

**HYPNOSIS FOR
WEIGHT MANAGEMENT
AND
EATING DISORDERS**

Editors

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CONTENTS

PART ONE: INTRODUCTION

1. Psychological issues in weight management 1
Greg J. Coman and Barry J. Evans
2. Eating attitudes and behaviours in the normal population 20
Nicole Lefkowitz and Barry J. Evans

PART TWO: OBESITY AND WEIGHT MANAGEMENT COUNSELLING

- Introduction 39
Barry J. Evans
3. Psychotherapy and hypnotherapy in the treatment of obesity . . 43
Fiona K. Judd and Graham D. Burrows
 4. Treatment issues in weight management counselling 62
Susan Hook
 5. Psychotherapy and hypnotherapy for overweight and
obesity counselling 78
Diane J. McGreal
 6. Weight management: A cognitive behavioural approach,
utilising hypnosis as a treatment strategy 84
Brian T. Jacka
 7. Hypnotic treatment of obesity in a general practice 104
Scott Inglis
 8. Hypnosis in a self-control behaviour modification
programme for weight reduction 114
Lorna D. Channon-Little

PART THREE: BULIMIA NERVOSA

- Introduction 121
Barry J. Evans
9. The nature and aetiology of bulimia nervosa 125
Rosalyn A. Griffiths

10. Hypnosis an an adjunct in the treatment of bulimia nervosa . .	164
<i>Rosalyn A. Griffiths</i>	
11. Hypnosis in the treatment of bulimia nervosa:	
A review of the literature	179
<i>Greg J. Coman</i>	
12. Some similarities between disordered drinking and eating	
patterns: Case illustrations and implications for treatment . . .	198
<i>Lorna D. Channon-Little</i>	
13. Hypnosis in the treatment of bulimia nervosa:	
A case study	203
<i>Rosalyn A. Griffiths</i>	
14. Hypnobehavioural treatment for bulimia nervosa:	
A treatment manual	212
<i>Rosalyn A. Griffiths</i>	
15. The use of hypnotherapy in the treatment of	
eating disorders	229
<i>Delia Young</i>	
16. Group therapy and hypnosis for the treatment of	
bulimia nervosa	236
<i>Marcia Degun-Mather</i>	

PART FOUR: ANOREXIA NERVOSA

Introduction	243
<i>Barry J. Evans</i>	
17. The nature and aetiology of anorexia nervosa	245
<i>Nola Rushford</i>	
18. Management of anorexia nervosa	273
<i>Nola Rushford</i>	
19. Hypnotic and strategic interventions in the treatment of	
anorexia nervosa	306
<i>Michael D. Yapko</i>	
20. Hypnotherapy in the treatment of anorexia tardive	319
<i>Elizabeth H. Georgiou</i>	

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CHAPTER ONE

Psychological Issues in Weight Management

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This introductory chapter reviews the clinical and research literature on the epidemiology of obesity in the community. It discusses the criteria for being overweight or obese and measurement techniques for determining the extent to which clients may be overweight or obese. The factors which affect weight management are discussed, with particular attention given to the role of social and psychological factors in weight preoccupation and weight management.

Obesity is a major health and social problem in most western countries and this applies in the Australian context. Data from a number of epidemiological studies show clearly the extent of obesity and demonstrate clearly the effect of age on weight problems. In Britain, for example, the proportion of the population classified as overweight or obese rises from 24% in the 20-24 age group to 52% in the 55-64 age group (Wardle, 1989). In the United States, 32% of 20-24 year-olds and 61% of 55-64 year-olds are overweight or obese (Millar & Stephens, 1987). Similar statistics have been reported in Australia. The National Heart Foundation's risk-factor prevalence study found that 17.5% of 20-24 year-old females 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, 57% of females and 60% of males are overweight or obese (Hetzel & McMichael, 1987).

Hetzel and McMichael (1987) also noted the prevalence of weight problems in the community has consistently increased since the start of large-scale data collection in 1918 and, since the 1960s alone, there has been an increase of between two and three kilograms in the average weight of both men and women, without any gain in height.

Being overweight or obese is a demonstrated causal factor in the onset and maintenance of many illnesses, including cardiac problems, diabetes, hypertension, pulmonary respiratory diseases, and gall bladder disease. The risk of premature mortality is greater for

individuals who are overweight or obese, even those who are up to 10% overweight. The likelihood of premature mortality rises significantly when the individual is more than 20% above optimum weight for sex, age, and height (Hetzl & McMichael, 1987). While such associations between body status and mortality and morbidity are clear, the therapist needs to bear in mind that, for any given individual, the health risks of being overweight must be considered in the light of gender, age, and motivation for becoming thinner. For example, weight problems or obesity is a far more significant concern in an adolescent or young adult than in a middle-aged person (Donatelle, Davis, & Hoover, 1988). Epidemiologically, weight problems are more serious for a male's health status than for a female's health status (Donatelle, et al., 1988; Kannel & Gordon, 1979), although both male and female clients may be equally concerned to maintain appropriate weight levels. Wardle (1989) commented that the motivation of an individual to lose weight is also very important, in that extreme weight control measures may be a more serious health problem than the obesity itself, particularly in relation to dietary control for adolescents and children. These factors need to be considered by the therapist when counselling for weight management.

DEFINING BEING OVERWEIGHT OR OBESE

The terms *being overweight* or *obese* refer to different physical states. Unfortunately, many people use the terms synonymously, thus creating confusion. For this reason, the clinical and research literature on weight management and eating disorders is difficult to evaluate, because different studies use different weight/height criteria and many researchers have failed to report their criteria. In her review of many weight studies, Lefkowitz (1994) reported a range of inclusion criteria. Several studies used the figure of 20% or more above ideal body weight according to the Metropolitan Life Insurance Company (1983) as their criteria (Davis, Wheeler, & Willy, 1987; Rosen, Murkofsky, Steckler, & Skolnick, 1989), whereas Mills (1991, 1992) used the criterion of being at least 50 pounds above ideal weight. Other researchers have used other criteria: at least 120% above average weight (Hood, Moore, & Garner, 1982); 20% greater than expected weight for height and age (Held & Snow, 1972); 15% above average weight (Garner & Garfinkel, 1979); 15% over desirable weight according to the Metropolitan Life Insurance Tables (Gormanous & Lowe, 1975); a tricep skinfold measure of at least 28mm (Chavez &

Michaels, 1980); between 10% and 80% overweight according to a national standard of obesity (Jeffrey, 1974); weights above the 75th percentile, according to age, sex and height-adjusted norms (Mizes, 1988); and above 10% of average weight for the individual's age and height (Kinsey, 1983). Practitioners may be excused their confusion when trying to evaluate such research and plan strategies for clients in therapy.

Table 1. Height and weight tables for males and females in metric and imperial measurements (adapted from the 1983 Metropolitan Life Insurance Company figures)

Height cms (feet, inches)	Weight in kilograms (pounds) in indoor clothing		
	Small frame	Medium Frame	Large Frame
Male			
157 cm (5' 2")	57-60 (128-134)	59-63 (131-141)	62-67 (138-150)
160 cm (5' 3")	58-61 (130-136)	60-64 (133-143)	63-69 (140-153)
163 cm (5' 4")	59-62 (132-138)	61-65 (135-145)	64-72 (142-156)
165 cm (5' 5")	60-63 (134-140)	62-67 (137-148)	65-72 (144-160)
168 cm (5' 6")	61-64 (136-142)	64-68 (139-151)	66-74 (146-164)
170 cm (5' 7")	62-65 (138-145)	64-69 (142-154)	67-76 (149-168)
173 cm (5' 8")	63-67 (140-148)	65-71 (145-157)	68-77 (152-172)
175 cm (5' 9")	64-68 (142-151)	67-72 (148-160)	70-79 (155-176)
178 cm (5' 10")	65-69 (144-154)	68-73 (151-163)	71-81 (158-180)
180 cm (5' 11")	66-71 (146-157)	69-76 (154-166)	72-83 (161-184)
183 cm (6' 0")	67-72 (149-160)	71-76 (157-170)	74-85 (164-188)
185 cm (6' 1")	68-74 (152-164)	72-78 (160-174)	76-86 (168-192)
188 cm (6' 2")	70-76 (155-168)	74-82 (164-178)	77-89 (172-197)
190 cm (6' 3")	71-77 (158-172)	75-82 (167-182)	79-91 (176-202)
193 cm (6' 4")	73-79 (162-176)	77-84 (171-184)	81-93 (181-207)
Female			
147 cm (4' 10")	46-50 (102-111)	49-54 (109-121)	53-59 (118-131)
150 cm (4' 11")	46-51 (103-113)	50-55 (111-123)	54-60 (120-134)
152 cm (5' 0")	47-52 (104-115)	51-57 (113-126)	55-62 (122-137)
155 cm (5' 1")	48-53 (106-118)	52-58 (115-129)	56-63 (125-140)
157 cm (5' 2")	49-54 (108-121)	53-59 (118-132)	58-64 (128-143)
160 cm (5' 3")	50-56 (111-124)	54-61 (121-135)	59-66 (131-147)
163 cm (5' 4")	51-57 (114-127)	56-62 (124-138)	60-68 (134-151)
165 cm (5' 5")	53-58 (117-130)	57-63 (127-141)	62-70 (137-155)
168 cm (5' 6")	54-60 (120-133)	58-65 (130-144)	63-72 (140-159)
170 cm (5' 7")	55-61 (123-136)	60-66 (133-147)	64-73 (143-163)
173 cm (5' 8")	57-63 (126-139)	61-68 (136-150)	66-75 (146-167)
175 cm (5' 9")	58-64 (129-142)	63-82 (139-153)	67-76 (149-170)
178 cm (5' 10")	59-65 (132-145)	64-70 (142-156)	68-78 (152-173)
180 cm (5' 11")	61-67 (135-148)	65-72 (145-159)	70-79 (155-176)
183 cm (6' 0")	62-68 (138-151)	67-73 (148-162)	71-81 (158-179)

4 Greg Coman and Barry Evans

The term *being overweight* refers to the presence in the body of excess body weight, including both lean and fat tissue. The term *obese* refers specifically to the presence of excess body fat stored within the body (Hetzl & McMichael, 1987; Morris & King, 1986; Wardle, 1989). Because fatness is distributed across the population, definitions of appropriate weight can become rather arbitrary. For the purpose of this anthology, the criteria for being overweight or obese will be related to standard tables for ideal weight based upon sex and height (Metropolitan Life Insurance Company, 1983) and the Body Mass Index (BMI) (Florey, 1970).

DETERMINING THE "RIGHT" WEIGHT

The Metropolitan Life Insurance Company in the United States originally developed its tables of ideal weight for height ratios, based upon its insurance records, in 1959. These were subsequently updated in 1983. Table 1 shows ideal weights (for ages 25-29), in indoor clothing weighing approximately two kilograms for males and one kilogram for females.

Generally speaking, if a person's weight is 15-20% above ideal weight as indicated by the table, then the person is classified as obese (Donatelle, et al., 1988).

The second common method for determining ideal body weight is the Body Mass Index (BMI), calculated by dividing the person's weight in kilograms by the square of their height in metres (Florey, 1970). A BMI of 20-25 is generally considered normal, 25-30 is considered overweight, 30-39 obese, and above 40 extremely obese (Coish, 1988; Lefkovitz, 1994; Wardle, 1989).

However, weight alone is not a good indicator of overweight or obesity. What is important is the *amount of fat* the body contains. Researchers agree that the male body should contain between 11-15% total body fat and the female body should have between 18-22% total body fat. A certain level of body fat is vital for body insulation and cushioning between body parts. For males, the level of body fat should not fall below 4% and the level in females should not fall below 8% (Donatelle, et al., 1988).

Assessment of ideal body weight for any client should take into account the individual's sex, age, height, percentage of body fat, length of time the person has been at the current weight, and previous weight history.

FACTORS AFFECTING WEIGHT MANAGEMENT

A number of genetic, physiological, psychological, and social factors play a role in weight management. This section provides a brief description of physiological and genetic factors in weight control, while greater attention will be given to the analysis of psychological and social factors affecting clients' ability and motivation to maintain appropriate weight levels.

Genetic Factors

A number of studies have suggested that one's genetic endowment contributes to weight management problems (Borjeson, 1976; Rona & Chinn, 1982; Stunkard, Thorkild, & Sorensen, 1986) but the evidence for asserting that heritability is a risk factor for weight management in all cases is not strong (Wardle, 1989). Certainly, one's genetic makeup will affect body size, but other physiological mechanisms and environmental factors play a much greater role in determining weight characteristics (Payne & Hahn, 1986; Rona & Chinn, 1982). Treatment for weight management should include an assessment of the client's beliefs regarding the aetiology of their problem. Should the client believe the problem results from their genetic endowment, then the therapist must challenge this belief, as it will impede the client from attempting to change their eating preoccupations and behaviours. As Morris and King noted, the "excuse" that "everyone in the client's family has a weight problem — it's in their genes" can be challenged with the counter-argument: "that just makes it harder (to lose weight), not impossible" (1986, p. 57).

Set Point Theory

The term *set point* describes the theory that there may be physiological mechanisms to ensure against weight loss in any individual but no such mechanisms against weight gain (Keeseey, 1980). Most individuals show consistency in weight over time, despite the great variability between individuals in weight. While the available evidence does suggest there are physiological processes which help maintain a minimum weight, there appears to be no convincing evidence to suggest physiological processes operate to maintain an upper boundary on weight gain (Morris & King, 1986; Wardle, 1989). Again, the argument from a client that they may be "fighting a battle with biology that never relents" (Brownell, 1982, p. 822) should be challenged by the therapist.

Fat Cell Theory

Another physiological interpretation of obesity that clients may use to attribute their problem to processes outside their control is known as the fat cell theory (Brownell, 1982). This approach suggests that weight gain may result from an increase in fat cells and/or enlargement of fat cells, caused, some researchers argue, by inappropriate feeding habits in childhood and adolescence. The individual is then burdened with this increased or enlarged number of fat cells throughout life, making weight management a problem. The available evidence does not support this view. Studies have confirmed that individuals with weight problems early in life are able to lose as much weight as easily as those who experience such problems later in life (Jeffrey & Katz, 1977; Morris & King, 1986).

The Body's Metabolism

There is now consistent and unequivocal evidence to show that the body's metabolism, and how it is used by the individual, is a primary determinant of weight management (Donatelle, et al., 1988; Morris & King, 1986; Payne & Hahn, 1986; Wardle, 1989). Body metabolism affects the individual's weight in several ways, including the effect on weight of the body's heat and fat production, resting metabolic rate, energy expenditure, and food intake. It is not necessary to discuss these in detail here, but the conclusions reached by Morris and King (1986) in their review of the data make pertinent reading for the therapist counselling the overweight:

1. Many diets exacerbate the problem of overweight or obesity by causing hyperlipogenesis and may also lower metabolic rate, reducing weight loss. Hyperlipogenesis describes the process in which the body speeds up the production of fatty acids. This occurs when clients have infrequent meals as part of a dietary regime and when they cease the diet. Hyperlipogenesis is often the cause of weight gain after a period of dieting and may also explain why weight loss after repeated dieting is often difficult to achieve.
2. The positive effects of exercise may be currently understated. As well as using up kilojoules and toning muscles, increased metabolic rate in exercise may cause increased thermogenesis, which increases weight loss.
3. The body's resting metabolic rate (RMR) is affected by diurnal rhythms, as well as sex, age, total body mass, overeating, and exercise (together with other factors). Therapeutically, the client

can use the effect of diurnal rhythms by eating at times when the resting metabolic rate is rising and restricting eating when the RMR is reducing. The therapeutic implication lies in the fact that breakfast should be eaten, when it is the meal most often missed by the diet conscious.

4. Given that eating causes the resting metabolic rate to rise, thus using up kilojoules and increasing thermogenesis, eating smaller meals regularly during the day is the most therapeutic eating pattern (Morris & King, 1986, p. 53).

SOCIAL PROCESSES IN WEIGHT MANAGEMENT

Individuals within society are subject to numerous social and cultural influences. The evidence suggests many in our community, particularly women and the young, are subject to influences which militate against appropriate attitudes towards eating, dieting, and proper weight management. Much of the research and clinical literature reports data for women, so that much of what we report here enables us to draw conclusions about female clients only. Clinical experience would suggest, however, that similar assumptions and conclusions can be made about male clients.

Culture appears to play a part in the acquisition and development of eating concerns and weight preoccupation, particularly within western societies. Few differences have been found between Australian, American and British females' eating attitudes and average weight distributions (Kenny & Adams, 1994). In these societies, late adolescence seems the highest risk period for weight preoccupation and eating disorder development (Fairburn & Cooper, 1984; Polivy & Herman, 1985). Within these Western cultures, there is considerable pressure to be thin. At the same time, for many individuals, there is a discrepancy between their actual weight and that which they perceive as their ideal (Kenny & Adams, 1994). Women tend to report dissatisfaction with their physiques, which they believe do not correspond with socially ideal fashion models (Gleitman, 1986). This social and personal ideal of slenderness is far more predominant in Western societies than in other cultures (Gleitman, 1986; Kenny & Adams, 1994).

Socio-economic status was thought to be a major influence on the prevalence and development of obesity and eating disorders. Researchers have discussed the greater likelihood of lower class women being obese, in contrast with the higher prevalence of anorexia

nervosa in the upper social classes (Garner, Garfinkel, Schwartz, & Thompson, 1980; Wardle, 1989). However, a number of studies have reported that weight preoccupation and eating disorders are evenly distributed across the different social classes (Gowers & McMahon, 1989; Toro, Castro, Garcia, Perez, & Cuesta, 1989). The therapist needs to carefully assess the client's socio-economic background and dietary history to assess the impact of these on weight management potential and problems.

The media appears to be an influence contributing to concerns with weight (Bruch, 1978; Garner, et al., 1980; Gleitman, 1986). Because of the role models used in advertising and films, pressure has been exerted, particularly on women, to maintain a slim physique for feminine beauty (Garner, Garfinkel, & Olmsted, 1983; Silverstein & Perdue, 1988; Fallon & Rozin, 1985). The current fashion for thinness is exemplified in a review of Playboy centrefolds and Miss America Pageant winners, carried out by Garner, et al., (1980). The models' average weights decreased over the twenty-year period considered, despite improved nutrition and an average weight increase for women during this time (Hetzl & McMichael, 1987). Articles about dieting in popular women's magazines also increased in the twenty-year period surveyed. The same researchers argued that greater pressure is placed on women than on men to diet and become or remain slim. In a study of ten widely read magazines, 10.5 times as many weight loss advertisements and articles appeared in women's than in men's magazines (Anderson & DiDomenico, 1992).

Research and clinical evidence suggests that women are far more weight preoccupied than men. More women suffer from eating disorders than men (Anderson & DiDomenico, 1992; Fallon & Rozin, 1985; Williams & Manaster, 1990). Numerous other studies have found that females experience greater body dissatisfaction than males (Adams, Katz, Beauchamp, & Cohen, 1993), greater drive for thinness than males (Harris, Waschull, & Walters, 1990), or both of these characteristics (Gupta, Schork, & Dhaliwal, 1993).

Many women's ideal female figure which they believe to be most attractive to men, is actually much thinner than the ideal figure nominated by men as the most attractive (Fallon & Rozin, 1985). This perception, coupled with the current fashion for thinness and importance of physical attractiveness in relation to self-esteem, is believed to be a major contributor to women's heightened incidence of weight preoccupation and concerns about being overweight (Davis &

Cowles, 1989). Their drive for thinness motivates most of the exercise behaviours of women, with most female subjects reporting trying to lose weight for social and aesthetic reasons (Wardle, 1989). This compares with the reason given by males for exercise, that is for physical fitness (McDonald & Thompson, 1992; Silberstein, Striegel-Moore, Timko, & Rodin, 1988).

Inability to control weight creates additional social and personal problems for people. Much research and anecdotal clinical evidence has confirmed the negative stereotyping of the overweight and obese. Overweight children and adults can expect to be teased, treated as less intelligent, told they are not suitable for certain jobs, and not socially acceptable (Davis, et al., 1987; Wardle, 1989).

In summary, weight preoccupation and eating problems are predominant among females, with late adolescence being a high risk period for development. Cultural and social influences contribute to weight concerns and preoccupations, and help determine what is subjectively, the ideal, attractive figure. Social pressures appear to contribute to weight preoccupation and desire for slenderness, possibly resulting in the development of obesity, eating disorders, obsession with thinness, and involvement with dieting.

Social demands affect different individuals in different ways, so that not all members of a culture or social group will react with the same eating preoccupations and behaviours. We turn now to examine the personality variables which may impact on individuals' eating behaviours.

PSYCHOLOGICAL FACTORS IN WEIGHT MANAGEMENT

Being overweight or obese are not classified as eating disorders by DSM-IV (American Psychiatric Association [APA], 1994). However, the obese person may share many of the personality characteristics seen in eating disordered clients. The most important of these are their feelings of dissatisfaction with their body, preoccupation with weight, distorted body image, and feelings of lack of control.

Body Dissatisfaction

Studies on body dissatisfaction have confirmed that individuals displaying weight control problems and eating disorders are more dissatisfied with their body size, shape and weight, compared with normal weight, non-patient females (Bunnell, Cooper, Hertz, &

Shenker, 1992; Garner, Garner, & VanEgeren, 1992; Hsu & Sobkiewicz, 1991). In an interesting study, Garner, et al., (1992) compared anorexics and non-patient college females, finding that while both groups reported similar levels of body dissatisfaction, the anorexic patients were approximately 30% thinner than the normal controls. This suggests that many eating disordered clients will not only be significantly dissatisfied with their body, they will generally have a significantly distorted body image.

Drive for Thinness

Body dissatisfaction and drive for thinness are related, in that women who are dissatisfied with their bodies usually desire to be thinner. Groth-Marnat and Schumaker (1990) mentioned the cultural fashion to "be thin," and Silverstein and Perdue (1988) discussed the desire for slimness as being associated with attractiveness, professional success, and intelligence. Clearly, the social demands placed upon women are in the direction of a thinner physique and thus, weight dissatisfied women will often perceive that they are too heavy (Silverstein & Perdue, 1988; Toro, et al., 1989).

While few studies have investigated obese females' drive for thinness, it has been suggested obese individuals do have a higher drive for thinness than normal control subjects (Garner, et al., 1983). A high drive for thinness has been closely associated with eating disorders in general (Beren & Chrisler, 1990) and has been reported in cases of anorexia (Rezek & Leary, 1991) and bulimia (Gross, Rosen, Leitenberg, & Willmuth, 1986).

Feelings of Personal Adequacy

Another common characteristic found in eating disordered and obese women is their sense of personal and social ineffectiveness (Brice, 1981; Casper, 1990; Williams, Power, Millar, Freeman, Yellowlees, et al., 1993). Ineffectiveness is described as a sense of low self-esteem, negative self-worth, lack of assertiveness, poor self-image, and shyness. Bruch (1973) defined ineffectiveness in terms of general inadequacy, lack of control, emptiness, insecurity, and worthlessness.

Studies have specifically noted this personal inadequacy in obese individuals (Davis, et al., 1987), bulimics (Rosch, Crowther, & Graham, 1991), and in anorexics (Kenny & Adams, 1994). It has also been reported that subjects with disordered eating thoughts and behaviours

are less assertive than both dieting and normal control subjects (Williams, Chamove, & Millar, 1990). The researchers suggested disordered eating subjects display a behavioural inability to counter the control and pressure exerted by others, despite being aware of its presence (Williams, et al., 1990).

Locus of Control

An internal control orientation can be described as the belief that experiences, events, and reinforcements are contingent upon one's own behaviours. An external orientation of control is the perception that events are determined by powerful others, or factors of chance or fate, and thus, are not personally determined (Levenson, 1981).

The research literature on the control orientation of obese subjects is inconsistent. Several studies suggest obese women display a high external orientation (Brice, 1981; Dunn & Ondercin, 1981), whereas others have not confirmed this (Gormanous & Lowe, 1975; Mills, 1991). In this range of studies the criterion for obesity is not always specified, and the weight ranges for the female subjects may vary, making it difficult to compare these results.

Studies on the control orientation of eating disordered women have also produced different findings. Many have suggested that bulimic and other eating disordered women have an external orientation of control, compared with obese dieters, non-obese dieters and normal controls (Williams & Manaster, 1990; Williams, et al., 1993), but this finding has been contradicted by other studies. For example, Garner, Garfinkel, Stancer, and Moldofsky (1976) reported no differences between obese, anorexic, and normal weight subjects and other researchers have failed to find a significant relationship between locus of control and eating disorders. Clearly, the control orientation of eating disordered individuals varies across studies and the outcome from any specific study depends on the subjects' age and weight.

Despite the confusion in the research literature, recent studies have suggested that obese females more often have an external orientation (Davis, et al., 1987; Mills, 1992). They attribute their weight problem to factors beyond their control and claim that environmental cues are operative in conditioning their feelings of hunger (Davis, et al., 1987).

Perceptions regarding locus of control appear to be related to weight management. Studies of individuals involved in weight loss programmes have found that weight loss is better achieved and maintained in obese individuals with an internal control orientation

(Kincey, 1983; Mills, 1991). These individuals are also more successful in maintaining their weight loss after completion of the programme (Jeffrey, 1974). It has been suggested that internally oriented individuals are more likely to lose weight because they attribute the responsibility and control to themselves. They are more likely than externals to actively seek information and believe that their behaviour and consequences are under personal control. Those with an external orientation feel less in control because they perceive that outside forces are responsible for their behaviour (Davis, et al., 1987; Mills, 1991).

Studies of Overweight and Normal Females

Obese and normal females have been compared in relation to their drive for thinness, body dissatisfaction, and ineffectiveness. The research has consistently found that obese individuals have lower self-esteem than normal subjects (Davis, et al., 1987; Morris & King, 1986). Obese subjects have greater body dissatisfaction (Garner, et al., 1983; Maude, Wertheim, Paxton, Gibbons, & Szmuckler, 1993) and drive for thinness (Garner, et al., 1983) than normal control subjects.

Bingeing behaviours have been reported in up to 46% of cases of obesity (Garner, et al., 1983; Marcus & Wing, 1987), with many obese individuals binge eating to the extent that a bulimia nervosa diagnosis may be warranted (Hudson, Pope, Wurtman, Yurgelan-Todd, Mark, et al., 1988). Similar bingeing behaviours to those of bulimic and some obese females has been reported by normal women (Button, 1993; Garner, et al., 1983). Halmi, Falk, and Schwartz (1981) found that 13% of their population of "normal" college females experienced a range of bulimic symptoms and up to 10% engaged in purging behaviours. In Chapter Two, Nicole Lefkovitz and Barry Evans report a study which suggests that so-called "normal" college female subjects could not be distinguished from a mildly obese group, and that scores of both groups on body dissatisfaction and other indices of disordered eating thoughts were consistent with those of eating disordered groups.

The impact of these studies for the therapist is clear. There is a significant likelihood that many clients presenting for weight management counselling will have a distorted body image, dissatisfaction with their weight, shape, and body image, and misperceptions regarding the most effective means of weight management.

Disordered eating attitudes and behaviours stem from the social pressures exerted on individuals who are subject to beliefs and

perceptions related to body image, body satisfaction, and personal ability to manage an ideal weight. This range of variables must be considered by the therapist when developing treatment programmes for weight management and eating disorder symptomatology. Another factor to be considered in counselling for weight management and eating disorders is the apparent ability of some clients to show strong dissociative capacity.

DISSOCIATION IN BULIMIA, BINGE/PURGING ANOREXIA, AND OBESITY

Research has generally demonstrated that bulimic clients score significantly higher on measures of hypnotisability than do restrictor anorexics and control subjects. Studies have also shown that higher hypnotisability is 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). Bulimia sufferers often describe themselves as becoming "someone else" when bingeing and they report feeling dissociated from their affective and cognitive internal experiences. 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 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? Spiegel's approach to understanding the factors in hypnotisability may provide some clues. Spiegel (1986) 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.

The bingeing behaviour of bulimia sufferers, bingeing anorexics, and the eating preoccupation of normal subjects reflects their capacity for becoming absorbed in the focal experience of overeating and purging, as a means of meeting the needs of the dissociated ego state. Spiegel (1986) argued dissociative capacity is used as a means of defence and coping by individuals, in this case, to help the eating disordered individual regain a (false) sense of control, when feeling inadequate and helpless. 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 hypnotic 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.

Given the probable hypnotisability of many obese and eating disordered clients and the fact that extreme weight control behaviours may be similar to an hypnotic-like state, hypnosis is often a valuable adjunct to treatment (Griffiths, 1989; Vanderlinden & Vandereycken, 1990 and see the chapters by Greg Coman and Michael Yapko which follow). The client's dissociated ego state can be effectively accessed using hypnosis, to help both therapist and client understand the

aetiological and perpetuating factors causing the behaviour. In this way, the dissociated state can be re-integrated into the client's ego. Hypnosis can also be used to help the client develop control over eating behaviour, using specific suggestions for mastery, even when previously obtrusive and uncontrolled thoughts about food or eating recur. At each stage of therapy, the therapist can use hypnosis to help the client change their perceptions and cognitions relating to body image, feelings of self-worth, and control over eating behaviour. Of course, all techniques for weight management, stimulus and response control, and cognitive and behavioural control are more efficacious when used in conjunction with hypnosis. Specific applications are discussed in the remaining chapters of this anthology.

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CHAPTER TWO

Eating Attitudes in the General Community

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Eating disordered individuals typically manifest the personality characteristics of body dissatisfaction, drive for thinness, bulimic behaviours, and feelings of personal inadequacy. These same characteristics are descriptive of many obese individuals. The study reported in this chapter attempted to clarify whether mildly obese females also show similar characteristics. The study also sought to determine whether a group of college females were an appropriate control with which to compare the mildly obese group. The results suggested that so-called normal college females appear to share some of the attitudes of clients suffering eating disorders.

The study described in this chapter was carried out as the research component of an Honours Psychology course completed by the first author. The aim was to examine personality differences between mildly obese female subjects and a group of female college students, who acted as the control group. What we found, however, was that many so-called “normal” subjects may share body image distortion and dissatisfaction with self, characteristics previously associated with eating disordered clients. The importance of this finding for therapists working with obese and weight-preoccupied clients is addressed in this chapter.

The research and clinical literature available on sufferers of eating disorders shows these clients generally have a marked distortion of body image, preoccupation with their body image, concerns about dieting, and a fear of being fat (Beren & Chrisler, 1990; Reiser, 1988; Williams, Power, Millar, Freeman, Yellowlees, et al., 1993). Researchers have also found that many obese women display these personality characteristics (Garner, Olmsted, & Polivy, 1983; Maude, Wertheim, Paxton, Gibbons, & Szmukler, 1993). In this study, we sought to determine if female subjects who were mildly obese (that is, with a Body Mass Index (BMI) between 25 and 30) would also report feelings

of body dissatisfaction, preoccupation with thinness, and the personality characteristics generally present in cases of more extreme weight or eating disorders.

To assess the validity of using female college students as a control group who would be expected to have so-called "normal" attitudes to eating and no weight preoccupation, we utilised a second "control" group of matched females from the Victorian Institute of Sport and Victorian State Netball Team.

Over the last three decades, many therapists and researchers have reported an increase in women's body dissatisfaction, drive for thinness, and weight preoccupation (Garner, Garfinkel, Schwartz, & Thompson, 1980; Groth-Marnat & Schumaker, 1990; Klemchuk, Hutchinson, & Frank, 1990; Lamb, Jackson, Cassiday, & Priest, 1993). Although the studies reported herein have not directly compared control groups with obese populations, there is evidence to suggest an increase of disturbed eating behaviour in so-called "normal" populations.

For example, in their study of "normal" college females, Klesges, Mizes, and Klesges (1987) found 52% of subjects skipped meals and 71% regularly restricted their caloric intake. Klemchuk, et al., (1990), in a study of college females, found that 10.1% of their subjects could be classified as pathologically weight preoccupied. Also using college females, Toro, Castro, Garcia, Perez, and Cuesta (1989), found that, while only 0.9% of their subjects were actually obese, 26% perceived themselves as obese. In a survey conducted by "Glamour Magazine" in 1984, 75% of female respondents indicated that they felt "too fat," and in a review of past literature, Kenny and Adams (1994) reported between 70% and 80% of females aged between 12 and 27 years desired weight loss and many had previously dieted. These studies suggest there is a large, but unacknowledged group of "normal" females, who indulge in unhealthy dieting behaviours and who hold disturbed body image and weight concerns.

This apparently widespread food and weight preoccupation within the so-called "normal" female population, led Halmi, Falk, and Schwartz (1981) to suggest disordered eating attitudes and behaviours should now be regarded as normal. The weight preoccupation, unhealthy dieting behaviours and disturbed body image, characteristic of eating disordered and obese females, seem to apply to many so-called "normal" subjects.

DEFINING "NORMALITY" IN OBESITY AND EATING DISORDERS

Obese and eating disordered females are usually compared with so-called "normal" controls. A control subject or sample provides a "standard of comparison for checking inferences deduced from experiment[ation]" (Concise Oxford Dictionary, 1982). In most studies, the normal controls are usually female college students, matched with the eating disordered subjects on such criteria as age, weight, height, and history of eating disorders.

Given the widespread body dissatisfaction and weight preoccupation of many women in the community, normal females may actually be inappropriate control samples. As indicated above, studies have found the frequency of eating disorder symptomatology, weight preoccupation and body dissatisfaction within school and college student females (Groth-Marnat & Schumaker, 1990), and amongst girls within a normal weight range, to be increasing (Hsu & Sobkiewicz, 1991; Klemchuk, et al., 1990; Rosen, Gross, & Vara, 1987). Significant body dissatisfaction has been reported among non eating disordered adolescents, most of whom were not overweight (Bunnell, Cooper, Hertz, & Shenker, 1992; Cooper & Fairburn, 1983; Wardle & Beales, 1986). Similar findings for females in general have also been reported (Connor-Greene, 1988; Drownowski & Yee, 1987). Thus, these groups may not provide an appropriate non-clinical control sample against which to compare mildly obese subjects.

In this study, college females were chosen as a sample against which to compare the mildly obese group. In order to assess their appropriateness as a normal sample, their scores on the personality measures used in the study were compared with a group of matched controls. This control group comprised members of Victorian Institute of Sport and Victorian State Netball Team. The netball group was matched with the normal group for age, sex and Body Mass Index (that is, a normal range between 20 and 25). Researchers argue that women exercise chiefly for weight control, whereas men exercise for physical fitness (McDonald & Thompson, 1992; Silberstein, Striegel-Moore, Timko, & Rodin, 1988). However, given that the control group of netballers were a Victorian state team and, thus at an extremely advanced level, it was argued that they would be more motivated to exercise for athleticism and competition, not only weight control (Davis & Cowles, 1989).

Our three groups of subjects were compared on the personality characteristics of body dissatisfaction, drive for thinness, bulimic behaviours, personal adequacy (ineffectiveness) (as measured using the Eating Disorder Inventory (Garner, 1991), and control orientation. External control orientation was assessed by the Powerful Others and Chance scales of the Levenson's Locus of Control, as they both tap externality (Levenson, 1973, 1981).

METHOD

Subjects

One hundred and forty-six females voluntarily participated in the study. There were three groups of subjects: mildly obese women, normal weight college females, and netballers. Group One comprised 31 mildly obese females, with a Body Mass Index of 25-30, recruited from Monash University and weight loss clinics. Group Two comprised 93 Monash University students, with a Body Mass Index between 20-25. Group Three consisted of 22 netballers from the Victorian Institute of Sport and Victorian State Netball Team, with a Body Mass Index between 20-25. The uneven sample sizes resulted from difficulties in obtaining larger numbers of netballers and mildly obese females.

All subjects were aged between 18 and 22 years. The inclusion criterion was that subjects' weight could not have fluctuated more than 10% below or above current weight within the six months prior to questionnaire completion. This ensured stable groups and facilitated more meaningful comparisons between the groups.

Materials

Two questionnaires were administered to all subjects: the revised Eating Disorder Inventory (EDI-2)(Garner, 1991), and Levenson's Locus of Control scale (Levenson, 1973).

The Eating Disorder Inventory-2 (Garner, 1991) is a self-report measure of symptomatology associated with eating disorders, particularly anorexic and bulimic attitudes and behaviours. It is used in non-clinical populations to identify individuals who are either at risk of developing eating disorders, or who suffer from sub-clinical eating pathology. The scale consists of 91 items, comprising eleven subscales. An overall EDI score is obtained by summing all scores

across the different subscales: Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, Maturity Fears, Asceticism, Impulse Regulation, and Social Insecurity. Each scale measures a conceptually independent characteristic which can be assessed in light of the knowledge that eating disorders are multicausal and multidimensional.

In the present study, the overall EDI score and four subscales were used in the analysis. The four were Drive for Thinness, Bulimia, Body Dissatisfaction, and Ineffectiveness. These subscales were used because they are specifically concerned with behaviours and attitudes towards eating, weight and shape, and are considered clinically relevant to eating disorders. The remaining subscales were also calculated, to obtain an overall EDI score and to prevent confounding of results through order effects.

The Drive for Thinness subscale consists of seven items and assesses preoccupation with dieting and weight, and fear of weight gain. The Bulimia subscale has seven items measuring subjects' tendency to contemplate and engage in bingeing behaviour. The nine item Body Dissatisfaction subscale measures dissatisfaction with one's overall shape, and specific areas of the body, including stomach, hips, thighs, and buttocks. The Ineffectiveness subscale, consisting of 10 items, measures general feelings of inadequacy, insecurity, worthlessness, and emptiness.

The Eating Disorder Inventory appears to have reasonable reliability and validity. Studies conducted by Garner and Olmsted (1984) and others, have reported coefficients of internal consistency between .80 and .93 for eating disordered individuals on each of the subscales. Other studies have reported consistent test-retest reliability estimates for samples of college women (Garner, 1991; Raciti & Norcross, 1987; Vanderheyden, Fekken, & Boland, 1988). The scale also appears to have adequate validity in both the original validation studies (Garner, et al., 1983) and subsequent research (Garner, 1991). Content, criterion, convergent, and discriminant validity have all been demonstrated for the different subscales. In the original validation studies, significant differences were found between eating disordered individuals and college females. It is considered to be a valid and reliable scale for eating disordered females, and is now widely used for assessing normal females' attitudes and behaviours (Rosen, Silberg, & Gross, 1988). The EDI was considered the appropriate scale for the present