Hypnotic Alteration of Body Image in the Eating Disordered

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Abstract

A driving force in an eating disorder like anorexia nervosa has been a distorted body image. The psychobiological dynamics of eating disorders have demonstrated significant hypnotic phenomena such as forms of dissociation, hallucination, time distortion and catalepsy, and therefore, pose hypnosis as a good fit for particular parts of treatment. Presented here are four hypnotic approaches designed to inspire the establishment of a reality based body image in the eating disordered individual. Conditional prerequisites for application of these interventions are described and case examples illustrate each approach. A discussion on some of the rationale for formulating these strategies is offered.

Keywords: Body image, eating disorder, anorexia nervosa, reality lens, body dysmorphic disorder.

A driving force in an eating disorder like anorexia nervosa (AN) is a distorted self-perception which advances a body image contrary to consensus reality. When successful treatment allows for the effective management of eating disorder (ED) thoughts and behaviors, body image is often the last thing to change, if it changes at all (Clausen, 2003; Cogley & Keel, 2003; Benninghoven et al, 2006). The psychobiological dynamics of eating disorders engage significant hypnotic phenomena (Edgette, 1995) such as various forms of dissociation, hallucination, time distortion and catalepsy. This poses hypnosis as a good fit for particular parts of treatment. Illustrated here are a number of hypnotic approaches designed to incite a reality based body image or destabilize a distorted body image.

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When even a modest shift in body image occurs, it is significant and reflects favorable therapeutic movement. The forces driving eating disorders like anorexia nervosa and bulimia nervosa are powerful and comprehensive. Research currently implicates genetics as a force in these psychiatric disorders (Bulik, 2006; Bergen, 2003; Grice et al, 2002; Mercader et al, 2007; Ribases et al, 2003; Ribases et al, 2004; Gunstad et al, 2006) which capture cognition, perception, emotion and behavior.

The interventions described here may be applied to various types of eating disorders as well as body dysmorphic disorder. For purposes of this article I will focus on anorexia nervosa. Preliminary to body image interventions are a number of important steps. Because starvation significantly affects psychobiological functioning, it is essential that the AN patient be sufficiently re-fed before attempting any intervention involving self-perception. The Minnesota Semi-Starvation Study (Keys, 1950) found various psychological symptoms to be diagnostic of the level of calorie intake. Others note cognitive deficits and mood impairment resulting from restricted nutritional intake and find measurable improvement in mood disorders with nutritional rehabilitation (Meehan et al, 2006; Choma et al, 1998 ). Most psychotherapeutic interventions will have little or no effect until the body has adequate nutrients to restore pre-morbid, baseline cognitive facility. For many, hospitalization is essential for re-feeding and medical stabilization.

The case examples cited in this text were treated at a multi-disciplinary outpatient eating disorders clinic (Kartini) for youth. I contract my services to the clinic as one part of a team offering medical and pharmaceutical management, physical therapy, yoga and individual, family and group psychotherapy. Family therapy is mandatory for all participating clients and often essential for a successful treatment outcome. With adequate re-feeding, a certain responsiveness and engagement of the AN patient becomes apparent. I then clarify client goals and map out a treatment plan. Most clients I have worked with indicate a desire to be free of the anxiety and/or depression that commonly accompany eating disorders.

The initial phase of my work typically involves teaching anxiety management skills, clearing the emotional slate of the past to whatever extent is possible (Walsh, 1997), and stabilizing emotional experience in the present. I introduce ideomotor signaling (Cheek, 1994) and hypnosis early in treatment both as a means to accomplish the above objectives and to provide a safe reprieve from the demands of treatment. I apply one or more of the following interventions when it seems appropriate.

**Method**

**Reality Lenses**

After providing information about the unconscious and hypnosis, and after helping the client develop “yes” and “no” ideomotor finger signals (Cheek, 1994, Rossi & Cheek, 1988), I offer an invitation to trance using whatever approach is suited to the individual. I secure confirmation, via verbal response or ideomotor finger signals, that the client is employing visual imagery in trance. I then suggest, “If you haven’t already, please notice that full length mirror over there. Next to the mirror on the ground are two pairs of eye glasses. Looking through one set, the eating disorder lens, won’t change the visual field much. The other glasses, however, have reality lenses and allow you to see yourself as you really are, as others see you. Please have some fun switching glasses back and forth, perhaps noticing one or two features of your body that you can privately appreciate through those reality lenses.” I solicit verbal feedback from the client about the experience.
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If the reality lens experience is favorable, inform the client that the same glasses are available in invisible contact lenses. I suggest, “You can enjoy this experience more often in your own private way because the lenses belong to you. Your unconscious can be very helpful in allowing you to gradually adjust to the reality lenses by perhaps applying the reality lenses one full day this week. I don’t know what day this will happen. You could add another full day of reality lenses each week if you like.” I then ask for confirmation from the unconscious, via ideomotor signals, that this progressive application of the reality lenses in the waking state is acceptable, and indeed will happen. I subsequently deal with that confirmation as an unconscious contract. A negative response guides me to take a different tactic, which may include one of the other approaches described in this article. Confirmation of this process inspires questions during subsequent sessions about body image and anything unusual. I revisit the reality lens theme hypnotically and either affirm the existing reality lens contract with the unconscious or re-establish a contract for the same.

Many clients have been reluctant or even embarrassed to admit any change in the way they view their bodies. One 17-year-old girl, during the session following introduction of the reality lens said, “It was really kind of weird when I walked by this store window and looked like I usually do and had to stop. I did a double take because I didn’t think it was me. She, I mean I, didn’t look bad. The next day it was back to normal.” “Normal” was her fat body image. Another approach involves talking to the body.

The Lying Body

The following will likely yield best results if the operator, like Candice Pert (1997), thinks of the body as the unconscious. As a research scientist at the National Institute of Health, Pert uncovered and investigated much physiological communication taking place within the body. Much of the communication is accessible to, and influenced by, what we call the unconscious. Her research exemplified the body-mind interface relevant to hypnotic interventions. Considering the body as the unconscious need not be a great stretch because body language is the primary domain of the unconscious. Asking the unconscious to respond to questions through finger signals is not so unlike asking the body to respond similarly.

With the client in a waking state, I share how the human body holds powerful instincts dedicated to survival, wellness and reproduction. I ground this reality with as much discourse as necessary. Then, I profess confusion about why the body, with its powerful instinctual imperatives, would present a lie about its own appearance which ultimately has such detrimental consequences.

If “yes” and “no” ideomotor finger signals (Cheek, 1994; Rossi & Cheek, 1988) have not previously been established, this is a good time to do so. The client develops trance and I indicate my desire to speak to the body about something I don’t understand. The body can respond verbally, or through “yes” or “no” finger signals. I again present the quandary concerning the body lying about its own appearance. I reference my belief that there must be some very important purpose behind this lie, as it threatens the very existence of the body. I ask if its alright to understand the purpose of the lie. With an affirmative response, I request an elaboration on the purpose. With a negative response about the purpose of the lie, I ask questions about what conditions need to be met in order to stop the lie.

A common initial explanation about purpose is “being thin”. To this I respond “No, no, no. That’s not a reason to die for, and the body already knows at some level that it is thin. What is the real purpose of the lie?” A common response is “Control”. To this, I reflect the hundreds of choices the client is presented with every day - get up/stay in bed, clothing
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options, talk/don’t say anything, etc. - and decisions made that indicate control. Then I talk a bit about the many things none of us have control over. Some confrontation or negotiation follows whatever explanation of purpose is presented.

Even when the response reveals there is no beneficial purpose to the lie, the client’s system has acknowledged telling a lie with potentially very serious consequences. Negotiation now begins to reconcile the lie. I ask the body, given its instinctual drive for wellness and survival, if it is willing to stop the lie and allow a realistic body image to develop. I ask the body if there are certain conditions that need to be met before the lie will end. Various responses may provoke Socratic questioning which ultimately inspires the inquiry: “Will the body now end this lie about its appearance?” A yes response prompts me to say, “As adjustments are now made to remove that lie from your consciousness, will a realistic perception of the body emerge in whatever way is best for you?” A no response to the lie question invites, “Will the body end this lie about its appearance within the next day (week, month)?” Another negative response causes me to pursue a different intervention. With an agreement to abandon the lie secured, remember there exists an elaborate network of eating disorder thoughts, behaviors, learning and other perceptions that evolved from the lie. Review the agreement to relinquish the lie at an unconscious level in subsequent sessions and speak to the need to clean up all the debris that was connected to the lie.

Anorexia Personified

The following draws upon the Ego State Therapy work of John and Helen Watkins (1997). Helen Watkins (1993) summarizes this work as a psychodynamic approach in which techniques of family or group therapy are employed to resolve conflicts between various “ego states” that constitute a “family of self” within the individual. From this perspective, I assume one or more ego states or parts of the individual are invested in or governed by AN. Whether as part of the induction process or as a segue to hypnotic intervention, invite the client to find or create a secure place that is all theirs. Develop “yes” and “no” ideomotor finger signals. Once the client confirms a secure experience, ask if a figure or entity representing the anorexia can be seen. If not, I suggest the client invite the anorexia entity safely into this place to see what it looks like. Should this figure appear, I solicit a detailed description of what it looks like. The description may be quite similar to what you see the client really looking like in a re-fed state. Hypothetically, this non-dysmorphic presentation may fuel AN pathology by reflecting the almost attainable goal as a contrast to the consciously held distorted body image. If the client describes this part as attractive with a desirable appearance, ask the client if she would like to see herself.

An affirmative response leads me to inquire about the emotional state of this anorexic part or ego state (Watkins & Watkins, 1997). Is she carrying anger, emotional pain, fear, shame or guilt? With the permission of the anorexic part, steps are taken to resolve the emotions held by this part using the Goldfinger approach (Walsh, 1997). This involves asking the client, “Since you have been through all the experience of the past and you have whatever learning from experience can help you in the present, will that anger (or other emotion) now be released and resolved in whatever way is truly best for you at this time?” I typically solicit an ideomotor finger response to the question and ask for a specific finger to lift when resolution is complete. Then I ask the unconscious, “Is there a place in the past to position the various thoughts and perceptions no longer appropriate in the present because those emotions have been resolved?” I ask for a finger to respond to this question. With an affirmative response, I suggest the adjustment can now take place and the “yes” (or “no”)
finger will lift up when this adjustment is complete.

Next, I ask the client how this AN part appears to be, now free of those emotional burdens. I also ask if this part is willing to direct its energy toward something other than the anorexia. This may inspire an elaboration by the therapist on various beneficial ways energy could be directed. Check to make sure the client really would like to see herself the way this eating disorder part appears to be. Assure the client that her body image can become more like what she sees before her by merging this part with herself. Inform the client about other possible, as yet ill-defined, benefits of this merger. Ask the client if this will be alright. Have the client ask the AN part if this will be alright.

If all is favorable with the client and the AN part, ask both to face each other in close proximity, suggesting the client will likely feel something as this part merges with her and disappears. Typically, I announce that I will count to three and the merger will take place by the time I reach three, saying “one, two, three... together now”. Ask for verbal confirmation of this happening once it happens.

**Parts without a job**

Quite often the client develops no clear picture of anorexia embodied. Sometimes, when an image of anorexia develops, it is not at all desirable or attractive and may embody what the client fears most. In cases like this, I will inquire about the number of parts invested in anorexia while the client is in trance. Soliciting ideomotor responses, I’ll ask, “Is there more than one (two, three, etc.) part of you still invested in anorexia at this time?” and determine how many ego states are openly engaged in the disorder.

I express interest in speaking to these parts and then acknowledge how they certainly need something purposeful to do. These parts are informed they may soon have nothing to do because anorexia is being gradually phased to inactive status. Next, I ask if parts are interested in a new and likely challenging job. Most of the time, parts issue an affirmative response.

Depending on how many anorexia parts are engaged, a job can be designated collectively to a group or selectively to a part. I describe a number of jobs before asking parts to select an option. This approach draws energy away from anorexia, and more indirectly allows for the formation of a reality-based body image. A more direct approach overlaps the reality lens intervention described earlier. If the client has previously reported a favorable experience looking through the reality lenses, then a new job option is described in which the former AN part ironically manages a sequential application and maintenance of reality lenses.

I describe the jobs as challenging, time consuming and beneficial to the entire system. I secure a start date as parts express a preference for a particular job. In subsequent sessions, I check in to determine whether the new job has actually been started, whether the new job is challenging enough, whether more parts are needed to do the job effectively and so forth. I attempt to tailor all new jobs to the particular needs, healthy goals and characteristics of the client at hand.

**Case Examples**

**Lea**

Lea, following hospital stabilization and partial re-feeding to a weight of 81 pounds, presented as a 13-year-old restricting anorexic who wanted to see herself as others do.
During our second visit, I introduced Lea to trance and the *reality lens* theme. Her unconscious contracted to apply the reality lenses progressively, starting with 2 days of the coming week. At the next session, she reported improvements in her body image. By our sixth and last session, Lea said she honestly felt good about her body which was at a healthy maintenance weight of 109 pounds. Lea was quite motivated to change. An 8 month follow-up found Lea doing well managing AN, maintaining a healthy weight and still feeling good about her body.

**Lorna**

Lorna, a 20-year-old restricting anorexic female, was admitted to the clinic’s intensive outpatient program at a weight of 122 pounds after sufficient re-feeding took place in the hospital. The first four of our 10 sessions involved emotional processing and stabilization. During the fourth session, Lorna developed trance and put reality lenses on with a favorable response. During the fifth session, Lorna reported having moments during the previous week of being alright with her body. I then spoke of the natural, instinctual imperatives for survival within the body and professed my inability to understand why the body would lie about its own appearance. When questioned, the body responded via ideomotor finger signals that there was no beneficial purpose to the lie. Further questioning revealed the lie would be stopped only after forgiveness was extended to self. After some negotiation, Lorna then offered forgiveness to herself.

During the sixth session, the body agreed through ideomotor questioning, to release the lie about its appearance. Questioning in subsequent sessions indicated this change to be stable. Lorna reported improved mood and we focused attention on other perceptual and attitudinal adjustments as well as management of anorexia thoughts and behaviors. Lorna exited the treatment program at a healthy maintenance weight of 152 pounds and did quite well with improved body image for 3 months. She then required some additional treatment for relapse of some restricting behaviors.

**Eva**

Eva, a 14-year-old girl with restricting type AN, began the clinic’s outpatient program after sufficient re-feeding to a weight of 96 pounds in the hospital. She engaged in 12 sessions of individual therapy. After addressing, negotiating and stabilizing Eva’s emotional state during the first 4 sessions, Eva saw herself favorably through reality lenses while in trance. She was informed that the lenses were hers and could be applied any time she liked.

The next session, Eva reported feeling alright seeing herself in the mirror except for one specific mirror in a friend’s house. Subsequent sessions addressed a specific phobia, AN triggers, thoughts and behaviors and revisited the reality lens theme. Eva identified anger as an eating disorder trigger.

Eva developed trance during our eleventh session and I asked her to invite the critical AN part she had previously referenced into her special place. She did this and described AN part as looking much better than herself. This part, when questioned, revealed it was holding significant anger and fear that it would like to resolve. Steps were then taken to release those emotions. Eva indicated she would like to see herself like this AN part. I suggested Eva face this part and it could merge with her at the count of three. I counted to three and said “together now”. Eva reported the part was gone. Whether an actual ego state merger occurred, whether an ego state was even present or whether this was simply an alteration of hypnotic imagery can be debated.
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The next session Eva said she was feeling good about her body and not experiencing anger like before. She had achieved a healthy maintenance weight of 101 pounds. This concluded our work together as Eva’s parents terminated treatment. An 18 month follow-up with Eva and her parents found Eva healthy and “proud” of her body.

Pat

During my fourth visit with a 19-year-old restricting AN female named Pat, she developed trance and I asked her to invite the part of her representing the eating disorder into her safe place. This part indicated it needed Pat’s attention and also carried much emotion from the past. After this part released fear, anger, shame and guilt, it remarked that it no longer needed Pat’s attention. Pat reported improved mood during the next session.

Over 13 sessions with Pat, 6 eating disorder parts presented interest in new jobs during trance work. All parts were given at least two job choices to pick from. The jobs ultimately selected included: maintaining a realistic perception of the body; organizing and categorizing new information for easy access; managing guilt; establishing more flexibility with food; identifying body parts to like, one at a time.

This young lady reported liking parts of her body before we concluded our treatment. Pat was admitted to the clinic following hospitalization re-feeding that brought her weight to 94 pounds. Upon discharge she was at a healthy maintenance weight of 109 pounds. Pat, at a 1 year follow-up, said she felt good about her body and maintained the healthy weight she had when treatment concluded.

Discussion

The case examples presented here reflect only a fraction of the work done in individual therapy, and individual therapy represents just one piece of the multi-disciplinary team approach provided at the facility where the referenced clients had treatment. The cases are intended only to illustrate variations of the specific body image interventions I employ. My aspiration with these procedures is about seeding change or disrupting some piece of the detrimental status quo.

Although body dysmorphic disorder, as defined in the DSM IV (American Psychiatric Association, 2000), is a common comorbid feature of ED, it is also expressed independent of ED. The interventions described here have proven quite useful in my treatment of this condition, with or without ED comorbidity.

The reality lens approach intends to pose a subjective perceptual contrast regarding body image. The eating disorder lenses re-affirm and objectify the distorted body image as part of the AN pathology. The reality lenses ideally offer a much more desirable perspective of self and perhaps a bit more incentive to follow through with treatment. The reality lens approach also implies some degree of perceptual choice is available.

The lying body intervention positions AN outside the realm of conscious intention or executive control. Whether the client perceives the unconscious mind or the body as responsible for ideomotor responses to questions is not significant. The responses come independent of conscious volition or analysis. Some force capable of overriding executive control directs the course of AN. This both objectifies the disorder and reflectively reframes the inner conflict likely taking place. For some this is liberating as it affirms they did not choose to have the eating disorder. Confronting the veracity of the body may also amplify incongruous aspects of AN and thus inspire motivation to change. This approach implies
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choice at an unconscious level and is intended to challenge and destabilize whatever unconscious construct may be sustaining the distorted body image. Evidence implicating AN related activity-dependent genes (Rossi, 2002) which rely upon idiosyncratic experience for their expression (Gunstad et al, 2006, Martinowich et al, 2003, Mercader et al, 2007, Ribases et al, 2003, Ribases et al, 2004, ) inspired this intervention. If AN related genes are turned on as a result of certain experience, then what might persuade the genes to turn off?

Personification of anorexia is, of course, a way to objectify the pathology and distinguish it from identity. Paradoxically, this also allows a person the possibility of favorably altering body image by merging with this objective representation of the AN. I am especially fond of this approach when it works because without even deciding to manage the AN, the client eliminates one of the driving forces of the AN. Improved body image, in my experience, typically invites more rapid and effective management of AN thoughts and behaviors.

Finding jobs for parts invested in AN is based on an understanding that ego states typically need some purpose (Watkins & Watkins, 1997). The proposition that AN is soon to reach inactive status is largely a facade intended to shift more inner resources away from AN mandates. Most eating disorders are chronic illnesses and may be perceived as inactive when thoughts, behaviors and perceptions are well managed. Any experiential shift in AN client can be perceived by the client as movement toward inactive status and thus reinforce treatment gains. Using one or more ego states to progressively restore a reality-based body image is a challenging and worthwhile new job.

Emotional states are addressed in this work not only as part of the coordinated therapeutic effort to stabilize or improve mood, but also because mood can have some influence on self-perception (Benninghoven et al, 2006; Fairburn, Cooper & Shafran, 2003; Masheb, Grilo, Burke-Martindale & Rothschild, 2006; Pompili, Girardi, Tatarelli, Ruberto, Tartarelli, 2006; Rotenberg, Talor & Davis, 2004 ). The emotional states held by particular ego states or parts typically support whatever purpose or function those states believe they have (Watkins & Watkins, 1997). Resolving the emotional states seems to add more flexibility to these ego states, and in some cases, cause an ego state’s function to be unnecessary. In the case of Pat, one AN part relinquished its need for Pat’s attention after releasing emotions.

Relapse is common with eating disorders and time is needed to stabilize any improvements. Even the physiological changes from nutritional deficit along the hypothalamic-pituitary axes often exist for months after weight gain or stabilization is achieved (Woolsey, 2002). When beneficial changes occur, those improvements need to be referenced and reinforced over time. Once planted, a body image seed requires proper attention to grow.

There exists no magic bullet for altering body image in the eating disordered. I present this paper as a way of sharing what seems helpful to many of the eating disordered people I work with. Addressing body image is but one piece of the AN puzzle. Success, however, with any of the interconnected aspects of this disorder will likely have some favorable influence on the rest of the system.

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