

A
DISCUSSION
OF
AUTOHYPNOSIS . . .
BY KATZ

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Katz's article makes the radical and theoretically enriching point that most chronic eating disorders involve dissociative mechanisms and phenomena.

This is a different (but overlapping) point from the one that I and co-authors have made in previous articles (Goodwin & Attias, 1993, 1994; Gardner, Segura, Wills & Goodwin, 1995). This previous work described a sub-group of incest survivors whose complex traumatic and dissociative sequelae include eating disorders, often of a mixed or atypical type and often mingled indistinguishably with other co-morbid self-destructive or addictive behaviors. Katz's last case has some features of this syndrome, which we have tracked back through historical cases to Sybil's adult anorexia nervosa (Goodwin & Attias, 1993), Estelle's food refusals (Goodwin & Fine, 1993), and finally to the mythic Greek heroine and sexual abuse survivor, Io (Gardner et al., 1995). Thus the Katz article supplies new data for this ongoing hypothesis-building.

More importantly, though, Katz is articulating a new hypothesis: that even in "classical" eating disorders, like childhood anorexia nervosa, even in the relative absence of trauma history or post-traumatic symptoms, disordered eating behaviors are manifestations of automatically occurring self-hypnosis. I find myself wondering if there is something intrinsically self-hypnotic about eating, as there is in drumming and dancing, especially if the eating is done ritualistically or to excess or combined with hypnotic drugs. I think of the Greek feasts and libations, including those of the Bacchic and other mystery cults, the Christian mass, the Jewish Seder, and so forth.

Katz posits that it is hypnotic anesthesia that dulls the hunger in these disorders, hypnotic hallucinations that make food-related sensation aversive, hypnotic auto-suggestion that causes the persistence of bizarre eating behaviors, depersonalization that substitutes an obese body image for the actual mirror image, and dissociative identity splits that underlie the oscillations between bingeing and dieting behavior in some individuals. One is reminded too of the vast historical documentation linking not-eating to trance phenomena, including the entire corpus of writings of the

early desert fathers like Saint Anthony, as well as descriptions of later hunger artists like Saint Catherine of Siena and Saint Rose of Lima (Bell, 1985).

Katz provides some support for her hypothesis in the body of her article: 1) detailed accounts of the subjective experience of some sufferers suggest dissociative processes; 2) survey findings report elevated dissociation scores in those with eating disorders; and 3) anecdotal data indicate that in some cases controlled self-hypnotic interventions facilitate recovery. This may be the beginning of a promising new line of research and theory in this area.

I will end with a cautionary note about clinical technique when working with eating disorder patients who also give a history of childhood abuse.

Some therapists experienced in trauma-dissociative treatment will wince at Katz's description of going grocery-shopping with a patient. It is important to remember that the eating disorders are a cluster of illnesses, not a single entity, and include cases primarily related to brain injury or metabolic illness or mood disorder, as well as eating problems that relate to post-traumatic and dissociative symptoms and to revictimization. The patient Katz was working with in the grocery store and home-visit context was not someone with a prominent child abuse history and was at that time so ill from her eating disorder that hospitalization had been recommended. Readers and therapists accustomed to dealing with uncomplicated eating disorders need to be reminded that it is trickier to weather this type of direct intervention when the patient is someone who has been repeatedly betrayed and hurt by care-takers.

Some of us believe that the entire protective superstructure of psychodynamic psychotherapy was invented out of catastrophes around reenactments in adulthood of childhood betrayals, reenactments which could only be prevented by this elaborate framework of boundaries, of opportunities for interpretation of wishes and fears about care-taking, and of continual renegotiation of the therapeutic alliance. Of course, it is precisely the patients who most require this delicate microsurgical intervention who land themselves in life-threatening jams that lead to crude and sometimes grotesque reenactments of intrusive, meddling parenting—the intensive care unit, locked psychiatric wards, county jails, live-in cults, and so forth. Even those of us most con-

vinced of the need for meticulously clean psychotherapeutic technique in these cases find ourselves tricked and provoked into boundary violations. The wish that we will actively care and care-take is so balanced in intensity with the fears that we will as to leave therapist and patient balanced on a tightrope. I believe that this tightrope can be walked not only in the therapist's office, but also in the emergency room, or on a wilderness trip, or probably in the grocery store. But it requires some thought and should not be walked blindfold. Therapists like Katz, who have developed direct and straightforward techniques with other populations, need to be warned that modifications may be required when applying them to individuals who have been severely abused. Ongoing development and sharing of such technical modifications is needed for all the adjunctive therapies utilized by trauma-dissociative patients. ■

REFERENCES

Bell, R. (1985). *Holy anorexia*. Chicago: University of Chicago Press.

Gardner, R., Wills, S., & Goodwin, J. (1995). The Io myth: Origins and use of a narrative of sexual abuse. *Journal of Psychohistory*, 23, 30-39.

Goodwin, J., & Attias, R. (1993). Eating disorders in survivors of multimodal child abuse. In R. Kluft & C.G. Fine (Eds.), *Clinical perspective on multiple personality disorder* (pp. 327-341). Reprinted with additions in M. Winkler & L. Cole (Eds.), *The good body: Asceticism and contemporary culture* (pp. 23-35). New Haven: Yale University Press.

Goodwin, J., & Fine, C. (1993). Mary Reynolds and Estelle: Somatic symptoms and unacknowledged trauma. In J. Goodwin (Ed.), *Rediscovering childhood trauma: Historical casebook and clinical applications* (pp. 113-133). Washington, DC: American Psychiatric Press.