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Article

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Using Hypnosis to Explore Subconscious Childhood and Early Adulthood Emotional Traumas and Situations Predisposing Towards Adult Refractory Obesity

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Qualitative Study

Abstract

Background: It has been suggested that many participants in weight management programmes are unable to achieve the permanent emotional and psychological changes necessary for long-term weight loss maintenance because of their having unrecognised, unresolved childhood food, eating, or weight associated traumas that continue to influence their adult eating habits and body self-image, and impair their weight reduction efforts. Hypnosis is now accepted as a valuable tool in the management of many chronic clinical conditions because of its efficacy in producing remedial behavioural change in individuals with seemingly intractable health problems. Hypnosis would therefore seem to be an ideal tool for identifying and resolving possible childhood obesogenic subconscious agendas, and in helping individuals with refractory obesity to minimise any recidivistic weight regain.

Methods: Seven participants with refractory obesity agreed to undertake a series of regression hypnosis sessions designed to allow them to search for childhood and teenage experiences that might be contributing to their current inability to lose weight.

Results: During their hypnosis sessions, each of these participants was able to recall childhood or early adulthood memories of emotional traumas or parental disharmony, which resulted in their making aberrant decisions at that time about their food preferences, eating habits, or their chosen body image. These episodes had subsequently become subconsciously internalised, but had gone on to have a significant and lasting, detrimental effect into their adult years, leading to their subsequent adult obesity.

Conclusion: This study has shown how covert, long-forgotten childhood emotional experiences can play an aetiological role in refractory adult obesity. It has also demonstrated the cathartic role of regressive, exploratory hypnosis in bringing to light such unresolved traumas in order for them to be discharged, and thereby, in facilitating future efficacious weight loss management.

Keywords: Hypnosis, Obesity, Childhood emotional trauma, Case studies

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Introduction

Obesity – the nature of the problem: The World Health Organisation (WHO), in their lengthy report of 2000 (WHO Technical Report Series No. 894), highlighted their fears of a global epidemic of obesity and how this might be prevented. The subsequent wealth of publications and of national and world statistics all attesting to the scale of the growth rate in obesity has reaffirmed the percipience of this report. Obesity has indeed become an increasing problem throughout the western hemisphere (Flegal, Kruszon-Moran, Carroll, Fryar, & Ogden, 2016), such that the Organisation for Economic Co-operation and Development (OECD) recently cited USA, Mexico, and England as the countries currently with the highest rate of adult obesity, with projected levels of obesity for 2030 of 48%, 38%, and 35%, respectively (OECD, 2017).

Despite the best efforts of governments, public health and primary care agencies, and commercial weight management clinics, current approaches towards managing acute obesity and chronic refractory overweight have only had limited success for many individuals and groups of people (Lean & Hankey, 2018; Cleo, Glasziou, Beller, Isenring, & Thomas, 2019; Varkevisser, van Stralen, Kroeze, Ket, Steenhuis, 2019). It would seem that standard weight management algorithms with their pedagogic focus on diet, exercise, and lifestyle advice, for many individuals, do not have the power to modulate food and eating habits and customs. Psychological therapies such as cognitive behavioural therapy (CBT), counselling, meditation, and lifestyle coaching are frequently recommended as adjuncts to standard weight and exercise protocols. However, the efficacy of such approaches in promoting the permanent emotional and psychological change necessary for long-term weight loss maintenance, and in reducing recidivistic return of weight previously lost remains unclear (Gurgevich & Nicolai, 2014; Volery, Bonnemain, Latino, Ourrad, & Perroud, 2015; Entwistle, 2016; Bo et al., 2017; Milling, Gover, & Moriarty, 2018). It would seem, therefore, that the time has come to look again at ways of maximising the potential of hypnosis in tackling this major health reducing and life-threatening problem.

A brief history of the use of hypnosis in weight management: A review of publications between 1950 and 2000 on obesity management using hypnosis concluded that most reported trials showed little or no benefit from the use of hypnosis as a weight-reducing tool. These studies generally involved small numbers of participants or individual cases and were rarely randomised, placebo-controlled studies with any long-term follow-up (Entwistle, Webb, Abayomi, Johnson, Sparkes, & Davies, 2014). Most published studies employed motivational approaches, predominantly of a socio-cognitive or authoritarian nature, employing combinations of suggestion, aversion therapy, anxiety reduction, and pedagogically delivered imagery designed to change habits and societal attitudes. It is not surprising therefore that, in the face of such poor results, hypnosis fell out of favour after 2000 and there was a subsequent dearth of academic papers on hypnosis in obesity management, despite the growing need for solutions to this major health problem (Entwistle et al., 2014).

It has been suggested that the poor performance of hypnosis in many of these early studies, as well as the recidivistic weight regain regularly reported in current weight management programmes might both be the result of the same phenomenon. That is, some individuals, who experience long-term, seemingly intractable obesity and regularly regain any weight they do lose, do so because of their having subconscious unresolved childhood emotional situations or traumas associated with their early food, eating, and body weight awareness (Entwistle et al., 2014). Such experiences have

left them with embedded obesogenic agendas that continue to echo throughout their adult life rendering these as aetiological factors for their adult overweight and obesity. These unrecognised subconscious imperatives are responsible for both their becoming overweight and obese, and for the difficulties they then have in losing this weight and successfully maintaining their weight loss after participation in weight management programmes (Entwistle, 2014).

In this situation, hypnosis when undertaken from a sociocognitive standpoint would very likely have only a limited efficacy and be little better than conventional non-hypnotic instructions for change. Until any such childhood obesogenic issues are identified and resolved, the obesity problems of many such individuals will continue to have only a limited response to simple pedagogic algorithms, as their deleterious subconscious agendas will continue to oppose such change and any resolution of their obesity. This paper describes the author's novel, case study use of an exploratory hypnotherapy approach, which was able to elicit and identify early life events, and emotional associations that appear to have been instrumental, in part at least, in engendering adult refractory overweight in a selected group of individuals. Only when the participants in this study were able to see and understand the impact that their childhood experiences had had on the development of their eating and weight problems, could they begin to deal with this effectively.

Methods

Study design: This was a multiple case, single system research study utilising a self-selected cohort of individuals with long-term overweight or obesity problems that had proved refractory in previous, commercial, National Health Service (NHS), or self-devised weight programmes. Participants with recurrent recidivist weight regain were particularly welcomed in this study. Participants needed to understand the premise of the study, that it was not just another short-term weight reduction program, but was an investigation into whether their obesity problems could be the result of their having unsuspected and unresolved childhood food and eating related experiences with which they needed to deal. The study would also determine whether hypnosis could be an effective way of exploring this possibility and, in doing so, helps them in their future weight losing efforts.

Participant recruitment and preparation: Participant recruitment for this project was through an email circulation across the university campus and by opportunistic word of mouth. The email poster gave brief details about the project and the inclusion criteria for participating. These were principally that participants be over 18 years of age, have a history of being unable to achieve a sustained reduction in their weight after having participated in more than one weight management scheme, and have exhibited a BMI greater than 25 over the past five years. Current active treatment for severe physical or mental health conditions was regarded as an excluding factor for this project. Ethical advice and approval for this study was obtained from Liverpool John Moores University Research Degrees Committee (Reference SIS no. 514041).

After being first approached by the researchers, all volunteers were given the opportunity to discuss the project either in person or on the telephone and were then given a copy of the participant information leaflet, an extensive six-page document describing the project. The information leaflet also described the various stages of the project with approximate timescales for these stages and the need for an audio-tape record to be made of all of the interviews and conversations that the researcher and the participants would have together. Those volunteers who wished to continue further were invited to discuss the project in more detail in a more formal face-to-face interview

Table 1. Participant recruitment and outcome

Stage Attained	Reason for not Continuing Further	n
Initial enquiry only	Not appropriate	2
	Too busy	4
	None given	2
Completed forms	Too busy	2
Attended interview	Family illness	1
Left programme before commencing hypnosis	Personal health problems	2
	Family bereavement	1
	Work pressures	1
Left programme after commencing hypnosis	Personal health problems	1
Total number of enquirers	-	22
Participants included in this study	-	7

with the researcher, at which point they would have the opportunity to ask further questions about the project and in particular about hypnosis itself.

In total, 22 individuals (20 women and 2 men), with self-admitted overweight problems, made initial enquiries and obtained further oral and/or written information, but as table 1 illustrates, most of these chose to withdraw early in the process because of personal circumstances, despite their initial interest in pursuing this approach to managing their weight problem. This left seven female participants none of whom had had any previous personal experience of hypnosis, and who went on to sign their formal consent form and take part in the project.

Table 2 gives some brief demographic details of participants and the number of sessions each was able to undertake. Each of these participants had a long history of refractory obesity associated with recidivistic weight regain on more than one occasion.

Participants were given the choice of where they preferred their hypnosis sessions to take place, in their own homes or in a different setting, and most opted to be seen at home. Hypnosis sessions always began against a soothing background of relaxation music. Participants were not required to talk whilst in hypnosis, as it was felt that this might lighten the degree of the trance state experienced, but were instructed to allow each particular visualisation to progress uninterrupted. On occasions however, an ideomotor signal was used to monitor the progression of the visualisation. During their hypnosis sessions, participants were observed closely in order to detect any physical changes that might suggest that they were having an emotional reaction.

After each session, once they were fully awake, the participants were quizzed about their memory of and overall experience of the session. They were asked about how much of the particular visualisation they could remember and how vividly they had been able to picture their safe place. They were also asked whether there was anything about this session that was different from their earlier sessions, or that was not as they expected it to be.

Table 2. Participant demographics

Reference code	Age	Height in metres	Weight in kilograms	BMI	No. of sessions
01	47	1.60	106	41	3
02	57	1.57	102	41	12
03	50	1.60	104	42	16
04	40	1.60	92	36	20
05	27	1.65	84	31	15
06	41	1.73	89	30	10
07	44	1.57	68	28	10

BMI: Body mass index

The participants were asked if there had been any pictures or memories that had come into their head during their visualisation that had surprised them, and about any unexpected emotions or feelings that they experienced during the session. Both sides of this conversation were recorded verbatim using a BBC quality Olympus DM670 hand-held recorder for subsequent transcription and analysis.

Immediately before each subsequent session, participants were given the opportunity to reflect upon how they had felt since their previous session. This included discussion about any unexpected emotional ups and downs they had experienced in the interim, any surprising and spontaneous changes in their behaviour, any flashbacks, recurrent memories, and ruminations over events and people from their past. Participants were encouraged to talk about any changes they had noted in the extent and content of their dreaming and about how they would interpret such dreams. All such pre-hypnosis conversations were recorded and transcribed verbatim for comparison with participants' previous and subsequent hypnosis remembrances.

After each hypnosis session, the researcher had a brief final conversation with participants immediately prior to their leaving to confirm that they were completely out of hypnosis and fully re-associated. This was important in order to minimise the risk that they would remain in a state of so-called "alert or awake hypnosis" (Alarcón & Capafons, 2006; Wark, 2011; Crabtree, 2012), especially if they were driving themselves home.

Induction of hypnosis and choice of visualisation and regression scripts: Hypnosis induction always began with focused abdominal breathing and progressive muscle relaxation followed by the participant descending ten steps down into their self-chosen "safe place". After being talked through the particular visualisation session, the session would be concluded by the participant returning up their ten steps back to full awareness, noticing as they did whether their steps had in any way changed as a result of their visualisation.

For the present study, the specific hypnosis scripts employed for exploratory and analytical hypnosis sessions were the author's personal adaptations of some well-established approaches as suggested by Wolberg (1948), Hartland (1966), Erickson (1980), Gibson & Heap (1991), Hammond (1990), Heap and Aravind (2002), and Brann, Owens, and Williamson (2011), and the author's professional training association, the British Society of Clinical and Academic Hypnosis (BSCAH). Although it is possible to derive highly specific hypnosis scripts using a "Delphi" approach (Arnon, Brodsky, Matter, Attias, Ben-Arye, & Schiff, 2017), it was felt preferable to employ familiar scripts that the author had modified, honed, and personally tested over 30 years of hypnosis practice, and which had been specifically re-phrased to suit the needs of this particular study. In total, they comprised two generic problem searching and solving scripts, four regression scripts (the "Corridor", the "Diagnostic Scan", the "Magic Carpet" timeline, and the use of the word "BACK" as a trigger-word), six individualised ego-enhancement and lifestyle modifying scripts, an ideomotor establishment script, and a habit modifying/reframing script. These are all described in detail elsewhere (Entwistle, 2016).

Each hypnosis session was followed by a discussion, which was tape-recorded. A further appointment was then agreed upon with the participant and they were reminded of the need for them to keep a record of any unexpected emotional or behavioural change or of any seemingly significant dreams or dreaming occurring in the interim.

Results

General observations about regression hypnosis in this study: The number of hypnosis sessions undergone by participants in this project varied from three sessions to twenty sessions according to the availability

of the participant and their personal and family commitments. There was also a wide variation in the length of the pre-hypnosis and post-hypnosis conversations ranging from only one or two minutes to 30 minutes. On occasions, there were significant telephone conversations and text messages were exchanged with participants between their planned hypnosis sessions. Recording and transcription of all such conversations and other communications between participants and the researcher were undertaken as carefully and as comprehensively as possible in order to record and retain all the nuances of the conversations and interactions. In this way, it was hoped to portray an accurate narrative record of each participant's personal hypnosis journey of discovery, and of their response to the overall hypnotic invitation to "go back to times and events, people and places, feelings and emotions which are in some way linked to your present problem".

Irrespective of the number of sessions for which they were able to attend, all participants in this study made significant discoveries and connections relating their childhood experiences to their current adult obesity. Regression hypnosis proved to be a powerful means of illuminating the long-term impact that specific traumatic childhood experiences can have on subsequent adult eating patterns and on the choice of body size and shape. All seven of the participants spontaneously recalled long forgotten childhood episodes, events, relationship problems, and emotional traumas, which they remembered had at the time become powerful influences on their childhood attitudes towards food, eating, or their childhood body shape and size.

These recollected past memories, as they came flooding back, felt very painful, and were frequently accompanied by strongly emotional reactions as the individual participants' realised how much they had been holding on to these feelings from their past. They recalled very powerfully the anger, fear, and sadness at the decisions that they had felt forced to make during their childhood and teenage years about their food and eating. Only during their hypnosis sessions did they realise with surprise that they had internalised these feelings to the extent that they subsequently had become subconscious raisons d'être for their adult obesity.

From the many hours of recorded discussion with participants, there is only room in this paper for a brief overview of the childhood family and domestic experiences, traumas, and events that participants' realised during their hypnosis sessions were still influencing their current eating habits and body image. A more comprehensive and verbatim account of participants' childhood experiences as recalled and recounted during the course of their hypnosis sessions is being prepared for publication elsewhere. However, the following extracts will give an indication of the range of childhood experiences that can adversely affect the subsequent development of a healthy adult body weight and shape. This will indicate the great potential of regression hypnosis in elucidating the aetiology of refractory obesity.

The Impact of Childhood Experiences on Adult Obesity: With the use of "state" regression hypnosis, it was possible to identify three distinctly separate decision-making processes that participants had employed as children in response to their specific aberrant childhood emotional and social environments. Because of their pervasive nature, these initially pragmatic decisions had become internalised and gone on to become a part of their adult subconscious agenda, their "storied bodies and storied selves" (Sparkes, 1999) that came to determine their future eating habits and/or their adult body size and shape.

Type One Effects: For three of the participants, parental attitudes and habits surrounding food and dietary choices had had a direct impact on participants' own understanding of food and eating, leading them as children to adopt poor or

inappropriate food choices and eating habits, which they maintained into their adult life.

Participant 02's hypnosis session immediately took her back to her father who was an inveterate meat eater. In regression, this participant relived childhood episodes when she was forced to eat offal, pig's heads and feet, and the like. "I used to stand there crying, thinking of the poor animal, and began to hate eating any of the food". She became very distressed at the killing of animals for food, and instead chose to live on a diet of junk food and chocolate, which then became the norm into her teens and adult life.

Participant 04 was a teenage mother with little knowledge of what constituted a healthy, nutritious diet for herself, her partner, and her baby, and no mother to guide her. All she knew was that babies needed to put on weight, and that husbands needed "feeding up". As a result she was "panicked into choosing cheap, sugary, easy foods, for my baby, myself, and him", and developing a very complicated, confused, and guilty attitude towards food and food choices. Participant 06 recalled being always hungry as a child as her parents did not provide suitable meals, "I was constantly hungry, and constantly looking in cupboards for food…searching around the house for anything to eat". Starting in her childhood, therefore, and continuing into her teens and as an adult, she hoarded food and binged on comfort food, especially biscuits and chocolate, whenever she could.

Type Two Effects: Three of the participants became aware of how their childhood and early adult experiences had resulted in their making conscious decisions at that time to allow themselves to develop an overweight or obese body weight, size, or shape. These decisions had then become internalised and were never reviewed or updated, and hence, continued to influence and determine their choice of body weight, shape, and size into their adulthood.

Participant 07 was surprised at how distressed she became during her early hypnosis sessions when she recalled being 11 years old and the boys teasing her constantly in her school because she had developed a large bust, which contrasted sharply with her otherwise very slim body. "I absolutely hated anybody looking at my figure, 'cause I felt like they were being vulgar". She remembered frantically over-eating to put on weight to disguise her bust. She later recalled being physically abused by her father and then later by her first boyfriend, and how this reinforced the need and her efforts to become, and to stay, big and heavy to withstand this abuse. Two other participants, 06 and 04, powerfully recalled during their hypnosis regressions, how they had chosen as very young teenagers to become obese as a means of avoiding unwanted sexual approaches. It was cathartic for both of them to realise that this decision had continued to influence their adult life, as it explained the self-blame, the reluctance, and even fear that they had both always felt as adults at the thought of losing weight.

Type Three Effects: Four of the participants realised for the first time during their regression hypnosis sessions, how their past adverse emotional environment had led them, unawares, into their becoming overweight, in order to use this obesity as a self-defence, self-punishment, or substitute for a perceived lack of love. Effectively, their excessive body weight had become a protective psychological carapace (Type Three Effects).

Participant 01 had become overweight soon after she was adopted into a difficult family environment. She recalled powerfully in hypnosis, how she felt unloved and unwanted by her adopting parents as well as by her birth mother, and that as a child she could not understand why no one could love her. Although not initially overweight at the time of her adoption, in hypnosis she remembered deciding as a child that if she became a "fat child" this would be a more emotionally acceptable reason for her being unlovable rather than her simply being a "not

nice person". Participant 02 realised during her hypnosis sessions that she "needed" to hold on to her weight as she was still in mourning for lost family members. If she lost weight now, "how would they recognise me".

During her "magic carpet" fly-by of her life, participant 03 was able to see clearly how her weight had fluctuated since developing self-esteem problems at six years old, increasing at times of school stresses and bullying, and professional problems, then normalising at good times in her life. For this participant, her weight and large body had become containment for her poor self-esteem, and most recently, a subconscious device for distracting other's attention away from the "inadequate" person she felt herself to be inside.

Participant 05 had put on a great deal of weight in her early teens for which she had been made to feel culpable and guilty, especially by her GP practice. Only after many years of increasing obesity, was her weight problem discovered to be the result of an undiagnosed hormonal condition. This was duly treated and her weight became more easily controllable, until that is, she needed to lose weight in order to try for a much-wanted baby, when her weight once more became a problem. During her hypnosis sessions, she became aware of how much guilt she retained from her teenage years of being overweight, and how she was punishing herself now by letting her weight become a barrier to her becoming pregnant. She realised that "I do constantly blame myself … that it's my fault that I put weight on … I realise now that is what I am doing, blaming myself yet again."

Discussion

Using hypnosis as an exploratory tool in refractory obesity: This project was not in itself directly aimed at engendering weight loss in the participants involved. Rather it was designed to help these participants explore their past childhood and early adulthood to ascertain whether they could identify any long forgotten unpleasant events and traumas which might have become adversely associated with their food or eating habits or with their body weight or shape. The premise of this study was that decisions made during such turbulent times could be continuing to play a part in these participants' adult lives, and have an aetiological role in their overweight situation by actively impairing their ability to achieve effective and sustained weight loss as adults. In discovering, understanding, and resolving such subconscious agendas, participants could be empowered into developing effective mechanisms that could help them change this situation for the future.

All seven of the participants in this study found that they were able to go into a hypnotic trance very readily right from their very first session which surprised them greatly. It would appear that for this highly self-selected cohort, the decision to volunteer into this project was intuitive, and that it was prompted as much by their *unconscious* as by their *conscious* mind. The researcher's experience of working for many years with patients and clients seeking hypnosis or counselling has seemed to indicate that there is a time and tide for subconscious decision-making and processing in hypnosis, counselling, and similar therapies. This it is that triggers the sudden desire and the drive to seek help, rather than other, more obvious conscious and pragmatic motivations.

Veracity and internal validity of hypnotic regression data: Questions naturally arise about the validity of participants' revealed and recounted narratives, especially in the light of the limitations widely expressed by many regarding the credibility of hypnotically revealed memories (see: Brown, Croft Caderao, Fields, & Marsh, 2015; Mazzoni, Laurence, & Heap, 2014; Patihis, Ho, Tingen, Lilienfeld, & Loftus, 2014; Scheflin, 2013; Entwistle, 2016; Entwistle, 2017). No formal attempts were made to corroborate the revealed "facts" about participants' earlier life or childhood that appeared as part of these evoked narratives.

Such corroboration would be hard to obtain, partly because of the length of time since these recalled episodes had occurred, and partly because they would not at the time have been seen as singularly dramatic or historically significant enough events to have been noticed or commented upon by other family members or friends.

Nonetheless, throughout the generation of these participants' ethnographies there was sufficient innate evidence pointing to the validity and veracity of the events and emotional connections being evoked in hypnotic regression. Such evidence came from several directions. First, there was an internal coherence about these narratives, once the whole story was revealed in its entirety. This was so even if the route to these revelations was circuitous and of a surreal "Alice in Wonderland" nature. It is true, as Smith and Sparkes (2002) have discussed, that the seeking for coherence is a common feature of all personal and therapeutic narratives and can often merely reflect the needs of the storyteller rather than constituting absolute proof of veracity. Nevertheless, there was an iterative nature in the way that sessions repeatedly and spontaneously returned to the same chronological age or geographical place or emotion until a given traumatic episode had been resolved – and not until.

The emotions expressed and released during sessions appeared subjectively and objectively very genuine, and were often accompanied by that "eureka" feeling, that what had now been disclosed by the participant's *unconscious* mind should have been clear to the participant's *conscious* awareness all along, and over all of the intervening years. Frequently, the visualisation as planned by the researcher was "hijacked" by the participant's unconscious mind that had other plans for that session. Often what was visualised in a given session made no sense on its first play, but only became clear on subsequent replays, a process difficult to reproduce or fabricate consciously and deliberately. Between their sessions, participants frequently experienced emotional "ups and downs", often accompanied by flashbacks, vague memories and significant-feeling dreams, all of which could only be best explained as the signalling of subconscious processing and change (Fillion, Clements, Averill, & Vigil, 2002; Pennebaker, 1997; Brann et al., 2011).

The majority of the events surfacing during participants' hypnosis sessions were ones that the participants could have consciously remembered if prompted. However, what was discovered through hypnotic regression was the connection between these childhood experiences and the consequent decisions made at the time, and the participant's current adult weight and eating problems. These connections constituted part of these participants' inner narrative, and as such, their obesity had become part of the structural interrelationship between mind and body, between the subconscious and the conscious, their "storied bodies and storied selves" (Sparkes, 1999).

Conclusion

What has been highlighted by this study is the value of hypnotic regression in identifying the degree to which parental and other adult carers' dysfunctional relationships and behaviours with their children can influence, albeit unwittingly, these children's future relationship with food, eating, and body self-image. In addition, hypnosis was able to reveal the impact of aberrant child rearing practices on children's ultimate adult resilience, motivation, and self-confidence.

The guilt that most of these participants discovered within their self-examined past, and which they realised they had held onto from their childhood or teenage years, would seem to have been placated by the compensatory comfort of food, so that their eating was being triggered more by emotional than physiological signals. Clearly,

closely associated with this guilt in these participants' narratives was the development of adult poor self-worth, and low resilience and ego strength (Karasu, 2012; Moore & Cunningham, 2012; Wang, Wu, Yang, & Song, 2015), all of which would have made them more vulnerable and susceptible to stressors (Kradin, 2012).

Hypnosis has a dual value in ameliorating this situation, first, by its facility to allow the exploration, discovery, and resolution of these past, but still on-going, deleterious processes, which is in itself therapeutic and healing. Second, hypnotic visualisations can expedite a rebuilding of self-worth, resilience, and ego strength by allowing individuals to seek out lost and misplaced core skills and qualities in order to reclaim them and be able to generalise them for use in their present and future lives. This self-empowerment and the letting go of guilt by making peace with their childhood traumatic past are vital steps to becoming a stronger and more resilient person, who is then able to understand and change the nature of his/her eating behaviour.

The unravelling of such childhood emotional and psychological connections and attributions can be difficult, time-consuming, and painful. This is a role for which a "state" dissociative hypnosis approach, rather than the more usually employed motivational "non-state" socio-cognitive option, would appear to be more appropriate. Hypnosis undertaken in this manner can facilitate the externalisation and objectification of our past and troubled histories in a way that enables a clearer understanding of the otherwise fruitless internal and internecine battles that we all have in our heads and in our minds.

Conflict of Interests

Authors have no conflict of interests.

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