling hungry was suggested with suggestions of lightness and emptiness, which was paired with eating a small but delicious meal in a slow, relaxed manner. Debbie was asked to focus on her stomach feeling comfortably full, satisfied, and relaxed. Suggestions of "being in tune" with her body and watching and listening to "her body clock" were given.

Direct suggestions for increased food intake and increased appetite in the future were given, with instructions to recall the bodily sensations and level of comfort she had just experienced. Ego-enhancing suggestions were incorporated, emphasising internal strengths and resources. At the end of the session self-hypnosis was taught, and Debbie was asked to practise daily. This and all subsequent sessions were taped for Debbie to use at home.

In the following sessions stimulus control techniques were rehearsed in hypnosis to reduce the frequency of bingeing and vomiting. After inducing and deepening the trance state, Debbie imagined herself in a situation of high-risk exposure (in her kitchen, putting away the shopping with multiple demands on her time being made by husband and son) but saw herself being able to exert self-control. The non-food reinforcer for self-control was positive images of feeling proud and relaxed about her control as she left the scene. Additional ego-strengthening suggestions were given emphasising personal power and control. Eating was to be limited to one environmental situation, food was

to be eaten slowly with enjoyment, and she was to recall feelings of comfort and satiation as a signal to stop eating.

Interoceptive awareness was focused upon in hypnosis by use of techniques outlined by Gross (1984). With typical rigidity, Debbie associated the attainment of the hypnotic state with an eye-fixation induction technique which became the standard. This structured induction was actually very appropriate in order to modulate the tendency towards dissociation, which would have been amplified by a more naturalistic induction. The image of lying on the sand on a beautiful day was suggested. Dissociation was enhanced in a controlled way through suggestions of pleasantly increased skin temperature and the smell and sounds of the rhythm of the sea. Her attention was directed inwards to the beating of her heart and the rhythm of her breathing, with suggestions of decreased sympathetic nervous system activity. The rhythm of the waves was likened to her own body rhythms, governing sleeping/waking, eating/excreting, heartbeat, peristalsis, with the cycle of activation or relaxation. I included specific awareness of hunger/satiation and full bowels/empty bowels. As Debbie had evidenced dissociation of body, and body-related experiences, this imagery was aimed at re-establishing a sense of connection between the mind and the body which was interrupted by anxiety. Debbie reported that this was meaningful to her and played this tape continuously regularly over the next weeks.

A relaxation-based desensitisation approach was implemented to help Debbie reduce her phobic anxiety about weight and food. Earlier suggestions in hypnosis of eating small amounts of nutritious foods while feeling relaxed and satisfied were incorporated into a hierarchy whereby she could ultimately see herself choosing a normal-sized meal in a restaurant without feelings of intense anxiety and being out of control. The positive feelings of comfort and self-control were emphasised, as was the linking suggestion that she could trust herself to be "in tune" with her internal sensations and stop when she'd had enough. In vivo exposure was requested and Debbie reported over two weeks that she had been able to manage an entree in a restaurant. She reported "needing" to use self-hypnosis to counter feelings of anxiety following consumption of food. The desire to vomit, although present, was successfully resisted, and her coping strategies were reviewed and reinforced in hypnosis at the following session, to enhance self-esteem.

Reframing through metaphor to counter perfectionism and resulting loss of self-esteem was used at this point. Although bingeing and purging has decreased and she had gained 3 kg, by the eighth session, Debbie expressed she was "hopeless," as progress had not been more rapid, and she still periodically had the urge to binge and vomit. In hypnosis, in the context of reinforcing her success, the notion of redefining perfectionism as negative was introduced to move her in the direction of tolerating, and in fact appreciating, the humanness of her shortcomings.

As was noted earlier, Debbie's body-image distortion was not as marked as the typical anorexic, however, she drew herself as a stick-like figure with a beach ball abdomen and pads at the sides of her hips.

Clinicians have warned of addressing body-image issues too early in therapy. By session 12, when she had gained 5.5 kg, she was asked to compare the instamatic photographs taken at that session with those of the first session. She judged that the change was positive and agreed that, at 42 kg, she was as emaciated as the figures in a photograph of Third World starvation which she was shown.

On this occasion hypnosis was induced and deepened by suggestions of going down a flight of 10 steps. A system of ideomotor signalling was established, and Debbie was asked to visualise three TV monitors. Control was emphasised by her imagining herself with remote controls, and able to stop at any time. On the left-hand screen she was asked to project an image of herself as she was at 42 kg. She was asked to describe what she saw, and how she felt inside. She indicated "full and bloated." On the middle screen she projected an image of herself at the present time, stating that she looked bigger and healthier but did not feel so fat. However, she was worried that she might gain too much weight. Reinforcement of her knowledge of coping techniques and ego-enhancing suggestions were given to reduce her anxiety level.

On the third screen she projected an image of herself as she would "like herself to be." In suggesting hypnotic age-progression in this way, the aim was to allow her to experience herself as healthy and normal and to be able to reframe her anorexia and bulimia as a stage which had been outgrown. She could conceptualise what personal changes were needed to allow this to occur. Debbie saw herself as 54 kg, with a flat stomach, and no loose skin. She stated she felt more energetic and healthy, and "able to stop wasting her life." She was then instructed to touch the various parts of her body, especially arms, hips, and stomach, and to concentrate upon perceptions of body warmth and smoothness as she restructured cognitively their size.

At the end of 13 sessions the goal of weight restoration appeared to have been achieved. She had stabilised at 48 kg, but was still amenorrhoeal. "Nibbling" and vomiting occurred on the weekends when she was home with her husband. Debbie was aware of the significance of this, and the next sessions were spent in working with her feelings about the marital relationship. She acknowledged feeling depressed when she considered the future and feared that change was not possible in the relationship. Feelings of entrapment were evident, as was a fear of independence. Her husband declined to attend sessions, and both refused my suggestion of referral for marital counselling.

At this point assertive techniques were taught and reinforced in hypnosis. Behavioural rehearsal was effective, and she was able to identify her feelings of anger and frustration rather than to experience lack of control in the relationship as a desire to binge and purge. Anger management strategies within a rational-emotive framework were taught out of hypnosis, and reinforced in hypnosis.

The therapeutic approach now focused on social-skill acquisition, and to move her social contacts beyond the immediate family and work. She was

encouraged to join any kind of social group (having refused support group or group therapy), and she choose a church discussion group. Social skills were taught and reinforced via behavioural rehearsal in hypnosis. Feelings of confidence, competence, and personal social attractiveness were enhanced.

One of Erikson's metaphors was adapted to facilitate Debbie's awareness of the necessity of constant change and growth in personal development, and to emphasise that ambivalence in experiencing transition need not block personal growth entirely. In asking her to consider that "each step forward means leaving something behind" she was encouraged to deal with her feelings of loss and vulnerability in coming to terms with maturity.

During this session she abreacted her grief experienced at her father's death. Out of hypnosis Debbie expressed her sense of loss and rage that she had been sick at the time and had been made to stay in bed by her mother and not allowed to attend the funeral. She spontaneously remarked that she was becoming aware that she was extroverted and had a sense of humour like her father, and expressed regret that his death came "just when I was getting to know him."

In the next session hypnosis was used specifically to allow Debbie to restructure her experience of her father's death, allowing her a feeling of control while working through hitherto unexpressed feelings, in the form of an imagined leave-taking ritual.

The induction technique was the typical eye-fixation and deepening imagery involved walking through the corridors of her mind, searching for the door behind which each of these particular memories lay. Instructions were structured but minimal to modulate dissociation. She was given the option of amnesia and whether she wished to discuss her experience out of hypnosis. She reported feeling very satisfied and "peaceful," having said goodbye to her father and exercised control in selection of hymns and attendance at the funeral. I suggested to her in the waking state that she may care to employ this restructuring technique to any other significant problem in her life.

One year into therapy, her sister became pregnant for the sixth time, which became the catalyst for Debbie developing some insight into the basic dynamics of her eating problems. Over the next sessions, age regression in hypnosis was employed, using Powlett's (unpublished) version of the Lift Technique, where one can use a barrier to retreat from affect and prevent flooding (if the subject chooses). Ideomotor finger signalling was established, and Debbie was asked to see the floor numbers on a panel corresponding to her age in years, and asked to stop at any level which was meaningful to her in the development of her problems. She created a glass-walled lift, but allowed herself to go beyond it. Several experiences were revivified with this technique. She saw herself at around five years of age, experiencing feelings of rivalry towards her sister, whom she perceived as bigger, prettier, and more skilled than herself. She saw herself as "stupid and weak," and abreacted feelings of frustration and rage. She also revivified an experience when she was 10

years old, when her sister had come home with an award for academic achievement. Debbie resented her parents' diversion of attention to her sister, and said, "I think my chest is getting worse, mummy will have to get the doctor."

Out of trance she was able to perceive the secondary gain in her adoption of the sick role and also the insight that her present "sickness" may be an inappropriate way of meeting her needs to be "special" and maintaining her closeness to her mother.

Using Bandler's reframing model (Miller, 1986) in hypnosis, she was able to generate several new alternative behaviours which she was required to trial over the next two weeks. One involved eating "normally" at her mother's house, and not talking about food with her mother.

Thirteen months after her initial consultation she was 50 kg and reported two periods of 3–5 weeks without vomiting. She was now working four days a week and feeling competent in her new job (cf. her initial two half days). She was relaxed about her son's child-care arrangements and general development. The need to see her mother daily for support had reduced and she attended only on the days that the mother looked after the boy. She stated she was feeling hopeful about the future and could reduce her sessions to monthly.

Fourteen months into her therapy, after a month's holiday with her husband, she confessed to having started vomiting more frequently again. Her weight had dropped to 47 kg. She reported her husband was increasingly anxious and depressed and would probably accept psychiatric referral. This was arranged through the GP, but he only attended two sessions, after which he obtained a more congenial job. This appeared to lift his depression in the short term. Weekly sessions were reinstituted with Debbie and the earlier goals and techniques of therapy reintroduced. Debbie regained her weight and curtailed her vomiting to weekends within a month. Marital therapy was again suggested and rejected.

In the last six months she has attended monthly. Her weight increased to 52 kg and she had vomited twice in the preceding four weeks, always after a weekend with her husband.

CONCLUDING COMMENT

Hypnosis as an adjunctive technique has been extremely useful in the management of this case.

Behaviours and attitudes germane to the eating disorder itself, particularly body image and interoceptive awareness, have been modified considerably by utilising the client's hypnotic talent. It is worth noting again the client's deep-trance capacity which gave her an expanded range of hypnotic skills and abilities which would not be available to someone with a lesser degree of hypnotisability.

The ability to enhance control of dissociation has been learned effectively, thus permitting increased awareness of the antecedents and consequences of

the disordered eating behaviour. The client's capacity for vivid imagery in the trance state has allowed her to create for herself, both in therapy and self-hypnosis, the possibility for more appropriately adaptive behaviour. She has developed the ability to move beyond the family by being able to initiate appropriate social relationships. The acquisition of social and assertive skills as well as development of confidence to utilise these skills in vivo have been potentiated considerably by the use of hypnotic techniques.

Hypnotic regression has enabled her to resolve the issue of chronic mourning of her father, and to obtain insights into some dynamics relevant to development of the eating disorder.

Therapeutic progress has been further potentiated by enhancing rapport in the client/therapist relationship. Probably the most important long-term outcome of this rapport and the use of hypnosis per se has been to reinforce the concept of personal control. The therapist has attempted to guide this in a positive direction with some success in minimising resistance issues. However, on the other side of the coin, the emphasis on client control has meant that the critical issues of addressing the marital relationship and the inability to have more children within that relationship have not, as yet, been permitted. These client-imposed restraints have been respected and therapy has been redefined within the parameters set by the client.

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