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EFFICACY OF HYPNOTHERAPY IN THE TREATMENT OF EATING DISORDERS

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Abstract: Research on the efficacy of hypnosis in the treatment of eating disorders has produced mixed findings. This is due in part to the interplay between the characteristics of people with eating disorders and the phenomena of hypnosis. In addition, several authors have noted that methodological limitations in hypnosis research often make evaluation of treatment efficacy difficult. Many of the studies extant provide insufficient information regarding the specifics of the hypnotic intervention(s) to facilitate replication and clinical implementation. Therefore, this paper only reviews literature with replicable methodological descriptions. It focuses on the three primary disorders of interest to clinicians: bulimia nervosa, anorexia nervosa, and obesity. The implications for evaluating treatment efficacy are discussed.

The publication of the Chambless and Hollon (1998) article, Defining Empirically Supported Therapies, has fueled the debate about determining what constitutes an empirically supported therapy. Several authors have noted the fact that the Chambless and Hollon guidelines are problematic for hypnosis research, because hypnosis is most commonly used as an adjunct to other established psychotherapies (Lynn, Kirsch, Barabasz, Cardenà, & Patterson, 2000; Nash, 2000; Schoenberger, 2000). Nonetheless, this was the yardstick chosen to assess efficacy for the April 2000 Special Issue of the International Journal of Clinical and Experimental Hypnosis on the Status of Hypnosis as an Empirically Validated Clinical Intervention (Nash). Lynn et al. summarized the evidence presented in the literature reviews for the effectiveness of hypnosis as an empirically supported clinical intervention. They concluded that “As a whole, the clinical research, to date, generally substantiates the claim that hypnotic procedures can ameliorate some psychological and medical conditions, as judged against the Chambless and Hollon methodological guidelines” (p. 239).

Lynn et al. (2000) concluded with recommendations for conducting future research, which include (a) define the population carefully;
(b) report the procedures in sufficient detail to permit replication; (c) clearly indicate whether participants were randomly assigned to treatments; (d) report hypnotizability; (e) report complete descriptive data; (f) ensure that the number of participants is adequate; (g) conduct single or multiple case experiments; (h) compare nonhypnotic treatments with hypnotic suggestions added; (i) conduct adequate follow-ups; (j) assess hypnotizability; (k) assess expectancies; (l) assess motivation; (m) consider measures of interpersonal and dynamic aspects of engagement in treatment; and (n) examine a variety of determinants of positive and negative treatment effects.

Reviews of the literature on the treatment of eating disorders with hypnosis have consistently raised concerns about methodological limitations in the studies reviewed (Schoenberger, 2000; Vanderlinden & Vandereycken, 1988). The present article reviews research on the treatment of eating disorders with hypnosis that approximate the Chambless and Hollon (1998) criteria and the recommendations of Lynn et al. (2000). Particular consideration was given to the criteria to report the procedures in sufficient detail to permit replication. If hypnosis is to be labeled as an efficacious treatment according to the Chambless and Hollon criteria, it has to have been found efficacious in at least two studies by independent research teams. When one study, which meets the Chambless and Hollon criteria, demonstrates a treatment to be efficacious but which has not been replicated or when all the research has been conducted by one team the treatment is labeled “possibly efficacious.” Obviously, replicability is critical. Hypnotic treatments will not be labeled efficacious if not replicated by an independent research team. Unfortunately, Lynn et al. (2000) note that in many of the studies reviewed replication would be problematic; “... procedures were often reported in detail insufficient to determine whether the intervention could be considered a manualized or replicable approach to treatment” (p. 246). Standardized inductions were rarely used, suggestions were described in vague terms, and exemplary suggestions were not provided.

**HYPNOTHERAPY IN THE MANAGEMENT OF BULIMIA NERVOSA**

Research revealing that women with bulimia demonstrate high levels of hypnotizability (Barabasz, 1991; Covino, Jimerson, Wolfe, Franko, & Frankel, 1994; Pettinati, Horne, & Staats, 1985) has spurred particular research interest in its use in the treatment of bulimia. In 1988, Vanderlinden and Vandereycken reviewed the status of research on the use of hypnosis in the treatment of bulimia and anorexia. They observed that most studies employed a multidimensional approach and noted that the findings were frequently anecdotal, reflected clinical
observation, had small sample sizes and frequently did not provide follow-up data. Other limitations cited were failure to report or inadequate reporting of client characteristics, assessment procedures, hypnotic inductions, and the specific hypnotic suggestions/scripts employed. These are limitations that would prevent the treatments from being labeled efficacious. Unfortunately, 18 years later, many of these criticisms remain unaddressed. The section will report on studies that have attempted to address these concerns.

Griffiths has published several articles on hypnobehavioral therapy for bulimia.

In 1995 (a), she published a manual on the hypnobehavioral treatment of bulimia nervosa. Hypnobehavioral treatment is “based on the behavioural principle that antecedent events such as dieting lead to consequences of events, such as the binge-purge cycle” (Griffiths, p. 26). It incorporates hypnotic techniques to reinforce and to maintain behavioral change. The intervention is an 8-week program that is divided into two stages. The first 4-week stage involves three sessions and consists primarily of behavior modification “which follows closely the treatment manual recommendation suggested by Fairburn (1985)” (p. 26). In the second stage, hypnosis is introduced and constitutes 20 to 30 minutes of the 1-hour session. Griffiths identifies a goal and provides a script for the hypnotic suggestions employed.

The aims of the positive suggestion in hypnosis are: 1) to enhance self control over binging and purging; 2) to reinforce changes in eating habits; 3) to reinforce advice on establishing normal eating habits given in Stage 1; 4) to increase control over problem situations which precipitate binging and purging; 5) to enhance self-esteem and relaxation and 6) to encourage increasing participation in social situations which may have previously been avoided. (p. 34)

In the present author’s opinion, the greatest emphasis is on reinforcement of changing eating habits and advice on establishing normal eating habits.

Griffiths (1995b) presented the results of a 2-year follow-up of hypnobehavioral treatment for bulimia nervosa. Data from 14 participants who met Diagnostic and Statistical Manual of Mental Disorders, third edition, revised (DSM-III-R; American Psychiatric Association, 1987) criteria for bulimia nervosa were analyzed. The Eating Disorder Inventory (EDI; Garner, Olmstead, & Polivy, 1983), the Zung Depression Scale (Zung, 1965), the Eysenck Personality Inventory (EPI; Eysenck & Eysenck, 1963), Goldberg’s (1972) General Health Questionnaire (GHQ), and five visual symptom severity and expectancy scales developed by the author were administered at pretreatment, immediate posttreatment, 6 weeks, and 2 years. Treatment included 4 weeks of behavioral therapy highlighting self-monitoring to establish healthy
eating patterns, followed by 4 weeks of hypnotherapy to enhance self-control of bingeing and vomiting episodes. Participants’ hypnotizability was measured pre- and posttreatment with the Stanford Hypnotic Clinical Scale (SHCS: Adult; Morgan & Hilgard, 1978–1979). There was a significant reduction in both bingeing and vomiting from pre- to posttest, pretest to 6-week follow-up, and pretest to 2-year follow-up. Eight of the 14 participants (57%) were abstinent from bingeing and 10 (71%) were abstinent from vomiting for 3 months prior to the 2-year follow-up. Participants reported significantly reduced symptoms on the drive for thinness, bulimia, body dissatisfaction, ineffectiveness and interoceptive awareness subscales of the EDI at the 2-year follow-up. There were no significant differences between pretest and the 2-year follow-up on the Zung Depression Scale, the EPI, or the GHQ.

These results suggest that an 8-week multifaceted treatment for bulimia may be effective over both the short and long terms in addressing specific bulimia symptomatology but not as effective in maintaining reductions in general psychopathology over a 2-year period. The outcomes also suggest that adding a self-hypnosis component subsequent to a behavioral treatment may aid participants in maintaining their progress during the 2-year posttreatment period.

The author (Griffiths, 1995b) cautioned, however, that several methodological issues limited the strength of the outcomes. The most significant problem was the lack of a control group. Others included self-reporting only, subjects potentially receiving additional treatment during the follow-up period, and use of a small sample. A more stringent test of hypnotizability, such as the Stanford Hypnotic Susceptibility Scale (SHSS:C; Weitzenhoffer & Hilgard, 1962), might also have been more informative than the measure used. Nevertheless, this study had much strength. In contrast to many of the previously reported case studies, this research appropriately incorporated formal pre- and post-test assessments, using standardized instruments of specific and non-specific bulimic pathology, hypnotizability, and outcome expectations. This adds further credibility to the results.

Griffiths, Hadzi-Pavlovic, and Channon-Little (1994, 1996) conducted a controlled evaluation to compare the effects of hypnобehavioral (HBT) and cognitive-behavioral treatments (CBT) for bulimia. Seventy-eight female participants between the ages of 17 and 50 who met the DSM-III-R criteria for bulimia nervosa were randomly assigned to either an HBT (n = 27) or CBT group (n = 23) or a wait-list control (n = 28). At the end of 8 weeks, the wait-listed participants were randomly assigned to CBT (n = 15) or HBT (n = 13). All participants received equal hours of individual therapy over an 8-week period. “Detailed manuals outlining style and content of HBT and CBT . . . were closely followed in each treatment session” (1996, p. 16). Hypnобehavioral treatment involved ego-strengthening suggestions, direct
positive suggestions for behavioral change, and self-hypnosis. In con-
trast, the focus of the CBT was on monitoring and challenging dys-
functional thoughts, beliefs, and values related to weight, shape, and
eating. Assessment measures included a patient information checklist,
the Eating Disorders Examination (EDE; Cooper & Fairburn, 1987), the
Eating Attitudes Test-40 (EAT-40; Garner & Garfinkel, 1979), the
EAT-26 (Garner, Olmstead, Bohr, & Garfinkel, 1982), the EDI (Garner
et al., 1983), and the Harvard Group Scale of Hypnotic Susceptibility,
Form A (HGSHS:A; Shor & Orne, 1962), plus measures of general
psychopathology.

Hypnotizability level was not repo rted, but the authors indicated it
was similar across the groups. They also concluded that the degree of
difference between the groups on the pretreatment variables measured
was not significant.

Immediate posttreatment outcomes indicated equal reductions in
bulimic behaviors and related eating pathology between the CBT and
HBT groups, with both showing statistically significant differences
from the wait-list control group. From the analyses conducted with the
original participants who completed the 9-month follow-up and did
not require further treatment, the authors found no differences between
CBT and HBT on eating pathology, bulimic behaviors, or general psy-
chopathology. It was also determined that both treatments were
equally acceptable to participants. From these findings, the authors
concluded that HBT could justifiably be recommended as an alterna-
tive to CBT for treating bulimia.

In evaluating this conclusion, it is  important to note that the first 4
weeks of both treatments involved behavior modification with self-
monitoring as the primary focus. Therefore, when considering the
effectiveness of both the CBT and HBT components, one must view
them as treatment phases following behavioral therapy. Midtreatment
assessments following the first phase of therapy would have facilitated
determining the specific effects of each treatment component. A
reporting limitation of this study is that the authors failed to indicate
the specific hypnotizability levels of the two groups when discussing
the similarities between their hypnotic capacities.

Barga and Barabasz (in press) compared CBT and CBT plus hypno-
sis (CBT+Hyp) in the treatment of women with bulimia. Thirty
women participated in the study and were alternately assigned to
treatments so that each treatment group originally had 15 participants
who met Diagnostic and Statistical Manual of Mental Disorders, fourth
edition (DSM-IV; American Psychiatric Association, 1994) criteria for
bulimia. Participants were recruited over a 2-year period. Due to attri-
tion, the total number of treatment completers included in treatment
comparisons and pre- and postfollow-up analyses was 14 (CBT+Hyp:
$n = 8$; CBT: $n = 6$).
Pretreatment measures included the Eating Disorders Examination-Questionnaire (EDE-Q; Fairburn & Beglin, 1994), the Beck Depression Inventory-II (BDI-II; Beck, 1996), and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, & Trexler, 1974). The BDI-II and the BHS were used to screen out participants. The EDE-Q was administered again posttreatment and at the 3-month follow-up. Additionally, a Weekly Behavioral Summary Sheet (WBSS), which asked participants to self-report daily frequencies of bingeing, vomiting, laxative use, diuretic use, fasting, and overexercising, was collected from participants at each therapy session, at posttreatment assessment, and at the 3-month follow-up assessment. Hypnotizability was assessed using the SHSS:C. Treatment completers had a mean score of 8.27 on the SHSS:C, ($SD = 1.82$). Treatment therapists remained masked to the hypnotizability level of participants.

The primary investigator for this research was a female doctoral candidate who facilitated all the assessments and conducted all but one of the CBT+Hypnosis treatments. The female therapists conducting the CBT treatments were trained in CBT and expressed confidence in its effectiveness.

Both treatments (CBT, CBT+Hyp) involved eight 60-minute, individual outpatient therapy sessions conducted over a period of 7 to 12 weeks. Detailed protocols were developed for the therapy sessions (Barga, 2005), and after each session therapists completed a corresponding checklist to assure standardization of treatment.

The therapeutic procedures were sequenced based on the stages outlined in Fairburn, Marcus, and Wilson’s (1993) CBT manual. Treatment was divided into three stages. Stage 1 involved teaching the cognitive model of bulimia, identifying participants’ thoughts and feelings about bulimia, and teaching clients to use the thought-monitoring log in Session 1. In Session 2 of Stage 1, thought-monitoring logs were discussed and behavioral strategies were introduced. In the second stage (Sessions 3–6), the focus was on promoting problem solving and applying cognitive restructuring during sessions. WBSS and thought-monitoring logs were collected each week. Participants’ behavioral practices and thought monitoring were reviewed, highlighting efforts and successes. Dysfunctional thoughts about body weight and shape and self were challenged. Problem-solving steps for effectively dealing with binge/purge triggers were taught and reviewed. The third stage (Sessions 7 & 8) was relapse prevention. Dysfunctional thoughts continued to be identified and challenged, and therapeutic progress and accomplishments were emphasized. Tips for preventing relapse were discussed.

For the CBT+Hyp treatment, the therapists provided the same CBT elements as described above. In addition, they integrated hypnosis as
an adjunct treatment beginning in the second session. Self-hypnosis was initially introduced into therapy as a means of developing relaxation. Participants were taught a simple eye-roll induction adapted from D. Spiegel (1996, pp. 102–103). Once hypnosis was induced, the researcher used a guided imagery and deepening script to increase relaxation and depth of hypnosis. Participants were taught this self-hypnosis procedure in session and instructed to practice it for relaxation once or twice daily.

Tapping into the typically high-dissociative capacity of individuals with bulimia (Barabasz, 1991; Covino et al., 1994; Pettinati et al., 1985), the researcher later worked with each participant to develop and to implement a tailored posthypnotic suggestion for reducing bingeing and compensatory behaviors and to reinforce rational thoughts about body weight and shape. Building on Barabasz’ (1990) work on posthypnotic suggestions for creating awareness in individuals with bulimia, the suggestion encompassed the awareness of four phenomena. These included (a) triggers precipitating urges to binge and to engage in compensatory behaviors, (b) negative consequences of bingeing/engaging in compensatory behaviors and benefits of not bingeing/not engaging in compensatory behaviors, (c) the participant’s control and choice over bingeing and engaging in compensatory behaviors, and (d) rational thinking about the participant’s body weight and shape. Participants were instructed to practice this hypnotic suggestion at least once daily.

Data on binge frequency and compensatory behavior frequency were collected at pretreatment, posttreatment, and 3-month follow-up with the EDE-Q and the WBSS. Body shape concern and weight concern were assessed at these times via the EDE-Q. Repeated measures MANOVAs showed a statistically significant effect from pretreatment to posttreatment for both groups on all variables and statistically significant lower binge frequency at posttreatment among the CBT+Hyp group than among the CBT group. Between-treatment nonparametric analyses revealed significantly less binge frequency and compensatory behavior frequency at posttreatment among the CBT+Hyp group than among the CBT group. Within-treatment analyses conducted with the CBT+Hyp participants indicated statistically significant improvement on all measures from pretreatment to posttreatment and pretreatment to 3-month follow-up.

In their book, Essentials of Clinical Hypnosis: An Evidence-Based Approach, Lynn and Kirsch (2006) reviewed the treatment of bulimia and obesity in a chapter coauthored with Maryellen Crowley and Anna Campion. They described how hypnosis can be used as an adjunct to cognitive-behavior therapy. As with other studies reviewed above, they drew upon the work of Fairburn as the basis for the cognitive-behavior therapy and in addition incorporated elements of interpersonal
interventions. They noted that incorporating hypnosis into treatment usually added one to three sessions to the 20-week program.

They recommended using formal assessment employing validated instruments such as the Eating Attitudes Test (Garner & Garfinkel, 1979), the Eating Disorder Inventory–2 (Garner, 1991), the Eating Disorder Examination (Cooper & Fairburn, 1987), and the BDI. They described three stages of therapy. In the first stage (Sessions 1–10), the focus was on education, developing alternative methods of weight control, and teaching self-monitoring of eating behaviors. They provided specific hypnotic scripts, e.g., for posthypnotic suggestions for self-monitoring of dysfunctional behavior, and for helping clients to focus on the benefits of change. In the latter half of Stage 1, the focus was on record review, reinforcing the model and education. They provided a hypnotic script to help clients become more interpersonally oriented and less focused on food and eating behavior.

Stage 2 consisted of eight sessions and focused on cognitive restructuring. “Once the pattern of binge eating is interrupted and less consistent, cognitive restructuring and problem solving can begin” (Lynn and Kirsch, 2006, p. 111). An important goal of Stage 2 was to reinforce the fact that the root of the problem is extreme dietary rules. They provided a hypnotic script to help clients reintroduce forbidden foods gradually and with control. Consolidation and maintenance of treatment gains was the goal of Stage 3. It was oriented to helping clients to set realistic expectations and develop plans to deal with urges to binge or purge. Unfortunately, no data was provided about the efficacy of the intervention.

Interestingly, all three treatments cited above were based on the cognitive-behavioral approach to the treatment of bulimia developed by Fairburn. Yet, as can readily be seen, the authors incorporated hypnosis into the treatment in very different ways. When treating such a multifaceted disorder as bulimia, there are many ways to employ hypnosis in treatment. This underscores the need to provide sufficient information to replicate.

Barabasz (1990) used posthypnotic suggestions to help three women enhance their awareness and control when they prepared to overeat, preventing the dissociative experience often associated with binge and purge behavior. At the outset of the study, all participants demonstrated high hypnotizability (scores of 9, 10, and 11) as assessed by the SHSS:C. After building rapport in a 2- to 2½-hour person-centered individual session with each participant, Barabasz (1990) introduced posthypnotic suggestions for awareness and control of binge urges. In each of the cases, no bingeing or purging behavior was reported after the initial session. However, as a relapse prevention measure, the same suggestions were given within a 7- to 10-day period following the first session. At a 3-month follow-up assessment, all 3 participants continued
to report binge and purge abstinence. With the exception of one binge episode, the first 2 participants reported no further bingeing and purging at 6-, 9-, and 12-month follow-ups. At the 6-month follow-up, the third woman expressed concerns about being overweight, even though she had experienced a weight loss of 8 kilograms, and apparently reinitiated bingeing, purging, and fasting once the weight concerns became intrusive.

Barabasz (2000) described a detailed case study of a cognitive-behavioral treatment addressing the dysfunctional cognitions associated with bulimia nervosa.

**HYPNOTHERAPY IN THE MANAGEMENT OF OBESITY AND WEIGHT REDUCTION**

In her article, *Research on Hypnosis as an Adjunct to Cognitive-Behavioral Psychotherapy*, Schoenberger (2000) notes that the “number of published studies is relatively small, and many of them have methodological limitations. . . . Currently, the efficacy of hypnosis as an adjunctive treatment remains unresolved” (p. 151). She says that hypnosis . . . as an adjunct to cognitive-behavior therapy for obesity was listed as a “possibly efficacious treatment” (Chambless et al., 1998) based on the results obtained by Bolocofsky et al. (1985). Other research in this area produced conflicting findings, however, those studies were not well designed or methodologically rigorous. (p. 165)

The issue of conflicting results was resolved according to the recommendations of Chambless and Hollon (1998).

Bolocofsky, Spinler, and Coulthard-Morris (1985) compared the effectiveness of a behavioral treatment and a behavioral treatment plus hypnosis on weight loss. The initial sample consisted of 156 participants (154 females, 2 males). Participants were randomly assigned to one of two treatment conditions and then randomly assigned to one of the therapists. Therapists were 13 female and 14 male psychology students who underwent an 8-week training program. They then were supervised in treating 2 clients (not included in the data analysis) for 9 weeks. Each subject met with a therapist once a week for 9 weeks. In the first session for the behavioral group, participant history was obtained and self-monitoring skills were taught. In the second session, the first three rules about eating and dieting were presented and the goals and specific examples of interventions (e.g., presenting additional rules) for the third through ninth sessions were provided. The hypnosis group received the same instructions and treatment as the behavioral group with the following additions. In the first session, the nature of hypnosis and its use was discussed. Subjects were asked to practice LeCron’s (1964) self-hypnosis at least once a day for at least
4 days. In the second and subsequent sessions, subjects were hypnotized using a progressive-relaxation form of induction and suggestions were presented that reviewed the program rules. In the final session, maintenance plans were developed for all subjects. Data were collected during therapy and at 8 months and 2 years following termination. The final sample consisted of 57 participants in the hypnosis treatment and 52 behavioral clients. Both treatments resulted in a significant weight loss from initial to final sessions. The behavioral plus hypnosis group demonstrated a significant additional amount of weight loss at 8-month and 2-year follow-ups. Little additional change was demonstrated by the behavioral group. The authors concluded that “hypnosis may have served as an effective motivator for subjects to continue practicing the more adaptive eating behaviors acquired during treatment” (p. 40).

Chambless and Hollon (1998) note that “meta-analyses can provide useful summaries of large bodies of empirical studies” (p. 14) but caution that the quality of the studies included needs to be considered and there needs to be confidence in the data.

Kirsch, Montgomery, and Saperstein (1995) conducted a meta-analysis of studies comparing CBT with and without hypnosis. The results of their meta-analysis indicated that “hypnosis substantially enhanced treatment outcome, so that the average client receiving cognitive-behavioral hypnotherapy showed greater improvement than at least 70% of the clients receiving nonhypnotic treatment” (p. 214).

Kirsch (1996) conducted a third meta-analysis of the effects of employing hypnosis as an adjunct to cognitive-behavioral treatment. This analysis focused on treatment for weight loss and concluded that the “addition of hypnosis appears to have a significant and substantial effect on the outcome of cognitive-behavioral treatment for weight reduction, and this effect increases over time” (p. 519).

One of the studies included in the Kirsch et al. (1995) and Kirsch (1996) meta-analyses was Barabasz and Spiegel (1989). Sixty-one participants who desired hypnosis to aid in overeating control were randomly assigned to (1) a behavioral self-management weight-loss procedure (n = 14); (2) the same behavioral self-management weight-loss procedure plus hypnosis employing the hypnotic induction and administration of instructions for weight loss and self-hypnosis from H. Spiegel and Spiegel (1978, p. 220–223) (n = 16); or (3) the same procedure as Group 2 except with alternative suggestions targeting aversion to specific high caloric, frequently consumed foods (n = 15). Follow-up data were collected 3 months after treatment. Participants in Group 3 who were exposed to suggestions for specific food aversion lost significantly more weight than the behavioral-management-only group. The behavioral group plus general hypnosis approached significance. Hypnotizability was measured using the SHSS:C. For Group 1,
there was no correlation between hypnotizability and weight loss; for Group 2, the relationship approached significance; and for Group 3, the relationship was significant. The authors explained that the participants “were instructed to reconceptualize their goal, not in terms of fighting the desire for certain foods but rather as primarily involving a desire to protect their bodies from the poison of overeating and to eat with respect for their bodies” (Barabasz & Spiegel, 1989, p. 339).

**Hypnotherapy in the Management of Anorexia**

The high hypnotizability of women with bulimia has resulted in a great deal of attention to the treatment of bulimia with hypnosis. It should be noted, however, that Pettinati et al. (1985) found that women with anorexia had a higher level of hypnotizability than average. The use of hypnosis in the treatment of anorexia nervosa is complicated by the issues of control associated with anorexia. However, the following treatment paradigm and case study provide excellent treatment guidelines.

Baker and Nash (1987; see also Nash & Baker, 1993) presented the following treatment paradigm for treating anorexia nervosa noting that women with anorexia “are a relatively heterogeneous group” (p. 188). Therefore, different aspects of the treatment approach were emphasized more or less with different patients depending on their individual needs and specific treatment responses. First, hypnosis was introduced to the client as a means of gaining enhanced self-control associated with various opportunities for increased security and mastery. Structured and permissive induction techniques were utilized. Early in treatment hypnosis interventions were specifically designed to enhance the client’s personal sense of power, to increase capacity for autonomous functioning, to support the therapeutic alliance, to provide a sense of ego support that leads to mastery and expectations for success. They discussed the use of hypnotherapeutic interventions that could be used to deal more directly with the core pathological features associated with anorexia nervosa; once the client learned how to use self-hypnosis and the therapeutic alliance has been strengthened, they presented techniques to deal with body-image distortions in hypnotherapy. Corrections in body-image distortion were seen as closely associated with the issue of integration or an appropriate and mature sense of personal identity. The use of hypnosis to explore negative affect and distorted attitudes toward eating was discussed. When body imagery and general identity integration were improved, clients’ general capacity for mastery was enhanced. Their multifaceted treatment approach was used successfully with 36 women with anorexia. Follow-up data at 5 and 12 months indicated that 76% of the patients demonstrated a remission of symptoms and an acceptable, stabilized weight. In contrast, of 38 women who were treated identically without the use of the
hypnotherapeutic paradigm, only 53% achieved the same level of symptom remission and stabilized acceptable weight.

Hornyak (1996) provided a detailed case presentation of an anorexic patient with false-self adaptation from a self-developmental, object-relations framework. She provided a detailed conceptualization of the case. Treatment lasted for 20 months, and Hornyak described the initial phase that focused on self-regulation. In the second month of treatment, hypnosis was introduced when Hornyak noticed the client “slipping away” and introduced the concept of dissociation and hypnosis. Later, when the client was agitated, hypnosis was used for relaxation—introducing the client to mastery and control of tension states. Next, the treatment goals of affect identification and symptom management to achieve self-regulation were pursued. Food talk was translated into feeling talk. Hornyak gave examples to the client of typical responses that served as an induction when she observed that the client was mildly dissociated. She also gave specific examples of ego-strengthening suggestions that she used. In the second phase, she worked with self states. She provided the client with a “parts metaphor” based on ego-state theory. Hornyak describes a hypnotic intervention for the frustrated self state. Phase 3 focused on autonomy and separation concerns. Hypnotic interventions designed to accentuate the experience of separateness were employed. During this phase, a hypnotic imaginary-mirror exercise was also employed. In the fourth or “wrapping up” phase, the themes of the first three phases continued to be addressed. A hypnotic session addressing internalization and integration issues was taped and given to the client. Hornyak stated that this “case illustrates the way in which hypnotic interventions can strengthen the self structure by providing needed self experiences within the context of a supportive relationship” (p. 70). The client contacted Dr. Hornyak almost 3 years after termination and reported continued progress. Although at one point she had lost 5 lbs., she had regained the weight.

Barabasz (2000) presented a case study example of an intervention for dealing with body image distortion with a woman with anorexia, which would lend itself to integration/replication.

**SUMMARY AND CONCLUSIONS**

Chambless and Hollon (1998) state “Psychological treatment research is not informative to the field if one does not know what treatment was tested; nor can researchers replicate an undefined treatment intervention” (p. 9). This review focused on hypnosis research in the treatment of eating disorders that provides the conceptual framework and methodological detail that would facilitate replicability. Replicability is crucial for hypnosis interventions to be labeled efficacious.
As noted above, Chambless and Hollon (1998) consider a treatment to be efficacious if two or more studies conducted by independent research teams prove treatment more beneficial than no treatment (e.g., waiting-list control), and the findings are not contradicted by others. Note: there are specific criteria for resolving such differences. Due in part to the lack of procedural specificity, replications from independent research teams on the treatment of eating disorders is lacking.

Under certain conditions (see Chambless & Hollon, 1998) treatments can be considered efficacious if not found to be significantly inferior to an established efficacious treatment. This would seem to be the most promising area of efficacy research, where hypnosis employed as an adjunct to an established treatment intervention is compared to the intervention alone, such as in Baker and Nash (1987), Barga and Barabasz (in press), and Griffiths et al. (1996).

Treatments found to be superior to conditions that control for non-specific processes (e.g., attention) or to another bona fide treatment are labeled efficacious and specific in their mechanisms of action. The results of Barga and Barabasz (in press) and Baker and Nash (1987) are consistent with this requirement although other Chambless and Hollon (1998) criteria may not be fully met.

Nash (2000) notes that adoption of the Chambless and Hollon (1998) guidelines is not a problem in evaluating the efficacy of
dot dot dot a more or less pure form of hypnotic intervention dot dot dot (e.g., with warts or asthma) but is a problem when the researcher seeks to test if hypnosis confers extra benefit when integrated with more general treatment approaches, such as cognitive-behavioral therapy or psychodynamic therapy. (p. 109)

Eating disorders are complex disorders and “pure forms of hypnotic interventions” are atypical. However, researchers should consider the possibility of testing such interventions as in the Barabasz (1990) study.

Frederick (2005) noted that some psychotherapeutic approaches such as cognitive-behavioral orientations lend themselves to demonstrating the criteria for “efficacy” in contrast to, for example, ego-state psychotherapy. This article has reviewed hypnotic treatment interventions for eating disorders representing integration into different theoretical orientations. It is apparent that the literature on cognitive-behavioral interventions may more easily and frequently provide the specific information required for replication. However, as exemplified by Hornyak’s (1996) case study, long-term (20-month) treatment of a woman with anorexia from a self-developmental, object-relations framework can be described in sufficient detail and with sufficient specificity of treatment interventions to allow replicability. Unfortunately, journal articles generally do not allow for the breadth and
depth of information provided by Dr. Hornyak in her book chapter. However, the treatment paradigm described by Baker and Nash (1987) provides conceptual and methodological detail that would facilitate replicability.

The description of the cognitive-behavior therapy plus hypnosis intervention for bulimia and obesity in Lynn and Kirsch (2006) would be an excellent conceptual and methodological basis for an empirical investigation.

Reviewing the literature on hypnosis and eating disorders within the Chambless and Hollon (1998) and Lynn et al. (2000) criteria/recommendations, I have focused primarily on the importance of the conceptual and methodological detail provided in evaluating efficacy. It is entirely possible that many researchers could have provided such necessary information if they had recognized the importance of doing so. However, it is painfully apparent that this needs to be a major consideration in the design and reporting of hypnosis research in the future, and scientific journal editors would be well advised to allow full descriptions of treatments—as do some journals in the field—rather than restricting article lengths to very limited word counts, such as is the policy of the American Journal of Clinical Hypnosis (currently 4500 words).

Finally, Chambless and Hollon (1998) also set forth the criteria for defining efficacy on the basis of single-case experiments. A treatment is considered to be possibly efficacious if it has been proven to be beneficial to at least 3 participants by a single group. Multiple replications with at least 3 participants by two or more independent research groups are required to establish a treatment’s efficacy. This might prove a reasonable avenue for establishing the efficacy of hypnotic interventions for more difficult to recruit participants such as anorexics.

Comprehensive information on the design and conduct of hypnosis research involving case study and group comparisons can be found in Barabasz and Barabasz (1992). An excellent guide to single-subject research using time series analysis appears in Borckardt and Nash (2002).

REFERENCES


Effektivität von Hypnose bei der Behandlung von Essstörungen

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L’efficacité de l’hypnose dans le traitement des troubles de l’alimentation

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La eficacia de la hipnosis en el tratamiento de los trastornos alimenticios

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Resumen: La investigación sobre la eficacia de la hipnosis en el tratamiento de los trastornos alimenticios ha producido resultados mixtos. Esto se debe en parte a la interacción entre las características de la gente con los trastornos alimenticios y los fenómenos de la hipnosis. Además, varios autores han notado que las limitaciones metodológicas en la investigación de la hipnosis frecuentemente hacen difícil la evaluación de su eficacia como tratamiento. Muchos de los estudios existentes no proveen información suficiente con respecto a las características de la intervención hipnótica como para facilitar la corroboración e implementación clínica. Por lo tanto, esta revisión sólo describe la literatura con descripciones metodológicas replicables y se enfoca en los 3 desordenes primarios de interés para los clínicos: bulimia nervosa, anorexia nervosa, y obesidad. Menciono también las implicaciones para evaluar la eficacia del tratamiento.

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