

AUTOHYPNOSIS, HYPNOTIC
ANAESTHESIAS, HYPNOID
STATES, HIDDEN EGO STATES,
DEPERSONALIZATION AND
OTHER DISSOCIATIVE
PHENOMENA UNDERLYING
ANOREXIA AND BULIMIA
CASE STUDIES: METHODS
OF TREATMENT

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ABSTRACT

This paper reflects years of clinical experience with a group of patients with diagnosed eating disorders. Three cases are described in which a connection is made between their eating behaviors and dissociation. The primary emphasis is on the phenomena of dissociation, including autohypnosis (self-hypnosis), hypnotic anaesthesias, hypnoidal states, ego states, and depersonalization as an operational component of anorexia nervosa, bulimia nervosa, and purging symptomatology. The primary focus of this anecdotal study is on the unconscious misuse of autohypnosis, hypnotic anaesthesias, and dissociation, which seems to be the predominant constituent behind the onset of these eating anomalies. The usefulness of this observation can be an essential precursor in the determination of an appropriate treatment strategy which incorporates autohypnosis into the overall therapeutic process. By virtue of years of unrecognized applications of dissociation, autohypnosis, and hypnotic anaesthesias, these three cases illustrate the likelihood that individuals suffering from anorexia nervosa and bulimia nervosa could reverse their aberrant eating behaviors by using positive autohypnotic suggestions. In the case of anorexic patients who believe that the only thing they are able to control is their eating, the decision to use autohypnosis over classical hypnosis makes more sense. This does not force the patients to suffer the subjective experience of relinquishing control to other persons.

INTRODUCTION

Despite numerous advances in the understanding of eating disorders, their etiologies remain unclear (Torem, 1990). As dissociation and the dissociative disorders are increasingly understood, links between those phenomena and the eating disorders have appeared worth exploring.

In the past decade, there have been a number of reports

and scientific investigations indicating a connection between spontaneous self-hypnosis and multiple personalities (Bliss, 1984; Kluft, 1982; Putnam, 1989; Braun, 1980). Similar correlations have, as well, been made between hypnoidal states and multiple personalities (Dickes, 1965; Elliott, 1982; Fagan, & McMahon, 1984; Kluft, 1984), hypnotic anaesthesias and multiple personalities (Braun, 1988; Bliss, 1983; Watkins & Watkins, 1990), depersonalization and multiple personalities (Bliss 1984; Putnam, Guroff, Silberman, Barban, & Post, 1986), dissociative phenomena and multiple personalities (Bliss, 1984; Braun, 1984; Coons, 1984; Putnam, et al., 1986; Bernstein & Putnam, 1988). However, only a few researchers have shown a relationship between dissociation and eating disorders (Bliss, 1983; Torem 1986, 1990; Demitrack, et al., 1990), and only one article was found indicating a connection between spontaneous self-hypnosis and anorexia nervosa and bulimia nervosa (Bliss, 1983).

The subject of the current study is a subgroup of patients who meet the *DSM-III-R* (American Psychiatric Association 1987) diagnostic criteria for anorexia nervosa or bulimia nervosa and in whom the primary operational components of these eating disorders appeared to be autohypnosis, hypnotic anaesthesias, depersonalization, hypnoidal states, ego states, identity duality, absorption, time distortions, derealization and other dissociative phenomena.

CURRENT RESEARCH SUPPORTING THE HYPOTHESIS OF DISSOCIATION IN ANOREXIA NERVOSA AND BULIMIA NERVOSA AND THE USE OF HYPNOSIS IN ITS TREATMENT

In recent years, there has been an upsurge in the reporting of individuals with anorexia nervosa and bulimia nervosa who have reported histories of childhood trauma, such as sexual abuse, incest and/or other forms of abuse (Folsoni, et al., 1989; Damlouji & Ferguson, 1985; Torem, 1986). There have been reports of post-traumatic stress underlying eating disorders (Putnam, 1984; Spiegel, 1984, 1988; Coons & Milstein, 1984; and Putnam, 1984). There have, as well, been reports of hidden ego states presenting as eating disorders in some individuals (Torem, 1986). Conversely, several researchers have demonstrated the presence of eating disorders and gastrointestinal symptoms in those patients diag-

nosed as having multiple personalities or other dissociative disorders (Bliss, 1983; Demitrack, et al., 1990; Torem, 1990; Vanderlinden & Vandereycken, 1988). Pettinati, Home, and Staats (1985) found that bulimics were more highly hypnotizable than were anorexics. They hypothesized that their higher levels of hypnotizability resulted from dissociative mechanisms. They further reported that the purging subgroup of anorexics had higher hypnotic capacity than the abstaining anorexics. Torem (1991) introduces the idea of using self-hypnosis with his anorexic and bulimic patients by putting it in the context of the patient's symptoms, complaints, or desire for change and reports that he obtains favorable results in its use. Vanderlinden and Vandereycken (1988) found that efforts to incorporate hypnotherapy in the treatment of anorexia nervosa was extremely difficult if not impossible especially in the beginning phase of treatment, (stage of emaciation). Their sometimes extreme if not continuous preoccupation with food and body shape may completely block these patients' ability to concentrate on even simple matters, let alone an hypnotic procedure.

Yapko (1986) found instances when direct hypnotic suggestions for the treatment of anorexia are not always effective and suggested that more indirect hypnotic and strategic interventions might prove more successful. Barabasz (1990) provides details of an easily replicable intervention using hypnosis in the treatment of bulimia. According to Gross (1986), if the eating disorder patient resists, even the best hypnotherapist may fail in the induction of trance, let alone achieving a therapeutic goal. He concluded that self-hypnosis might prove a means for better self-control. Schwartz, Barrett, and Saba (1985) hypothesized the existence of a dissociation process in bulimic patients. According to their theory, bulimic patients usually can identify two separate 'voices,' which represent two fairly distinct parts of the patient (Schwartz, Barrett, & Saba, 1985). In a study of 36 patients, McCallum, Lock, Kulla, Rorty, and Wetzel (1993) concluded that dissociative symptoms are related to the behaviors characteristic of patients with eating disorders and that trauma should be considered in those who present with dissociative disorders. They further point out that these comorbid factors, dissociative phenomena, and trauma, may alter treatment outcome of patients with eating disorders.

CLINICAL CASE EXAMPLES

Case One: Spontaneous Autohypnosis and Hypnotic Anaesthesias as Precursors of Anorexia Nervosa

Kelley (a pseudonym) was a 20-year-old married female. She was referred by her family doctor for the evaluation of her depression, food restriction, and dangerously extreme weight loss. Hospitalization had been the doctor's preference, but Kelley declined his recommendations and would only agree to come for a professional consultation. Her husband

had forced her to seek medical attention following the reported death of Karen Carpenter from anorexia nervosa. During the first consultation, Kelley complained of bloating and gastritis whenever she ate. She alleged she was allergic to all sorts of foods, and claimed that the only things she was able to tolerate was lettuce, carrots, grapefruits, potatoes, and unleavened bread. She was obsessed with her bowel function and used laxatives and diuretics seven times a day. Kelley refused to eat any foods containing fat and knew the nutritional value of almost everything. She refused to be weighed, but agreed that the weight of 80 lbs. that the family doctor had recorded was correct. Her height was 5'9." She was emaciated and in extreme danger. Kelley contracted to enter treatment under specific guidelines and was advised that if her weight continued to drop her family doctor would have no choice but to hospitalize her. She agreed to return for future visits and treatment was scheduled once a week for one hour sessions.

Stage One: Food For Thought

Kelley returned to see me at my office for the next three weeks at which time it had been decided that we would begin to meet at Kelley's home for treatment. In my experience working with individuals suffering from anorexia nervosa, I had found that it was difficult to get an accurate enough picture of their aberrant eating behavior by mere self-report. Going to the patient's home helps to put the eating disorder into the context of the patient's living environment.

The first home visit was conducted in Kelley's kitchen. We sat at the dinette table directly in front of the refrigerator. The appointment time was scheduled at noon and it was agreed that we would have lunch together. Kelley's anxiety mounted to extreme levels as we established the goals of the visit. The following dialogue ensued between us.

Therapist: "Kelley, I'd like to be introduced to your refrigerator and its contents. Would it be okay with you if I take a look inside your refrigerator to see what we could put together for lunch?"

Kelley: (With surprise in her voice) "I guess so...but I'm really not hungry."

Therapist: "We will not be making a large meal so you will only eat what you can handle."

Kelley: (Following a deep sigh) "Okay, go ahead."

Kelley sat and watched as the refrigerator was opened. The goal of this session was not just to get Kelley to eat, but was to teach her that eating did not have to be "fattening." As suspected, the refrigerator was close to empty. Aside from baking products, there was a turkey breast which was for her husband's dinner, a few eggs, skim milk, matzos (unleavened

bread), salad, and two potatoes. Working with the foods that Kelley had available and which she would eat; the matzo, two eggs, and milk were removed from the refrigerator.

Therapist: How 'bout some matzo brie?

Kelley: Matzo brie? What's that? I never heard of it before.

Therapist: Matzo brie is a mixture of eggs, matzo and skim milk which is usually prepared by frying it.

Kelley: I'd rather die than eat greasy, oily food. I might as well swallow a bottle of poison since grease is just another one of those poisons that will get us in the end.

Therapist: You happen to make some interesting and sound points. However, when eaten in small quantities, fat is an essential food source for our healthy sustenance.

Respecting Kelley's distaste for fat and oil, we decided to bake the matzo brie. In this therapeutic exercise, Kelley was shown how to use the foods she was willing to eat in order to produce a meal that she could tolerate. In this way, behavior modification was taking shape in a positive and effective meeting of minds. Only the whites of the eggs were used since Kelley insisted that eating the yolks would make her ill. Instead of arguing over these issues and causing further resistance, it was preferable to join Kelley in achieving our goal. Kelley assisted in preparing the meal and we sat down to eat it together. During the meal it was learned that Kelley was an avid baker and was known by friends and family for her delectable pastries. This is a common aspect of the anorexic profile. Often, individuals with anorexia nervosa are known for preparing incredible meals for everyone else, and forcing others to eat while they sit back and watch or nibble on bits of low calorie vegetables. When we completed our meal together we discussed further goals and established a weight gain of five pounds within the next two weeks. Kelley was reassured that we would not go too quickly and that she would not be forced to gain weight unless she agreed to it. Together we planned the week's menu and before leaving, the following dialogue ensued between us:

Therapist: How 'bout using the last fifteen minutes of our session to do some body image work? Would you be willing to change out of the baggy sweatshirt you are wearing, and put on an outfit that would show your true shape?

Kelley: With hands placed over her belly. I really do not know what that would accomplish now that I

am so bloated following our meal. Can't you see how enormous my stomach is? I couldn't bare to see how fat I look. I could be mistaken for a pregnant lady.

With considerable resistance, Kelley retreated to her bedroom and returned wearing a very tailored outfit.

Therapist: Let's see how you look in the full length mirror in your hallway, Kelley.

Kelley: With tears trickling down her cheeks and arms extended in front of her stomach. I already told you that I look like a pregnant lady.

Therapist: What else do you see?

Agonized over the request, she softly spoke.

Kelley: I see the image of a fat girl looking back at me in the mirror.

Therapist: Does the fat girl have an age?

Kelley: (Barely audible) Thirteen.

Therapist: Is there any relation between the image in the mirror and the person you were at age thirteen?

Kelley: Yes, when I was thirteen I was 145 lbs., fat, and ugly...and all the kids at school would tease me. That was when I decided to go on a diet. I lost the weight and thought that my entire life would change, but I still felt fat and ugly every time I saw myself in the mirror. So I just stopped looking at myself in mirrors.

Therapist: You've done some excellent work today. I would like you to think about what it is that makes you dislike yourself so much; then write your thoughts on a sheet of paper and bring it to your next appointment. When we meet next week we can begin to look at how your mirror image got so distorted.

We agreed to meet at the nearby supermarket for our next session.

Stage Two: To Market We Go

We met at the supermarket for our therapy session and together we embarked on the second stage of Kelley's journey to recovery. The purpose of going food shopping was to help Kelley work through her resistance and to teach behav-

ior modification techniques as we went along. We took two separate shopping carts and went down each aisle selecting the foods that were on Kelley's safe list. When Kelley's cart was completely full, the focus then switched to the empty cart. We repeated our shopping a second time, with Kelley wheeling her full cart next to the empty one. In this exercise, Kelley was asked to imagine what it would be like to be able to eat anything she wanted and never have to worry about gaining weight. She was then asked to put into the empty cart all the foods that she would want to eat under these imaginary circumstances. Together we walked up and down the aisles as Kelley filled the shopping cart with food. When this exercise was completed, we stood off to the side and discussed the overall experience. Kelley's cart was filled with vegetables, fruits, pastas, whole grains, bread, poultry, and fish. The other cart was filled with desserts, candies, chips, nuts, frozen waffles, pancakes, french fried potatoes, watermelon, honeydew, grapes, and a large rib steak. Although Kelley selected foods high in fat and sugar content, she insisted that the very thought of eating them repulsed her. However, she was confused by her selections. She described this exercise as if another person inside her had chosen the foods in the second cart. What was even more perplexing to Kelley was that she barely remembered doing this part of the exercise. "It's like my mind completely numbed out," she confided. In fact, this was the same struggle that went on inside her for years. "One part of me wants to eat and the other part of me won't let."

It is not surprising to hear anorexics describe their inner struggle with food in this way. In fact, all of us have had the experience, at one time or another, of struggling with different aspects of ourselves. One part of us may be craving to eat something we know is fattening while the other part of us tries to control the impulse. Yet we eat it anyway and just tell ourselves that we will eat less tomorrow. In Kelley's case, this inner struggle became more exaggerated and eventually manifested itself in the shaping of dissociative mechanisms such as autohypnosis, hypnotic anaesthesias, depersonalization, and other dissociative phenomena. In Kelley's words, she "numbed out" and her subconscious mind took over without her awareness. It was pointed out to Kelley that the foods in her cart were sound nutritional choices and that eating those food sources would help to sustain her nourishment and health. The foods in the other cart, for the most part, were fattening and nutritionally unsound. It was further explained that if Kelley were to eat the recommended portions of most nutritionally sound foods that she would be able to maintain a lean shape, that would neither be too heavy or too thin. With a proper balance of good nutrition and exercise she would feel stronger and less anxious and fearful about her life. We spoke about how starvation distorts the thinking process, how it attributes to irrational thinking and all sorts of psychological difficulties, not to ignore the havoc it causes to the body physically. We left the super-

market with Kelley's groceries and planned to meet for our next session back at the office for a picnic lunch that Kelley was to prepare for both of us.

By incorporating eating into the treatment hour, it was possible to provide a more supportive environment for Kelley's fear of getting fat. Respecting Kelley's food choices and working with them instead of against them enabled us to establish a trusting environment. In this way, she was less resistant to explore the deeper issues underlying her aberrant eating behaviors.

Stage Three: Discovering and Uncovering Dissociative Phenomena

In her third month of treatment, Kelley related a story in which she referred to herself as having incredible mystical powers. The following is a segment of the conversation with Kelley:

Kelley: When I was seventeen years old, I had been preparing dinner for my parents. I burnt my finger on the stove and did not even feel the heat under my hand. When blisters formed on the skin I put myself into a "deep psychic spiritual experience..." and when I came out of this spiritual experience, the blisters were completely gone. I just stood in the same spot for what seemed like an eternity trying to understand what had just taken place. I never told anyone about this because I feared that I'd be taken for being crazy.

Therapist: I do not think you are crazy. In fact, I find this rather interesting, Kelley, and wonder if you have ever had any other similar experiences that you would like to share.

Kelley: Yes, there have been others. When I went on a diet last year I was able to convince myself that I was not hungry even when my stomach was growling. Whenever I would feel hungry I would suck on an ice cube and the freezing cold feeling of the ice hitting my stomach would make me forget about my hunger and eventually my hunger pains would just disappear. I could even make a table filled with all sorts of enticing food disappear.

The more Kelley spoke the more it became apparent that she was a virtuoso at autohypnosis, and this might perhaps be an asset in our treatment plan. Recognizing that Kelley had a need to be in control at all times, the idea of using hypnosis with her was broached cautiously in the following dialogue between us:

Therapist: I am quite interested in your profound "psychic spiritual experiences" and wonder if you

would be willing to share with me how you go about it. Have you had any experience using hypnosis clinically in the past?

Kelley: No. I never have been hypnotized.

Slowly she raised her eyes all the way up into her head (the Spiegel Eye Roll) and took in very deep breaths. With her high upward gaze an internal squint occurred. It was an amazing experience watching Kelley as she had completely entered trance. Her breathing became slow and deep; her face muscles relaxed, her head fell forward, and her body slumped down in a relaxed state.

Therapist: So that is the way you enter your "profound spiritual experience." I am glad that you have been able to share this with me. Now would you be willing to learn some techniques that would help you to feel less bloated when you eat?

Kelley: (With her eyes still closed, nodded her head.) Yes.

Therapist: I would like you to imagine yourself sitting down to a meal. You can relax yourself by taking long, deep breaths prior to your eating. Concentrate on your breathing...feel your abdominal muscles becoming looser as the tension in your body just melts away. Just imagine yourself eating any food of your choice. As you continue to take long, deep breaths, imagine yourself placing a very small piece of food into your mouth. Chew it slowly and carefully and don't swallow it until you have chewed it thoroughly. Slowly count to 50 and when you are ready let the food slip down into your stomach where it will rest peacefully as it gets digested and you will not even be aware of it inside you. You will feel satiated, calm and peaceful.

Kelley smacked her lips to the count of fifty, took a deep breath and smiled. Then she made a swallowing sound deep in her throat, took another deep breath and opened her eyes.

Kelley: Glancing at her watch. I think it is time to go.

We spoke for several minutes about this experience and Kelley was encouraged to practice at home the exercise we had just done. She admitted that she had no recall of what had been discussed (hypnotic amnesia). She was encouraged not to be concerned about it.

When Kelley came to the next session, it was explained to her that this "profound psychic experience" was called

autohypnosis. She was further informed about autohypnosis and was asked if she would be willing to proceed in treatment, learning to use autohypnosis to improve her physical status, to help her relieve her anxieties, and alleviate her fear of losing control over her food and her life. Kelley agreed to give it a try.

Final Stage: Cognitive Restructuring And Reframing

When Kelley returned for the next session, permission was obtained to assist her in initiating a trance. An attempt was made to induce a trance state, but Kelly was resistant and was unable to enter trance. She was then asked to try it on her own without help and she went deeply into trance. Under autohypnosis, Kelley was asked to envision a table laden with all sorts of enticing food that she once had been able to make completely disappear. It was further suggested that it was not necessary to make the entire table laden with food disappear; that she could learn to selectively choose her foods without losing control over her eating. "From now on," I told her, "when you feel hungry you will no longer have to numb your hunger pains with ice. Just imagine that your hunger pain is an alarm which cannot be turned off until you eat something. You will not gorge yourself or starve yourself. You will eat just enough to shut the alarm off. And you will feel satiated and in good spirits."

Behavior modification under autohypnosis was accomplished when Kelley returned the following week to report that she was able to eat a tiny piece of cake and two teaspoons of ice cream at her sister's birthday party and was able to exercise self-control without fearing that her eating would get out of control. We continued to use autohypnosis as an adjunct to the treatment as a means of exploring the power of the subconscious mind over Kelley's eating behaviors and overall mental state.

This set of experiences led to my exploration of the potential for using autohypnosis in the treatment of anorexia nervosa and bulimia nervosa. In the course of treating individuals suffering from anorexia nervosa, it became more apparent that the fear of relinquishing control under hypnosis was a major issue. This was minimized when the patients put themselves into trance without any assistance. Patients were taught how to use autohypnosis in a positive way and to eliminate some of the negative dissociative applications that they had been using for years. The ease at which individuals with anorexia nervosa seemed to be able to use autohypnosis became an asset in the reduction of clinical resistance and in their increased willingness to explore the underlying issues relevant to their aberrant eating behaviors.

CASE TWO: SPONTANEOUS AUTOHYPNOSIS, HYPNOTIC ANAESTHESIAS, ABSORPTION, TIME DISTORTIONS, AND DEPERSONALIZATION AS OPERATIONAL COMPONENTS OF ANOREXIA NERVOSA

Melenie (a pseudonym) was a 15-year-old female who was referred by her family doctor for suspected anorexia nervosa. She was 5'8" tall. She had dropped to 77 lbs., a loss of over 25% of her original body weight. She did not want to be in therapy and made it clear that her mother had forced her into keeping the appointment. Melenie was reassured that her reluctance to trust was understandable and that she was in control of what she would bring to the therapy sessions. A smile instantly appeared on her face and she began to talk about how accomplished she felt when it came to her ability to control her eating.

"When I was a little kid," she said, "I remember how I would pass by a bake shop with my mother and the very smell of fresh baked cakes would compel us to enter the bake shop and force us to buy a cookie or even a whole cake which we would eventually gorge ourselves on. When I was thirteen, my dad made fun of my pot belly and would make oinking sounds. A part of me recognized that he was joking, but another part of me felt like I was letting my father down. I was always daddy's little girl and I would do anything to keep it that way. So I made up my mind that I had to do something to get rid of my belly. I loved to eat and savored the wonderful aromas of my mother's cooking. When I first began to diet, my stomach would growl all night long and kept me awake with hunger pains. I would stay awake all night thinking about food and every waking moment I would fantasize the foods I wanted to eat. Before long I became so preoccupied with my food that I could not concentrate on anything else and I even found myself missing appointments because I lost track of what time it was. And with all that, I still felt so fat and bloated. My hips would stick out too much and I did not know why my parents and everyone kept trying to make me think like them. No matter what, you will never be able to convince me that I can be too thin."

Melenie stayed in therapy for six more months. During this time she described how painful hunger had been to her and how desperate she had felt in trying to control it. Eventually she became an animal activist and stopped eating meat completely, saying that it was the cruelest thing in the world to "kill animals for man's survival." She had been convinced that she would rather starve to death than eat an animal. Her cravings for her favorite pastries and breads ended when she no longer could stomach the thought of poisoning her body with such "toxic foods" that cause "teeth to decay and bellies to bulge." Eventually the wonderful aromas of her mother's cooking began to make her sick. She developed severe headaches and felt repulsed at the smells that would come from her mother's kitchen. Before long she

had her parents convinced that she was allergic to all sorts of foods and they took her to see an allergist.

Like Kelley, Melenie presented a vast array of dissociative features which contributed to her anorexic profile. Her description of a distorted body image (depersonalization), as well as her ability to lose track of time or time distortion due to her constant rumination and preoccupation with food (absorption) were among the dissociative features that manifested themselves in her aberrant eating behaviors. Her ability to formulate images of food that would cause her to become ill (autohypnosis) and to numb and shut out her pangs of hunger (hypnotic anaesthesia) became an integral part of the operational components that perpetuated her anorexic behaviors. Starvation in the face of real hunger and plentiful food has been the feature that has made this eating disorder an anomaly to researchers through the years.

Autohypnosis became an adjunct to psychotherapy, which included cognitive restructuring. Autohypnosis made it possible for Melenie to regain appropriate control over her life. Suggestions were made 1) to formulate more positive images of food in lieu of directly stimulating her appetite, and 2) to replace the more aversive images that Melenie used to destroy her appetite. Suggestions were made to help Melenie to reestablish her relationship to food as a means of survival rather than as a means of self-destruction. With this unconscious and innate ability to dissociate, Melenie had been able to accomplish a major loss of appetite. She had successfully been able to alter her mental images of food by numbing and anaesthetizing the sensations of hunger. In this way, she was able to desensitize herself from the pain of hunger. The therapeutic use of autohypnosis helped to sensitize her self to her organic needs for nourishment. She was able to make suggestions to herself that enabled her to become more independent and less in need of her father's approval. Autohypnosis helped her to become less fearful of growing up and helped to release her from the grips of a hidden ego state or state of mind that wanted forever to be "daddy's little girl."

CASE THREE: HIDDEN EGO STATES AND IDENTITY DUALITY AS A MECHANISM OF BULIMIA NERVOSA

Sophia (a pseudonym) was a thirty-five-year old, married woman with two daughters, aged 13 and 10. She was a successful artist and lived in an upper middle-class residential community. From the outside, everything looked perfect, but on the inside, Sophia was falling apart. She was self-referred and came to see me after a tremendous inner struggle with her decision to get help. Sophia weighed 135 lbs. and was 4'9" in height. She was terribly upset over her weight since she had gained over 30 lbs. in the last four months. In our initial session, she denied laxative or diuretic abuse as well as purging after meals. However, after one month of therapy, Sophia admitted to taking 20 laxatives a few times a week

and two diuretics a day. In addition, she also owned up to purging following the binge episodes during which she lost complete control.

Her eating problem was making her miserable. She would wake up in the morning and make a pact with herself not to eat all day, but then something always seemed to happen to ruin things. "It's like this other person just takes over and forces me to eat even if I am not really hungry. I can't take the struggle any longer. I keep telling myself I don't want to eat but this voice inside me keeps telling me it wants to eat. I feel like I am going crazy."

Sophia continued to feel guilty throughout our sessions because she had everything to be happy about: a professional husband, two beautiful daughters, a magnificent home, and plenty of money. When asked about her childhood and her relationship with her parents and siblings, she initially painted a beautiful portrait of her childhood years. We met weekly for four months before, Sophia broke down and confided that she had done something very "naughty" and that she could not share with me or anyone else. As Sophia spoke, her posture assumed a child-like stance. Her shoulders drooped, her face pouted, and her voice sounded much younger. She burst into sobs as she related an incestuous experience she had with her father when she was seven. Incestuous experiences had continued throughout her childhood years into her adolescence. The only person Sophia had ever told was her husband. It was at this point that we had discussed using autohypnosis as an adjunct to our therapy. Sophia agreed that she could no longer stand the pain she was going through and was now willing to try anything to make herself feel better and bring relief to this endless nightmare.

In her first autohypnosis session, Sophia was taught progressive relaxation exercises which she agreed to practice at home between sessions. I explained to her that there were many different ways to enter trance. I assured her that once she had become more familiar with this process, she would be able to alter it to her immediate needs and could select the methods that she was most comfortable with. Sophia was instructed to use autohypnosis twice a day. When she returned, she appeared to have a new vigor. She reported that she had practiced the autohypnosis twice a day through the week and it had helped her enormously to reduce her anxiety. She even felt a bit better. We continued to use autohypnosis in our sessions, with Sophia putting herself into trance and taking control of the process. Autohypnosis enabled us to explore the ego state that was behind her aberrant eating behaviors. In addition, it enabled Sophia to work on some of the more painful repercussions of incest with her father. She was taught relaxation skills using autohypnosis. Autohypnosis was not used for purposes of probing or searching for answers. Autohypnosis was used to help Sophia achieve cooperation from her "subconscious mind" in integrating the detached ego state. This ego state was the

operational component responsible for Sophia's binge-purge behavior. Therapeutic use of autohypnosis enabled Sophia to come to terms with her guilt, shame, humiliation, and anger and eventually freed her from the grips of her perpetrator. In other words, by being able to communicate directly with the "subconscious mind," Sophia was able to more clearly understand the dichotomy of her binge/purge behavior. It further helped to establish a more integral understanding of her ego state and the role it had played in the dynamics of Sophia's binge/purge behavior. One year from the date that Sophia entered treatment, her weight was stable at 100 lbs. and she was no longer using laxatives or taking diuretics. She no longer felt like she needed to get rid of an undesirable part of herself or her father, and her binge/purge activity ceased. She remained in therapy for another six months, during which we concentrated on cognitive restructuring and reframing.

DISCUSSION

Cognitive restructuring and reframing is a method of coming to terms with a problem. The individual is taught to develop a new perspective with which to view an old problem (Spiegel & Spiegel, 1978). It is my understanding that mind and body come together in the resolution of conflict and in symptom recovery. The conception that mind and body are an integral part of one's whole being is what lies behind the powerful outcome of this process. In other words, the person is neither his/her body nor is he/she entirely his/her mind. In essence, the goal of the individual is to become in harmony with his/her body. Thoughts and sensations are recognized regardless of any pain that might be attached to them. The individual is encouraged to reestablish and restructure his/her relationship between himself/herself or his/her body. Problem-solving and resolution occur when the individual creatively finds solutions to enhance the relationship between mind and body and achieves a harmony between the self and the body. Problem-solving is not a contest between the mind and body or an attempt to deny or push away the problem. It is a method in which the individual views the problem openly and honestly, examines its consequences, and reconciles himself/herself to find acceptable solutions.

According to Dejerine and Gauckler (1913), true mental anorexia occurs when individuals successfully alter their mental images of food in order to destroy their appetite and achieve their goal of thinness. In view of the power of the mind to alter the body's physiological need for food, it is useful to look at the phenomenon of dissociation as an operational component of these eating disorders. This premise has been derived from years of clinical experience and observation. What I discovered was that individuals with these disorders demonstrate an extraordinary ability to numb and anaesthetize their pain of hunger (hypnotic anaesthesia), to

alter and distort their perceptions of their body image (depersonalization) and their external world (derealization) as well as to alter their perceptions of hunger and influence their aberrant eating behaviors (autohypnosis).

In the case of individuals suffering with anorexia nervosa and/or bulimia nervosa, the usefulness of cognitive restructuring and reframing cannot be overemphasized. Utilizing autohypnosis, the individuals with aberrant eating behaviors can teach themselves to respect their bodies since they cannot live without them. Individuals learn to experience their bodily sensations in new ways, and that the sensations of the body can be altered. Anorexics and bulimics have a profound ability to alter their images of food and their perceptions of hunger. The clinician helps them own their body perceptions of hunger. They appreciate that they already know how to alter their body's sensations through starvation, bingeing, and purging. Since they already are familiar with being able to alter their body's sensations in a negative and destructive way, they will have little problem being able to learn to apply what they already know in a positive, healthy and constructive way. Cognitive restructuring and reframing invites the anorexic and bulimic to tap into their innate abilities by developing more positive ways of altering the sensations of their bodies, experiencing hunger, and allowing themselves to eat without restriction or compulsion. It helps to give them a sense of empowerment in knowing that they can take charge of their lives.

The ability to dissociate enables the anorexic to deny the hunger state by anesthetizing the pain of hunger causing virtual starvation. Such an ability to dissociate enables the bulimic to binge and purge, putting the individual in the grips of pressures that force the ingestion of food in while an internal dictator forces the food back up and out. It is also not uncommon to hear an anorexic say that he/she is struggling with two distinctly different parts of himself/herself (identity duality): one part tells him/her "to eat" while the other part says "You had better not."

It is this author's experience that the crux of the anorexic and bulimic syndromes seems to be the patients' unrecognized abuse of autohypnosis. This unintentional misuse seems to be a primary mechanism of the disorder. Furthermore, under hypnosis the depth of these dual states (hypnoid states, ego states) become more evident. It is the ability to use dissociation as a way to obtain thinness that precipitates the onset of these eating anomalies and attributes to the perpetuation of the aberrant eating behaviors leading to starvation and binge-purge activity.

In the case of anorexics who believe that the only thing that they are able to control is their eating, the decision to use autohypnosis over classical hypnosis as an adjunct to their treatment makes sense because it is consistent with their own preoccupation with maintaining control of their bodies.

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