THE USE OF HYPNOSIS AS AN AUTO-ETHNOGRAPHIC MODALITY IN THE EXPLORATION AND MANAGEMENT OF OVERWEIGHT AND OBESITY

SELECTED CASE STUDIES

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“Truth is nothing but a path traced between errors.”

Franz Anton Mesmer, 1799

“If we cannot see things clearly we will at least see clearly what the obscurities are.”

Sigmund Freud, 1926

“It’s no use going back to yesterday, because I was a different person then.”

Alice, in Alice's Adventures in Wonderland, Lewis Carroll

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However this work would not have been possible without the help of my participants who very bravely volunteered to undertake an expedition into the unknown regions of their past and who allowed me to share this journey with them. I hope and believe that we are all a little wiser from our hours spent together.

ABSTRACT

The increasing incidence of obesity around the world has become a major problem with health and economic implications for most countries, and one which currently available methods of weight management including diet, exercise and lifestyle advice all seem incapable of controlling. The premise of this project was that some instances of adult obesity could be due to adverse, unresolved childhood traumas and experiences the consequences of which were continuing to act subconsciously in those individuals to impede effective and maintained adult weight loss; and that hypnosis was an appropriate exploratory tool for identifying and resolving these problems to facilitate more effectual weight management. For this purpose a group of seven overweight female volunteers were invited to undertake a series of "state", dissociative hypnosis sessions involving regression back through their childhood and early adulthood. The resulting recalled autobiography from each participant's series of hypnosis sessions was recorded, transcribed and analysed to constitute a piece of narrative autoethnography of their childhood past.

All seven participants in this project were able to utilise hypnosis effectively to enable them to recall barely remembered past events, feelings and connections which, they realised for the first time as adults, had had a major and long-lasting impact on how they felt about food, their body weight or their body image. Hypnotically recalled memories of guilt and anger were associated with dysfunctional family relationships and childhood eating experiences. For most of these participants the strength of the association between these past times and feelings, and their current long-term overweight problem came as a total surprise. Even in advance of any weight loss most participants were inspired by their discoveries and felt that the telling of this hidden story had had a transformative benefit for them in bringing about reconciliation with the past, understanding of the present and planning for their future. These narrative accounts and results suggest that hypnosis might have wider application for use as an ethnological modality in sociology and health studies more generally.

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Unconscious Agendas in the Etiology of Refractory Obesity and the Role of Hypnosis in Their Identification and Resolution: A New Paradigm for Weight-Management Programs or a Paradigm Revisited?

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PREFACE

As a senior clinical scientist I have worked in the National Health Service and in Private Medical Practice for over 50 years. My research interests during that time have been numerous but principally in enzymology, protein biochemistry, and most recently working in an assisted conception and In Vitro Fertilisation (IVF) unit researching the parameters of sperm functionality in male and female infertility. However it was in 1983 whilst managing the fertility treatment unit for a national charity that I first became interested in the possible role of hypnosis in exploring and influencing interactions between the mind and the body. Whilst working with the many infertile couples attending this unit I quickly came to realise that not only were stress and anxiety the natural consequences of infertility and failed fertility treatments - but I began to believe that emotional problems of this same nature could in themselves be the cause of infertility *per se*, and that poorly managed anxiety, stress and depression from the past could be playing a part in the aetiology of some patients' subfertity or infertility by adversely and measurably influencing their physiology, biochemistry and endocrinology. Moreover such physical and physiological problems were frequently, and inexplicable, refractory to standard pharmacological and surgical treatment regimes.

Additionally I was aware that a further high percentage of the patients in the unit who were unable to achieve a pregnancy naturally and even with assistance, had apparently no discoverable reason for their infertility despite extensive medical investigations, and as a result were diagnosed as suffering from "unexplained infertility". This situation is not uncommon and estimates of the frequency of such unexplained infertility around the world vary, with figures as low as 8% and as high as 30% quoted by researchers, infertility units and patient support groups (Veltman-Verhulst, 2012; Kamath & Bhattacharya, 2012; Ray *et al*, 2012; Dickey, 2015), whilst Brandes *et al* (2011) have claimed that this is still one of the

most common infertility diagnoses. Nonetheless despite the dismissive label of "unexplained infertility" I felt that there must be a reason for these patients' fertility problem and if no physical one was discernable then I surmised that it might be that there was an emotional barrier preventing conception. However most patients with such unexplained infertility did not show any significant signs of stress or depression other than that appropriate and attributable to their negative diagnosis, and to the distress of their being given no reason for their failure to achieve a pregnancy and no recourse to any further treatment for their problem. For this reason I felt that any such emotional barrier to their fertility must be deeply buried, and that it was going to require a psychological therapy with considerable power in order to be able to determine whether this group of patients had an emotionally generated infertility, and to be able in turn to alleviate their problem.

I therefore decided in 1984 to explore an hypnotherapeutic approach which I felt might be of help both in managing such patients' emotional distress, and in facilitating the exploration of possible psychological routes to promoting fertility enhancement. For this reason I undertook training in hypnosis with the now defunct, National Association for Hypnotists and Psychotherapists (NAHP). This hypnotherapy training was very much based on the John Hartland approach, a predominantly socio-cognitive, pedagogic modality (Hartland 1961, 1971; Kirsch and Lynn, 1998; Pekala *et al*, 2010a, 2010b), where an hypnotic trance state is used primarily to deliver repeated instructions and visualisations for improving physical and emotional health, in effect providing a "mantra" for the focusing of mental attention on the end result needing to be achieved. This is the approach that forms the basis of hypnosis usage in many other, non-therapy contexts including sport (Iglesias & Iglesias, 2011; Uneståhl, 2015), education (Conley *et al*, 2015) and dance (Riley, 2012; Karageorghis et al, 2012), and is the one utilised in stage and nightclub performance hypnosis. However my course of training included also some of the exploratory dissociative elements of Milton Erickson (Erickson, 1980; Sheehan & McConkey, 1982; Lankton & Lankton, 1983; Lankton, 2013), Michael Heap (Gibson & Heap, 1991; Heap, 2012) and

Brann *et al*, (2012), in which the impact of past experiences and traumas are explored through hypnotic regression therapy. The histories and relative merits of these two theoretical approaches has been the subject of much academic debate for many years and this controversy is discussed in detail, along with a brief history of the early roots of hypnosis, in appendix D.

Having completed this course, to further strengthen my alternative therapies credentials, I obtained the Diploma in Fertility Counselling at the London Hospital, Whitechapel, a qualification specifically designed to address the needs of people suffering with infertility, and who may be having to deal with the emotional and psychological rigours of its consequent invasive treatments. I also undertook training in Gut Directed Hypnotherapy under the auspices of the highly acclaimed clinician hypnotherapist Dr. Peter Whorwell (Miller *et al*, 2015), and I obtained the diploma in acupuncture from Active Acupuncturists in General Practice and Hospital (AAGH), studying under Dr. Charles Walker. Most recently in 2014 I updated my hypnosis skills by completing a further diploma in hypnosis with the nationally recognised medical hypnosis association the British Society for Clinical and Academic Hypnosis (BSCAH).

In 1984 I began using hypnosis clinically, working initially with patients attending the charity's infertility unit, before moving on to become the counsellor with the IVF unit where I was also the research scientist, and subsequently, and in response to the demand, began to develop a private infertility hypnosis practice based in Liverpool and in Harley Street, London. Overall my clinical approach entailed using a combination of counselling skills and hypnotherapy for those patients whose infertility was long-standing and appeared refractory to conventional treatments. My hypnosis sessions were particularly focused on the use of dissociative hypnosis regression visualisations for these patients (Gibson & Heap, 1991; Heap, 2012; Brann *et al*, 2012) which allowed them to explore their earlier years looking for hidden barriers and connections which might be impairing their fertility. Used in combination with the teaching of relaxation skills and the use of ego-enhancing and motivational

visualisations, these hypnotherapy sessions were frequently efficacious in helping patients to discover and to deal with past issues and connections which had been impeding their fertility, thus enabling them to move forward into a more positive and fertile present and future. Using this approach many subfertile and infertile individuals with apparently unexplained fertility or with infertility symptomologies refractory to standard treatments, discovered to their surprise that they had covert subconscious agendas which appeared to be proscribing fertility or conception. These related to unresolved emotional traumas and distress from their childhood and early adulthood which had become connected with their fertility or with their becoming a parent. Once these were brought to light and could be analysed by the adult that they had since become, such issues became manageable and resolvable, and ceased to be a part of their lives, thus allowing their fertility to increase and making more likely the chances of a conception.

In those early days this combination of emotional therapy and formal hi-tech fertility treatment was innovative and attracted the attention of the Media. As a result, over the subsequent 12 years, the hypnosis approach I was using in Liverpool and in my London, Harley Street and Wimpole Street practices was reviewed on many occasions in the national press and in magazine articles (Entwistle & Turner, 1986; Entwistle, 1988a; Entwistle, 1988b; Entwistle, 1989; Entwistle, 1990a; Entwistle, 1990b; Entwistle, 1992), my work was also featured on BBC Radio Four, BBC Womens Hour and BBC World Service, and I delivered over 30 lectures and informal talks to national and local infertility support groups, talking about the efficacy of hypnosis as an exploratory tool in unexplained infertility.

I first came into contact with the Nutrition Unit staff at Liverpool John Moores University five years ago, in my role as a student support worker. It was only then that I fully appreciated that overweight and obesity was as common and as serious a health condition as was infertility. It was apparent that the out of control increase in the incidence of obesity was not just a problem in the UK, but as the wealth of published papers and reports testified, many other countries in both the developed and the developing worlds were also having to

tackle a major “epidemic” of obesity (Ogden *et al*, 2016; Skinner *et al*, 2016; Flegal *et al*; Ludwig, 2016). This was and still is having an increasing impact on the medical services, social services and budgets of these countries, one which current dietary, exercise and psychological advice and guidance programmes all seem relatively ineffective in controlling. It also appeared to be that this obese population included a large percentage cohort of individuals with refractory overweight and an unaccountable failure to achieve long term maintained weight loss despite their dietary and exercise regimes. This group of individuals could be regarded, in part at least, as being unexplainedly overweight, a condition which might therefore be amenable to hypnosis therapy.

However before I could begin to begin to design a study of the possible value of an hypnotic approach to weight management and make a case for this, I needed to understand more about the scale of the obesity problem, and about currently available approaches to weight reduction and their failings. This proved to be a major task in itself as the range of publications on obesity causation and treatment seemed close to outnumbering the population of obese individuals themselves. Nevertheless this time was well spent as it did help to reaffirm for me a belief in the need for a fresh and radical look at current theories of overweight and obesity aetiology and management. This thesis therefore begins with a review of the literature on the causes and the treatments of obesity, in which the currently available options for achieving weight loss are examined and discussed in the light of their efficacy and failings. This review looks firstly at the two most commonly used approaches to achieving weight loss those of diet and exercise, followed by an examination of the role of food supplements, pharmacologicals, surgery and alternative therapies. This is followed by brief reviews of the various psychological and lifestyle interventions advocated for weight management, and concludes with an analysis of the history and usage of hypnosis for weight reduction.

From this literature survey it became apparent that the majority of these programmes and interventions, worthy though they may be, are not in themselves proving powerful enough

to engender the permanence of psychological change that long term weight loss maintenance requires. It seemed to me therefore that there was a strong possibility that for many individuals with particular obesity problems not readily responsive to standard educative approaches, there might be an inner, psychological drive which was not responsive to simple pedagogy and common sense formulas, and which necessitated a deeper reaching psychological approach to elucidate. Without appropriate therapeutic help, this deleterious psychological situation was likely to remain in the unconscious realm of many such individuals with refractory obesity, and that these individuals were likely to go on to perpetuate their repeated cycles of weight loss and weight regain. From my experience with fertility, one therapeutic approach which would appear to have the facility and the power both to identify and to resolve such unconscious barriers and agendas would seem to be hypnotherapy.

My premise for this present project therefore is that subconscious factors and agendas might be playing a similarly important role in "unexplained obesity" as in "unexplained infertility", and that hypnosis and hypnotherapy might be a useful therapeutic modality in explaining weight gain and facilitating weight loss in individuals with long-term refractory overweight and obesity. I have therefore transposed my fertility approach to exploring unconscious barriers in a way that it can be used to ascertain whether the hypnotic trance state has an applicability in identifying the subconscious concomitants of overweight and obesity. This premise and approach is one that has already been described in a recent publication (Entwistle *et al* 2014), and the various hypnotic visualisation scripts developed for this study are described in full in appendix A. Appendix D outlines the complex history and development of hypnosis from its mid-18th century roots as "mesmerism" and discusses the many dilemmas and much dissent still current in defining and describing the phenomenon of hypnosis.

Using this approach a small cohort of obese volunteer participants have undertaken a series of hypnosis sessions designed to allow and encourage their unconscious minds to

take them back into their past to look for and re-experience forgotten occasions, events, interactions and feelings which have for some reason become enjoined in the causation of their refractory overweight and obesity, and which need resolving in order for them to achieve maximum efficacy from their usual dietary and exercise regimes. During the course of this project, as I started to accrue hypnotically revealed biographies of these participants, I increasingly sensed that hypnosis could have a wider application in sociology for use as an ethnographic modality. I have now come to believe that hypnosis could in effect be utilised in a generic way as a means of exploring an individual's past experiences to produce an autoethnographic biography of the recollections and memories stored in their unconscious mind. In chapter four of this thesis therefore I discuss how hypnosis might function in this manner and have attempted to provide an analytical critique of the potential of hypnosis as a sociological, ethnological and anthropological tool.

CHAPTER ONE - LITERATURE REVIEW

1.1 SOCIAL AND MEDICAL IMPLICATIONS OF OBESITY

Obesity has become a growing problem over the past two decades, throughout the Western hemisphere (Flegal *et al*, 2016; Ludwig, 2016) especially, but increasingly also within developing countries (Lewis & Basu, 2016; Stokes & Preston, 2016; Arnold, 2016; Smith & Smith, 2016; Aschner, 2016). The fears of a global epidemic of obesity and how this might be prevented were highlighted by the World Health Organisation in their lengthy report of 2000 (WHO Technical Report Series No. 894), and these fears have been echoed and amplified by the subsequent wealth of national and world statistics, and of publications, all attesting to the scale of the growth rate in obesity. The WHO estimated that in 2004 1.6 billion people worldwide would be overweight and at least 400 million would be obese, and these figures were predicted to rise to 2.3 billion and 700 million respectively by 2015 (ibid). Figures for the UK indicate that England is developing one of the highest obesity rates in Europe (Hilton *et al,* 2009; Department of Health, 2011) and the fourth highest incidence of obesity-associated cancer (Arnold et al, 2014), with an increase in male obesity (BMI>30) from 13.6% to 24.0% between 1993 and 2004, and a rise in the incidence for women from 16.9% to 24.4% over the same period. Zaninotto *et al's* 2009 prediction for 2012, of an incidence of adult obesity in the UK of 32.1% and 32.0% for men and women respectively, with manual social classes reaching 43%, seems set to continue into 2020 (NHS Health and Social Care Information Centre 2013), even if there is some hint that this rate of increase might be slowing down (Sperrin *et al*, 2013).

There is also a rising incidence in the UK of morbid obesity (BMI>40), from 1% in 1993 to 2.2% in 2007 (Knight *et al*, 2010), whilst in 2008 29% of UK children aged 5-17 were categorised as obese (Scarborough *et al*, 2008). Papers by Canoy & Buchan (2007), Sacks,

Swinburn & Lawrence (2009), Stern & Kazaks (2009), Selassie & Sinha (2011), Swinburn *et al* (2011), Samper-Ternent & Snih (2012) amongst many, have all referred to the challenge that this presents to the maintenance of the long-term health and welfare of populations around the globe. Recent data for childhood obesity in the United Kingdom (van Jaarsveld & Gulliford, 2015) appears to support the possibility of some stability in the rate of increase of childhood obesity (at least in the under 11 year olds) and similarly in Russia (Jahns *et al,* 2012). However Hamilton-Shield & Sharp (2015) caution that the childhood obesity crisis in England is far from over, and perhaps the general picture therefore still appears to be as pessimistic as the 2000 WHO report feared.

Whilst it is still unclear how body weight is optimally maintained (Cannon & Nedergaard, 2009; Heinhelm, 2011; Flegal *et al*, 2014), the implications of being overweight are clearly not just cosmetic or social (Finer, 2011; Ludwig, 2016). Being obese is a risk factor for many clinical problems including cardiovascular disease (Hall *et al*, 2010: Mathieu *et al,* 2010; Miller *et al*, 2012; Gillison *et al*, 2012; Booth *et al*, 2013; Rider *et al*, 2014; Hajifathalian *et al*, 2015), and for type-2 diabetes with its increasing implications for the developing countries (Dandona *et al*, 2004; Yach *et al*, 2006; Hossain *et al*, 2007; Shigetoh *et al*, 2009; Oza-Frank *et al*, 2009; Melanson *et al*, 2009; Shaw *et al*, 2010; Wing *et al*, 2011; Mainous *et al*, 2014; Huxley *et al*, 2015), as well as being a causal factor in childhood and teenage diabetes (Lloyd *et al*, 2010; Han *et al,* 2010; Tzoulaki *et al*, 2010; Spruijt-Metz, 2011). Excess adiposity is acknowledged as being a causal agent for the metabolic syndrome, as adipose tissue is a storage site for inflammatory cytokines, adiponectin and angiotensinogen which together generate a syndrome of low-level inflammation, accompanied by hypertension (Bender, 2008; Mathieu *et al,* 2010; Miller *et al*, 2012; Mica *et al,* 2014; Morris *et al*, 2015). Recent studies have highlighted also the increasing incidence of childhood obesity in the USA (Ogden *et al*, 2016; Skinner *et al*, 2016).

1.2 THE MULTIPLE CAUSES OF OVERWEIGHT AND OBESITY

In order to devise appropriate and efficacious individual and group programmes for weight management and achieve long-term weight reduction, it is clearly necessary to gain an understanding of the causality and aetiology of weight gain. In simplistic terms, being overweight is an imbalance in the homeostatic control of the "energy intake ⇔ energy expenditure" equation, whereby the body takes in just enough energy via eating, as it is currently utilising in its activities, whilst maintaining an appropriate and predetermined reservoir of carbohydrate as glycogen in liver and muscle stores, and fat as triacylglycerol in adipose tissue. For the individual, and for society in general to begin to tackle effectively the obesity problem, it is necessary to identify, attribute, quantify and attend to, the various factors – genetic, epigenetic, prenatal, nurtural, biochemical/hormonal, psychological, social and commercial, which for the individual or the community, can contribute towards failure in maintaining appropriate homeostatic control (Butland *et al*, 2007; Kit *et al*, 2014).

The incidence of gestational obesity is continuing to rise, resulting in an increasing proportion of babies being born to mothers who are overweight (Heslehurst *et al*, 2013a; 13b; Briley *et al*, 2014; Fox *et al,* 2014; Meehan *et al*, 2014; Zozzaro-Smith *et al*, 2014; Davis, *et al*, 2014; American College of Obstetrics and Gynecology, 2014; Knight-Agarwal, 2014). Gestational weight gain, which has been associated with poor body image in overweight mothers-to-be (Zhixiab *et al*, 2013; Shloim *et al*, 2015), has been shown to be a predictive factor for subsequent development of childhood obesity (Rooney *et al*, 2011), and Biro *et al* (2013) have emphasised the crucial role of midwifes in monitoring and reflecting back such excessive gestational weight gain in their patients. However a note of caution has been voiced by Warin et al (2013) ("Mothers as smoking guns"), about the dangers of further and unfairly castigating women at a crucial point in their lives, by allocating yet further blame on them for the health and weight of their offspring. Nevertheless there is clear evidence now accrued to show that obesity induced intra-uterine factors can lead to an obesogenic uterine environment, which can then, perhaps in

association with a genetic susceptibility (Freeman, 2010), programme a biochemical and physiological propensity in the foetus towards obesity, and consequent diabetes (Strakovsky & Pan, 2012), as well as prejudicing future neonatal and child growth and predisposing towards other childhood and adolescent ailments (Bellver, 2009; Maheshwari, 2010; Knight *et al*, 2010; In-Iw & Biro, 2011; Han *et al,* 2010; Ehrenberg, 2011; Archer, 2014; Santangeli *et al*, 2015; Ogden *et al*, 2016; Skinner *et al*, 2016).

Children conceived to obese women are themselves liable to be overweight at birth, and remain so, becoming fat children and obese adults, with various health problems including diabetes, insulin resistance and metabolic syndrome (Freeman, 2010; Catalano *et al*, 2009; Oken, 2009; Lloyd *et al*, 2010; Sonneville *et al*, 2012; Prior & Armitage, 2009; Robinson *et al*, 2015). The role of breast feeding in preventing, or encouraging this neonatal obesity has been the cause of much debate, and many reviews and metanalyses (O'Tierney *et a*l, 2009; Ahuja *et al* 2011; Stolzer, 2011; Kulie *et al*, 2011; Nambiar *et al,* 2013; Yan *et al,* 2014; Lefebvre & John, 2014; Marseglia *et al*, 2015; Carling *et al,* 2015), amongst many. The consensus of the majority of these studies is that breast feeding is beneficial and protective against excessive weight gain for most mothers and babies (Ramirez-Silva *et al,* 2015) and is particularly important for mothers with type-2 diabetes, whose babies are prone to hypoglycaemia (Rasmussen *et al*, 2015). O'Tierney *et al* (2009) have suggested that undue prolongation of breast feeding can prejudice towards childhood overweight and Ji *et a*l (2014) have shown that in rats at least, neonatal over-feeding can enhance early onset fatty liver deposition.

The value and the risks factors associated with breast feeding where there is maternal or pre-existing neonatal obesity both appear unpredictable (Lefebvre & John, 2014; Marseglia *et al,* 2015), which may be related in part to the higher glucose and insulin levels demonstrated in the breast milk of some obese mothers (Ajuha *et al*, 2011). Rosas-Vargas *et al* (2011) have suggested that maternal stress and a poor pre-natal social situation can generate epigenetic modifications in some women such that their subsequent children

develop elevated CNS levels of brain-derived neurotrophic factor (BDNF) and consequent obesity and behavioural problems. From the male perspective, studies in rats have shown that epigenetic changes in sperm brought about by high fat levels in the adult males can imprint signals for metabolic disorders in the subsequent young (Teague, 2011; Martire *et al*, 2014), as can early life traumas (Gapp *et al* 2014) and low maternal folate levels (Lambrot *et al* 2013).

Even without this prejudiced start to life however there are many factors acting to increase the likelihood of neonates becoming overweight children and adults. These can include over- or inappropriate feeding behaviour on the part of parents (Prior & Armitage, 2011; Chivers *et al* 2012; Jennings *et al,* 2012; Skouteris, 2012; Santoncini *et al*, 2013); maternal weight, and parents' eating and dieting habits during their children's early childhood (Roos *et al,* 1998: Li *et al*, 2008; Paradis *et al,* 2009; Webber *et al*, 2010; Vos and Welsh, 2010; Sonneville *et al*, 2011; Sonneville *et al*, 2012; El-Behadli *et al,* 2015); and parental (and especially maternal) concerns, conceptions, conversations and subsequent information provision, on eating and weight issues (Chivers *et al* 2012; Gonzalez *et al*, 2012; Santoncini *et al*, 2013; Moroshko & Brennan, 2013; Tanner *et al,* 2013; Thomas, *et al* 2014; Van Allen *et al*, 2014; Wellard *et al,* 2014 MacDonald *et al*, 2015; Krömker *et al*, 2015). Scudder *et al* (2015) have also demonstrated that children with risk factors for metabolic syndrome exhibit poorer inhibitory control and lesser cognitive flexibility than non-risk children.

The development of inefficient or poor sleep patterns has also been linked to increased adiposity in children (Mcneil *et al*, 2015: Chuang *et al*, 2015). Interestingly a major review of the literature by Bleich *et al* (2011), in examining the findings of 26 studies, came to the conclusion that there was no consensus as to whether the increase in childhood obesity was the result of increased intake or decreased expenditure of energy. This may well be the case, as also may be the contention of Waynforth (2010) that a more laissez faire, less pedagogic approach to food provision for children will naturally lead to more healthy eating habits. Nevertheless the available evidence remains highly significant, that overweight, and

an elevated BMI in childhood and during adolescence, are both highly correlated with obesity, raised BMI and cardiovascular problems in adulthood (Ylihrsila *et al,* 2008; Stovitz *et al*, 2008; Stern and Kazaks, 2009; Juonala *et al,* 2011; Spruijt-Metz, 2011).

Psychosocial and socioeconomic aspects of early childhood also play a major part in determining the degree to which exposure to and acceptance of overweight leads on to long-term and adult obesity, with poverty and its associated lifestyle concomitants therefore being major determinants of obesity (Ball *et al*, 2002; Stovitz *et al,* 2008; Hajata. *et al,* 2010; Mahera *et al*, 2010; Spruijt-Metz, 2011; McCormack *et al*, 2011; Levine, 2011; Gonzalez *et al*, 2012; Mitchell *et al,* 2011; Holm-Denoma *et al*, 2013; Lane *et al*, 2013; Schumacher *et al*, 2013; Van Hulst *et al,* 2015; Walsh & Cullinan, 2015; El-Behadli *et al*, 2015). Parental and childhood traumas and adversities, along with childhood maltreatment and sexual, physical and emotional abuse, have all been shown to be associated with an increased prevalence of body image dilemmas, anorexia and obesity in adult life, as publications and surveys by Tamayo *et al* (2010), Crosnoe (2012), Richardson *et al* (2013), Lane *et al* (2013), Salwen *et al*, 2014, Danese & Tan (2014), Hemmingsson *et al* (2014), El-Behadli *et al* (2015), amongst others have indicated. Sexual abuse has been long recognised as a frequent associative if not necessarily causative factor in precipitating anorexia and bulimia nervosa in female teenagers and in young women (Carter *et al*, 2006; Castellini *et al*, 2013; Dworkin *et al*, 2014; Racine & Wilde, 2015), but evidence is accruing of a similar association between childhood sexual abuse and refractory obesity in adulthood (Lissau & Sorensen, 1994; Pine *et al,* 2001; Friedman et al, 2015; Rossiter *et al,* 2015).

The move from neonatal overweight to childhood obesity is also influenced by the cultural differences evident with regard to perceptions of childhood body weight and BMI ideality, and the accuracy and inaccuracies with which these are assessed by parents of different ethnicities, as Gardner *et al* (2010), Chan & Wang (2013), Lundahl *et al* (2014), Schooler & Daniels (2014), Mareno (2014), Gordon & Mellor (2015), Black *et al* (2015), Kakinami *et al* (2015), Farajian *et al* (2015) and others have indicated, which can add to the difficulty of

predicting and preventing future childhood and adolescence obesity (Rooney *et al*, 2011; Morandi *et al,* 2012). This may necessitate the development of specifically designed tools for the measurement of appetite and eating behaviour in children as Nelson & Davis (2013) and Braet *et al* (2014) have suggested. However there is no doubt that many overweight and obese children do go on to become depressed and obese teenagers and adolescents, carrying forward their childhood weight misconceptions and maladaptive lifestyles (Anderson *et al*, 2010; Chivers, 2011; Gonzalez *et al*, 2012; Woolhouse *et al*, 2012; Schumacher *et al,* 2013; Santoncini *et al*, 2013; Pinhas *et al*, 2013; Berge *et al*, 2014; Fitzpatrick, *et al*, 2015). As a result with much childhood and teenage obesity it can be unclear at times whether the obesity is the cause of, or the result of, their depression (Britz *et al*, 2000; Onyike *et al*, 2003; John *et al*, 2005; Simon *et al*, 2006; Mather *et al*, 2009; Hickman *et al*, 2012; Lieberman *et al*, 2012; Freitas-Rosa *et al,* 2013; Hart *et al*, 2013; Jahromi *et al*, 2013; McBride & Cole, 2014). Once established, obesity becomes perpetuated by most children's and teenager's easy access to fast foods and to constant exposure to obesogenic food advertising (Lobstein and Dibb, 2005; Zimmerman, 2011; Veerman *et al*, 2009; Shrapnel, 2012).

Inactivity and a sedentary life has long been assumed to contribute to overweight and obesity and there is evidence that this is the case for both children (Mushtaq *et al*, 2011; Mitchell *et al*, 2011; Williams & Mummery, 2012) and adults (Tomer, 2011; Scarborough *et al,* 2011; Church *et al,* 2011; Cleland & Ball, 2013), but a dissenting voice is that of Metcalf *et al* (2011) who felt in their study of childhood obesity that it was the overweight that was causing the inactivity and they could find no evidence of the reverse process. However as most overweight individuals become less active their weight continues to increase, which in turn exacerbates their inactivity, and the resulting combination of excessive eating and a sedentary live steadily increases body weight, BMI and associated health problems. Without a change in their lifestyle they will remain morbidly obese and incur all of the problems that this engenders. Paradoxically reduced sleep has been associated with

diabetes and hyperlipidaemia (Zizi *et al,* 2010; O'Keeffe *et al* 2013; Cooper *et al*, 2015; Larcher *et al*, 2015). Yang *et al* (2012) have suggested that there are obesity problems are also generated by the inherent unsuitability of the conventional Western diet for maintaining a healthy weight, as the content of this consists of cereals of predominantly high glycaemic index (Berti *et al*, 2005), and which are less satiating (Shrapnel & Noakes, 2012).

Many emotional and behavioural scales have been devised to assess eating motivation including Tylka's (2006) Intuitive Eating Scale, The Trait and State Food-Cravings Questionnaire as modified by Nijs *et al* (2007), the Three Factor Eating Questionnaire, (Stunkard & Messick, 1985; Keranen *et al*, 2010), the Food Craving Acceptance and Action Questionnaire (Lillis & Hayes, 2008; Juarascio *et al*, 2011), The Emotional Eating Scale (Arnow *et al,* 1995), the Yale Food Addiction Scale of Gearhardt *et al* (2009b), Renner et al's (2012) Eating Motivation Survey, and others. All of these questionnaires appear to have their relative merits and demerits. Westenhoefer *et al* (1994) in their studies on the disinhibition phenomenon and its cognitive control raised doubts about the validity of interpreting the popular Three Factors Eating Questionnaire-disinhibition scale at face value, suggesting this was better seen as a measure of "susceptibility to eating problems"; whilst Koball *et al* (2012) have added additional questions to the Emotional Eating Scale of Arnow *et al* (1995) to include an assessment of "boredom" eating.

Clearly it is not within the scope of this present work to review and discuss in detail all of the many factors which play a part in maintaining body size, shape, weight and BMI in the normal, healthy individual, and which therefore can adversely influence these parameters when homeostasis goes wrong. As the Foresight series of maps (Finegood *et al*, 2010) indicates there so many factors and process acting individually and in tandem to promote and provoke overweight and obesity, that it is not surprising that there have been so many different approaches to managing obesity.

1.3 NON HYPNOTIC INTERVENTIONS FOR WEIGHT REDUCTION

(i) Diet and Exercise Approaches

The history of weight reduction programmes stretches back many centuries, as Schwartz (1986), Foxcroft (2011), Gilman (2008) have all described, but it was during the 19th century that diets and dieting first became fashionable on a large scale, popularised by the Banting high fat moderate protein diet which initially was so denigrated by the medical profession (Taubes 2008). The 20th century saw the commercialisation of dieting with the Dukan, Atkins and Ornish diets, and the appearance of slimming aids, specialised foods and foods supplements, along with the now familiar and omnipresent advertisements for slimming clubs such as *Slimming World*©, *Weight Watchers©, LighterLife©, Mayo Clinic©, Conley*© and *Cambridge*© Diets (Foxcroft, 2011: Bijlefeld & Zoumbaris, 2014). A brief non-academic "Google" search will produce around 2.5 million entries for "weight reducing diets", 9 million entries for weight reducing clubs and 885 million entries for weight reduction plans! Clearly the battle lines against adiposity have been drawn even though the war against obesity is not proving easy to win.

Diet based approaches to weight reduction and maintenance can be broadly divided into the more conventional dietary regimes based upon supposedly scientific theories as to what mix of dietary macronutrients will best reduce weight, blood pressure and diabetes risk; and the more radical diets, often built around pre-packaged, commercially prepared meals, and which frequently entail severe restrictions on what can be eaten and in what combination, such as Gerson©, Macrobiotic, Hay©, Grapefruit, Beverley Hills©, Zone© diets, amongst many other similar prescriptive and proscriptive diets (Foxcroft, 2011). Only the former group will be considered here, not because there are none of the latter that have any merit or any published advocates, but because it is only the more conventional diets that have undergone any real scientific scrutiny or study. All conventional diets whether they are described as low calorie (LCal), low carbohydrate (LC), low fat (LF), low glycaemic index

(LGI), low glycaemic load (LGL) or high fibre (HF); or have specific names such Weight Watchers© and Nutrisystem© (LCal), Atkins and Dukan (LC), Ornish and Gerson (LF), F-Plan (HF), primarily involve manipulation of the relative proportions of the various nutrient components in the daily food intake.

From most of the available studies, and population comparisons of dietary regimes, it would seem that all of the available approaches are capable of producing weight loss and improvements in health but there appears no real consensus about which if any is most efficacious (Dansinger, *et al*, 2005; McAuley *et al*, 2006; Alhassan *et al*, 2008; Hession *et al*, 2009; Katan, 2009; Delbridge *et al*, 2009; Brinkworth *et al*, 2009; Sacks *et al*, 2009; Abete *et al*, 2010; Foster *et al*, 2010; Ludwig and Ebbeling, 2010; de Jonge *et al*, 2012; Champagne *et al*, 2011; Astrup and Pedersen, 2012; Chisholm *et al*, 2014). In their review of 48 randomized dietary trials involving 7286 participants, Johnston *et al* (2014) concluded that although diets low in carbohydrate or fat diets produced marginally better results, there was little to choose between the different dietary approaches, and concluded, as did Matarese & Pories (2014) in their extensive review, that the main criteria for success was that of being on a diet that the individual could and would adhere to. An excellent review by Katz & Meller (2014) which looked at the rationale surrounding many dieting approaches came to a similar conclusion, and disappointingly, a recent paper by Hung *et al* (2015) has cast doubt on the effectiveness of 27 school based obesity management programmes involving 26 114 children.

High protein intake has been reported to be of benefit in maximising weight loss and subsequent weight maintenance (Westerterp-Plantenga *et al*, 2004; Layman *et al,* 2009; Westerterp-Plantenga *et al*, 2009; Larsen *et al*, 2010: Josse *et al*, 2011), as has reduced energy density (Raynor *et al*, 2011). Low glycaemic index (LGI) and low glycaemic load (LDL) diets have been shown to be beneficial for some obese individuals especially where diabetes is already established (Thomas & Elliot, 2009; Larsen, 2010; Esfahani *et al*, 2011), although a 5-week controlled feeding study of an LGI diet by Sacks *et a*l (2014) showed no

improvement in insulin sensitivity, lipid levels, or systolic blood pressure. Ketogenic diets have been utilised both in managing epilepsy and in enhancing weight loss through their ability to reduce appetite whilst dieting (Paoli, 2014; Gibson *et al,* 2015), although Kossof (2014) has warned of inherent dangers of inducing arterial stiffness and damage, and of elevating serum cholesterol, when using this approach for the management of epilepsy in children and young adults.

Low calorie diets has been shown to modulate insulin sensitivity (Olza & Calder, 2014) and to facilitate significant weight loss and reduction in HbA1c in type-2 diabetes (Farrer & Golley, 2014), surprisingly however work by Labonté *et al* (2014) was unable to show any influence of dietary dairy produce on inflammatory markers in patients with established inflammatory disease. The timing and frequency of eating has also been shown to influence weight loss and gain (Arble *et al*, 2009; Sofer *et al*, 2011; Chaix *et al,* 2014), and meal timing restriction (in mice at least) was effective in maintaining weight and lipid biochemistry, even on a high fat diet with no reduction in total fat ingested (Hatori *et al*, 2012). In their extensive review of 36 low fat diets by Fattore *et al* (2014), the authors concluded that all reports provided only limited experimental evidence of their efficacy and that their economic evaluation required major improvement.

There are intrinsic benefits in moving from a more sedentary to a less sedentary lifestyle, as it has been shown that exercise can: improve muscle and joint function (Law *et al* 2010; Karatepe *et al*, 2011; Uthman *et al*, 2013; Koepp *et al*, 2014; Jahanbin *et al,* 2014); increase cardiac output and lung capacity (Marcus & Forsyth, 2009; King *et al*, 2009; Donnelly *et al*, 2009; Tomaz *et al,* 2014; Shaibi *et al,* 2015; Banerjee *et al*, 2015; Lakoski *et al*, 2015); improve HDL and HDL antioxidant properties (Wiklunda *et al,* 2014; Papadakis *et al*, 2015); modulate appetite and satiety parameters in children (de Freitas *et a*l, 2013); improve memory (Barnett, 2011; Anderson & Brice, 2011; Cooper, Bandelow *et al*, 2015); enhance mood, well-being and endorphin production (Roriz *et al*, 2009; Youngstedt, 2010, Rueggeberg *et al*, 2011: Gaitan-Sierra *et al*, 2013; Lindwall *et al,* 2013); aid recovery from

breast cancer (Swisher *et al*, 2015; Meneses-Echávez *et al*, 2015); cure or ameliorate diabetes (Narendran *et al*, 2015; Sukla *et al*, 2015); assist in mental health management (Penedo & Dahn, 2005; Lindwall *et al,* 2013; Penedo *et al,* 2015; Zschucke *et al*, 2015); and much more (Gebel *et al,* 2015; Ngandu *et al*, 2015). For many people with only minor degrees of overweight, minimal dietary changes coupled with exercise could prove sufficient to achieve much of the above health benefits, without recourse to a formal dietary regime (Marcus & Forsyth, 2009; Shaw *et al*, 2009).

There have been a number of surveys in which diet alone has been directly compared with diet and exercise in combination (Wing & Hill, 2001; Del Corral *et al*, 2009, 2011; MacLean *et al*, 2009; Goodpaster *et al*, 2010; Chaput *et al*, 2010; Villareal *et al*, 2011; Reel *et al*, 2011 Khoo *et al*, 2015), and the value of exercise has been clearly attested to, although a randomised trial by Geliebter *et al* (2014) comparing diet alone with diet plus either strength or aerobic training could show no benefit in terms of weight reduction or metabolic changes from the exercise. Clearly then the interaction of diet and exercise in achieving weight loss is not entirely straight forward. Masuo *et al* (2012) suggested that the mechanisms influencing weight loss induced blood pressure reduction following dietary restriction, and that resulting from exercise, are different; whilst Soenen *et al* (2010) have demonstrated that increased dietary protein increases exercise stimulated fat oxidation. Physical exercise and dieting remain the two cornerstones of all weight reduction programmes, despite their lack of success for many individuals. The challenge appears to be in making these acceptable and palatable enough to attract and retain those overweight and obese individuals who really need to lose weight, and in changing psychological motivation so as to engender a permanent change in lifestyle, daily activity and eating habits, that will remain with them throughout the rest of their life. Pedogagy and commonsense alone seems inadequate whereas hypnotic empowerment might help to facilitate this.

(ii) Other Non-Hypnotic Approaches to Weight Loss

In 2006 a telephone survey of 2,300 Americans revealed that one-third of those who had made a serious attempt to reduce weight, had at some time used one or more dietary supplements to help with this (Pillitteri *et al,* 2008), and no doubt this figure has grown considerably since then. Since that survey Bolton *et al* (2014) have drawn attention to the perils inherent in the increasingly over-vigorous marketing of weight reduction remedies and supplements, and the consequent reliance that the public has come to place on erroneous information distributed about commercial products, in contrast to their unawareness of correct scientific health information, contrasting *remedy knowledge* with *nutrition knowledge*, as the authors put it. Similar concerns were expressed by Droz & Marques-Vidal (2014) regarding the marketing of slimming products in Switzerland, which blatantly continue to offer false promises of rapid and easy weight loss through the use of their products.

Over the past 15 years a multitude of plants, herbs, spices, fruits, micronutrients and so-called nutraceuticals have been advocated for the management of obesity, metabolic disorders and diabetes. Several wide ranging reviews have been published notable by Najm & Lie (2010), Palatty & Saldanha (2012), Zelig & Radler, (2012), Mohamed (2014) and Kazemipoor *et al* (2014) which report the benefits of such supplements, postulating various mechanisms whereby they might influence weight and facilitate weight loss, including control of appetite, inhibition of adipogenesis, stimulating thermogenesis and modulating lipid metabolism through effects on pancreatic lipase activity and lipolysis. Based on such reviews the consumption of these recommended medicinal plants and products at appropriate dosage could be perceived as a safe and effective complementary treatment for obesity. Nevertheless, and despite the above commendations for the value of such dietary supplements, five major reviews (Pittler & Ernst, 2004; Pittler *et al,* 2005; Onakpoya *et al*, 2011; Podder *et al,* 2011; Cohen, 2014) have drawn attention to the paucity of clear scientific evidence to demonstrate proven efficacy for these products, a view echoed by Gibson-Moore (2010) and Blundell (2010), both from the British Nutrition

Foundation, who are in agreement that this scarcity of randomised clinical trials, and of safety data, does not permit proper assessment of the claims of the manufacturers of many of these products. Werner (2014), Alissa (2014), Stickel & Shouval (2015) and many others have drawn attention to the possible health risks from many of such products on the market due to their side effects, because of contamination in these products, or when used by individuals with chronic health disorders (Corey & Rakela, 2014; Saxena *et al*, 2014), and Wallace (2015) has recently initiated a debate on how the US Dietary Supplement Health and Education Act (DSHEA) of 1994 can be applied more effectively.

Public interest in the use of so called complementary and alternative medicine (CAM) has been increasing steadily over the past 50 years, and this increase has been mirrored by a similar increase in the number of academic publications on the subject (Treister-Goltzman & Peleg, 2015). In the decade 1963-1972 Google Scholar quoted 27,170 citations related to CAM but by 2003-2012 this had increased to 2,521,430 (ibid). CAM is currently being utilised by a large percentage of the population in this country and worldwide, for a range of acute and chronic health conditions (Pittler *et al*; 2001; 2006; 2007; Hunt *et al,* 2010; Dossett *et al*, 2014; Fries, 2014; Alwhaibi *et al*, 2015). After massage and aromatherapy, neither of which appears to have been much investigated for their benefits in reducing weight, acupuncture is the third most used of CAM therapies for health improvement (Hunt *et al,* 2010). Although a high percentage of CAM is still performed within private clinics and funded by patients themselves (Hunt & Ernst, 2009), increasingly CAM is being incorporated into formal medical practices and health services, although such a move is not without its critics. Hunt & Ernst (2009) and Sheppard (2015) have all expressed concern that much of CAM is still not fully evidenced-based, whilst Herman *et al* (2012) have questioned the financial cost-effectiveness implications of such therapies. In addition to this, despite the widespread acceptance and use of alternative therapies in many areas of social and medical problem solving, such physical therapies seem inadequate in dealing with psychologically mediated obesity.

Bariatric surgery as a treatment for gross overweight and obesity has now become the most commonly performed surgical procedure in the western world (Finks & Dimick, 2014). From its early beginnings in 1952, by the early 1990s 10,000 cases annually worldwide were undergoing open surgery gastroplasty or Roux-en-Y gastric bypass; and with the advent of laparoscopically directed sleeve gastrectomy, adjustable gastric banding and biliopancreatic diversion surgery, by 2011, this had risen to around 350,000 bariatric surgery operations annually (Buchwald & Oien, 2013). For morbidly and grossly obese individuals with a BMI of ≥ 35-40 (depending on symptomology), surgery is increasingly being seen as the definitive treatment (Schauer *et al,* 2014; Sjöström *et al*, 2014; Chang *et al,* 2014; Ochner *et al*, 2015; Risstad *et al*, 2015). Surgical intervention is certainly capable of producing a rapid weight loss greater than that which could be achieved by non-surgical approaches, as well as being extremely effective in producing short-term remission in type-2 diabetes (Courcoulas *et al*, 2014; Sjöström *et al*, 2014; Münzberg *et al*, 2015; Ochner *et al*, 2015). There is still however a great deal to be learnt about the long term changes induced by bariatric surgery as Chang *et al* (2014), Courcoulas *et al* (2014), Randall *et al* (2014), O'Brien (2015) and Hopkins *et al* (2015) have all pointed out.

Whilst most patients benefit psychologically from bariatric surgery there is published evidence to indicate that some indivduals' emotional state deteriorates post-operatively leading to exacerbation of depression (Karmali, 2013; Ivezaj & Grilo, 2015) and even suicide (Mitchell *et al* 2013). The reasons for this are unclear but might be compatable with the premise of this present study that for some individuals their refractory obesity or inability to retain weight loss after an apparently successful weight reduction programme is the result of their having covert unconscious imperatives proscribing those individuals from losing weight and becoming a slim person. The *raison d'être* for such an apparently counter-intuitive subconscious decision and agenda being generated is being posited as lying in the past emotional experience of the individual, and related to past childhood misinterpretations or misperceptions of events and situations, or to unresolved childhood or early adult

traumas. The result in adulthood becomes the setting up of a protective barrier within the subconscious mind (Faden *et al*, 2012) which then acts to maintain the required and subconsciously determined status quo, and for the purpose of this study, the necessary obese state (Entwistle *et al*, 2014).

The hidden nature of such unconscious barriers would be such that the conscious mind would be unaware of the hidden agenda, and would therefore be continually exploring and pursuing routes to losing weight and staying slim, whilst at the same time the subconscious mind was continually mobilising biochemical, physiological and psychological processes associated with satiety, appetite and lifestyle, in favour of weight gain rather than weight loss. Behavioural, diet and exercise approaches to losing weight are easy enough for the subconscious mind to circumvent but the instigation of a surgical procedure such as bariatric surgery may be too powerful and can overwhelm the unconscious mind's plans and protections. Bariatric surgery therefore may be able to promote weight loss under such conditions, but will leave the individual with an internal dilemma of being, as has been already mentioned, "A fat person in a thin body" (Alegría & Larsen, 2014), leading to depression, anxiety and perhaps even to depersonalisation, and certainly to ultimate weight regain.

(iii) Lifestyle, Behavioural and Psychological Approaches

Lifestyle counselling is (or should be) an integral part of all weight reduction programmes, whether in individual or group settings. Such counselling can range from simple advice and education about different food groups, meal portion sizes, and the benefits of physical activity; through group and individual structured activities as are organised by commercial providers such as Weight Watchers© and Slimming World©; to specifically targeted and individualised therapies including Cognitive Behavioural Therapy (CBT), mindfulness and hypnotherapy. Because simple pedagogic and common-sense instructions about the

lifestyle and behavioural changes necessary for long term weight reduction maintenance so often prove ineffective, weight management professionals are constantly needing to explore other more sophisticated approaches to changing behaviour. Stubbs & Lavin (2013) have drawn attention to the challenge that weight reduction agencies face in attempting to formulate effective psychological interventions which are capable of implementing the long-term behavioural change that can lead on to sustained weight loss.

In agreeing with this Sniehotta *et al* (2014) have expressed regret that so few developments in counselling technique and psychological theory have become translated into practical interventions, and along with Holt *et al* (2006) and O'Carroll (2014), decry the dearth of larger multi-centre controlled trials and studies. A major review by Teixeira, *et al* (2005) looked at the value of pre-treatment psychosocial factors in predicting long-term weight reduction success. The authors' extensive survey examined 29 weight reduction programmes and found that the only two factors with any significant predictive value were having few previous weight loss attempts and an autonomous, self-motivated cognitive style (ibid). Nine years later the picture had hardly changed and Booth *et al* (2014) in their major review of behavioural interventions for overweight adult participants in primary care settings were scathing of the inability of these to achieve significant weight loss. Barte *et al* (2010) were equally negative in their review of 12 studies in which various lifestyle interventions were used, as they were unable to find any conclusive evidence of major benefits to long term weight loss maintenance from such interventions, whilst Moldovan & David (2011) in their review of 18 studies concluded that psychosocial interventions were clearly inferior to surgical interventions. Despite the findings reported above, Presti *et al* (2010), in a long review acknowledging the limitations of current psychological treatments for obesity, still gave their firm and well considered approval for the value of techniques such as behavioural and family therapies in the management of obesity in both children and adults as being of some value in improving emotional states and in reducing post loss weight regain.

Underlying all of such behavioural and psychological interventions has to be their evoking of a desire and a facility for conscious and subconscious change within the overweight individual, and the efficacy of weight management programmes in generating significant and long-term maintained weight reduction is determined entirely by the strength and appropriateness of this change. Presumably most individuals commencing a weight reduction programme of any nature are keen to change their attitude and motivation towards eating and exercise habits, if only in order to lose as much weight as possible. But this desire has to be moved from its initial future intent, to become present action, and then in turn become an on-going and continuing process, which overcoming relapses, firmly establishes itself as a permanent feature in the individual's life. Such a process will likely necessitate reviewing many aspects of their home, family, work and leisure life in order to accommodate the new lifestyle pattern needed for effective and permanent weight loss. The process has been described by Marcus and Forsyth (2009), in their motivational approach to encouraging people to become more physically active, in which they identify five stages of "Motivational Readiness for Change", these being Stage One: inactive and *not thinking* about becoming more active, Stage Two; inactive but *thinking* about change, Stage Three: *doing some* physical activity, Stage Four: *doing enough* physical activity, and Stage Five: making physical activity a *habit*. The selection of appropriate advice for any individual is then determined by that individual's stage at presentation (ibid).

Working along these similar lines CBT has been utilised in several reported and reviewed weight loss trials but with mixed results. Buclin-Théibaud *et al* (2010) incorporated CBT into their diet and physical activity weight reduction programme and out of the 39 subjects who completed the programme after 5 years, 15 % maintained their post treatment weight, 55% lost further weight and 30% had regained some or all of their weight lost. This was seen as a successful outcome, despite the small numbers involved. Encouraging results have also been reported for weight loss enhancement following the incorporation of CBT into conventional dietary programmes by other groups including Rapoport *et al* (2000),

Mefferd *et al* (2007), Tsiros *et al* (2008), Corbalán *et al* (2009), Werrij *et al* (2009), Vanderlinden *et al* (2012) and Boisvert & Harrell (2015), but only Werrij *et al* (2009) were able to demonstrate improvement in long term weight loss maintenance. A large review by Spahn *et al* (2010) for the American Dietetic Association covering 87 studies also concluded that CBT and behavioural therapies were of benefit in obesity management; Grave *et al* (2011) have reported that CBT can be of value in enhancing and maintaining the uptake of physical exercise during obesity management programmes; and Swencionis *et al* (2013) found that CBT aided weight loss was associated with positive changes in psychological well-being.

Not all such trials have been rated a success however. Cooper and Fairburn (2001) published details of their new and highly structured CBT approach to obesity which it was felt addressed the psychological barriers thought to be acting against the long term adherence to effective weight control behaviour; and this was subsequently published as a textbook for clinicians (Cooper *et al* 2003). The approach is highly time and effort intensive, both for the patient and for the overseeing clinician, and certainly not relevant to working with groups, even small groups. Furthermore a more recent paper by the same authors (Cooper *et al*, 2010) seems to have concluded that this new approach is in fact no more effective in the long term than standard behavioural treatments, a viewpoint strongly supported by work done with overweight, depressed women reported by Linde *et al* (2011), and with obese women with binge eating (Zwan *et al*, 2006). Amongst the reasons for the poor efficacy of many weight management programmes may be the lack of adequate skills amongst those health professionals designated to identify and treat obesity in the populations at risk. Chur-Hansen (2012) and Farrer & Golley (2014) have all highlighted the need for dietitians to receive appropriate training in behavioural modification approaches, and Knightsmith *et al* (2013) noted that school staff were lacking in the psychological skills necessary to detect and motivate the children in their care, and that most teachers felt that they were in need of appropriate specialist training. Many other surveys and meta-analyses

have drawn attention to deficiencies in the abilities of primary care staff to manage weight programmes effectively (Ballew *et al,* 2013; Erickson *et al*, 2014; Heslehurst *et al*, 2014; Booth *et al*, 2014; Dietz *et al*, 2015).

The concept of mindfulness, or Acceptance and Commitment Therapy (ACT) as its modern day variant is often referred to, has its roots in the 2000 year old Buddhist meditative traditions of unconditional acceptance of thoughts and feelings, both negative and positive, as being merely a part of the ebb and flow of the cognitive process that needs to be acknowledged and then let go (Lama Surya Das, 1997). Meditation has long been advocated for stress, anxiety and depression management, and as a route to healing of both physical, and emotional and behavioural problems (Dhar, 2008; Hussain & Bhushan, 2010). In an update on mindfulness research, Greeson (2009) concluded that laboratory and clinical trials all suggest that mindfulness benefits extend beyond relaxation, into shifts in cognition, emotion, biology, and behavior that may work synergistically to improve health. Lynn *et al* (2007) have presented a cogent rationale for the use of mindfulness meditation in clinical scenarios in their extensive review of the benefits of mindfulness, and posit a hypothesis for a synergistic melding of mindfulness with hypnosis. Lynn *et al* (2007) also review the evidence that attempting to avoid or suppress negative thoughts and thought patterns, or allowing such thoughts to catastrophise the individual can have an adverse impact on health and wellbeing, and that accepting these negative thoughts equally along with the positive and productive thoughts can be of value in promoting behavioural and cognitive change. Where this paper covers new ground is in the suggestion that mindfulness can be used in tandem with Kirsch & Lynn's (1998) response-set theory of hypnosis, to maximise change and recovery and to convert maladaptive cognition into creative and life-changing cognition. These authors hypothesise that as hypnosis is an acceptance state in a similar way to mindfulness, the two approaches can be used in a complementary way to assist the individual to acknowledge negative thoughts without trying

to suppress them and to allow these to drift on without generating a legacy of rumination and the automatic responses that they previously engendered (Lynn *et al* 2007).

Mindfulness has been extensively recommended and utilised in the management of overweight and obesity, but despite the apparent benefits in terms of weight loss and amelioration of compulsive binge eating, variously described in reviews by Godsey (2013), Katterman *et al* (2014), O'Reilly *et al* (2014), Lofgren (2015), Forman & Butryrn (2015), Olson & Emery (2015), Mantzios & Wilson (2015), Ciarrochi *et al* (2015) and others, the overall conclusion is that much work still needs to be done to establish the psychological and physiological mechanisms whereby mindfulness might produce such effects, before the therapy can be regarded as being fully validated in terms of efficacy and evidence-base. Enhancement of weight loss has been noted in a number of small trials, ranging from a single case study up to 62 participants, notably by Singh *et al* (2008), Tapper *et al* (2009), Lillis *et al* (2009), Dalena *et al* (2010), Forman *et al* (2007; 2009), Barnes and Tantleff-Dunn (2010), Niemeier *et al* (2012), Friese *et al* (2012), Jenkins & Tapper (2014) and Corsica *et al* (2014), with weight loss benefits variously attributed to better appetite control, reduction in impulsive eating, reduction in portion size, better stress management and more regular attendance at weight reduction programmes. Three trials were also able to demonstrate significant increases in physical activity amongst participants (Singh *et al*, 2008; Tapper *et al*, 2009; Moffitt & Mohr, 2015). However Cavanagh *et al* (2013) and Marchiori & Papies (2014) were unable to detect any decrease in portion size resulting from mindfulness, nor did the therapy help with emotional and uncontrolled eating in a trial by Kearney *et al* (2012) or improve weight loss or physical activity regime (Fletcher (2011). From an extensive revewing of lifestyle counselling, CBT, mindfulness, neurolinguistic programming (NLP) and similar therapies in the management of obesity, it would appear that whilst these may all be beneficial in supporting those individuals already committed to losing weight none have the potential to trigger the deep psychological change that many individuals required in order to begin and continue their weight loss journey.

1.4 Review of Early Publications on Hypnotic Weight Loss

The current application of hypnosis to clinical and medical environments, including the management of obesity, has been developing since the mid-20th century, and an early review of hypnosis research by Wadden & Anderton (1982) discussed the wide range of conditions for which hypnosis was being proposed as a treatment, including anxiety, depression, addictions, chronic pain, warts and obesity amongst others. Although these authors recognised some areas of success with regard to addiction and to obesity management, their conclusions were that there was little proven benefit from such treatment, that any apparent benefits were probably non-hypnotic and non-specific, and that there was a need for further research and larger studies with post-treatment follow-up, before hypnosis could be recommended as a routine treatment for addiction and obesity.

Amongst the earliest descriptions of use of hypnosis in a medical situation to treat obesity was Brodie (1964) who (rather controversially) would tell his obese patients that they had the equivalent of a “fat cancer” that had been growing inside them for years and which needed removal by their learning to eat properly, through the use of his hypnotic therapy. He claimed great success with this personalised approach to treating over 525 patients, but Brodie did not employ any control group nor did he publish any numerical data to substantiate his claims and it is difficult therefore to assess the true efficacy of his idiosyncratic approach. Despite this rather mixed history, and the difficulties brought about by the indecision and debate about the true nature of hypnosis and the hypnotic trance, the use of hypnosis became increasingly explored as a tool for managing problems relating to overweight and obesity over the latter part of 20th century, but surprisingly has been little investigated since then.

Table 1. (i) SOME EARLY TRIALS OF HYPNOSIS FOR WEIGHT REDUCTION

Ref	Authors	Date
1	Winkelstein, L.B.	1959
2	Flood, A. O.	1960
3	Wollman, L.	1962
4	Brodie, E.I.	1964
5	Long, R. F. & Kreykes, G.	1965
6	Cautela, J.R.	1967
7	Harris, M.B.	1969
8	Lick, J. & Bootzin, R.	1971
9	Wick, E., Sigman, R. & Kline, M.V	1971
10	Janda, L.H. & Rimm, D.C.	1972
11	Miller, M.M.	1974
12	Hanning, P.J.	1975
13	Stanton, H.E.	1975
14	Miller, M.M.	1976
15	Leon, G.R.	1976
16	Aja, J.H.	1977
17	Deyoub, P.L.	1978
18	Douglas Ringrose, C.A.	1979
19	Deyoub, P.L.	1979
20	Deyoub, P.L. & Wilkie, R.	1980
21	Davis, S. & Dawson, J.G.	1980
22	Channon, L.D.	1980
23	White, D.M.	1980
24	Bornstein, P.H. & Devine, D.A.	1980
25	Wadden, T.A. & Flaxman, J.	1981
26	Schramm, A.T.	1981
27	Goldstein, Y.	1981
28	Gross, M.	1983
20	Fawzy, Pasnau, Wellisch, Ellsworth, Dornfeld, & Maxwell.	1983
30	Jupp, J., Collins, J., McCabe, M., Walker, W. & Diment, A.D.	1983
31	McCabe, M. P., Jupp, J. J., & Collins, J. K	1985
32	Jupp, J.J., & Collins, J.K.	1985
33	Bolocofsky, D.N., Spinler, D. & Coulthard-Morris, L.	1985
34	Andersen, M.S.	1885
35	Jupp, J., Collins, J., McCabe, M., Walker, W.	1986
36	Cochrane, G. & Friesen, J.	1986
37	Smith, G.	1986
38	Cochrane, G. J.	1987
39	Munro, M.	1989
40	Barabasz, M & Spiegel, D.	1989
41	Cochrane, G.	1991
42	Levitt, E.E.	1993
43	Vanderlinden, J. & Vandereycken, W.	1994
44	Schaumberg, L.L., Patsdaughter, C.A., Selder, F.E., Napholz, L.	1995
45	Platt, R. W.	1995
46	Griffiths, R. A., & Channon-Little, L. D.	1995
47	Johnson, D.L. & Karkut, R.T.	1996
48	Stradling, J., Roberts, D., Wilson, A. & Lovelock, F.	1998
49	Green, J.P.	1999
50	Johnson, D. L., & Brinker, G. D.	2001
51	Vanderlinden, J.	2001
52	Mewes, I., Stich, A., Habermüller, M.S. & Revenstorf, D	2003

Between 1959 and 2003 over 50 reports were published describing the use of hypnosis for weight reduction, see table 1. (i). The studies varied in size from individual case studies (Hanning, 1975; Davis & Dawson, 1980; Channon, 1980; White, 1980; Smith, 1986; Munro, 1989; Green, 1999) through smaller trials of 20-75 patients, to larger groups of >100 participants (Goldstein, 1981; Jupp & Collins, 1985; Bolocofsky *et al*, 1985; Johnson & Karkut, 1996). Most of these trials employed an authoritarian based sociocognitive hypnosis model with their patients, utilising varying combinations of suggestion, imagery, anxiety reduction, aversion, covert sensitisation and self-directed programming to facilitate changes in eating habits. Such an approach coupled with appropriate instruction about eating and exercise habits was found to yield benefits in achieving weight reduction. Some researchers utilised a more analytical or exploratory approach such as Channon (1980), Gross (1983), Munro (1989) and Barabasz & Spiegel (1989), with reported success also. Whether working in group or individual settings, hypnotic inductions predominantly involved eye gaze fixation accompanied by progressive relaxation, with hand levitation or heaviness to enhance the depth of hypnosis (Goldstein, 1981). Some trials involved teaching self-hypnosis along with hypnosis tapes for home use.

Only 17 out of 43 trials contained a control group which makes it difficult to accurately evaluate the claims made in many of these reports, and in only 9 studies were patients followed-up after their hypnosis-induced weight loss to monitor for weight regain, and usually for six months or less. Exceptionally, Bolocovsky *et al* (1985) and Stradling *et al* (1998) were able to demonstrate maintained weight loss benefits in their hypnosis cohorts at 24 and 18 months respectively. It was rare for there to be any standardised assessment of hypnotisability prior to commencing hypnosis but where this was measured, there appeared to be a correlation between such measurements and subsequent weight loss (Stanton, 1975; Andersen, 1985; Jupp *et al*, 1986; Barabasz & Spiegel, 1989; Mewes *et al,* 2003), an exception to this being that of Deyoub (1979) who found little correlation between weight loss and hypnotisability as measured by the Harvard Scale assessment. Although

there was much variation in how the success of hypnosis was assessed and how much (or little) follow-up took place, 40 out of 52 (77%) of the papers referenced in table 1. (i) deemed hypnosis to have been efficacious in enhancing weight loss in their obese patients.

Between 1976 and 2000 ten reviews were published analysing and summarising the weight reducing benefits of the various trials and papers included in table 2 (Leon, 1976; Mott & Roberts, 1979; Wadden & Anderton, 1982; Heap, 1982; Spiegel, 1983; Cochrane, 1992; Levitt, 1993; Vanderlinden & Vandereycken, 1994; Allison & Faith, 1996; Schoenberger, 2000). Whilst these were predominantly positive in accepting that there were benefits from the use of hypnosis in weight reduction programmes, most reviewers stressed the need for more rigorous research through controlled trials with larger cohorts of subjects, along with greater selectivity of participants to enable hypnosis approaches to become more personalised and targeted. Clinical trials of hypnosis for various problems, including obesity, were reviewed by Kirsch and colleagues in two meta-analyses (1995, 1996) which reported that the addition of hypnosis to cognitive behavioural psychotherapy (CBT) substantially enhanced outcomes for many clinical conditions including obesity (Kirsch *et al,* 1995). In their later meta-analysis Kirsch *et al* (1996), using recalculated data from their earlier publications, demonstrated even larger benefits for obesity treatment, with weight reduction often continuing beyond the end of the treatment period. However other reviewers have cast doubt on the veracity of such conclusions because of the methodological difficulties involved in interpreting the data from some of these early trials (Allison & Faith, 1996; Schoenberger, 2000).

Subsequently further reviews analysing the same data appeared to re-affirm the efficacy of using hypnosis, especially when used in conjunction with cognitive behavioural therapy in weight reduction programmes (Allison *et al* 2001; Hutchinson-Phillips & Gow, 2005: Pittler & Ernst, 2005). A similar conclusion was reached also by Byom (2009) in a study comparing CBT alone with CBT plus hypnosis, and by Prag (2007) in her single case study, who found this combination additionally useful for improving self- and body image, even in the absence

of any significant weight loss. Papers by Holt *et al* (2006), Barabasz (2007) and Kiothan (2009) all supported the case for the efficacy of hypnosis when used for weight reduction, although the paucity of recent published trials means that their opinions are still based on those trials undertaken over 15 years previously. The most recent of the available reviews, by Hartman (2010), Wickramasekera (2010) and Montgomery *et al* (2011), whilst concluding that hypnosis has potential as a weight management tool, all expressed concerns about the reliability of the available data due to various factors, notably the problem of small cohort numbers, of variations in procedures and in the measurement of their outcomes, and the lack of long term follow-up. This may account for the fact that a 2006 Cochrane collaboration review of obesity interventions for adults contained only one reference to a study using hypnotherapy as a stand-alone therapy (Shaw *et al*, 2006).

Two textbooks by Ernst and colleagues published in 2001 and 2006 undertook extensive systematic reviews of the literature on the perceived efficacy of a range of mind-body therapies including hypnotherapy, over a wide range of medical and psychological problems (Ernst, Pittler, Stevinson & White, 2001; Ernst, Pittler & Wider, 2006). The editors of these books subsequently utilised the data collected during the preparation of their publications, in an attempt to quantify the efficacy of three of these therapies (hypnotherapy, autogenic training and relaxation therapy), and at the same time to monitor any apparent changes in their effectiveness between 2000 and 2005 (Ernst, Pittler, Wider & Boddy, 2007). From this wealth of date the authors derived a "weight of evidence" index based upon the various criteria which they saw as determining the quality of reported clinical trials. These included whether the report was of a single trial or a meta-analysis, the number of participants in the trial, and the "blinded-ness" of the assessment. All three therapies showed an apparent improvement in their effectiveness for the majority of the clinical conditions over the period 2000 and 2005, the marked exceptions being alcohol and smoking dependences, where the benefits of hypnotherapy appear not to have improved over the years. The 2000 survey had no available data for the use of hypnotherapy in the treatment of obesity but the 2005

index indicated a high weight of evidence for the efficacy of the technique in obesity management (ibid).

The relationship between hypnotisability and quality of response in clinical trials including weight reduction programmes, has been the source of as much conjecture and opinion as is still apparent amongst non-clinical research programmes. Andersen (1985), Hutchinson-Phillips *et al* (2007) and Montgomery *et al* (2011) were all able to demonstrate a small but significant relationship between hypnotic suggestibility and clinical response, in contrast to Cochrane and Friesen (1986) who were unable to do so in their study. Other than these reports, few of the pre-2000 trials investigated the correlation between hypnotisability and weight loss, and the small numbers of participants in many historical trials would have render such correlations of doubtful significance, as a recent paper by Montgomery *et al* (2011) would seem to indicate. Notwithstanding the concerns of Sapp *et al* (2007), there appears to be some evidence accrued attesting to a degree of correlation between hypnotisability and weight loss (Allison, 2001; Mewes *et al,* 2003; Barabasz, 2007), as well as hypnotisability having a significant relationship with a number of behavioural and cognitive eating-associated characteristics such as weight, shape and dissociation (Hutchinson-Phillips *et al*, 2007) and playing a role in body self-image malleability (Frasquilho *et al*, 1998). Publications such as Lynn & Shindler (2002) and Milling *et al* (2010) have provided further evidence of such correlations, and Lynn *et al* (2004) have emphasised the value of assessing hypnotisability in some (if not all) clinical environments.

A major review of confidence intervals for obesity and hypnotisability correlations by Sapp *et al* (2007) appears to add weight to the contention that hypnosis either alone or in combination with other therapies is effective in producing weight reduction, although, as has been discussed above, firm correlation between this weight loss and hypnotisability is still not fully established. This conclusion is in general agreement with that expressed by Flammer & Bongartz (2003) with regard to other, non-obesity hypnotherapy programmes. Usefully, in addition to its use in formal weight management programmes, hypnosis has

been shown to be capable of ameliorating some of the concomitant cardiovascular symptomology of diabetes (Adlercreutz *et al* 1982; Xu and Cardeña, 2007; Bay & Bay, 2011), and was reported to be of benefit in a group of overweight smokers who were able simultaneously to deal with both their health problems (Heinkel *et al*, 2003).

Hypnosis is not as widely used for childhood ailments and disorders which is surprising as young children spend most of their time in a state of waking hypnotic trance (Stanton, 2011), however reviews by Kohen & Kaiser (2014) and Sugarman & Wester (2013) have recently drawn attention to the great potential and the many applications for, hypnosis, both awake and during trance states in managing paediatric physical and emotional disturbances. Kuttner (2014) has eloquently described her work with young children suffering from pain, musculo-skeletal and oncological problems, and the ease with which her young patients are able to collaborate with her hypnotic approach. Olness (2008) is very much in agreement with Kuttner in emphasising the benefits of using hypnosis and biofeedback with children, whom she says respond well to being put in charge of their own health, and Zhao et al (2012) has reported favourably on the benefits of hypnosis as an adjunct to psychotherapy for obesity in children. It is surprising therefore that the 2009 Cochrane collaboration paper on obesity interventions with children by Oude Luttikuis *et al* (2009) was unable to find any use of hypnotherapy for this purpose despite the clear evidence that hypnosis can be beneficial and efficacious in children and young adults. It is disappointing also that a recent paper prepared for Belfast Health and Social Care Trust on the provision of psychological therapies for adults and children with mental health problems failed to include either obesity or hypnotherapy in its proposed remit for future implementation (Irvine *et al,* 2011).

In the light of the above historical analysis and of the increasing utilisation of hypnosis in other areas of clinical and psychological research and practice, there would appear to be a place and a need for further exploration of the potential role for hypnosis in the management of obesity, and its many clinical and physiological consequences. In view of the growing problem of obesity in most countries of the world and the increasing focus on behavioural

and lifestyle interventions for managing this, it is surprising there has been such a dearth of new trials of hypnosis for obesity since 2003. Despite the continued commercial advocacy of hypnosis for weight reduction there have been very few academic papers published to indicate that clinical and health researchers are choosing to follow up these past studies. In part this may be down to the very nature of hypnotherapy treatment itself, which requires time, facilities and specialist training. This tends to make hypnosis less suitable and not cost-effective enough for large scale group therapy, and more relevant therefore to individual, one-to-one settings such as are provided by private therapists and many commercial agencies and clinics (Askay *et al*, 2009). It may also be the perpetuation of the reputation that hypnosis has had in the past for many scientists and clinicians, for whom, as Upshaw (2006) has suggested, hypnosis has always been a “dirty word”.

Alladin (2012) has suggested however, that the recognition of cognitive hypnotherapy as an integrative psychotherapy paradigm is necessary for hypnosis to become acceptable to the psychotherapy community, both in research and in clinical practice. In the interim however, in an attempt to stimulate further exploration of the emotional factors which might be driving weight gain and regain in some individuals, and to explore the potential for hypnosis to engender effective and maintained weight reduction for such individuals, the current author and colleagues have published a protocol for how this could be undertaken based upon the design of this current thesis and the premises discussed therein (Entwistle *et al*, 2014).

1.5 Hypnotherapy for Obesity - Public and Private Viewpoints

Any lay person undertaking a "Google©" internet search for information on the use of hypnosis for weight loss enhancement will discover in excess of 12 million pages, including over 100,000 entries for hypnotic gastric banding and 1,500 books on hypnosis or self-hypnosis for weight management. Additionally books advocating hypnosis for weight reduction and other health problems, intended for popular lay use, continue to appear almost monthly, with over 20 between 2010 and 2012. The picture thus presented is that problems with obesity and overweight can be easily and quickly remedied through hypnosis and a visit to the local hypnotherapist, precisely the impression that such practitioners and the private hypnotherapy clinics would wish to portray, whether or not this picture truly reflects the actual efficacy of hypnotherapy in treating weight and obesity problems. As a result there is a growing willingness on the part of the general population, despite their lack of knowledge about hypnosis, to consider using hypnosis for their disparate needs, especially when the therapy can seemingly be tailored to these needs (Keller, 1996; Green, 2003; Davis & Gao, (2014). However in looking for scientific justification for this apparent success story for hypnosis, a more formal and robust search for academic publications recovers less than 1,500 trials of hypnosis over the last 40 years, 60 of which report genuine scientific or medical accounts of hypnosis being used in obesity situations (Entwistle *et al*, 2014). Many of these are the small scale or anecdotal reports from 15 or more years ago, and reviews and citations of earlier papers reporting positive or encouraging results for the efficacy of hypnotherapy in obesity and weight management as discussed above. However a search for more recent academic publications from the past five years yields only fifteen papers, of which only three are scholarly papers reporting current studies on hypnosis and obesity during 2010-2012 (ibid). This all suggests a very different picture from the lay perspective, and that hypnosis is not perceived by the scientific and medical community as any sort of magic bullet for alleviating the current obesity avalanche.

This marked dichotomy of perception and opinion, a flourishing of commercial weight-directed hypnotherapy services, contrasting with a significant dearth of contemporaneous scientific and clinical research publications, would seem to arise from four distinct factors as Entwistle *et al* (2014) have suggested. Firstly there is the increasing popularity of commercial hypnotherapy amongst the lay population - on the one hand seen by those disillusioned by the NHS and formal medical services as a therapy for all medical and emotional ills, and on the other hand as an available career option in current times of economic crisis and low employment availability – as any cursory internet search will demonstrate. Recent surveys by Hunt *et al* (2010) and Harris *et al* (2012) have demonstrated that increasing numbers of the population are exploring complementary and alternative medical services, including hypnotherapy, for their physical and emotional problems, and that there are many others therefore prepared to provide this service, a situation which has raised calls to limit and licence hypnotherapy practitioners (Aviv *et al*, 2007; Beaven-Marks, 2013; Etzrodt, 2013). Secondly there is the growing problem of obesity, evidenced by Nguyen & El-Serag (2010), Hurt *et al* (2011), Zimmerman (2011), Ogden *et al* (2016), Skinner *et al* (2016), Flegal *et al* (2016), Ludwig (2016) and many others, amongst all ages and all social levels of the population, many of whom have experienced the rigours of other, more conventional, diet and exercise based programmes, and who are aware of the low success for these in achieving long term sustainable weight loss benefits (Stubbs *et al,* 2011; Stubbs & Lavin, 2013; Barte *et al*, 2010; Ludwig, 2016). Many of these weight-troubled individuals may turn to hypnosis either as an “easy” option for their problems, or in a last, desperate attempt to find a weight loss method that will work for them.

The important third factor which undoubtedly contributes to the lack of recent scientific and medical trials of hypnosis, as Askay *et al* (2009) have pointed out, is the very nature of hypnotherapy treatment itself, which requires time, facilities and specialist training. This tends to make hypnosis less suitable and not cost-effective enough for large scale group

therapy, and more relevant therefore to individual, one-to-one settings such as are provided by private therapists and many commercial agencies and clinics. A fourth and final factor might be the disparaging reputation that hypnosis has had in the past for many scientists and clinicians (Upshaw, 2006). However the increasing number of clinical textbooks and papers attesting to the validity and efficacy of the hypnotherapeutic approach for many physical and emotional disorders is evidence of a "sea change" in attitude which is tending towards giving hypnosis a more respectable and accepted image (Lynn & Kirsch, 2006; Barabasz *et al*, 2011; Heap, 2012; Brann *et al*, 2012; Nash & Barnier, 2012; Hilgard & Hilgard, 2013; Lynn *et al*, 2014; Yapko, 2015).

Public, lay and professional knowledge, attitudes and beliefs about hypnosis have been widely explored and measured using questionnaires notably those devised by Spanos *et al* (1987), Hilgard & Hilgard (1989), Carvalho *et al* (2007), Capafons *et al* (2008a, 2008b, 2010). These have been used to demonstrate the varying degree of knowledge and expectation that individuals can have about how hypnosis works, and the corresponding impact of such expectations on the degree and depth of hypnotic trance attained during experimental and therapeutic hypnosis sessions (Hawkins & Bartsch, 2000; Green, 2003; Green, 2012; Green *et al*, 2012; Shimizu, 2014; Yapko, 2014); also the influence of gender (Költő et al, 2014) and culture (Capafons, 2004b; Green *et al*, 2006). Nevertheless, as Hunt & Ernst (2009) have indicated, there still remains a significant absence of valid scientific evidence offered as to the efficacy of hypnotherapy for weight control. This is the case even amongst those alternative medicine societies and professionals who frequently oversee and underpin the commercial and lay promulgation, propagation, and presumably uptake of hypnosis by a general public attempting to manage their weight and obesity problems - and whom these authors accuse of exhibiting "double standards" (ibid). In the face of this discrepancy there is clearly a need for further robust scientific research to help clarify the situation, and hopefully establish hypnotherapy as a respectable, evidenced treatment for obesity.

However the design of any scientific research project involving hypnotherapy with volunteers from the general public still takes place against the background of the extensive mis-information and misunderstanding that there is in the public domain about what hypnosis is and what it can do (Vernon, 2009; Raz, 2011; Pekala *et al*, 2010a). That the public is confused is hardly surprising, in view of the dissent and confusion that continues to exist even amongst the experts in psychology, neurophysiology and personality studies, about the true nature of the hypnotic state; and about the mechanisms of, and what is being accessed during, hypnotherapy, both in the laboratory and in the clinic (Oakley & Halligan, 2009; Kirsch, 2011; Lynn & Green, 2011; Pekala *et al*, 2010a; and appendix D below).

CHAPTER TWO - METHODOLOGY

2.1 Research Aims and Approach

The basic premise underlying this research project was that some individuals suffer with long standing refractory overweight and obesity, and are unable to achieve and maintain long term weight loss, because of psychological factors in their unconscious minds which are proving more powerful than their conscious will to lose weight (Sniehotta *et al,* 2014; Booth *et al,* 2014; Olson & Emery, 2015; Mantzios & Wilson, 2015; Ciarrochi, *et al* 2015). This project was designed to investigate whether such aberrant and covert unconscious agendas might have arisen in some overweight individuals because of past and unresolved emotional and psychological traumas and episodes which were continuing to act to maintain their weight and reduce the efficacy of their weight management attempts (Brann *et al* 2012; Entwistle *et al*, 2014). This project furthermore set out to explore the value of hypnosis as a psychotherapeutic approach with the power to enable such overweight individuals to explore their unconscious mind in order to identify such putative emotional barriers to weight loss, and to resolve them.

For this purpose the researcher, who has been a professionally trained hypnosis therapist for over 30 years, personally undertook a series of graded and targeted "state", dissociative hypnosis sessions (Yapko, 1995; Brann *et al*, 2012; Hammond, 2015; Wickramasekera, 2015) with a specifically recruited volunteer cohort of overweight individuals. It was hoped that this approach would allow these research participants to access their past subconscious history so as to produce for them a subconscious autoethnography within which any connections between past emotional issues and their current overweight situation might become evident and remediable. This approach was based upon earlier work undertaken by the researcher in the investigation of the emotional basis of unexplained infertility (Entwistle & Turner, 1986; Entwistle, 1988b; Entwistle, 1989) and was further

stimulated by the experience of a past clinical client of the researcher whose hypnosis sessions revealed a striking narrative of a single episode of childhood trauma which went on to cause obesity many years later in her adult life (Appendix E and Entwistle *et al*, 2014).

During 2014 and 2015 hypnosis sessions were undertaken with each of seven participants (between 3 and 20 sessions each according to their availability), with participants being interviewed immediately before and after each hypnosis session. In these interviews participants were firstly able to discuss any apparently significant emotional, behavioural, or dreaming experiences occurring since their previous hypnosis session, and secondly to describe and discuss the content of the hypnosis session they had just completed. All of these interviews were digitally tape recorded and transcribed in full for future analysis. The narrative data accruing from participant interviews in this multiple case design study (Yin, 2009) were coded and examined from a predominantly realist thematic or "theory of action" (Patton, 1997) perspective, in an attempt to demonstrate interaction between the hypnotic process and participants' evolving narrative ethnographies as evidenced from their hypnotically evinced experiences and recollections *vis-à-vis* their overweight and obesity state.

2.2 Participant Recruitment and Enrolment

The only major inclusion criteria for this research were that participants should be over 18 years of age, have been overweight with a BMI greater than 25 for over five years, and have a history of being unable to achieve a sustained reduction in their weight. On the basis of these criteria, recruitment of volunteer participants was initially commenced through an email circulated across the university campus (detailed literature available in Appendix B), but despite thirteen individuals expressing interest in this project, only seven continued beyond their first approach. All of these seven gave their informed consent and completed their questionnaires but three withdrew at this stage because of personal, family or work

pressures. This left four participants, one of whom was unable to continue beyond two sessions because of work commitments and chose to withdraw from the project, and one participant who only managed three sessions then had to stop for health reasons, but with her permission, her three sessions are included in the final data analysis. The remaining two participants went on to complete a series of hypnosis sessions. A simultaneous opportunist, word-of-mouth circulation solicited a further eight responses, two of these stopped at an informal enquiry, a further two commenced hypnosis but were obliged to stop after just one hypnosis session due to severe ill health, and the remaining four continued to completion. In total there were 19 female and 2 male volunteers but the two males were amongst those who chose not to continue beyond the interview stage. This left a cohort of seven female participants whose interviews are analysed therefore in this project, and they are of necessity a highly, self-selected group, which is what would be expected in any hypnosis project (table 2 (i)).

Following their first approach all volunteers were sent a copy of the participant information leaflet, an extensive five page description of the project (Appendix B). This explained the background and reasoning behind this piece of research and why the researcher was positing that hypnosis might be of value in the management of overweight or obesity problems. The leaflet also briefly discussed current opinions on the nature of the hypnotic phenomenon and the implications and risks of undergoing hypnosis, as well as the details of the commitment that participants were being invited to take on and the psychological and counselling support available during the course of this project and beyond. Reassurance was given regarding the confidentiality of all biographical and personal information, and of the participants' freedom to withdraw from the project at any point. The various stages in this study were described with approximate timescales for these, and reference made to the need to tape record all of the interviews and conversations that the researcher and the particpants would have together.

Those volunteers who wished to continue further were then invited to discuss the project in more detail in a face-to-face conversation with the researcher, at which point they had the opportunity to ask further questions about the project and in particular about hypnosis itself. It was also an opportunity for the researcher to explain about his own background in hypnosis and as a counsellor and a clinical scientist, and to discuss fully what would be required of them. Only two of the volunteers had had previous experience of hypnosis and only one was familiar with the concept of interviewing as a sociological tool. However as far as could be ascertained from these conversations none of the participants had any qualms about becoming involved in hypnosis *per se*.

All of those interviewed appeared to have been reassured by what they learnt from this interview about the naturalistic aspects of hypnosis and about the degree of control and safety that they would be able to maintain whilst in hypnosis. None of the volunteers cited the nature of hypnosis or their fears about this as their reason for not continuing beyond their initial interview or for their opting out of the project prematurely. For those who had never previously contemplated engaging with hypnosis for help with health or emotional problems and who chose on this particular occasion not to become involved in this project, it may be that their brief contact with an hypnosis practitioner might make it more likely that these individuals will consider hypnosis as a comfortable option for themselves in the future should the need and the opportunity arise.

The various reasons given by volunteers and participants for their not continuing into or through this project are summarised in table 2. (i). For seven of the volunteers/participants these predominantly related to the commitment involved in attending regularly, whilst for a further four, personal or family health issues were important. These same two factors continued to be problematically uppermost for the remaining participants during their time working with this project, and influenced greatly the frequency and regularity of their attending for their hypnosis sessions, and hence majorly determined the overall time span of their involvement in this research.

Table 2. (i) OUTCOME OF 21 PARTICIPANTS RECRUITED

STAGE ATTAINED	**REASON FOR NOT CONTINUING FURTHER**	**NUMBER**
Initial enquiry only	Not Appropriate	2
	Too Busy	4
	Not Known	2
Returned Forms	Too Busy	2
Attended Interview	Family Illness	1
Left Programme Prematurely	Personal Health Problem	2
	Family Bereavement	1
	Work Pressures	1
Completed Programme	-	6
Data Included in this Thesis	-	7

Prior to their commencing hypnosis sessions participants were asked to complete a brief demographic questionnaire requesting some limited family and personal health and weight history (see Appendix C). Four further questionnaires were utilised as summarised in table 2. (ii). The Generalised Anxiety Screening Questionnaire (GAD-7), (Spitzer *et al*, 2006) and the Personal Health Questionnaire (PHQ-9), (Kroenke & Spitzer, 2002) were employed to screen for significant mental health problems on the part of participants. These are both well validated and much used tools in general practice and in counselling situations for the screening and measurement of anxiety (Delgadillo *et al*, 2012; Quon *et al*, 2015; Plummer *et al*, 2015 ; Vasiliadis *et al*, 2015) and depression (Carey *et al*, 2015; Moriarty, *et al*, 2015; Maske *et al*, 2015), respectively. Garaulet's Emotional Eater Questionnaire (EEQ), (Garaulet, 2012), was employed as a relatively brief indicator of the eating habits of participants, but also as a subconscious prompt for future hypnosis sessions, and all seven participants in this project fell into the category of being moderately emotional eaters. The Spanos (2012) Attitudes Towards Hypnosis Questionnaire (Spanos *et a*l, 1987) was utilised to assess participants' attitudes regarding hypnosis in lieu of formal hypnotic susceptibility

testing, and as might have been anticipated most participants had a positive attitude towards hypnosis, with only one participant (MK-03) being less than fully comfortable, but whose subsequent performance in her hypnosis was nevertheless good.

Copies of these forms and of the consent form can be found in the appropriate appendices as can the full results and demographic details for each participant, whilst a summary of the data derived from these forms is shown in table 2.(iii). It was initially hoped that all hypnosis sessions could be undertaken on the university campus, but it proved difficult to locate an appropriately quiet, comfortable and confidential room, with a reclining chair, suitable for use for this purpose, and especially one that would be available of an evening and weekend, times most preferable to all participants. Hypnosis sessions were therefore split between participants own homes and the home of the researcher, as preferred.

Table 2. (ii) QUESTIONNAIRES COMPLETED BY PARTICIPANTS

QUESTIONNAIRE NAME	**FUNCTION**	**REFERENCE**
GAD-7 scale	Anxiety Assessment	Spitzer *et al* (2006)
Personal Health Questionnaire (PHQ-9)	Depression Screening	Kroenke & Spitzer (2002)
Emotional Eater Questionnaire (EEQ)	Intuitive Eating Pattern	Garaulet (2012)
Attitudes Towards Hypnosis ATHQ	Awareness and Attitudes Regarding Hypnosis	Spanos *et a*l (1987)

Table 2. (iii) SUMMARY OF QUESTIONNAIRE DATA

Participant Reference Code	Age	Height	Weight	BMI	GAD-7 (i)	PHQ-9 (ii)	EEQ (iii)	ATHQ (iv)
HP - O1	47	5’ 3”	16st 9	41	12	15	14	49
MK - 03	57	5’ 2’’	16st 0	41	20	20	15	34
AL - 04	50	5’ 3”	16st 5	40	7	4	12	53
BC - 06	40	5’ 3”	14st 7	36	7	14	12	59
VS - 07	27	5’ 5’’	13st 3	32	10	7	16	59
BL - 08	41	5’ 8’’	14st 0	30	9	6	12	57
RC - 09	44	5’ 2’’	10st 9	27	6	7	15	63

(i) Generalised Anxiety Screening Questionnaire (GAD-7)

Score: 0-5 Minimal, 6-10 Mild, 11-5 Moderate, 15-21 Severe

(ii) Stanford Personal Health Questionnaire Depression (PHQ-9)

Score: 1-4 Nil, 5-9 Mild, 10-14 Moderate, 15-19 Moderately Severe, 20-27 Severe

(iii) Emotional Eater Questionnaire (EEQ)

Score: 0-5 Non-Emotional, 6-10 Low, 11-20 Moderate, 21-30 Very emotional eater

(iv) Attitudes To Hypnosis Questionnaire (ATHQ)

Score Range: 7 – 98: 7- Very negative to 98- Fully positive - with regard to hypnosis

2.3 Design and Organisation of Hypnosis Sessions

All conversations were recorded verbatim using a BBC quality Olympus DM670 hand-held recorder. Despite the high fidelity of this machine there were occasions when brief moments of conversation were lost due to the researcher or participant moving about or because of traffic noise, police sirens etc. Where it was impossible to understand clearly what was being said, such (rare) incidents were indicated in the transcriptions. On four occasions there was a failure to record due either to researcher error or to an unanticipated low battery level. Where this happened, as much of the interview as possible was transcribed from memory immediately after the interview, and a comment made to this effect was made in participant's transcription records.

These hypnosis appointments were arranged at a time and in a place amenable to and chosen by the individual participants. For three participants who lived locally this was in their own homes, whilst the four non-local participants chose to be seen locally in the researcher's home where he maintains a private counselling and hypnosis practice and which was therefore judged to be an appropriate and reassuring environment for their sessions. Appointments were usually arranged for the evening or the weekend as this suited the convenience of all of the participants.

As with counselling and with most other types of therapy, convention is that the usual time span between individual hypnosis sessions is two weeks but in practice it was never possible to maintain this regularity because of participants' week-to-week personal, family and work commitments. In addition there were major gaps between some groups of sessions for most of the participants, notable with one lady who tragically experienced two closely associated major bereavements soon after her starting in the project, but who nevertheless wished to continue even though these bereavements clearly became a factor during her hypnosis sessions; another participant who became very ill as a result of a major bereavement and retired from the project; a further participant who underwent major surgery

during the time she was being seen; one participant with chronic health problems who was having to attend a series of appointments at the local National Neurology and Pain Management Centre; one participant who underwent in-vitro fertilisation (IVF) treatment and conceived during her time with the project, and another participant who had a major career change during the course of her sequence of hypnosis sessions.

All hypnosis sessions began against an ambient sound background of a compact disc of meditational music entitled Fairy Ring© by Mike Roland, published by Elfinston Music in 1982, available from New World Music. This has been the background music for all of the researcher's clinical hypnotherapy work for over 30 years and copyright was obtained from the publishers many years ago to use this for this purpose. Once into hypnosis the volume. of this music was turned down very low so as not to masked the researcher's words or the participants' responses, but gradually increased as the session was coming to an end. Participants therefore came to associate this music with their relaxing and re-awakening. For this reason participants were recommended to purchase or download their own copy of Fairy Ring© to use at home both for general relaxation and for re-enacting some of the visualisations used in this programme. They were advised however not to play this whilst driving their car or operating any machinery.

Prior to commencing each hypnosis induction participants were invited to make themselves comfortable on the couch, whether in their own or the researcher's home, preferably lying in a semi-supine position with their back and head well supported with cushions. Participants were asked not to sit with their legs or arms crossed or their hands and finger clasped together as this can create muscular tension which militates against their relaxing, and can cause cramp (Brann *et al,* 2012). A check was made to ensure that all doors were closed to ensure privacy, and that all phones, mobiles and landlines were turned off or put on silent. Lighting was ambient daylight or reduced artificial lighting, with no light shining directly on the participant's face.

The researcher sat at a little distance from the participant, to one side of their couch and remained seated and immobile during the hypnosis session so as not to draw attention away from what the participant was experiencing in hypnosis. The exceptions to this were when there was a need to sit closer in order to be able to observe any movement of fingers or head, which can be unconscious ideomotor response (IMR) signals (see below) and which can be very minimal and difficult to detect, especially in subdued lighting; and also in one particular visualisation involving "anchoring" (see below) where it was necessary to sit close enough so as to be able to grasp the participants' wrists. In these situations there was prior discussion and agreement about the requirement for the researcher to sit closer than usual to the participant, and/or to touch the participant's wrists during hypnosis.

At each appointment the hypnosis session was preceded by the recording of an update of the participant's experiences, thoughts, flashbacks, recollections of past memories and events, any surprising or apparently unexplainable emotional episodes and outbursts, and any conscious or unconscious changes in their own behaviour or in those around them that they had noted since their previous session. This interview also gave participants the opportunity to discuss any problems or concerns arising about their continued involvement in this research project. Participants were also invited to talk about any seemingly significant or relevant dreams they may have had since their last hypnosis session. The possible implications of such dreams were then examined and decisions made as to whether any of these of these indicated topics which could or should be targeted in the current hypnotic session.

Dream analysis has long been the subject of academic study as well as a popular pastime, and throughout history dreams have been seen as signifying subconscious activity, change and motivation (Hartmann, 1998; Heap & Aravind, 2002; Pick & Roper, 2004; Fonagy, 2012). Dreams are associated with rapid eye movements (REM) sleep and occur when generalised reality orientation is absent, either prior to drifting off to sleep as hypnagogic dreams or just prior to awakening as hypnopompic dreams (Brann *et al,* 2012). The analysis

and interpretation of dreams had a high importance in the psychodynamic work of Freud (1991), Adler (1936), Jung (1961), Lee & Mayes (1973) and Kihlstrom & Evans (1982), as well being an important aspect of hypnosis research and practice (Wolberg, 1945: Hilgard & Nowlis, 1973; Sheehan & McConkey, 1982; Brann et al, 2012). Although the function of dreaming is still much debated and many theories abound positing subconscious organisation and consolidation or emphasising the exploratory and creative manifestations of dreams (Hartmann, 1998; Forrer, 2014; Steck & Steck, 2016), it was felt that dream recording should be included in the analysis of between session data in this project.

Although the seminal publications of Freud and Jung were intent on finding meaning, generic or specific, in dream metaphors, as do still the plethora of “dream bibles”, “dream dictionaries”, and “dream guides” currently published for lay use and entertainment, much of the content of dreams does not fit into such easy categories and would seem to have a specific metaphorical meaning and intent for the dreamer (Hartmann, 1998; West, 2011). For this reason, in this project participants who reported dreams which they felt were important or iconic and which therefore might have implications and repercussions reflecting subconscious changes being evoked by their hypnosis sessions, were asked to make their own interpretation of these dreams based upon their own intuitive or “gut” feelings about them. It was felt that if these were messages from the unconscious mind to the conscious mind, then the individual dreamer might be the best person to understand their meaning.

Most authorities stress the need for hypnosis subjects to understand and be reassured about the nature of hypnosis before this is commenced, about the autonomy that they maintain and the variability to be expected from session to session, and also the need to allay any fears they might have about the process by correcting such misinformation (Hartland, 1971: Gibson & Heap, 1991; Brann *et al,* 2012). For this reason the researcher was careful to explain to the participant what was going to happen in the impending hypnosis session, what visualisation would be attempted, and what this was meant to try to achieve. However the participant was reminded that always their unconscious mind was in

charge of each session and this ultimately would determine how deep they would go into hypnosis and what, if anything, occurred during their session. They were reminded also that their unconscious mind would at all times keep them safe (Gibson & Heap, 1991; Brann *et al*, 2012). With this in mind the suggestion was made that the unconscious mind was now free to choose what it wished to achieve or deal with in that particular session. The participant was then invited to settle down into their usual comfortable position on their couch, the Fairy Ring© music CD would be started, and the participant encouraged to look forward to relaxing, to the induction of hypnosis, and to discovering where their unconscious mind would take them in that the session.

At the end of each session, once the participant was fully awake, they were invited to talk about their experience of that particular session. This included how much they remembered about their time in hypnosis, how much of what had been said to them they could remember, and what images, memories, feelings they were aware of, especially those that surprised them. There was discussion about how such images, memories and feelings fitted in to their personal experience of their life in the present, and with regard to their overweight problems. Both sides of this conversation were recorded in full, after which an appointment was made for the next hypnosis session. Participants were reminded that they should make a note of any, possibly significant, events, dreams or experiences occurring in the interim and that they were welcome to make contact in the meantime if they needed to talk about this.

There has been much debate in the scientific and clinical hypnotherapy literature about the necessity for and the value of preliminary testing for hypnotisability. This lengthy debate is reviewed in Appendix D, and will only be summarised briefly at this point. There is no doubt that the facility to be able to go into hypnosis, and the depth of hypnotic trance achievable, qualities which are variously referred to as hypnotisability, hypnotic suggestibility, hypnotic susceptibility, and hypnotic inductability, are both very variable from person to person. For this reason therefore many authorities most notably Lynn & Shindler (2002), Cardeña &

Weiner (2004) and Spiegel (2014) regard the testing for hypnotisability as *de rigueur* for any creditable clinical or scientific use of hypnosis. By contrast most of those working predominantly in the clinical arena choose not to undertake pre-hypnosis hypnotisability either because of its poor correlation with clinical efficacy (Weitzenhoffer, 2000; Montgomery *et al*, 2011) or because it was seen as a time wasting imposition for the client and therapist and was likely to frighten or upset clients if they scored low when tested (Kuttner, 2014; Bloom, 2014).

Amongst this latter group of hypnosis practitioners there is general agreement that most if not all hypnotisability measuring algorithms only partially reflect the ability of individuals to go into hypnosis, and rarely have a close correlation with their subsequent clinical and insightful response. In addition such procedures tend to be tedious and time consuming, can frighten off prospective clients or participants, and can generate an inappropriate sense of failure even before hypnosis proper begins. Hypnotisability testing is therefore perceived by many of the above authorities, at best, as an unnecessary luxury or even worse, as a time wasting imposition for the client and therapist in most clinical situations. It is very possible to gauge the depth of the trance state by simple observation of the participant during hypnosis; and by post-hypnosis questioning of participants about their degree of memory recall of the hypnotists instruction during hypnosis and how long they feel they have been in a trance. Post-hypnotic amnesia and subjective time dilation and contraction are good indices of being in an "other" state (Naish, 2007; Noreika *et al,* 2012; Brann *et al*, 2012). Hence this was the approach taken in this study, as it was felt that time constraints and the small number of volunteers continuing in the project would have made it impractical to reject such self-selected participants because of their apparent failure to respond efficiently to complex hypnotisability testing protocols.

2.4 Induction of Hypnosis

Despite the commonly used expression “induction of hypnosis”, there is considerable doubt as to whether hypnosis should be seen as something which is *induced in* and *done to* the hypnotic subject by the hypnotist; or whether more validly it is a process *done by* and *brought about by* the subject themselves (albeit guided by the hypnotist) because of their (the hypnotic subject’s) desire to explore their unconscious mind and to help solve their problem. This is a difference that Yapko (2014) describes as “doing hypnosis versus being hypnotic”. However in the absence of any definitive explanation of what hypnosis truly is, the expression “hypnotic induction” remains the most convenient and certainly the most commonly used term to describe the process of hypnosis, and is therefore the term used throughout this thesis. Nonetheless and irrespective of what may prove to be the final theoretical conclusion regarding this differing focus, there are practical implications both for the hypnotist and for the hypnotic subject, especially with respect to the way hypnosis is seen by and described to hypnotic subjects and therefore to participants in this research project (see fuller discussion in Appendix D).

For those participants who fear losing control during hypnosis it can be reassuring and feel more comfortable for them to know that *they* are “doing the hypnosis” and that *they* are therefore always in control and are not going to be “taken over” by the researcher (as hypnotist). However for those participants who worry that they are not going to be able to *do hypnosis* effectively and therefore might let themselves and the hypnotist down thereby, it can feel better if they feel able to leave it up to the hypnotist to do this, and if it does not work out then it is not their fault. The approach taken by the researcher in this respect, and which is reinforced with each participant at each of their hypnosis inductions, is that it is neither the participant’s n*or* the researcher’s *conscious* mind that ultimately determines what happens in any given session, and even between these sessions. It is the participant’s *unconscious* mind which is the primary determinant of what happens during an hypnosis session or induction. The participant’s unconscious mind alone controls and decides how

deep an hypnotic state is achieved, how much of the visualisation is seen and remembered subsequently, how insightful is the visualisation, and how efficacious and effective is the overall hypnosis session.

Prior to commencing their first hypnosis session it was explained to participants that each of their sessions would include some time spent in a relaxed and safe, visualised place, of their own choosing. In order therefore for the researcher to be able to choose the most appropriate words to use during their hypnosis session, participants were asked about where they would choose to go to for this safe haven, for a relaxed, safe, happy time away, a mini holiday away from all of their troubles. Brann *et al* (2012) sees this as an important task before starting therapy, and participants were asked to choose between a garden, a country setting or a beach, and this could be an actual place they had visited, somewhere they had seen in a photograph or picture, or it could be a totally imaginary place. Their chosen place would then become the participants' "own, special, safe place" for all of their future sessions. It would be a place to which they went each session and from which they could safely explore difficult and painful memories, as well as reclaiming good happy memories from their past. It was also a safe place within which they could confront other people from the past with whom they may have had a difficult relationship. This "own, special, safe place" would always be accessed by their walking down a set of ten steps after their hypnosis induction. This was a place also to which the participants could take themselves to at home, whenever they needed to relax or get away from problems, or if they wished to re-enact any of the visualisations that had previously taken place with the researcher

The hypnotic induction protocol and script utilised in this project is the researcher's modification of a generic induction procedure of the type used by most clinical and academic hypnotherapists, and recommended by the author's professional association the British Society of Clinical & Academic Hypnosis (BSCAH). It is a script which the researcher has employed and refined over 35 years of clinical practice and which is transcribed in full in

appendix A (i). In essence this involves guided progressive physical relaxation with suggestion of the eyelids becoming gradually heavier and sleepier, followed by directed abdominal breathing potentiated by the trigger word "NOW". These together allow the hypnotic participant to move imperceptibly from the wide awake state into increasing relaxation with gentle abdominal breathing and on into a pleasant and deeply relaxed state.

At this point in the induction, the word "relaxation" is replaced by the word "hypnosis". Although there may be little difference for most hypnotic subjects between this deeply relaxed state and hypnosis itself, Gandhi & Oakley (2005) have demonstrated, to their own satisfaction at least, the necessity for this relaxed state to be specifically called "hypnosis" during induction, as they see this as "the magic word" necessary for subsequent efficacious hypno-therapy to be achieved (ibid). In this study this transition was determined by careful observation of the participant, as when a suitably deep *relaxed* state had been achieved, the breathing became slower and more regular, muscle tone relaxed so that facial frown lines softened and the mouth and jaw relaxed, with usually the head turning slightly to one side. It then became appropriate to refer to *hypnosis* rather than relaxation.

2.5 Deepening of Hypnosis and Setting up a Special Safe Place

Once the participant had clearly achieved a deeply relaxed state and moved into a light hypnotic trance, it was then necessary to deepen this. Amongst the many available metaphors and approaches to doing this is that of the hypnotic subject walking down a set of steps, and as this fitted in well with the overall pattern of hypnosis induction in this project, this was the approach used for all sessions and is described in full in appendix A (ii). Once in an obvious hypnotic trance therefore it was suggested to the participant that she saw herself on a warm summer's day, standing at the top of a set of ten stone steps leading down a grassy slope. At the bottom of this slope waiting for her would be her "own, special,

safe place", her garden, her country setting or her beach. All of the senses were utilised to reinforce this image "the blue sky with white clouds above", "the warmth of the sun, and the gentle breeze on her face and arms", "the sound of the sheep on the hills, the sound of the birds in the sky above", "the smell of the flowers and shrubs around her, or the smell of the salt in the sea air" (as appropriate).

The participant was then counted down each of the ten stone steps leading down the slope in front of her, on each step the researcher emphasising the increasing calmness and relaxation and safety induced by that step, pausing on step five to draw attention to the scene below, the sunlight on the stream in the garden or on the sea across the beach (as appropriate). On the ninth step there was a further pause to take in some of the sounds appropriate to her safe place, of the water trickling over stones in her stream or of the surf at the water's edge (as appropriate), and for her to anticipate the relaxation and safety that will happen as soon as she steps down into her safe place. This she then does, and once in her safe place the participant was encouraged to walk about on the grass or the beach, taking in all the sensory aspects of her garden or beach, and feeling all the benefits of relaxation, peace, calmness, confidence, and most importantly, of safety. It is from here that each future visualisation and regression was then directed.

After each visualisation the participant was returned to her "own special safe place" to become re-oriented in time and place, and then to begin to climb up the ten steps back to the non-trance, fully awake state. As she did so each step was used to re-inforced what had been achieved during the earlier visualisation as well as encouraging the expectation of feeling calm, confident, and optimistic on awakening and in the future, thus rekindling the feelings engendered by being in her special safe place. At the first hypnosis session this climb back up the steps was preceded by a full description of how the participant could use the content of the first session to return to her relaxed and safe place in the future whenever she wished. She was encouraged to try this out by herself at home as soon as possible, and in subsequent sessions was reminded about the benefits of using this safe place for

relaxation and ego-enhancement. In some later sessions it was suggested that on her return to her safe place after her visualisation she would, to her surprise, find that her steps up had changed in some subtle but positive way to reflect and potentiate her new future, and she would be asked after the session in what subjective way her steps had changed as a result of this suggestion.

The time scale of this overall sequence from the start of induction through to fully awakening could be tailored to suit the setting, the hypnotic susceptibility of the individual hypnotic participant and their session to session needs. In general a longer, slower relaxation sequence was used for participant's initial one to three sessions, but this was accelerated as the participant became increasingly accommodated to relaxing and hypnotic induction, thus allowing for greater time for visualisations and exploration in later sessions. The first session particularly was carried out very slowly and was covertly timed using a clock out of view of the participant. At the end of her first session the participant was asked to judge how long she had been lying on the couch with her eyes closed. Invariably she would greatly underestimate this time, suggesting 10-15 minutes, when it would have been in the range of 35-45 minutes. This lack of awareness of time passing is highly characteristic of the hypnotic state (Naish, 2007; Noreika *et al,* 2012; Brann *et al*, 2012), and this time discrepancy was used to illustrate to participants that they really had been in an "other" state and not simply conventionally relaxed. Further evidence of the depth of hypnosis is the ability to elicit an ideomotor signal or reflex (Peter *et al,* 2014; and below).

2.6 Visualisation and Regression Sessions

Textbooks and papers on clinical and therapeutic hypnosis such as Hartland (1966), Wolberg (1948), Erickson (1980), Lankton & Lankton, (1983). Heap & Aravind, (2002), Barabasz *et al* (2011), Brann *et al* (2012), Kuttner & Jensen (2013) all discuss the many metaphors and hypnosis scripts suitable for use in adult and child exploratory and

regression hypnosis, and which can be adapted or modified to meet the particular focus of the hypnotist and the clinical or demographic requirements of their hypnosis clientele. Nevertheless, whilst most of the above authors agree that it is important for hypnotherapists to have their own individual compendium of such scripts, Gibson & Heap (1991) have expressed their doubts about the universal utility of such metaphor usage in hypnotic exploration. For the present research the researcher has adapted thirteen familiar and well-validated scripts based upon the approaches proposed by Hartland (1971), Gibson & Heap (1991), Heap & Aravind (2002) and Brann *et al* (2012), and his own previous practice usage, for use in this exploration of the emotional concomitants associated with overweight and obesity. These comprise two problem seeking and solving scripts as described below, six life-style and ego-enhancement scripts and four regression scripts, all of which were employed at various times with the seven participants whose data are contained in this thesis, and all of which are described in full in the Appendix A.

Most of these visualisations, which are in effect simply metaphors to prompt subconscious activity, merely required the participant to listen to the script recited by the researcher so as to allow the subconscious mind to respond appropriately. Although it is very possible for participants to talk whilst in an hypnotic trance, speech does require the involvement of the conscious mind and therefore involves some lightening of the trance state, hence direct oral conversation during hypnosis was used only sparingly. Because of the limited number of sessions available for participants in this research project, problem searching via metaphors began with the first session. Thus the first hypnosis session incorporated “The Bottle”, a generic problem seeking and solving visualisation, whilst the second session included “The Vessel” a similar problem identifying visualisation.

Both of these visualisations are described in full in the appendix and entail related problem seeking and solving scenarios. In the first of these, “The Bottle” visualisation, is the finding of a bottle in the stream or sea somewhere within the participant’s safe place, into which they are able to place all those problems and anxieties - personal, emotional, relationship,

from the past, the present or the future, that they realise have now become redundant and no longer necessary in their life. The bottle is then sealed and sent off for disposal into the stream or the sea. In the second visualisation "The Vessel" the participant is asked to visualise a clear glass vessel standing on a table somewhere in their safe place into which they place any further redundant and "dealt with" problems as above, after which the vessel fills up with a magical, healing golden liquid which dissolves away these expired problems. These two hypnotic visualisations allow for the possibility of early subconscious revelation of previously covert unresolved problems or connections from the participant's past in these first two sessions, and also highlights those "not yet finished with" problems that will not go into their bottle or vessel. After these first two sessions specific visualisations and regressions were selected according to the individual participant's progress and apparent need.

The visualisations which follow these two preliminary sessions are metaphors designed to facilitate regression into younger adult, teenage and childhood years, looking for forgotten traumas and painful episodes, and connections between these and their current adult life and their weight and body image problems. Additional visualisations are designed for ego enhancement, relaxation and revitalisation. These can be used repeatedly where necessary, and changed to suit the progress of the sessions or the content of adjacent dream reports. Two additional non-metaphor techniques used in this project were "anchoring" and "reframing".

"Anchoring" is an hypnotic device by which past emotional skills, strengths and qualities, which had been forgotten over the years but which are needed in the present, can be sought out and reclaimed in hypnosis (Gibson & Heap, 1991; Brann *et al,* 2012). These strengths when identified, are bound or anchored to some pre-determined physical or emotional signal which in the short term can be used to evoke and elicit these strengths until they have become implicitly part of the participant's present and future life, after which they become more easily and spontaneously readily available in the long term to manage their

problems. Because this technique requires the researcher as hypnotist to make physical contact with the participant during hypnosis, it requires prior specific explanation and permission before being performed. Another technique called “reframing” which was used in this project is a modification of that employed by Rossi & Ryan (1985) and Brann *et al* (2012). In this hypnotic technique the unconscious mind is asked to identify that part of the unconscious mind responsible for managing the particular problem, in this project this ostensibly is that of weight and eating management. The creative section of the unconscious mind is then requested to generate some alternative subconscious parts for managing weight and eating habits in the participant’s life, and to put one or more of these new alternative parts into place and operation. This process has to be monitored using an IdeoMotor Response (IMR) and is difficult to do where an IMR cannot be established (see below).

2.7 The Ideomotor Response (IMR)

Where it was felt that asking the participant to answer questions directly was essential in directing the progress of a visualisation, in some regressions for instance, and during the “reframing” technique as described above, an ideomotor response (IMR) (sometimes referred to as ideomotor signal) was utilised. This process allows for the questioning of a participant’s unconscious mind through a dialogue between the researcher and the participant which only partially, if at all, requires the involvement of the participant’s conscious mind (Sheehan & McConkey, 1982; Gibson & Heap, 1991; Brann *et al*, 2012). The setting up of an IMR is described in full in the appendix A (iv) but briefly it involves the unconscious mind being asked to choose individual fingers or head movements to indicate the answers to specific questions. Once established the IMR enables the unconscious mind to respond to these questions from the hypnotist by making minute movements of specified fingers or by a nod of the head, often without the participant being aware of these actions.

Where it is possible to elicit an IMR from participants in clinical and research hypnosis situations, this was a useful means of obtaining information held in the unconscious mind, which perhaps the unconscious mind was not yet ready to reveal to the conscious mind. Although the unconscious mind is not always prepared to co-operate in producing an IMR, where some degree of IMR could be established, this was used for monitoring the progress of any visualisation – “Have you found your safe place yet? Is there anything further you wish to put into your problem disposal vessel today?” Or for asking questions of the participant without bringing them out of hypnosis – “Is there a subconscious reason for your weight problem? Is your bereavement part of your weight problem?” The IMR is particularly useful in doing regression scans where there is a need to ask about traumas and events at different ages, and as Peter *et al* (2014) have suggested is a useful measure of the depth of hypnosis.

2.8 Analysis and Interpretation of Narrative Data

> "Would you tell me, please, which way I ought to go from here?" asked Alice. "That depends a good deal on where you want to get to," said the Cat. — Lewis Carroll, Alice in Wonderland.

2.8 (i) Theoretical Considerations

Studies using narrative research comprising discursive descriptions of connected events and experiences are most commonly undertaken in order to explore and elucidate particular sequences of experiential or sociological phenomena. However narrative research studies are also employed in facilitating the examination and verification of the validity of a particular mode of narrative research itself and its fitness for purpose (Lieblich *et al,* 1998). In view of the unusual nature of this project and of the data accruement during its course, the analysis of the data in this study has to serve both of the above functions. Firstly, addressing the primary research question, is the need to demonstrate that the analysis and interpretation of these data supports the contention that hypnosis has the power to identify the presence of covert subconscious agendas from earlier life which may have become factors in determining later adult refractory weight gain and failure to achieve maintained weight loss. Secondly it has to demonstrate that such hypnotically collected data is capable of being analysed in a rigorous and heuristically apposite manner which accurately reflects the factual content and the emotional flavour of these participants' narratives, such that exploratory hypnosis can be considered as an autoethnological modality and take its place as a valid sociological tool.

An additional aim associated with this study became the need also to demonstrate the reality of the hypnotic experience itself, and to reaffirm that, despite the continuing discussion and conjecture about the true nature of the hypnosis phenomenon, "the state versus the non-state" debate, hypnosis as brought about in the clinic and the research

laboratory is a very real and palpable experience for those involved, on both sides of the hypnotherapists' couch. For the purpose of this study, an effective analytical approach to the accrued data needed to be derived, one which could document this story as it emerged, and one in which the participant's experiences were at the forefront of the data presentation rather than being obscured by the researcher's interpretive needs and biases. In discussing the merits and limitations of interviewing as a sociological and ethnological tool, Yin (2009) cautions against the danger of allowing the researcher's need to follow a particular line of enquiry and to seek answers to specific research questions, to take precedence over the freedom of the research respondent to answer such questions honestly and fully, without feeling undue pressure and constraint which could result in a biased overall picture, a view echoed by Bold (2012). Allowing the interviewee to explore beyond the researcher's original question allows the interviewee to become truly involved in the interviewing process and to use their intuition and insight to move beyond the bounds of the researcher's initial questions, becoming therefore more of an informant than simply a respondent (Yin, 2009).

In contrast to other sociological modalities of analysis it is more difficult to be formulaic when analysing narrative data, which is very much "data-driven" (Tonkiss, 2012) and "context laden" (Bold, 2012), and both authorities therefore encourage a more holistic approach to the examining and analysing of narrative data. For this project particularly this was necessary in order to retain the interconnecting and temporally-linked elements of the transcribed text and so allow for a better preservation of the participant's storyline. This emerging storyline, which may perhaps be a rare situation in sociological and narrative research, is as much a part of the analysis (and the subjective and objective importance) of hypnotherapeutic exploration, as is the final *dénouement*, and as such therefore needs to be preserved. The nature of this current project is such that it was very much interviewee (participant) led with the researcher's role being mainly that of reflecting back to the participant their comments and thoughts for further consideration by the participant, but it was their thoughts and insight which provided the data for subsequent analysis. Because

the hypnosis style in this project involved a “state” or dissociational stance rather than the more authoritarian and pedagogic “none-state” socio-cognitive approach, there was much less need and tendency for suggestion and instructions to feature in the pre- and post-hypnosis interviews. These interviews were rather more opportunities for the participant to talk spontaneously about their experiences and feelings, and to feel free to show their emotions where necessary. The only structured questioning was in asking about these experiences and feelings, and about any significant dreams or behavioural changes.

Despite extensive reading of seminal texts on qualitative and narrative analysis such as Coffey & Atkinson (1996), Lieblich *et al* (1998), Smith (2007), Smith & Sparkes (2008a), Yin (2009), Bold (2012), Tonkiss (2012), Seale (2012), Saldaña (2013), Benwell & Stokoe (2012), it was not possible to find a sociological modality which appeared suitable or had been employed for analysing the output from a series of hypnosis interviews. Conversely and equally elusive were published papers and textbooks on hypnotic case studies which included formal qualitative sociological analysis of their interview data. Most published texts discussing hypnotherapy data were either quantitative analyses or meta-analyses focussing on the observed benefits of a specific therapy such as weight loss, pain-relief or anxiety remission; or were verbatim narratives of hypnotic subjects’ recountings (Hartland, 1966, 1971; Sheehan & McConkey, 1982; Brann *et al* 2012), on occasions extending to 100-150 pages such as those recorded in the classic text by Wolberg (1948), in which the hypnosis recall is reproduced without comment or analysis with the words being allowed to speak for themselves. For this project therefore it is was necessary to extrapolate, in a pragmatic manner, from the more widely available but generic approaches to narrative analysis commonly advocated for work with non-hypnotically derived data, as suggested by Yin (2009) and Bold (2012).

2.8 (ii) Coding and Analysis of Recorded Data

As has been discussed at length by Coffey & Atkinson (1996), coding functions as an heuristic sociological tool in understanding and manipulating data, and these authors have stressed the inherent dangers of letting such data accumulate without simultaneously considering how this might ultimately need to be understood and conceptualised. This was clearly a danger particularly inherent in this current project in view of the long time scale over which data would be accumulating, and the unpredictability of how such data might change, or be changing. Clearly the nature of hypnotherapy is for the relationship between hypnotist and subject inevitable to change and mature over the time course of any such therapeutic interaction. Continuous assessment of the accruing data for pertinent and valid coding options was therefore necessary. It became clear from initial interview data that, despite the apparent commonality of the study's participants in terms of their being overweight and their wishing to remedy this situation, this small group was far more heterogeneous than might have been supposed and perceived, by and within a standard weight management programme. For the researcher therefore there was the realisation that the *fallacy* of a "one size fits all" concept in the design of approaches or methodologies to serve the needs of all overweight individuals applies as equally to hypnosis, at least in this project, as it does for any other non-hypnotic approach aimed at achieving sustained weight loss. Hence analysis of the information and data contained within these transcripts needed to be undertaken in a way that reflected the widely differing hypnotic responses that these seven uniquely different case studies demonstrated, and the journeys along which they were each travelling.

As Bold (2012), Coffey & Atkinson (1996), Saldaña (2013), and others have all discussed, codes are ostensibly the links between the raw data obtained during research and the researcher's theoretical premise and ultimate conclusions. In coding and analysing the data in this project it was important to ensure that this would demonstrate the role of hypnosis in highlighting the obvious differences between the participants, as much as to demonstrate

any utilitarian and universal role for hypnosis in the management of overweight and obesity. This is consistent with the original premise for this study, that a large percentage of the overweight population have specific and complex emotional factors underlying their obesity, which would not necessarily be adequately addressed within a generic weight management programme. Coding of these conversation transcripts needed, first and foremost, to be based upon a pragmatic approach which would demonstrate the strengths and weakness of hypnosis in allowing participants to explore their feelings both overt and covert, whether or not these were directly weight or body image orientated. Additionally, coding should be able to bring to the fore examples of participant's gaining insight through the revelation of connections between such feelings and emotions, and specific individual, past and present events and situations, all hopefully within a weight orientated context.

Prior to assigning codes, all transcriptions for all participants were read through several times to obtain an overview of the total data. This was important as the hypnosis sessions and interviews were undertaken over a long period of time, hence the full content of much of the early conversations and interviews had been (partially at least) forgotten by the researcher. Over this same period the relationship of the researcher to each participant had also altered, as this project was very much a learning process for all parties, as well as a reflexive exercise for the researcher in particular. Finally there was a need to reflect on the nature of regression hypnotherapy which is not a single fixed and isolated photograph of a situation but more properly an analysis of a continuously developing process, much more of a "moving target" than when hypnosis is used simply as a motivational tool. Working from the original research questions and the premises underlying the project, coding was therefore designed to identify a number of specific aspects of the hypnotic sessions themselves, and some of the consequential effects of hypnosis, identified both directly after each session and in the time period between the sessions. The endeavour was to use this coding and its subsequent analysis to draw out from the data some of the emotional and psychological concomitants experienced by the seven participants in this project, and which

might be contributing to their overweight or obesity problem and their history of being unable to achieve long-term weight reduction.

Preliminary attempts at coding based on the reading and examination of participants' early sessions were focussed on the identification of specific words and phrases which seemed intuitively to be important to the interviews, rather than the selection of larger pieces of text, what has been referred to as a categorical versus an holistic approach (Lieblich *et al,* 1998) or formulaic versus playful (Smith, 2007). However such a categorical coding regime, essentially a semi-quantitative, content analysis, was found to be ineffective when applied to the full sequence of hypnosis sessions as the progressively changing nature of such a series of conversations meant, quite appropriately, a changing focus for participants' thoughts and feelings over time, with the consequent abandonment of some words and phrases and the appearance of new ones as participants moved to concentrate on newer aspects of their exploration. However when moving to a less specific coding system of more generalised topics this second approach was quickly found to be inadequate, as although this allowed for more of a "level playing field" for the coding across all sessions by all participants throughout their time in this study, it resulted in the loss of much of the detail, the emotion and the "flavour" of participants' highly experiential hypnosis journeys, as content analysis overshadowed the form of the narrative (Lieblich *et al,* 1998).

An alternative set of codes was therefore designed around thematic and conceptual principles, which was felt to be a pragmatic, but constructive and informative compromise between intense content analysis and mere generalisation. This coding was centred around five related themes, these being: the depth of hypnosis achieved by participants during their sessions; the emotional and visualised content of these sessions; participants' emotions on "awakening"; the evidence for regression within these sessions; and participants' dreams, emotions, subconscious messages and behavioural changes identified by them between sessions. This new coding regime encompassed a range of depth of generality, from individual words to whole paragraphs, and was felt to reflect the varying pace and content

of participants' interviews, from the very brief comments or single-word insights, through to the more discursive outpourings of emotion and life history recollection, whilst at the same time ensuring that the coding did not incur too much loss of contained information or emotional content. Once coding on this basis was thought to be complete, all coded segments of the data for each participant were brought together for interrogation as one continuous piece of participant autoethnography. Reading through this and comparing this selected content with the original transcripts indicated that further fine tuning was needed to ensure that no (retrospectively) significant comments by participants' had been missed, and that even inconclusive but nevertheless potentially significant aspects of participants' interviews had been included.

Sociologists including Rossman & Rallis (2003) and Saldaña (2013) have stressed the need to differentiate between "codes" and "themes" as they are unhappy about other researchers' implications that these two categories overlap to a degree that makes them appear synonymous. In the context of this present analysis however "theme" is used purely as a convenient and practical means of grouping related "codes" together, codes that appear to reflect a specific aspect of the hypnosis experience and that may have a common heuristic value. It is the codes themselves that are used to extract information from participants' transcripts, not the themes. This approach however is effectively the reverse of that usually employed in ethnological and sociological data analysis, in which the "themes" arise spontaneously from the coding process and are part of the *discovery* element emerging from the data analysed.

Table 2.1(i) CODING CATERGORIES

CODINGS RELATING TO POST-HYPNOTIC CONVERSATIONS (EXPERIENCES DURING AND IMMEDIATELY AFTER SESSIONS)		
THEME	ASSESSMENT INDEX	CODE
Depth of Hypnosis	Prolonged time to awakening	A1
	Misjudged elapsed time during hypnosis	A2
	Exhibited or reported deep relaxation during hypnosis	A3
	Post-hypnotic amnesia regarding visualisation	A4
	Became very involved in the details of the visualisation	A5
Content of Session	Surprised at unexpected emotions during hypnosis	B1
	Surprised at or surprising content of session	B2
	Appropriate IMR response elicited	B3
	Weight/body image connection identified	*B4*
	Able to identify & deal with specific problems in hypnosis	B5
Emotion on waking	Felt relaxation or relief on awakening	B6
	Felt agitated, anxious or tearful on awakening	B7
Evidence of Regression	Generalised regressive remembering and searching	C1
	Went back to an earlier identifiable age	C2
	Went back to specific remembered event or person	C3
	Went back to specific remembered feeling	C4
	Recalled previously forgotten event, memory or feeling	C5
CODINGS RELATING TO PRE-HYPNOTIC CONVERSATIONS (EXPERIENCES OCCURING BETWEEN SESSIONS)		
THEME	ASSESSMENT INDEX	CODE
Between session Feelings and Behaviour	Unusual, emotional or seemingly significant dream(s)	D1
	Experienced surprising emotional ups and downs	D2
	Higher degree of spontaneous dwelling on the past	D3
	Spontaneous recollection of forgotten memories	D4
	Spontaneous flashbacks to past events/people	D5
	Changes in behaviour or relationships noted	D6
	Weight/body image connection or change identified	*D7*

Tonkiss (2012) warns of the danger of trying to make the data fit preconceived ideas, but the heterogeneous nature of this cohort of case studies appeared to necessitate some intuitively pre-determined overarching thematic analysis in order to draw out the differences and the similarities across the group. This it was felt was in keeping with the original premise of research, and the emerging findings - that overweight and obese individuals are all very different and require differing management. This therefore is the logic underlying the final coding criteria used in this study and which is summarised in table 2.1 (i), above.

This same coding protocol was used both for pre-hypnosis and post-hypnosis transcriptions and for any significant texts or email communications exchanged between the researcher and participants between sessions. Once coded material was assembled into one continuous sequence of temporally acquired data for each participant, analysis of this material could begin. However it immediately became apparent that this presented some epistemological challenges due to its unique nature when compared to analytical approaches usually employed with more conventional sociological interviews. Standard ethnological exploration more usually documents a "snap-shot" of a *developed* situation, rather than the *developing* situation that a series of hypnosis sessions, an ethnological journey into an unknown land to an unknown destination, entails. Along this journey things change unexpectedly as new information accrues unpredictably in an apparently random nature, with the emergence of significant emotional changes often preceding the acquisition of knowledge and awareness regarding their causal factual events, a process more analogous with psychotherapeutic counselling than with standard socio-ethnography, and perhaps therefore more akin to dream recall than to real life.

Analysis of the coded material therefore needed to reflect this situation, in describing and documenting the *journey* aspect of regression hypnosis rather than trying to generate all-encompassing and all-inclusive heuristic ground rules for the interpretation and understanding of what at times seemed like "Alice in Wonderland" experiences and recountings. In addition to the coded extractions specified above, a further trawl of each

participant's series of conversations, interviews and feed-back was undertaken at the analysis stage to identify any additional participant's comments, observations and expressed thoughts which did not necessarily fit into the above categories, but which were nevertheless highly pertinent and significant, and which therefore could be or needed to be, quoted as part of detailing and signposting these participants' hypnotically elicited subconscious autoethnographies. However, throughout this process, and despite the apparent reasoning behind the search for an analytical method appropriate for purpose, the researcher was very much working intuitively, an ethnological fledgling and tyro, "dancing in the dark" as Frankham *et al* (2014) put it.

2.9 Ethical Considerations and Informed Consent in Hypnosis

Many of the ethical issues inherent in psychotherapy and counselling are relevant also to hypnosis and hypnotherapy including recognising the possibility that the clients or hypnosis subjects might have some undiagnosed psychological condition or personality disorder, including conditions such a conversion disorder or other somatization, a severe psychiatric illness or iatrogenic drug-related symptoms, which may make them unsuitable for hypnosis and allied therapies (Kradin, 2013). A recent article by Popescu (2015) has examined in detail some of these clinical, existentialist and moral dilemmas incident in the provision of therapies for clients including the need to screen for significant mental health problems, and much of this is highly relevant also to clinical hypnosis. It is equally important also for hypnosis practitioners, like counsellors and psychotherapists, to explain to clients the sort of information which if it came to light during therapy, would require the breaking of the bonds of confidentiality, such as criminal or national security issues, the possibility of self-harm or harm to others especially children or young persons, or where the therapist is working as part of a medical, legal or forensic team. Participants also need to understand the difference in confidentiality between undergoing hypnosis as part of their personal therapy where their control was maximal and undertaking hypnosis sessions as part of a research project, the results of which will be shared more widely, amongst the research team and in subsequent publications.

Barabasz & Barabasz (2015) have published a timely reminder of the many situations outside of formal hypnosis where individuals can slip into spontaneous hypnosis, such as during intensive emotional counselling or psychotherapy, whilst in a daydream in a lecture theatre or during a long distance car journey, as a result of prescription or social drug ingestion, and after exposure to a stressful or traumatic event, where a dissociative, fugue-like state leading to subsequent amnesia is not uncommon. During all of these hypnosis-like situations there is an increased susceptibility to suggestion and to post-suggestion amnesia, especially with those individuals who have a naturally high hypnotisability, such

that merely talking to them about hypnosis, or even just their arrival in the researcher's or clinician's office or reception can be enough to precipitate them into a spontaneous and unnoticed light hypnotic trance. This needs to be recognised and taken regard of by all hypnosis practitioners who need to ensure that participants in research projects and clients in therapy are prepared for this possibility as they arrive for their hypnosis appointment, and are thoroughly debriefed and re-associated prior to departing for home. This latter process can be a particular problem when working with a group of individuals where members of the group are likely to have different hypnotisability and dissociation potentials such that some highly susceptible members of the group may not be fully out of their trance state by the time the group are sent away at the end of the session (Kluft, 2012a, 2012b, 2012c, 2012d).

Other practical considerations and ethical concerns surrounding the obtaining of informed consent to use hypnosis in this research project, and that were expressed by those individuals responding to the researcher's call for volunteers, were clearly related to public, lay and professional knowledge, attitudes and beliefs about the controlling nature and power of hypnosis, and the degree of mis-information and misunderstanding that there is in the public domain about what hypnosis is and what it can do (Vernon, 2009; Raz, 2011; Pekala *et al*, 2010a). The early roots of hypnosis were tagged with magical, supernatural and religious attributes to the extent that the British Medical Association was for a long time reluctant to assign hypnosis a valid therapeutic role in the compendium of medical treatments because of middle-class Victorian England's moral attitudes and concerns about the potential controlling nature of hypnosis (Chettiar, 2012); whilst in France there was concern about potential danger of moral indoctrination of sick children through the application of hypnotic practices, what Rose (2011) refers to as "moral orthopedics". Such attitudes coupled with George du Maurier's famous 1895 portrayal of Svengali using hypnosis to entrance and control the unfortunate young singer Trilby, and the links that hypnosis has acquired since then, with stage entertainment, charlatans, spiritualism and the Christian Science movement (Hammond, 2014), make it hardly surprising that hypnosis

is so much of a misunderstood and maligned phenomenon amongst the public, and as suggested by Upshaw (2006), even amongst many scientists and clinicians.

Because of this situation therefore a first essential in seeking participants' informed consent to undergo hypnosis in this research project was to allay any fears and correct any misconceptions that potential participants might have, especially any concerns that, once they were in hypnosis, they would be asleep, out of their own control, and be under the power of the hypnotist. The true nature of hypnosis it was explained was a very natural one, that of being in a relaxed, day dreaming state such as they would have experienced many times before in their lives. Participants were reassured to realise that even when simply listening to a piece of music in the concert hall or a story on the radio, and all those times when "miles away" in the middle of a room crowded with people, they were actually in a state of natural and spontaneous hypnosis. The purpose of their hypnosis sessions in this project, it was explained, was that during their hypnotic trance state they would be able to let their mind wander back to times and places in the past, remembering past events and relationships, whilst at all times being as safe and in control as if they were lying relaxed on their own couch at home. Their unconscious mind at all times would stay around, monitoring what was happening in the room and keeping them safe, and they would be able, if necessary, to "awaken" of their own accord if anything external in the room needed their attention.

It was explained to participants that their hypnosis sessions would give them the opportunity to feel calm, relaxed, and good about themselves, but in order to bring about the life-long changes in health and their weight management behaviour which they needed, they would be encouraged to seek out and deal with any past events and difficult times which might not have been fully resolved at the time, and which might still be interfering in their ability to achieve long term maintained weight loss. This of necessity would entail their re-visiting past emotional traumas and re-experiencing them once again, but in a way that allowed the pain and the stress to come out safely and completely. The value of having this regression

(going-back in time) experience whilst in hypnosis was that the therapist would be there to gently steer them through these recalled memories in a way that allowed them to be explored and then released safely, rather than their feeling overwhelmed by them, or simply trying to bottle them up again. Once these emotions and feelings, which really should have been dealt with in the past as and when they were happening, had been identified and dealt with as part of the hypnosis session and in subsequent discussions, they would then cease to be a factor in their lives. Before each hypnosis session the researcher was careful to explain to the participant what was going to happen in the impending hypnosis session, what visualisation would be attempted, and what this was meant to try to achieve.

At the time of their first approach and at intervals during their time in the project participants were reassured and reminded that anything which would identify them would be kept securely locked away or in a password protected file with access limited to the researcher and his supervisors. Similarly other information that accrued about them during their sessions would be kept anonymous and retained for only as long as research project required, and that any publications arising from the project would be carefully screened to protect participants' anonymity. Participants were reminded of this at intervals as consent given at the commencement of the project might need to be reviewed as sensitive information became revealed. Participants were reassured that they would remain free to withdraw from the project whenever they wish at which point they could request that information about them could then be destroyed. If necessary, at such a time, and also at the end of the project, the researcher would be available to provide immediate and confidential counselling, followed if wished, by referral to appropriate sources of longer term help, or by referral to the participant's GP.

As is discussed later in this thesis concerns have been expressed by some authorities about the risks of hypnotic regression evoking false memories of apparent past childhood traumas and abuse (Scheflin, 1997; Patihis *et al*, 2014; Mazzoni *et al* 2014); and Fernández, (2014) has posited an innate memory distortion which protects us, by reconstructing our past rather

than simply preserving the past. Sheehan (1988) and Spanos *et al* (1999) appear to have demonstrated that the "remembering" in hypnosis of events which had never actually occurred is a frequent occurrence, and Gleaves *et al* (2004), Wagstaff *et al* (2008, 2011) and Gudjonsson *et al* (2014) all accept that memory recall can generate both genuine and false memories, a mental process that appears to be a selective phenomenon (Painter & Kring, 2015). There is evidence that the deliberate introduction of false suggestions can induce false memories which can then effect subsequent eating behaviour, as Scoboria, *et al* (2012) and Bernstein *et al* (2015) appear to have demonstrated. False memories may also arise spontaneously in hypnotherapy (just as in psychotherapy) when either the therapist or the hypnotised individual has a powerful personal agenda to find "proof" of some past (usually sexual) childhood abuse, resulting in conscious and unconscious collusion to elicit a false, and uncorroborated "memory" of such abuse (Appelbaum, 2001; Patihis *et al*, 2014; Mazzoni *et al,* 2014).

Lynn (2001a, 2001b) has expressed great concern about the evincing of such false memories and the danger of subsequently reifying false recalled material and "memories", and he urges that all participants undergoing hypnotic regression should be specifically counselled about such risks and be asked to give informed consent regarding this before undergoing ego-state and dissociation therapies. However this extreme approach has been criticised by Kluft (2001) as being unproven and counter-productive, and by Hammond *et al* (2001) as being extreme and overly excessive. Nevertheless all participants in this research were informed about such concerns and about the possibility of their recalling false traumatic or abuse "memories" from their past, and were told that any such memories or recollections would be examined very carefully and verification obtained, before they could be regarded as valid and complete.

Despite the concerns of Frischholz (2001, 2007, 2015a, 2015b) around the ethical dilemmas of obtaining truly informed consent from patients prior to hypnosis therapy, and the contention that the informed consent form is invalid unless it identifies hypnosis as

"dangerous," "experimental," and "unproven" by long-term outcome studies, it was felt that all participants in this project were comfortable enough to become involved in this research, and remained so throughout their series of hypnosis sessions. The inherent nature of hypnotherapy is that there is no way of predicting what ultimately may be revealed to participants about their past, forgotten events and relationships. For this reason consent has to be a “rolling” process, entailing constant review of accruing information and revelations session by session with participants being asked about any new concerns they may have about the project and the continued retention of recorded information about them, and a regular updating of their verbal informed consent.

The extensive interview data which follow are taken from the transcriptions of participants’ pre- and post-hypnosis conversations. Major extracts from every session undertaken with each participant are included to illustrate the full extent of the participant’s experience during, after and between sessions. This form of presentation is necessary in order to preserve and demonstrate as much of the content and the flow of the emerging biographical storyline as possible. Only in this way can this thesis give full credence to the evolving narrative which each participant evinced during their hypnosis sessions. To anonymise these data all names have been removed from the transcriptions and a non-identifying reference code allocated to each participant

CHAPTER THREE – CASE STUDIES

3.1 Transcribed Interview Data

CASE STUDY FOR PARTICIPANT - HP / 01

This participant was the first to volunteer into this project. At the time of this approach she was 47 years old in a stable marriage. She had been adopted at an early age into a family in which she had always felt unhappy and marginalised. She was very overweight with a BMI of 41 and had been so for most of her adult life, and suffered from concomitant associated health and psychological problems as a result. Her GAD-7 score was 12/15 indicating severe anxiety, her PHQ-9 score was 15/27 consistent with moderately severe depression, she was a moderately emotional eater scoring 14/27 on the Garaulet scale and her Spanos Attitude to Hypnosis score of 49/98 indicated moderate positivity regarding hypnosis.

She was only able to attend for three sessions before having to opt out due to increasingly severe physical health problems and psychological distress. These conditions were both of a chronic nature but became exacerbated by the sudden death of her adoptive mother. Nevertheless these three sessions were sufficiently deep and regressive enough to demonstrate to her the connections between her childhood history and her current weight problems. Despite her initial reservations and anxieties the participant responded well to hypnosis, as the coding analysis demonstrated, with 8 positive codings for “Depth of Hypnosis” and 25 codings for “Content of Sessions” over her three hypnosis sessions. Within each of her three hypnosis sessions she achieved a good depth of trance and was able to evoke a wide range of rich regression content. It would have been very challenging

but rewarding for both the participant and the researcher to have had the opportunity to explore and analyse in greater depth, in further sessions. The participant expressed surprise at how quickly, easily and deeply she was able to relax and drift off into an hypnotic trance, even during her first session, and of her subsequent lack of awareness of elapsed time whilst in hypnosis:

> [Researcher - *Was there anything about that that surprised you?*]: "The fact that I started to relax. I find it hard to relax – but I did start to relax, and as I started to relax, something just welled up inside me. And the fact that – a safe place, I don't have a safe place. I've never thought about being in a safe place." [R - *But could you find any safety on your beach?*]: "Yes, because I started to feel as though I didn't have to answer to anyone. I think as a child I probably read a lot of books to try and find that safe place. I just kept on reading and reading. Probably to do with children who were happy, like Enid Blyton and the Famous Five, those kinds of scenarios where people feel at home and part of a family."[Session 1]

She was surprised to realise how many negative and self-derogatory feelings from her traumatic adoptive past she was still carrying. She thought that she had moved on from these but they were clearly still a factor in her present life:

> "I was sorry for some of the things I've done, and something I did a while ago as a child … I felt guilty about one of the things … I did something that I am ashamed of now. It's just a couple that were so nice to me, and I broke their trust" [Session 1]

The participant was able to find and use her "Vessel" (problem solving device) successfully and was able to apply this in dealing with some past unresolved issues:

> [Researcher - *Did you get to talk to the people you wanted to talk to?*]: "Yes – In my own mind I said what I wanted to say to them, yes … [R - *Do you feel comfortable about that now?*]: "Yes – I do actually … it did go in." [into her problem disposal vessel]. [Session 1]

In discussions prior to the second hypnosis session it was apparent that the first hypnosis had initiated a subconscious change in which the past was clearly being processed:

> "Since four weeks ago I have been feeling different, I can't say quite how or why. I have been having a lot of thoughts about my [birth] mum and dad. I was looking at some letters that they wrote to each other when they were still together, talking about the new baby – that was me. I have felt slightly nervy and different." [Pre-Session 2]

In session two response to hypnotic suggestions to go back to times and places and people associated with her obesity problem, she was again surprised at how readily and spontaneously she was taken back to revisit earlier times in her childhood, to four, seven and twelve years old:

> "I think I must have gone back to somewhere around the age of four. But I didn't go there immediately. I started off around the age of 12 ish, and then started flitting back through the years, and stopped I think around the age of four." [Session 2]

And at the feelings that emerged as a result:

> "I am surprised–I don't really want to say anymore. I didn't expect that to come up – funnily enough not now … I was surprised at the place where I went to…I thought I'd dealt … but I gone [sic] back to there again … I must subconsciously think about those things. They do still hurt. … I couldn't put a child under the pressures that I was put under. I don't know if they realised, or whether it was their hate or their venom around that time, but … "[became very emotional and impassioned here] [Session 2]

At one particular point the participant experienced the archetypal dissociation that can be most instructive and therapeutic in hypnotherapy:

> "I had an image. With these people around me, I was back there as a child and then I was looking at myself as an adult also, looking at that child and at the people around me, thinking "how could you do that"" [Session 2]

In session three she was also able to identify a connection between her many past problems and her weight:

> "One thing springs to mind is, I thought around the age of seven or eight, that I was fat or big. – when I looked at the photograph…I wasn't. I was just normal, but I felt as though there was something I didn't like. … I realise that it's all connected with my past, and when thing went really wrong. … I think there are already things from the past - that are still there. … I think I still have to deal with a lot of things in my past. Judging by today, judging by the way my mind flitted everywhere before settling on a certain point." [Session 3]

At this point, after her third session, the participant asked to have her hypnosis sessions deferred for a while as she was having health problems. I later learnt that she had had a major bereavement and felt too distressed to resume.

DISCUSSION

It was quite clear from this participant's first hypnosis session that she was holding on to a great deal of subconscious anger, sadness, and negative and self-derogatory feelings from her traumatic past, which emerged immediately and very readily, and which could hardly be disassociated from her extreme obesity and her concomitant health and emotional problems. Regrettably it was not possible with this participant to follow up the body self-image dilemma at 7 years of age, identified in her third hypnosis session. However there is much documented evidence for associations between self-denigration and shame resulting in poor body image and subsequent adult eating behaviour (Lissau & Sorensen, 1994; Koch *et al,* 2008; Danese & Tan, 2014; Hemmingsson, 2014; Salwen *et al*, 2014; Tagay *et al* 2014; Ferreira *et al,* 2013; Wade *et al*, 2016; Lewis-Smith *et al*, 2016 and many others); and certainly this participant left her childhood with more shame, low self-worth and childhood angst than most children. It is unfortunate therefore that she was unable to continue beyond

her third session as even within her first three sessions, there were some early indications of how much benefit might have been achieved for her from exploring her childhood subconscious ethnography. However it is also possible that such an in-depth psychological exploration would have proved too intense and too life affecting for her in the context of this short-term research project. Nevertheless the researcher's more recent chance contact with her has indicated that she has now more insight into the connections between her very difficult past and her obesity, and that she feels she has benefited from this. Sadly she is currently too overwhelmed by subsequent events to be able to recommence hypnotherapy. She was however still happy for her experiences across the first three sessions to be included in this project.

CASE STUDY FOR PARTICIPANT - MK /03

At the time of her first approach to the research project this participant was 57 years old, was 5 feet 2 inches tall and weighed 16 stone, which gave her a BMI of 41. During her extended time in the project her eldest son died at 33 years and this was followed nine months later by the unexpected death of her husband. Despite these tragedies she chose to remain in the project although there were of necessity some long gaps between her hypnosis sessions. Even before the death of her son she had clearly been depressed and anxious as a result of his chronic illness even though she had the support of her three other children. Her GAD-7 score and her PHQ-9 score were both 20, indicative of severe anxiety and moderate to severe depression respectively, and she was under regular medical surveillance as a result. She was a moderately emotional eater scoring 15 on the Garaulet (2012) Emotional Eater Questionnaire. Her compounding medical conditions were some arthritic joint problems, a benign thyroid nodule under review and an occasional flare up of gout.

Despite her relatively low score of 34/98 in the Attitudes Towards Hypnosis Questionnaire (Spanos *et al*, 1987) this participant was able to relax well and to go into a trance state right from her very first hypnosis session. Overall in her 12 sessions she exhibited 34 coded examples of "Depth of Hypnosis" and 70 coded examples of "Content of Sessions". She was surprised how well she was able to relax for her first ever hypnosis session and how clearly she was able to visualise her problem disposal bottle and use this to dispose of some of her problems:

> "I felt….I didn't realise that it would be so easy. I didn't imagine it would be so easy. I did feel relaxed. I still feel strange now. Is that alright?" [Session 1]

> "But it was all very strange. I didn't think it would be as easy as it was. I thought I'd fight it, that it would be a fight. … I did have a slight panic – I don't know whether I like this - but something made me go with it. I actually feel quite relaxed, instead of always…" [Session 1]
>
> [Regarding her safe place and her problem disposal bottle] "It's somewhere I think I have been before – I just can't remember. The bottle was square, brown, an old-fashioned one. What you would see in Victorian times. Just like that. The cork – it was supposed to be a cork?" [Session 1]
>
> [Researcher-*What did you put in the bottle, can you remember?*] "Guilt. Guilt, fear, - whether that will ever go. There was something else. … Guilt, fear – and sadness. Sorrow. I just want to be someone different. … But when it comes to now, I found it difficult." [Session 1]

The participant was very impressed with herself for being able to relax so well, and was surprised to wake up still feeling so relaxed and to realise how much time had elapsed during her hypnosis. She commented that this was the first time for long time that she had felt so relaxed, she didn't think that this was possible, and was looking forward to her next session.

In session two the participant again went into hypnosis very quickly and deeply and took a long time to re-awaken at the end of the session. Once in hypnosis the word "back" was used to suggest that she go back in time to look for problems relating to her weight. Without further prompting she began seeing lots of lilac lights which she saw as a symbol for her mother:

> "Well I could see lilac lights, spreading in different directions. … Yes it was these lilac lights. My mum liked lilac, she like lilac and lilac trees … Yes just the lights. Branching off into different places." [Session 2]

These pleasant images and memories then quickly changed to unpleasant childhood memories and images of food associated with her father, who had a very easy-going and open relationship with animals as food, which was not shared by his wife and children:

> "[M]y dad's cooking. He used to cook pig's heads and feet and everything. And I used to stand there crying, thinking of the poor animal. But that was the way my dad was brought up. … stand looking into the butcher's shops crying for the animals which had been killed. It became a part of my life." [Session 2]

> "The worst one was the white rabbit [*a live one*]. He brought it in, he'd bought it off someone he'd met in the pub … which me and my sisters were playing with it. But it was for dinner next day. [T]here was this awful sweet smell, of blood, this smell, and that was our rabbit. So we refused to eat it – but it was one of those times when we could not move until we had eaten it." [Session 2]

> "I hated it … and began to hate eating any of the food. I started just to eat sweets and chocolates so I would not have to eat this terrible food. We never had chips like any other people did. It was always mum's healthy eating, or dad's. So when I could choose what to eat, I think maybe I chose wrong choices." [Session 2]

Regression in session 3 resulted in a medley of images, memories and feelings with no apparent clear direction indicated:

> "That was very confusing … everything was jumbled up. I trying desperately to be where I was before. My mind was so…I don't why … I don't know, I can't see a way of sorting things out, without some terrible showdown. Don't know, I want to run away from all this. … I was relaxed, but when I got to the garden, [her safe place] I got confused." [Session 3]

Much of this confusion and distress related to family pressures and we discussed how she will cope with these and with her grieving during the forthcoming Christmas period:

"I've had enough Paul, it's not fair. And all the stuff and grief… and they [the rest of her family] should be helping me. But they're not. "You've got to be strong" … but I'm sick of being strong! Its … just the phone. When I heard it going, you know, that dread, I thought what's next." [Session 3]

[Research-*Do you ever go into your garden (her safe place) by yourself*?] "I have done, when people are not bothering me, but there is always somebody coming in or out. I did when we first started." [Research-*Well do it again. Sometime today, tonight or tomorrow – do it again, go back down there again, and try to re-create what you do with me*.] "I think you're right Paul" [Session 3]

On the positive side, during session 3 discussion, the participant did report that – "I am losing a little [weight], I can tell, slowly". Sadly by session 4 her sick husband had died hence this session was simply a regressive search for problems, people and barriers needing to be dealt with. This began for her with a spontaneous return to recollections of past losses as signalled by the lilac lights of her mother [now deceased], before she moved on to some positive thoughts and conclusions about how to manage her grieving and move forward with this, and about the connections between her past and her weight problem:

"I saw lilac-y white lights again. And when you mentioned people I'd lost, they were very strong. … "I did feel a bit of positivity today – is that good? That there is something there for me, that it's not all over. That maybe there is a way to live without them [son and husband]". [Researcher- *But to live with them in a different way*]. "They know that I still respect them so much, even beyond the grave. There is too much of this…'oh they're gone now'. They [her family] are so very hard. You can't really love someone then…" [Session 4]

"I do feel that much of this [her weight problem] is from childhood." [Session 4]

Because of her distress and her need to grieve for the loss of her husband, the participant felt that she needed a long break, and therefore decided not to continue with her sessions.

When she presented for session 5 hypnosis session seven months later she was asked whether she really felt ready to resume this and whether she felt it would help her:

> I'll try but don't think it will be much good…I am feeling very agitated and anxious about all the things I have to sort out, I have so much err… debt, the garden is a mess, I'm really ashamed about it. But, but…I'll do my best [Pre-hypnosis session 5]

This hypnosis session was down to her safe place (her garden), followed by relaxation and ego-enhancement only, with no attempt at exploration or regression. The participant appeared to relax quickly and deeply and took a long time to awaken after the session, remaining calm, relaxed and quiet sitting in her chair for some time after this:

> [Researcher- *So are you relaxed?*] "Yes" [R-*Are you surprised?*] "Yes, I've not felt …for a good while I've feeling so…as if … [long pause] something come out of me, you know, badness and worry." [Session 5]

The following conversation then followed:

> Participant: do you think it's a punishment, is it a punishment? .
>
> Researcher: For what?
>
> P. Why my life so terrible [laughs] … maybe…[long pause] little things I've done in the past.
>
> R. Have you done bad things in the past? Really wicked things?
>
> P. Nothing really bad…maybe…
>
> R. Bad enough to have your son and your husband taken from you?
>
> P. I wouldn't think I deserve that.
>
> R. I wouldn't think so either. And who punishes you…who's in charge of punishing you?
>
> P. God.
>
> R. And you think God would take away…?
>
> P. I love God … but…
>
> R. Do you think God would take away your son and your husband, just to punish you for some little misdemeanour?
>
> P. I think he lent me my son, you know, I borrowed him.
>
> R. We only ever borrow our children. Our children are the children of the earth.

P. Yes.

M. And we can only do what we can…we point them in the right direction and then we let them go, and we can't control them after that.

P. And he was suffering, I don't think he wanted to suffer any more. And maybe he took M., my partner to look after him.

M. You predominantly, looked after him on earth, perhaps M. is to look after him elsewhere.

When next seen the participant reported back that after session 5 she had had a highly emotional and clearly significant dream which she had found very reassuring:

"I had one [a dream] about M. [husband who died unexpectedly one year ago]. Last Friday I wasn't well and I fell asleep for about 20 minutes on the settee. He was actually there in his car, the car was in the living room, a grey one. And I said "M., you're back with the car". And he was all dressed up like he was for S.'s [youngest daughter who married three years ago] wedding. And he said it's gonna be alright, everything is gonna be alright. When I woke up I really did feel as if he'd been there" [Pre-session 6]

Before commencing session 6 hypnosis, we talked at length about this dream which was clearly delivering a positive message, looking at it both from a psychological/psycho-hypnotherapy perspective as well as from a religious perspective. The participant is a Roman Catholic who believes in life after death, and after this discussion it was concluded that it perhaps did not matter whether this dream was a subconscious response to her hypnosis session; a direct spirit message sent from her husband to reassure her; or whether it was her husband speaking to her indirectly by influencing her through her unconscious mind to produce this dream in response to her hypnosis. Whatever the route or mechanism behind this dream it was a reassuring and encouraging signal for her about her future.

The discussion after session 6 hypnosis was only brief as the participant was unwell with a chest infection. Her hypnosis instructions in this session focussed around looking for further subconscious past problems, and their disposal:

> "I liked the bottle", [bottle in her safe place to dispose of redundant and unnecessary problems and worries]. [Researcher-*what did you put in your bottle, can you remember?*] "The garden, it got done, well will be soon get done. And I tried to put feelings of guilt inside the bottle … I could actually see this garden. And the bottle, one of those old green ones … you used to find as children?" [significant that s
>
> he chose a childhood image for her bottle].

When the participant attended for her session 7 she had two more important feeling dreams to report about. Both were about J, the previous partner of her eldest daughter C. He was the father of C's two children, two of the participant's grandchildren, and was therefore someone who clearly was an important person in the participant's life. This man is of a similar age to her deceased son and like her son with alcoholism, J. has a severe addiction, in his case to street drugs, which is ruining his life and that of his children:

> "I had two strange dreams about J. I've never had any dreams about him, so it was really strange. He got involved with heroin and other drugs and he's been very ill for a long time. He was at K.'s funeral [K. is her son who died of alcoholism last year]. Yes he looked terrible, you know, all untidy and thin and … looked very ill." [Pre-session 7].
>
> "We tried to get him to stop his drugs, we thought he'd make a better effort seeing how K died. We'd thought he could change, but …for his kids … but, he looked so ill at the funeral. Even in the dreams … I don't know what they mean … I daren't tell C." [Pre-session 7]
>
> "I felt that Joe was trying, twice, was trying [long pause] trying to speak, to, to say something … it did feel important, but …" [Pre-session 7]

The participant felt that these dreams were her deceased son K. trying to communicate with her through J. who was his friend and a contemporary. The possible interpretation of these dreams was therefore examined in the light of the (understandable) guilt that the participant still felt at having been unsuccessful in protecting her son from his addiction and saving his life. In these dreams J., despite his being an intelligent and very likeable young man with two young children to consider, was presented as being just as oblivious to reason and just as recidivistic to dealing with his addiction as her own son K. had been. The messages being sent to her therefore, whether through the spirit of her son, or through her unconscious mind, seemed to the participant to be telling her that her son K's failure to beat his addiction and his consequent death, was just like J's addiction, due to the power of the addiction and the inability of the sufferer to deal with this. It was "not her fault", not in any way due to the participant's (his mother's) lack of effort and love, and that she had done all that she could to save her son, to no avail. This explanation for these "dream messages" seemed to feel right for the participant, and as hypnotically evoked subconscious messages it made sense to the researcher.

In the subsequent session 7 hypnosis the participant went particularly deep as shown by the long delay in her becoming full awakened and her odd thoughts and sensations as she recovered from hypnosis:

> "That was strange … you look different … different." [Researcher- *Different in what way?*] "I don't know … your head looks bigger … somehow". [R -*How do you feel now?*] "I'm not sure how I feel, strange but quite calm, that's all." [Session 7]

She also had more post-hypnosis amnesia than usual which is usually associated with a greater depth of hypnosis, when the processing is predominantly subconscious rather than conscious (Brann *et al*, 2012; Hartland, 1966):

> "I couldn't remember much today, not so much." [Researcher- *Can you remember what you put into your bottle today?*] "No, but there were some barriers to go in, yes, but I'm not sure what they were." [Session 7]

When she attended for her session 8 hypnosis the participant had her arm in plaster having fallen and broken her wrist since her previous session. Nevertheless she was able to report having a series of dreams about her son K. who was only 33 when he died 18 months previously:

> "I have been having lots of dreams about K. I don't know why. They're always happy ones. You know …he is always smiling and happy in the dreams. [H]is hair is dark as well. He looked good. Some were in my daughter's house and some were in mine. Those in my house he was tidying up and fussing around me. He always was a fuss pot with me. [H]e was err … smiling at me. It made me feel happy also." [Pre-session 8]

> [Researcher- Have you had many dreams about K.?] "A few, but usually … [pause] … sad ones … about not being able to save him. Just before he died I said to him in the hospital that if he didn't stop drinking he was going to die … [long pause] … but he just said "it's OK mum". They were his last words. I had a dream a while ago. But not like these other ones, you know. It's like he is trying to help me, or something. But he was happy and smiling, Paul. That's a good sign, isn't it … d'you think?" [Pre-session 8]

> "Oh! … and he had a baby with him … I asked him whose baby it was, and he said "Mine". … Isn't that strange? I asked the baby's name … and he said "Diego". That's a Mexican name, isn't it?" [Pre-session 8]

It is significant that she could remember these dreams in such detail and this clearly reflects the emotional importance of these dreams for the participant (Jung, 1961; Freud, 1976; Hartmann, 1998; Samson, 1998). Whilst the earlier part of the dream(s) seems to suggest

a subconscious processing of the grief and the memories she has about her son and her husband, and her sadness surrounding their deaths, the reference to K. having a son and the choice of a Mexican name for the child is obscure. There are no South American connections whatsoever in the participant's family or history, but as K. was a football fan this might have been a reference to Diego Maradona the famed Argentina footballer?

In hypnosis session 8 the agreed plan was for the participant to go down to her garden safe place where the researcher would then count her back through the years to search for any remaining barriers that there might still be in the unconscious mind which were impeding weight reduction and the changing of body size, shape and self-image, with this sequence being monitored using an ideomotor response. The unconscious mind would then be requested to let these barriers go so that the participant could become slimmer and healthier and more able to maintain her role as mother and grandmother, and importantly, her role as the person to keep the memory of her son and her husband alive, and make them real for her two new grandchildren who never knew their grandfather M. or their uncle K. However the participant's unconscious mind had other plans for this session, and although she very quickly relaxed and drifted off apparently down to her safe place, it became apparent to the researcher that she seemed to be struggling with, and puzzled by something, at which point she "awoke" quite abruptly, prematurely, and before being given any instruction for this to happen. She opened her eyes looking puzzled and remained in a semi-trance state for a few minutes before she could talk clearly:

> [Research- *How was that?*] "That was strange … you look different again." [R- *Could you find your steps and your garden*] "Er … yes, but the steps were different. They were rounded, you know, curved. … Like church steps. My steps are usually, well, er … square like, old fashioned … square dark brick type. But these were round, curved, just like the steps out of church." [R- *Do you know what church it was?*] "No. … And also Paul … I couldn't see my garden, it was all just white, you know ... Err, like misty on the stairs, and down in the garden. All white and misty … foggy type

mist. I'm sorry but I couldn't see anything else … just all this mist. I'm not sure … what did that to me, it felt strange." [Session 8]

"But I was very relaxed. I did feel that warm relaxy feeling spreading over my body. It was just all this white mist on the steps, and right down, you know, down into my garden. My shoulders and back seem to … I feel like a lot of tension has been taken away from the body, relaxed you know. That feels good." [Session 8]

So despite the participant having had a bad fall and being in pain as a result of having her wrist in plaster, for its own reasons her unconscious mind chose to use this particular session for a specific purpose, contrary to the conscious plans of both researcher and participant. This demonstrates an important message about hypnotherapy, that being relaxed and calm and in a consciously receptive mood is not a prerequisite for, nor a guarantee of, a deep and successful hypnosis session (Entwistle *et al*, 2014). The unconscious mind is at all times in control of the proceedings and it alone determines the outcome of any particular period of hypnosis. Despite the pain and distress of her wrist fracture, the participant's mind chose this occasion to inhibit her from processing other aspects of her past as planned, and decided instead to deposit her on some church steps, symbolic perhaps of those which she might have walked down at the funerals of her son and her husband, although they were not recognised as such. Significantly after this scene the participant did spontaneously comment that "I feel like a lot of tension has been taken away from the body", and perhaps therefore this session and her dreams of the past two weeks, signalled a watershed in her moving forward in her bereavement.

Discussions prior to hypnosis session 9 were again dominated by the report of a further powerful and strange dream experienced by the participant in the interim:

"I was sitting in a dimly-lit car in a foreign country with a young man. But I was young. And mum and dad came up. And my dad had sunglasses on his head [laughs], and his sleeves rolled up. He was never that kind of man. And my mum looked younger,

like I remember her as a child. And she just stood there smiling, and erm … my dad said something, "What did you say" but he was looking pleasant, which he never did. He didn't want them [her parents] to go. It was just so strange, you know … the way they stood at this table [sic], smiling at me." [Pre-session 9]

"They did, [look happy] they looked like what I always wanted them to be like. They were always miserable people, you know. Where-ever they went there had to be a problem. But seeing my dad with his rolled up sleeves and sun glass, which was not him at all." [Pre-session 9]

No hypnosis was possible on this occasion as the participant had an urgent hospital appointment but the following session 10 five weeks later, like session 8, did not go according to plan and was another example of the unconscious mind taking control. The visualisation planned for this session was to be "Brain Washing" in which the participant was go down her steps to her safe place, and from there to visit a lily pond in a glade set in the middle of a woods. Here she would experience a summer shower which would "wash" away all of her problems, anxieties and stresses, including the dust and grime deposited on her brain from the past (hence the title "Brain Washing"), as she visualises the refreshing, cleansing and invigorating rain running over her brain. This metaphor would help to give her a "clean start" for the future. However right from the start things did not go to plan:

"I found the steps threatening, slippery. I got up [the steps] by holding on, but it was particularly the middle ones that seemed, slippery and … Not properly formed steps. I don't know why." [Session 10]

"I couldn't break through … the trees. Would not break through this barrier of pink and purple colour. I wanted them to but they wouldn't. I was getting … er … not annoyed, a bit frustrated at these tress would not break through, through this colour barrier. I don't know why they wouldn't. … I don't know. … I'm still grieving." [Session 10]

[Researcher- *What does pink and purple feel in your life? Are they colours your like?*] "Erm … I don't know really. 'Cause I'm a blue person. I don't know. But these trees would not come through this colour." [Session 10]

[Researcher- *Did you feel any rain then?*] "I wanted to feel the rain, but I couldn't … because of the trees." [Session 10]

The significance of the pink and purple colours impeding her progress was not clear although the participant had previously seen lilac flowers in session 2 and had said that lilac was her mother's favourite colour. By over-riding the visualisation intended to help the participant let the past go and make a new start, it can only be assumed that the unconscious mind was perhaps indicating to the participant that (understandably) she had more work to do with her grieving before being allowed to move forward and start to deal with other problems including her overweight. This would seem to be the message for her and the reason why she could "not break through this barrier of pink and purple colour".

There was a further long gap between this session and hypnosis session 11, and during this time the participant had a further dream about her deceased husband M., but a much different one from her encouraging dream after her fifth hypnosis session:

"I had a dream about M. last week, it was in the park near here. He seemed very angry and was throwing money down for me. I've had a few like that involving money and him being angry, it upset me, I don't understand why he would be angry." [Pre-session 11]

The participant was unclear as to why, in her subconscious mind, she would perceive her husband as being angry with her, whether because she feels that she should have done more to protect him:

[Researcher- *Could you guess why he would be angry?*] "Not really, he never was generous money wise. You know. The other time we were in somebody's …

somebody I know, but I can't remember whose house - he was there and he was angry again."

She wondered perhaps if it was because she was unable to protect him and save his life and this was why she felt guilty still about his death – "I still feel guilty about the way he died, I should have spotted it … so should the doctors." But she also considered the possibility that perhaps he was angry now (in contrast to his earlier reassuring dream appearance) because she has continued to let her weight rise and not tackled her weight problem properly, which she knows would annoy him:

"I know I need to do something about my weight … also I am worried about my walking, it's getting more difficult. Do you think it's my arthritis?" [Researcher- *That's bound to be a contributory factor, along with your weight and generally we get less flexible joints and ligaments with time and age. Also you need to exercise more, swimming is the best for you*.] "Yes, I really, really need to get back to swimming." Pre-session 11]

In session 11 the participant went very deeply and very quickly into hypnosis and awakened only slowly, remaining very relaxed even when fully alert. On this occasion she was able successfully to complete her "Brain Washing" visualisation:

[Researcher- *How was that?*] "Very strange. Nice but strange. Yes it was, it was good. If I could feel like this all the time!" [Session 11]

{Researcher- *did you find your little glade?*} "I did yes. I pictured it, to this side it was. I always find the bottle. [R- *What did you put into it?*] It was … Just the usual normal questions, and for just peace really. And kindness." [Session 11]

For her final session 12 she felt that she would simply like to have some relaxation as she had some imminent and important anniversaries to do with her bereavement. Understandable she had had a few dreams about her son and her husband but nothing that felt dramatically significant. She reported that she had registered with a gymnasium and swimming club and had recommenced her swimming lessons, which she was very pleased

about as she had already lost a bit of weight. She also asked whether I thought that her son and her husband would mind if she lost weight and was no longer the "big woman" that they knew when they were alive, a classic example of her having a secondary gain from her obesity state.

DISCUSSION

This participant's early sessions, sessions one and two, clearly elicited some of the roots of her early food problems, principally the attitude of her father towards animals as being merely food. This upset her greatly, as she recollected crying frequently as a child at seeing animals being killed and cooked as well as her having to eat her cooked pet rabbit. For this reason she said that she needed to escape from this environment and the family home. In session two she recalled that "I hated eating any of the food. I started just to eat sweets and chocolates so I would not have to eat this terrible food. So when I could choose what to eat, I think maybe I chose wrong choices". With her BMI of 41 this participant was now considerably obese and the impact of this on her general health, her breathing and her joints was very clear, and she urgently needed to lose weight.

However her anxiety and depression indices indicated a higher degree of psychological and emotional distress than was justified by her obesity problem and was predominantly the result of family, domestic and financial pressures, and especially because of her youngest son's alcohol addiction. His death, followed nine months later, by that of her husband obviously exacerbated her emotional suffering and she is currently nowhere near to reaching a resolution of her double bereavement. It was not surprising therefore that after her second hypnosis session her unconscious mind appeared to be directing her hypnosis sessions in the direction of her bereavement problems, and where necessary her

subconscious was prepared to override the researcher's planned visualisations around weight management in order to maintain this bereavement impetus and focus.

In sessions two and four there were associations around her mother indicated by the appearance of lilac lights and flowers, lilac being her mother's favourite colour and flower, and this perhaps reflected the participants' own pain as a bereaved mother. The participant's dreaming throughout also reflected the family connections, with highly significant feeling dreams about her husband in session six, her son's best friend in session seven, her son himself in session eight and her parents in session nine. Some of the later hypnosis sessions further illustrated an imperviousness and obduracy on the part of the unconscious mind about not moving through the resolution of the bereavement and moving on to weight reduction, even to the point, in session eight, of waking her up in the middle of her hypnosis. Such taking control of the hypnosis session by the unconscious mind so as to produce a different result from that planned, or no result at all, is often referred to as "resistance" (Wolberg, 1948; Hartland 1971; Heap & Gibson, 1991; Brann *et al,* 2012).

In both sessions eight and ten, it was very well demonstrated how effective the unconscious mind could be at keeping control of what was to take place during hypnosis, which reaffirmed the premise that hypnosis, despite its stage show and cinema depictions, is not a technique whereby an individual can simply be taken control of and be "brain washed". However there were signs in the last session 12, of her working towards better weight management and hints also of the possible connection between her body image as a fat woman needing to maintain weight and body-image and her grieving process.

During the course of her time in this project it became apparent that, for this participant, there was an urgent need for her to be helped with her grieving for her son and her husband. This was very apparent also in the participant's dreaming, where all of her many, and highly significant dreams related to her lost son and husband. There was therefore a regular correlation between the content of her hypnosis sessions and that of her dreams which could be seen as the unconscious mind keeping both the participant, and the researcher,

regularly appraised of the progress of her therapy (Jung, 1961; Freud, 1976; Hartmann, 1998; Samson, 1998)

As with all the participants this woman enrolled in the project knowing that its primary focus was to explore the use of hypnosis to identify and ameliorate covert subconscious agendas which might be playing an aetiological role in refractory obese and overweight. However she was aware, as were all participants, that other perhaps associated emotional problems could very likely surface as a result of their hypnosis sessions, and that these would need to be dealt with as they arose. The subconscious mind may need to prioritise the revelation and the resolving of problems during hypnotherapy in order that more recent or more urgent events and emotions are dealt first, and any course of hypnosis sessions is therefore more likely to follow a circuitous rather than a direct route (Entwistle *et al*, 2014). Not until she has been able to find some peaceful resolution to her grief will she be able to move on and perhaps then become free to deal with her weight.

CASE STUDY FOR PARTICIPANT - AL /04

This female participant was 50 years old, married for 25 years with two adult children. She began to put on weight during her late teens and her weight has fluctuated since then, her current BMI being 40. Her mother and her two brothers were consistently overweight, but not her father nor her children. On a number of occasions she has tried using dietary approaches to lose weight along with exercise and sport, but, especially in recent years, none of these attempts has resulted in substantial, maintained weight loss. Her general health was relatively good aside from knee problems and some gastric reflux, for which she takes a proton pump inhibitor. At the time of presentation her GAD-7 score was 7, suggestive of moderate anxiety whilst her PHQ-9 depression score at 4, was within normal range. She was a moderately emotional eater scoring 12/27 on the Garaulet scale and her Spanos Attitude to Hypnosis score of 53/98 indicated good positivity regarding hypnosis.

Despite her concerns that she would not be able to relax into hypnosis, this participant's unconscious mind seemingly was prepared to become involved in the process from her very first session. This she judged to have lasted for 10 minutes when in reality it was over 45 minutes, good evidence for her being in an hypnotic "other" state rather than mere gentle relaxation. "Depth of hypnosis" codings appeared to confirm this hypnotisability facility with 41 incidences of depth indices and 57 "Content of Session" indices noted over her 16 hypnosis sessions. This is further reaffirmed by the clarity with which she was able to visualise her problem disposal "bottle" in her first hypnosis session and her disposal "vessel" in her second session:

> "[O]ne of those earthenware type bottles. With a sort of metal attachment on the stopper. That you pull down. The old type. … They are very old fashioned. They are old fashioned bottles, and they are heavy." [Session 1]

> "It was, kind of cylindrical at the bottom, with a kind of straight …conical top on it." [Session 2]

From her very first session onward she was able to recall and identify problems from her past which appeared to be contributing to her negative self-image:

> "There are quite a few [problems] that surfaced. When you said about relationships with friends and things like that. Some of the negative emotions that have attached to some people … disappointed by my friends occasionally. A bit let down, for various things. I do, yes, want to get rid of those feelings. … I definitely came up with a lot of problems. … I did feel a bit of a "tug", an emotional tug. I felt emotional about some of them, in particular." [Session 1]

> "[A] couple of them that I haven't felt for a long time popped in, that I haven't thought of for a long time. Particularly in terms of friends and things like that … Kind of quite strong negative emotions…about myself. … There were a couple of things that I felt definitely kind of I really wanted to put in yes. Especially…particularly ones like I feel about myself. [T]he lack of self-belief. I have a lack of confidence, I have fear of being judged – and criticised. It's what's held me back, in respects of what I am doing now. But I'm not getting there because I have this fear of being judged, fear of failure." [Session 2]

The participant's unconscious mind's response to an hypnotic search for times, events, people and feelings from the past linked to and underlying her current weight problem, resulted in a gradual re-discovering of forgotten past hurts and difficult relationships, and the realisation of the impact that these have been having on her life since early childhood onwards with their weight management implications. This became a developing theme of her hypnosis sessions, as did her awareness and acknowledgment of how these were contributing to her long-term negative self-image and resulting weight gain. She recalled having a "very volatile" and "fractious" upbringing, due to her parents' (both of whom are

now deceased) “very volatile” marriage, and which was highlighted in our discussions after her second hypnosis session:

> “They didn’t get on ... My mum was very you know, up and down emotionally and my dad was quite cool. … My childhood memories of my mum and dad were that they rowed a lot and my mum, I remember on a number of occasions, my mum threatening to leave, because I suppose he was a bit difficult. So she was craving, craving, craving attention really, and when he wasn’t giving it to her she, she would threaten to leave. And she didn’t leave but she threatened it, and I was a witness to this and saw this. And it would really upset me. I would be really terrified of her leaving.” [Session 3]

This difficult start to her life the participant now realised had resulted in her gradually accumulating guilt and sorrow through her childhood and was a contributory factor for her in her development of the poor self-image which became re-affirmed as the participant’s series of hypnosis sessions progressed. This low self-image was apparent even up to very recent events in her life and appeared not to have been eradicated or ameliorated by her subsequent adult experiences which were clearly evidence of marital, social and academic success:

> “[T]he feelings that that left me with. Very strong feelings of sorrow, and guilt, quite a bit of guilt – not a huge amount, but a bit of guilt. And then with my dad, and then things I feel about myself. Kind of quite strong negative emotions…about myself.” [Session 2]

Sessions three and four were this participant’s first formal regression visualisation sessions and during her diagnostic time regression scan in session three, to her surprise she went back to her school years between being 6 and 11. In particular she re-experienced very powerfully her feelings at being 6 years old and the day her “best friend” L, who lived nearby,

moved away and she never saw her or heard from her again. They had been friends since they were toddlers and had always played together and went to school together:

> "She was my best friend. And during the summer holidays, during the transition from infant to junior school, I went down to visit my nana who lived down in Kent. And they [her best friend L. and family] moved house during that time, and I've never seen her again. I knew she was moving and I remember we were driving home on the day they were moving. … I accepted the fact that they were moving. But I went into junior school with no friends, I just, quite isolated, very lonely, I felt like I didn't fit in."[Session 3]

The participant was surprised to go back in her regression, so readily and so powerfully, to this episode 45 years earlier and to wake up after this revelation feeling so distressed and tearful. However she said in a later discussion that this episode had come into her mind spontaneously several months earlier when we first began to discuss this project, indicating even then that "the time and the tide" was right for her unconscious mind to be willing to accept the need for change. At this first emergence of this episode she dismissed this flashback as it did not seem relevant to her current weight problem – but clearly it was, and is in some way, for it to re-appear in her first regression visualisation. This experience was clearly her first major loss as a child, perhaps seen by this little girl's emotional mind as her first desertion and betrayal, as despite her "knowing" cognitively that her friend L. was moving away that day, she had not fully absorbed this fact nor been encouraged to mark this significant event. She was away from home on holiday the day L. moved, no arrangements had been made by either set of parents for the two little girls to say a formal goodbye, and there had been no party and exchange of presents and cards to signify what was about to happen:

> "Maybe that's why I think about L., because L. is one of the friends, first friends I sort of lost …I went down south … and when I came back she'd gone…. That's why I kind of think about L." [Session 4]

In this same session she also recalled that at some point when 5 or 6 years old, she had stolen a children's watch from a room in L's house. Significantly, although she said she could remember clearly what this watch looked like and see it clearly in her head today, she could not remember why she took this, whether she ever wore it, and how she returned it back to the other family, whether she took it back voluntarily without anyone knowing she had taken it, or whether she was caught with it and was forced to return it. She also found it impossible to recall what her friend L. looked like, yet could remember in detail some of her other friends at the time. For the participant to go back on two separate occasions, without any prompting, to this same childhood relationship was highly significant, but there was obviously more emotional content and implications to this episode which at the time of these early sessions she was still unable to recall, but the whole episode clearly made an impression and an impact on her young malleable mind at that time and subsequently:

> "That's obviously [is] a bit that has really stayed with me."[Session 3]

> "I missed her a lot, when I went up to junior school, I felt a bit adrift." [Session 6]

However it would seem that the emotional and cognitive catharsis achieved in sessions three and four was enough to bring about a major resolution of the subconscious issues surrounding this parting from her school friend, as this episode never re-appeared in latter hypnosis sessions, and she appeared able to move on from this. She did however continue to talk about L. in later sessions which suggests that she was continuing to process and examine this experience, which is often a part of the process of letting go of past emotional traumas (Fillion *et al*, 2002; Pennebaker, 2012). In session five spontaneous regression was predominantly related to being at Junior School and feeling lonely and unhappy:

> "I was quite unhappy in junior school. I felt very isolated, quite lonely. And I didn't have a constant friend, I kind of drifted between friends. I did have friends, you know, through the years, but sometimes they weren't constant, and I got…I got bullied quite a bit." [Session 5]

> "[T]he main thing that kind of, sort of, came into my mind was to do with, I didn't like being a child. … I don't think I was happy as a child …I remember, on more than one occasion, wanting to be grown up." [and feeling] "on my own … shy, very shy and … definitely sort of feelings of uncertainty and insecurity." [Session 5]

As one of the youngest of her cousins she was always being left out of events and activities, as being too young. However in this session she did find some joy when she regressed spontaneously to age 12:

> "[I]t was one of the first times I was allowed to stay up for New Year, and thinking it was just great. That's kind of what occurred to me, don't know why. That's what popped in." [Session 5]

Towards the end of this session I felt it appropriate to suggest to the unconscious mind that it might like to send to the participant's conscious mind a reassuring signal to indicate that things are changing and moving on for her. Most authorities acknowledge that such hypnotic and post-hypnotic instructions do not always work, the mind can have its own agenda and priorities which hypnosis may not overcome (Sheehan & McConkey, 1982; Gibson & Heap, 1991; Brann *et al* 2012), however in this case it is possible that such a signal was elicited. As the participant was walking up her steps back to wide awake, unexpectedly she saw a bird (a dove?), which she felt could have been such a subconscious message:

> [Research - *And did you get any message at all, as you walked up the steps?*] "Something sort of, I don't know whether it was like a dove, a bird of some sort. I don't know whether that was contrived though. Do you know what I mean? It's hard to

know whether I tried to push that into my mind or … myself." [R - *What does a dove mean to you?*] "Peace. I'm searching for peace of mind, that's for sure. Maybe there, maybe. Hmm." [Session 5]

The feeling of her "searching for peace of mind" continued for the participant throughout her sessions, but became successful apparently towards the end of her participation in the project. However it was suggested that she should ask again of her unconscious mind, for a further signal to say that things are changing and resolving as a result of her hypnosis sessions, and that this best done as she is going off to sleep. This interim state between fully awake and fully asleep is akin to hypnosis, and is an "other" state in which the unconscious mind is very approachable.

Further recollections of junior school were elicited in session six around being lonely, being bullied, not having a stable friendship and always being on the periphery of other groups. Lack of self-confidence was also a marked feature of her school days and later:

"When I heard you saying about going back to a time when I was confident, that really struck a chord, because I don't think I've ever been confident." [Session 6]

"I find when you say certain words, I get a bit of a jolt, it's like a physical jolt, and [my] eyes kind of flutter, it's almost like I want to spring my eyes open. [Researcher - *Any words you can remember?*] "Well, confidence is one of them, which resonates quite strongly with me. I think that's definitely the one, because you used it a few times, and I felt myself jolting each time you said it, and I don't know whether that's it, maybe it is." [Session 6]

Discussions prior to hypnosis session seven focussed around the fact that the participant had done as I had suggested and had asked for a further signal as she was drifting off to sleep one night. She was very excited to report that a few days earlier, as she was close to going asleep, she had a powerful and a very significant feeling dream. This "dream" as detailed below she knew strongly was an important milestone for her and that it was clearly

a metaphorical reference to her physical appearance, “fashioned into sort of beautiful things”, “it melts away”, and therefore that it should be seen as a reassuring subconscious signal:

> “I did what you suggested, going to bed one night, just as I was relaxing down. Strangely, I don’t know why, it came into my head, ***Ice***! It just popped into my head and I think it’s, it’s to do with the fact that’s it’s obviously a complex structure, maybe it’s just a symbolic thing. … I was just dozing off, you know, you’re going into that sort of like, relaxed state, and it was like … I can’t remember all in detail, at the time it was … and the reasons why were quite apparent. And I think it’s to do … with the fact that, maybe, as I say, it’s symbolic. It melts. Ice can sort of melt.” [Pre-session 7]

> “The other thing as well about it [ice] is, people can fashionise [sic] it into sculptures and things like that. So it has, the properties are multi-dimensional.” [Pre-session 7]

> “[I]t was, yes, to do with the properties of ice, it being really hard, and you can create these fantastic sculptures out of it,… really hard, and being able to be sculptured and fashioned into sorts of beautiful things. At the same time you know, it can melt.” [Pre-session 7]

This timing of this signal, which felt very reassuring and comforting for her and its metaphor of physical change and the beauty of shape, was not coincidental, but appropriate in the context of what was to follow in this participant’s hypnotherapy. Hypnosis in in this seventh session brought further surprises for this participant because of the regressed memories that were evinced during the session and because of the strength of feelings it invoked, much to the participant’s surprise. In response to using *back* as a trigger word for regression, as in previous sessions, the participant initially experienced a kaleidoscope of images, followed by a powerful emotional surge, and a then some strong memories about her grandmother, which she had long forgotten:

> "I got a sort of flashes, of like bits of my childhood. Nothing defining, nothing definitive, but like, memories." [Session 7]

> "I got this overwhelming feeling of anxiety which just rose up in me almost to the point of panic. Really, really strong, really strong. Almost like panicky, even though I felt like relaxed, I felt rigid at the same time inside. I just felt like this really, really strong anxiety, and a self-consciousness. Feelings of self-consciousness." [Session 7]

> "[T]hen I got this definite memory. I can't remember how old I was. Let me see – I might have been about 8 or 9. And it was my Nana. I remember, I was at the kitchen sink, I was washing up. And she said she preferred my brother to me. I remember her saying something about how she found him a lot easier than me. It must have been something to do with him being a boy, she made me do the washing up, because she preferred him to me." [Session 7]

> "I must have been 10 or 11 … when it happened, that incident. When I was at junior school. I had very low feelings of sort of self-confidence feeling very sort of self-conscious. [Y]ou feel you want to withdraw into yourself, don't you, hide away. So I don't know, I don't know what, what the meaning is. Why that's come out" [Session 7]

This memory was clearly distressing to this participant who woke up feeling hot and distressed and tearful. She said she had forgotten this incident, until it came back to her in this hypnosis session, when it was re-experienced with all of its powerful feelings of being rejected. She was also able to recall and remember feeling this same rejection by her "Nan" on a later occasion when her grandmother immigrated to Australia two years later and:

> "She invited my brother Robert down in the weeks leading up to her departure, for him to help her pack up and she wanted to spend time [with him], and didn't invite me, even though she… I would never see her again, which I didn't, she chose not to ask

me to go, and she invited my younger brother instead, to go down and spend that time with her. … I remember feeling very hurt at the time" [Session 7]

After this session, almost as a compensation for the distress this had caused, the participant had a couple of pleasant dreams about her past, both concerning the same boy she knew at school, someone she had never dreamt about before. He was not somebody with whom she had had an intense relationship with but simply someone who had been kind to her. This seemed to a way of reminding her that there had been such people in her life even amidst the rejection and loneliness she was recalling in her sessions:

"I dreamed about a particular lad that I was at school with. I didn't have feeling for him… or a crush on him at any time. I was fond of him, he was a really nice lad … and I dreamt about him twice!" [Pre-session 8]

"[In my dream] he just came to the [office] door. He just came in, and I was genuinely pleased to see him. Really delighted to see him. And we had a really, warm kind of encounter. … I always felt comfortable with him." [Pre-session 8]

This boy also featured in her subsequent hypnosis session when she regressed to recalling when she was around 13 years old and as her friend he was very kind to her, and was warm and witty and funny. This brief time coincided with the grandmother immigrating to Australia and this conjunction came into her mind during her hypnosis, when she saw him as a compensatory ego-enhancer for how her grandmother had treated her. She also had further images of the *ice* metaphor.

Session 9 entailed a regressive scan through the participant's past to look for any further barriers to her future weight which needed to be explored and dealt with, and which resulted in her re-visiting her school days and using the opportunity to dispose of some further relationship problems from that time. Session 10 began with further spontaneous regressions to school days and recalling internecine squabbling amongst her peers, a quarrel which she became involved with through her, at that time, only friend, Janet:

> "They couldn't understand why Janet would go round with me. And it [the painful memory] was the emotion you get with confusion … because you don't [know] what's the matter with you … why are people being really mean. What do they see in you? What is it that they're seeing? Why would they say … "[Session 10]

This session ended with my suggestion that, as the participant returned from her (beach) safe place up her steps back to awakeness, that she would find that these steps had changed in some way that would signify a change in her future. That this change would signify a move towards more confidence and self-belief and better weight management. The response to this suggestion had a profound effect on the participant, she afterwards stated, and one which subsequent events suggested reflected a crossing of a subconscious watershed:

> "That was very strange. I was remembering some things … and was … really relaxed. Then as soon as you said about a new set of stairs – it was like, I got a jolt, it was like, electricity, like buzzing, my body starts buzz, when you said that. I thought that was quite sort of strange. I almost started to feel a bit, excited." [Session 10]

When we next met the participant reported that she had in the interim felt inspired to begin a new weight management programme of healthy eating and exercise, one which felt right for her and with which she felt very happy. Equally significantly she disclosed that she had been carrying around for some time the memory of a past, emotionally traumatic event with which she thought she had dealt, but which she had in the previous two weeks realised was still a factor in her life and a source of current guilt for her - even though it was over and done years ago, and even though, she acknowledged, her guilt about this was totally unwarranted:

> "I think I've been carrying … quite a bit of guilt around with me, about something that happened, in my past… I was talking to my husband about it … and I got really, really upset. I've put into my vessel last time … And I felt, maybe that's had a bit of a release.

Having done that. … I kind of know …I think I had to deal with it. Maybe this was something I'd been … put to the back of my mind, something that I think I needed to deal with." [Pre-session 11]

[Researcher - *Can you see a connection between that and your weight*?] "Yes, in the later stage. I've always thought of my weight as being something I've had since childhood …and I've had to struggle with all my life, but when you see it relative to how you were in your teens and early twenties … I'm like a strip of nothing, there's nothing of me. … I can see a relationship between my weight gain over the last few years …and this incident that occurred." [Pre-session 11]

Regression in session 11 was via her "Magic Carpet" where she was able to travel back in time to the last time that she felt comfortable about her weight management. This visualisation she felt very powerfully and was able to watch her weight decrease as she travelled back in time. She was surprised that this journey back stopped at 1997 when she was 32 years rather than continued back to aged 16, however as she came forward again she saw, significantly, how much her weight had started to increase in 1999 when she experienced this traumatic incident.

"Going back, it was like seeing my weight go down. I went back to about 1997 maybe. I think because I remember being really active at that time. And actually good, you know quite fit. Very active, did lots of different things. Played badminton, in really good shape. [Since that time] it has gradually gone up and up and up over those years. [It] is about 1999, probably when this kind of incident took place, and [I]see it from there." [Session 11]

"I think that's something in me, the lack of confidence. I think that's something that does stem back from when I was younger. But I think the guilt I associate with this incident is a feeling of being punished over the last few years. Or a feeling that I ought to be punished for it, and I see some of the incidents that have happened … all of the

bad things like a punishment. I do make that connection with this particular time in my life." [Session 11]

The participant seemed now have started to accept that it was time to stop punishing herself over past traumas and time instead to move forward, letting go of such aspects of her past life, along with their containing carapace of her overweight. As a result of these hypnosis session she did feel that this process of self-forgiving had already started and would continue, and that she felt more positive about the future:

"The turning point was definitely a couple of weeks ago, with those wooden stairs (hypnosis session 10). It changed me, it took me in a different direction. … But I think the other part is still relevant because I think obviously I've had to deal with stuff, you know, that I've had to think about. I've had to think about my childhood, when I was growing up. [It] moulded me as a person. They are part of what I am." [Session 11]

"I talked to my husband, not too long back. I got terribly upset and it was quite cathartic in a way, I've never got upset about it. I refused to let myself think about it. I need to deal with it, and forgive myself, and really let it go. [O]bviously you can't go back and change things can you?" [Researcher- *You can't change the facts, but you* ***can*** *change what the facts have changed you with*.] "Definitely. And I think that's probably what I need to do." [Session 11]

The final four hypnosis sessions for this participant were designed to maximise the benefits of the changes now taking place for her, consciously and subconsciously, and were therefore more concerned about the present and the future than dealing with the past. The first of these, session 12, was the "Walking Backwards" visualisation which is a metaphor for changing from moving through life looking backwards (consciously and subconsciously) at the past, and instead turning around to look forward. Significantly this was the first visualisation that she could not remember fully when she awoke. Such post-hypnotic amnesia occurs when hypnosis is particularly deep, and in this case suggests that the

unconscious mind did not need her to be aware of what was happening and what was being consolidated, *behind the scenes*, as it were. After this session she had a significant and probably related dream:

> "I only vaguely remember little bits of this one, but I remember looking after some children, one was a four or five years old, and then there was a little toddler. And I lost them, I just lost them, and I was … frantically searching for them. It was just this mad, mad, frantic search for them." [Pre-session 13]

Very often when we have let go of something major or a major part of our past, this is signalled by the subconscious mind in a dream about loss, which is effectively a metaphor for having given up a part of who we were in our past childhood (West, 2011, pp.79-80). Session 13 was the "Brain Washing" visualisation, a subconscious cleansing and revitalising visualisation, with which the participant became very involved in and from which she felt immediate benefit:

> "I remember going into the woods, walking amongst the trees. … Just looking up and seeing the leaves above. And the pool, with all the lilies floating on the surface. It did feel safe, like my beach itself. Very calm and restful." [Researcher- *Did you find your bottle there?*] "Yes, I always find my bottle. I put in my incident from the past." [Session 13]

Session 14 was concerned with hypnotically recalling past subconscious skills and qualities which the participant needed to help her manage her present and her future life and weight management, qualities which she had neglected but needed now to revive. Her self-selected qualities were Self-belief, Positivity, Calmness and Commitment. These skills she recalled by regression into her past experience to find them, and which were then enabled as an "anchor" for her to make them more easily available for their future use:

> "I think I'll remember them, it's one of those things isn't it. It's funny how you just know, you just know what you need." [Session 14]

Prior to her final session, the participant spontaneously and unprompted provided an update on how she had been feeling over the previous four weeks since her previous session, and what she felt she had achieved:

> "I definitely do feel kind of more positive about things. I do feel like I've come through something, and feel calmer and less anxious about a lot of things. So it's had a definitely positive effect overall. I feel almost, almost happy [said with enthusiasm]. I have more peace of mind at the moment, so I do feel like I've got some peace of mind … I haven't for a long time had those stress dreams where you feel like you're wading through mud, or varying off course. I've had a few of those in the past. But not recently." [Pre-session 15]

Finally in session 15 a reframing technique was used to facilitate a more effective future for her. This entailed communicating with that part in the participant's unconscious mind which handled and organised the physical, cognitive, psychological and emotional concomitants of her weight management. This part was thanked for its good work to date and then the creative part of the unconscious mind was asked to create some alternative parts to manage her weight in a different and better way in the future. One of these parts was chosen for use and the chosen new part was then put in control of the participant's weight management from that day forth. This process was monitored using an IMR, in this case this being a nod of her head which was clearly an unconscious signal, and all went well with this final hypnosis:

> "I like that wrist. I quite like that squeezing of the wrist, just a squeeze around the wrist. I felt that quite, it's, it's that firm and positive and yes, I quite liked that. [Session 15]

This participant's mood this session resonates appropriately with her contention in hypnosis session 5 that her subconscious signal indicated to her that she was searching for: "Peace. I'm searching for peace of mind, that's for sure."

DISCUSSION

Right from the start of hypnotherapy this participant's unconscious mind set out to remind her of the difficult start in life which she had had and how this had resulted in early feelings of low self-confidence and poor self-image, which then in turn set the emotional scene for a consequential series of negatively perceived situations through childhood into adult life. Sessions two and three were initially predominantly relaxing but there were anxieties and agitation hinting at what was to come. Session three regression brought forth memories and feelings of turmoil and trauma due to her parents' fractious relationship, and session four took her back to being four years old and stealing a friend's watch, and also seemingly, at least to her childlike mind, of being abandoned by her best friend. Such bereft feelings were to echo through most of her remaining hypnosis sessions, as they were through her life, as sessions five to nine regularly took her back to times of distress, loneliness and poor self-image. Regression visualisations continued to show a consistent correlation between her weight increases and these difficult times.

However prior to session seven the participant excitedly reported back a dream which appeared to have been elicited by the researcher's request in session six for the unconscious mind to send to the conscious mind a positive and reassuring signal about the efficacy and progress of her hypnosis sessions. The result was a powerful and significant feeling dream containing an unexpected but potent image, an image of "ice", an image which continued to recur in her subsequent hypnosis sessions. A further watershed appeared to have been reached in hypnosis session ten which elicited a distinct emotional reaction, a "buzz" as the participant described it, and which resulted in a major subconscious revelation about the implications to her weight management of a hitherto undisclosed emotional trauma occurring some years previously. This trauma had never been resolved and was merely contained undiscussed and unprocessed therefore. Discussion of this in sessions eleven and twelve brought great emotional and psychological relief, which the participant felt was beneficial to her hypnotherapy and to her future weight management.

Lifelong accumulation of guilt, low self-worth and lack of confidence often needs a barrier to be put behind and obesity is a suitable such barrier. Hemmingsson (2014) and Faden (2011) have suggested that excess body weight can become a useful containment and way of preventing others from looking further and deeper, and discovering the "unworthy or inadequate" person within. The *real* person becomes hidden within the fat body, and unperceivable and a psychological justification and barrier is created which prevents normal weight management and weight loss (Karasu, 2012; Moore & Cunningham, 2012; Hemmingsson, 2014; Wang *et al*, 2015). Had this participant had a text book perfect figure and body shape, there was a risk that others would be looking for the catch, the less than perfect person within this otherwise outwardly perfect body. But presenting herself most obviously as an overweight person with an obese body, as a "fat woman", in part at least, defocussed attention from her as a person and offset a more penetrating scrutiny which might reveal the inner, and self-perceived, "unworthy" person. An examination of the timeline for her weight increases shows that these tended to be temporally associated with times of emotional trauma or guilt, or anxiety about her relationships, whilst those times of ideal weight were related to times when she felt more at ease, comfortable and confident about herself.

Dreams can be indicative of subconscious activity and motivational change, and often have content which yields to generic interpretation (Adler, 1936; Freud, 1991; Jung, 1961; Steiner, 1995). This participant's dream of "ice" however was an uncommon one, clearly encompassing a very specific subconscious metaphor, one that did not appear to have any obvious correlates with dream analyses published by the above authors. The participant's own intuitive interpretation (a very important perspective) was that "ice" related to her own physical appearance, as ice - like herself perhaps, could be "sculptured and fashioned into sorts of beautiful things", people could "fashionise [sic] it into sculptures", make "fantastic sculptures out of it". Equally importantly also perhaps was the fact that "ice" was "multi-dimensional" "it is really hard … and at the same time you know, it can melt … it melts away".

It is to be hoped that having seen clearly what she has been doing to herself in the past, and having now the appropriate psychological tools to deal with this, should facilitate for this participant a more efficacious weight management journey in the future, as her weight “melts away” and she becomes “sculptured and fashioned into … beautiful things”.

CASE STUDY FOR PARTICIPANT - BC /06

This female participant was 40 years old, a single mother of one daughter aged 22 years who still lives with her most of the time. She began to put on weight during her late teens, during and after her only pregnancy and birth of her daughter, and her weight has fluctuated since then but has never returned to normal. She has a sister who is overweight and her father (now deceased) also had weight problems, but her mother (from whom she is estranged) and her daughter, are both of normal weight. She has tried various diet approaches and some exercise regimes to lose weight but rarely have these been at all effective. She has suffered from agoraphobia since her teens and also has an irrational fear of swallowing her tongue, and these two problems severely limit her living a normal social and family life, something about which she feels very guilty, especially with regard to rearing her daughter.

Whilst she has been involved in this project she has suffered from recurrent lumbar spinal disc protrusion and stenosis, requiring two surgical interventions of lumbar decompression. Both her surgery and her chronic pain have been factors adversely influencing the regularity and efficacy of her hypnosis sessions including one particularly long gap in her sessions, and it is very much to her credit that she has persevered in the project. At the time of her presentation her BMI was 36 but this fluctuated according to the degree of her immobility problem brought about by her lower back pain. Her GAD-7 score was 7, suggestive of moderate anxiety whilst her PHQ-9 at 14 reflecting her moderate depressive state. She was a moderately emotional eater scoring 12/27 on the Garaulet scale and her Spanos Attitude to Hypnosis score of 59/98 indicated good positivity regarding hypnosis.

Despite her initial anxieties about being a successful candidate for hypnosis she was able to relax into the hypnotic trance state very readily from session one, and over her 20 hypnosis sessions exhibited 53 identifiable “Depth of Hypnosis” indices and 62 “content of session” indices as coded in table 2.1. During her first session she was able to clearly

identify a “safe place” from which to explore past events and relationships in her life and within which she was able to locate and visualise a “bottle” into which she was able to dispose of some problems, both past and present. During her time in this visualised safe place she quickly found herself regressing to some early memories of her relationship with the father of her daughter (with whom she and her daughter have had no contact with since her daughter was a baby), and she recalled how worried she had been as a teenage mother with little cooking and culinary skills and having to feed her partner and her new infant:

> “I thought about my ex- and when I was slim … And remember I started cooking and eating and obviously to make him happy, and cooking for him and things like that, and cooking for him and “A”. [daughter]. And I remember putting weight on and … and I said I was putting weight on. And he said don’t worry I’ll never leave you even if you go fat. And I did and he left me [laughs]. And I thought maybe that’s why I don’t want to lose it [the weight] because I don’t want to be hurt again. I don’t know, that’s what I thought actually in my head.” [Session 1]

> “I just wanted the little family thing, I just wanted to keep the nice, family thing of cooking. Or maybe because my body wasn’t used to eating so much. I never ever thought I would put weight on, never. Never did I think I would put weight on. And then I did obviously.” [Session 1]

As is often the case with hypnotherapy, when the unconscious mind wishes to encourage further therapy it rewards this first session with an immediate positive response, or a dream:

> “It’s so strange to be honest, I don’t know if it’s because of last week, I’m just not sure Paul but I’ve really cut down this week – I really have cut down. I’ve had Wheatabix every morning with skimmed milk no sugar or honey, just plain, and like I’ve had an apple, as a snack and later maybe a cup-a soup. And I’ve just like naturally done that, I’m not actually thinking of food through the day … and I think no it’s far too greasy

[laughs]. I don't know whether it's because whether I'm not conscious of it or whether it's the hypnotherapy." [Pre-session 2]

"But I haven't stressed over it whatever – my *usual* thought is what can I have for dinner, what can I have for tea, what can I have for in-between, what can I have for a snack? And I just haven't bothered. So… if that's how it's working, it's working." [Pre-session 2]

"I think I had a dream about my ex boy-friend you know, I'm sure it was." [Researcher-*Do you have these often?*] "No, never. Never! The one I was talking about last week. I never ever think about him ever. At first I did, obviously, but now, never, ever! Oh my God. I dreamt about him!" [Pre-session 2]

In session two the participant spontaneously regressed to the eventful years between 17 and 18, just before and just after she became pregnant and gave birth to her daughter. She remembered how happy she felt being at college and working with her friends in a residential home. This was a time which she re-experienced as being at her happiest:

"[W]hen I was young, and I didn't care … when I was in college, when I went to college. And err… yes I was, happy and had not a care in the world. And then it popped into my head, going to this shop, years ago called Ethel Austins. 'Cause I used to go in every week when I was working, when I get my wages, and every week I used to pick little bits and pieces up. Every day, six days per week and I didn't have a care in the world." [Session 2]

"I loved it, like it was my own like little … as much as I hated getting up for work at that hour, which I didn't, as it was my own little routine. Six days a week I used to stay in me friends practically six days a week, or in work…and I was never in me mum's. Come and went as I pleased. I was one of the most laid back, didn't care about nothing." [Session 2]

However soon after this time she became unexpectedly pregnant and things began to go wrong for her. This was reflected in her regression experiences moving to her being pregnant. As her weight began to increase through her pregnancy, she had the first of her many subsequent panic attacks which have since become linked with her weight gain:

> "I remember exactly the day, I remember exactly the day. I remember when, when I had all this anxiety, obviously I could feel it coming on me. I didn't know what it was but I still got on with my normal life, even though I still had it. … [W]hen I was pregnant I started coming home on the bus and feeling that I couldn't swallow. So I'd literally hold all me spit in, in my mouth on the whole bus journey, full 30 minutes and I wouldn't swallow, yes. I once I got off the bus I'd be fine. Erm…then I started to feel anxious just travelling, like." [Session 2]

Further complication around her being pregnant was the high expectation that her father, to whom she was very close, had of her:

> "I remember I moved in with my auntie 'cause I didn't want to tell me dad, I was too scared…my dad was like…well he wouldn't have went mad but I know my dad was always like wanted me to go and have a career, and so did I. Like I disappointed him having a baby." [Session 2]

She remembered being pregnant and becoming a mother of her daughter "A", as times of great stress for her. As her weight increased during her pregnancy and she continued to experience her panic attacks, she became somewhat reclusive, and then soon after her delivery she moved in with her boyfriend's family, living with him in just one room:

> "And I really, never really never went out when I was pregnant, I was kind'a stuck in the house all the time. I think it was mainly the whole change, A's dad asked me to move in with, move in with his mum. And I've never liked, never been with him a lot during my pregnancy to be honest…then all of a sudden we were living with "A", together in his mum's house upstairs in the bedroom." [Session 2]

This unsettling time appears to have engendered some very difficult, temporally-associated connections for the participant, linking her pregnancy and her daughter's birth, to her increased weight and her agoraphobia-inducing panic attacks. As a consequence the greater part of this participant's future hypnosis sessions and discussions became centred around trying to unravel and explain her weight and her panic/anxiety aetiologies; and in extricating her daughter (whom she loves dearly) from inadvertent subconscious causality for these long standing problems:

> "Everything goes right back to before I had "A". All the time. Because that's the only time I can remember, before I had the panics." [Session 3]

Within a short time of my arriving at the participant's house for her third hypnosis session, she started crying and took some time to stop. She said that she had been crying almost constantly and every day since her previous session two weeks ago. She had even cried right through her Benefits Agency job interview. She had no clue as to why this was happening, but I reassured her that there was a reason for this, and that something she accessed during her last session has caused the release of emotion from the past (Williamson, 2008), and that this is obviously a good thing, and part of what we were trying to achieve:

> "I feel a little calmer. I do feel a little calmer. Instead of crying. Even the poor women today looked at me, I felt so bad. I felt she was looking at me and asking "Why are you crying, it's only a job interview." So I said I don't know why I'm crying, and she said it's OK." [Pre-session 3]

In view of her emotional state this third session was primarily to provide her with some respite from how she was feeling, and to enable her let go of any immediate problems. Once we began the session she was able to calm down and there was no more tears until just at the end of the session:

[Researcher- *What do you feel when you are down in your garden?*] "I like, err, safe, I try and think safe. That nothing can hurt me. That I am warm and safe and, you know, safe." [R- *Did you find your bottle?*] "I put A's [daughter] dad in it funnily enough! I don't know why! I just put her dad in it. And that's the only person – and I put him in, and that was it. I've never thought of A's dad, ever. He's not a person I think off." [Session 3]

[Research-*What else came into your mind?*] "I always want the old life, and the old life was when I was young, and I know I can never be young again. I've just been thinking then - well, never mind all that, I'm older now, I had the baby and I'm older now. Get on with it. What was I thinking? So what – you couldn't handle a baby, and you can now, you know you're older and you're wiser, you're not a kid no more, get over it kind of thing. … my life didn't have to end because I had a baby. There's millions of people out there who have kids and just because maybe they weren't ready for it, didn't have to stop their lives." [Session 3]

The participant clearly surprised herself when this came into her head, and I suggested that she needed to think this through to explore in a future session. I also suggested that she should try to get her mind to give her a dream about why she had been crying so much lately. Interestingly therefore, when updating me about her progress since session 3, she remarked that although she had not had a significant dream in the interim, she had realised where her tears were coming from. Those two weeks of constant crying were very reminiscent of how she reacted to the death of her father who died a few years ago, and that these tearful episodes were in effect flashbacks to his death:

"It brought me back to my dad, in the way that I'd just burst out crying when my dad passed away… when I'd be just sitting in the bath, and the next second I'd burst out crying and I couldn't stop it. And it just took me back to that, when I was bursting out anywhere and everywhere." [Pre-session 4]

Her father's death had an extra significance because, as well as being her daughter A's grandfather, in the absence of a true father figure he was very much also a substitute father figure to "A", as the participant realised. Realising this appeared to have removed some of the guilt from off the participant for having split up with her daughter's biological father, as a result of which her daughter and the daughter's father have had no contact since she was a baby. The participant also reported that she was continuing to note changes in her eating habits, mainly in terms of portion frequencies and sizes:

> "I've been more conscious of what I'm eating. Just chicken fillets on the griddle pan, and fish and salad. The other night I really felt like some pasta, so I made myself some pasta, carbonara, it was one of those packet ones, but whereas I'd usually have a big plate of pasta, I just had a small portion. And just three little mini garlic breads and salad. And I really enjoyed it, and it was all like a nice portion. And I think my stomach is going smaller. And I did want something else last night and I went to the fridge, and I had grapes. So I'm getting there. Even though that is like a basic, typical, normal whatever – usually I would go back for more and more." [Pre-session 4]

Although it was not the intention in this project to give eating and dietary advice nor to monitor and record weight loss, it was interesting and encouraging to note that even at this early stage, and without any formal prompting, this participant had intuitively amended her eating habits in an appropriately positive way. This seemed to suggest a change in unconscious motivations and that subconscious was responding to the call for change.

Session 4 was a time regression visualisation using the participant's finger movements as an IdeoMotor Response (IMR) to monitor the progress of the regression, and which she said took her back yet again to the beginnings of her panic attack time and to a time when she was trying to work out why she was so unhappy with her life:

> "I remember being with A's dad. We were in town with his mum and dad, and I was thinking just kept let it go, just let it go. I had the panics, but I had it all, like I had the

> fella and the baby, and I lived with his mum and dad yes, but let it go, what was I stressing about what was I worried about, I must have been worried about something. And at that second I felt like, I think what was I worried about back then because I had it all, and I never … that's what I was thinking about anyway." [Session 4]

Although there was a good IMR response there was some resistance, of which the participant was consciously not aware, to answering some significant questions. But objectively it was apparent that *something* was happening, as her breathing changed, she was clearly getting more anxious, and her breathing moved from slow relaxed to more rapid breathing.

Discussions prior to session 5 were about another significant step forward in the participant's "de-cluttering" of her mind, as she told me that:

> "I've got a bad hording thing, I won't throw anything away, nothing from years ago. And yesterday, I started cleaning my room, and I've thrown away loads, so much from the past and I felt…and I thought I wondered if that's part of what we're doing. Because that stuff I've had for years which've never dreamed of throwing. But I do actually feel so much better in myself. There's a box outside waiting to go to the bin men tomorrow. So I'll throw that out and there's no going back. I'm quite pleased with myself actually, and like I was lying in my room last night and I was so happy with what I've got left. I'm so happy. … I actually feel more clear in my mind, as if like I've had a clear out in my brain. So I am pleased with that anyway." [Pre-session 5]

Following these discussions there was a further regression, again with the participant exhibiting a good subconscious IMR, which took her back to ages 19 and 20, to the time when finally she split up, acrimoniously, with A's father. This split was due largely to the participant's anxiety and agoraphobia problems causing fights between them both, and with his parents, and resulted in him acquiring a new partner with whom he had a child and he began to neglect the participant and her daughter.

> "We went out to his sister's 40th it was and then to a party in her house and all of his family were there at New Year. I fell out with his mum, and his sister, I fell out with the whole family [laughs]. Maybe it just saying let them go. It's 20 years ago." [Session 5]

This was the last session in which her regression was to focus entirely on the relationship between the participant and her ex-partner and his family, so it would seem that her de-cluttering session four weeks earlier had produced some benefits. This subconscious advance was illustrated by her realisation in the discussions prior to her 6th session that perhaps her weight "was a cloak to hide her other anxieties behind". In this same discussion she also to her surprise admitted that she had been having thoughts about a future baby:

> "funnily enough I have had a thought this week, like… of … you know…I've never wanted another baby, but I thought I'd love another baby." [Pre-session 6]

Presumably as a result of her recent conscious thoughts about having another baby, hypnosis session six that followed, produced a spontaneous regression taking her back to when she was pregnant, during this regression she was reminded about how much weight she put on during this pregnancy as, in regression, she watched herself daily getting bigger and bigger. She said that she did not go out much at all during that time, and after her pregnancy her weight had risen from 8 stone to over 9 stone, where it stayed. After I finished recording she began to talk further and saying she had felt strong and frequent thoughts over the past few weeks about connections between her problems and her pregnancy.

Significantly during the following two weeks after this session she continued to have regressed thoughts and feelings linking her distress about food and cooking with her caring for her daughter:

> "I felt so guilty bringing A. up. Maybe there's the thing. I felt so guilty that I didn't know how to feed her, and that I wasn't feeding her properly. And I was thinking, I felt so guilty that I didn't give her good nutrition growing up – because I didn't know what to

feed her. And I did feel guilty when she was a baby, trying to introduce her to foods, off the baby foods. I didn't know what to give her because I couldn't cook, she wouldn't eat and I'd stress out over it." [Pre-session 7]

"I was just on my own living with "A". [She] was only young so I wasn't really cooking either. Like, I'd be happy if I actually, like…I used to take these freezer meals, and one of them I got used to buying, because I couldn't cook, was chicken and chips and I be over the moon with myself if I actually ate a meal…because I classed that as a meal off me mum. You know what I mean - because I couldn't cook." [Pre-session 7]

She also reported that she had had a powerful and, it felt, significant, dream about her being poisoned, as well as finding herself thinking constantly and ruminating about the relationship between her over-eating and her anxiety which suggests that this was being processed subconsciously(Jung, 1961; Freud, 1976; Hartmann, 1998; Samson, 1998) :

"I think about the past. …it's weird … trigger things off in my mind. And remember things, to see was it this, or was it that. And I was thinking, when I did have my anxiety, I couldn't eat. … I can't eat, can't swallow, can't drink. Maybe I overcompensate when I can and eat, thinking I might as well as I mightn't be able to eat tomorrow. So maybe that's why I over eat." [Pre-session 7]

Perhaps as an escape from these feelings of inadequacy and guilt, in her 7th hypnosis session her regression was spontaneously back to happier times as a child:

"back to my happiest time, like where I was young and independent, … and then little pictures in my head, about what I was wearing, I could remember certain outfits, … when I was five or six [years of age] I think I remember a picture came in and I had these red, I think back then you used to call them knickerbockers, and I used to love them, red ones, me and my sister had them." [Session 7]

Then at the end of this session, in response to a request for a reassuring subconscious signal:

When you said about the signal I thought I seen [sic] a light, and that's why I said yes, but then when I wasn't thinking I seen [sic] like a star shape." [Researcher- *What does a star shape mean to you?*] "I don't know, I don't know. [laughs]" [Session 7]

When she attended for her 8th hypnosis session the participant reported that the night after her 7th session she had had a very vivid dream in which she saw a star which became a button, which she very powerfully related in her mind to her deceased father. This dream was then echoed in a further dream that she had had the night prior to attending today's session:

"Do you know when I said about the star, do you know the next night, I had a dream, and a button came in to it, really prominent like, in the dream, it was there, it was so clear and so big…just a button, you know, with four holes in. And it was like a mustardy colour first then it was just a black button. And I was thinking is there anything significant about the button…and I remember that my dad always had this button jar, it's just a basket full of buttons. Then last night I had a dream about the button basket .. I was thinking maybe this button is the thing that's come up, even though I seen [sic] the shape of a star, this button was so much clearer. So obviously it was made an issue in me dream. I can see it clearly in my mind now. Growing up we always had this button basket, just like a little wicker basket with a lid on full of buttons, odd buttons." [Pre-session 8]

Significantly perhaps in session 8 hypnosis the participant spontaneously, and for the first time in this project, regressed to being with her father, comparing his body shape with her own and seeing herself in his eyes. Towards the end of this session she again saw her button image which changed into a star as she was awakening:

"I didn't hear much of what you said. But I went back to my dad, and it was funny 'cause I compared my body to my dad's. Like I've said I've got my dad's body that's what I seen on my dad and I said that's what I've got , flabby arms, oh God! He didn't

like it. He never used to say much but now and then he'd say something about it, and I'd know he didn't like me putting weight on. I'd forgot all about that." [Session 8]

"And at the end I couldn't see nothing then I seen [sic] a button, a button shape, then a ball shape, a circle, then it went back to a star shape again." [Session 8]

Hypnosis session 9 included a formal regression (diagnostic) scan down through the years and return, during which the participant was able to recall the years back to childhood, and to move through this and back to adulthood. During those years prior to her pregnancy at 17 she could find only happiness and security, but once she had become pregnant and then a mother she could find only sadness, and this coincided with her increasing weight gain and the onset of her anxiety attacks. Hence whenever she goes back to the past and to the times around the birth of A [her daughter] she feels sad:

"I always get a feeling when I come up about "A" …it's so sad. I always think about "A" [sounds sad]. I should stop saying that. … I feel like, it's sad and I hate saying it, I feel like "A" has made me like this. And I hate saying that. 'Cause I would never be without her." [Session 9]

During this session the participant also became more aware of how she has been using her weight to contain her situation and her emotions, and also the high penalty she is paying for this protection:

"Maybe I stay like that so I can hide behind... I keep fat then I keep hiding away, 'cause I don't want to go out. … Maybe, maybe I stay fat because I don't want to meet someone. But I hate it, Paul, because I'm 40 now, and I…oh my God, am I actually going to die, no life and lonely on me own. The only person I've got is A. Is that how I'm going to live the rest of my life? Horrible!" [Session 9]

The next group of hypnosis sessions were designed to monitor, understand and consolidate the unconscious changes that seem to be taking place for her. These regression sessions were to enable her to go back to various times, pre and post pregnancy in order for her to

deal with any further past problems, and to help her to differentiate her daughter's birth from her weight and her anxiety problems, and to separate these two problems from each other:

> "It sounds more better [sic], like it's [the problems are] not associated, it's just happened at that same time, and you know, that my weight is just a barrier to keep people away. Because when I was young, and I was attractive and I did get a lot of attention. And maybe that's my way now of just…because of the way I am I feel I can't be in a relationship because the way I am [her agoraphobia], because people expected you to go on holiday, to go out normal, even just to go normal shopping normal, and I just can't do that so I keep the weight on to keep people away from me. And if I lost the weight now, you know, I'm older now so I wouldn't be as confident as I used to be because back then I was only young. " [Session 11]

Session 12 was a regression intentionally triggered by the researcher by referring to her father's "button basket" and this was the most emotional session of the series, both during and after her hypnosis:

> "I just pictured the basket and then it just reminded me about me dad and I felt I was getting choked up, and I think I actually fought to keep the tears away. But erm…I could feel a big lump, a very large lump and that's when it reminded me of me dad. From my childhood [became tearful]" [Session 12]

> I don't know if I am crying about me dad, I don't know if it's all just because… maybe because that was before all this, before I felt like this. When I was living at home, with me mum and dad, before I had "A", and that was the good times what I felt being at home with me mum and dad. [Session 12]

> "But I feel like I haven't got a life…I've never had a life [crying and tears ++, can hardly talk for the tears]. I had a life before A. … [long pause]…but now I haven't." [Session 12]

Subsequently she had further emotional outbursts at home plus an unusual dream about her family which left her feeling emotional and tearful – "for the next day or two I was tearful and … I think the whole week I was emotional actually." She also felt a surprising new confidence about beginning a weight reducing initiative – "[Trying] Just to cut down … try and lose some weight. And I have enjoyed it I must admit." Regression in session 14 elicited the following response from the participant's subconscious mind when she was directed to go back to a time in the past where she was how she would like to be now:

> "When you said about going back, and how would I like to be, in never came into me head, skinny or nothing, in come into me head, happy. You know, I'd like to be happy. Never even come into me head about being skinny or slim, I just thought "I'd like to be happy." [Session 14]

During this time she reported several dreams which may reflect her changing subconscious activities and priorities. These included a dream about death and dying, and it has been suggested that such dreams, whether about one's own or another's death, can be a metaphor for the letting go of an important aspect or phase of one's own (earlier) life (Barrett, 1992). Another of her dreams about a further pregnancy might have been a reassuring signal to the conscious mind that things are becoming better and that the past is becoming more acceptable to the present life and persona:

> "I did have a dream but … it was just, someone dyin', [hushed voice]. I seen [sic] someone actually dying, like killing themselves. … I think it was they jumped off or somethin', and just, basically committed suicide. But I seen [sic] them. And I think I had a dream the other day that I was pregnant. But like, literally … this was actually … I could feel, everything, and in me dream it was saying "do I really want this" I think because I've always wanted another baby and it was saying do I want this. Yes it was weird … something like that it was on me mind." [Session 15]

The participant's next three sessions were focussed around putting the past to rest, letting it go and preparing for a different and healthier, slimmer future. In session 16 which comprised a relaxation and problem disposal exercise set in a magical forest glade, it was suggested that she should return to awakening from her safe place into her *new* future, by finding that she was walking up a *new* set of ten steps. A *new* set better designed to lead her into her *new* slimmer future. Subsequently I asked her about these steps:

> "I went on the new steps and they were better. 'Cause last week they were concrete and I didn't like them. This week they were just like the steps what I wanted to go on. And I can see the old steps next to them." [Researcher- *And how were the new steps different?*] "They're just better than the other ones next to them, nicer, they're better than the ones I was thinking about last week." [Researcher-*Better, why are they better?*] "Well. Why? [forcefully], 'cause they're nicer steps. [laughs]" [Session 16]

Session 17 was the "Walking Backwards down a Country Lane" visualisation in which the participant was encouraged to stop focussing on the past and to turn around and change to focussing on the present and the future. When asked about her lane, the participant spontaneously and appropriately recalled the part of lane looked back on in the first part of her visualisation as being different in nature from that looked forward to in the second half of the visualisation:

> "There was a difference in the lane. When you said about the past behind and going forward, the past was like a dark lane … and the, the one ahead was lighter, brighter, and the one behind me was more dark. [long pause] That's what that was". [Session 17]

The participant's next session in this series was "Brain Washing" in which a Summer shower is perceived as washing the brain (i.e. the subconscious mind) clean of the dust and grime of the past, cleansing, revitalising and energising the brain (the mind) for the future. After this she would be able to return up her stairs from her safe place into a happy and confident

future. In her visualisation and without prompting the participant's, simply "nice" stairs, from her previous session became upgraded to:

> "Nice. I've picked nice stairs now. There like, worn and …you know the way you get little paths, and they're well-worn, and you can see they've still got all their grass and rough flowers … Flowers, wild flowers. They're like them, but worn, nice. They're nice! They're not the concrete ones any more, they were horrible" [Session 18].

Session 19 was a review of the past problems requiring resolving, within which nothing significant was recalled, whilst her session 20 was an invitation to recall the good times of the past to keep with her for the future. To her surprise the participant was able to spontaneously regress to a whole series of happy memories associated her teenage past before her pregnancy:

> "I thought of the good times … I remembered everything … It was nice, it was nice … they used to have a lot of family gatherings, and stuff like that. I'd go to all of them. And then I remembered all that. Strange, it was strange to think of that, of the good times. , I've never thought of the good parts and I only thought of the bad parts. " [Session 20]

However she then found herself moving to recalling times in her early 20's and her ambivalence about a future pregnancy:

> "I always wanted another baby. But I always thought, I don't want a baby because I might kill the baby, I might suffocate the baby, if have a panic attack. How am I gonn'a cope? I was always terrified and I was thinking, I could never, never, have another baby. What if I die, what if I kill the baby, what if, what's gonna happen to the baby if I have a panic attack? And then I always blamed having A [daughter] so I didn't want another baby." [Session 20]

Surprisingly then the participant began to talk about another aspect of her weight maintenance which had only come into her head over the past two weeks. The idea that

being fat is like being pregnant, but without the risks and without the possible further exacerbation of her panic attacks which had begun when she first had her daughter:

> "Maybe, having a big belly is like a comfort. I don't know, that's just the thing that was playing on me mind. Like the comfort and wanting another baby … 'it's strange ... but it feels like [pause] is that why. It doesn't feel right, but it feels, like … it's given me a thought … the past two weeks. .But it's kinda been under me nose if you know what I mean, like that feeling of … feeling, not feeling pregnant. I've … I've had a few pregnancy dreams to be honest. But … I don't know, I've always wanted to be pregnant again [laughs]. Maybe that's why I'm eating, 'cause I wanna … 'cause I know I can't have a baby now 'cause I'm too old. [Session 20]

> "And like I have felt, I have, don't get me wrong … sometimes when I've been lying in bed and I've gone "oh, I feel like I've overeaten, it's like I've got a baby". But it's been like a comfort thing, as well, when I've actually lied there [sic]. And, like, I kinda "imagine if I was pregnant". And it's made me feel happy. It's so strange, well I don't even understand it to be honest [laughs]. But, it's, it's just been, it has played on me mind the past couple of weeks. I know it's weird isn't it?" [Session 20]

This was the first time that the participant had suspected that being overweight could be providing her with the experiential sense of being pregnant again, and that sensually, visibly and socially, being a fat woman with a large "belly" was in many ways analogous to being a pregnant one. If this was indeed the case then it would be a further and very powerful reason for her staying overweight over the years. She admits to having wanted to have another baby for a long time, but sees the risks involved in achieving this to be overwhelming. Firstly she would have to become involved in a relationship which would be difficult as her anxiety, her agoraphobia and her reclusive lifestyle would make having a sexual and social relationship very difficult for her to maintain. Secondly she sees a risk that her anxiety symptoms, which started when she became pregnant, might get even worse with a second pregnancy – "because of what happened with "A", like I blamed her for having

it (her panic attacks). Thirdly she has concerns about whether she could cope with bringing up another child in view of the problems she had when her daughter was little, and her fears about coping with a baby and her anxiety and panic attacks – "I could never, never, have another baby". This session ended with the participant pondering over her realisation of the importance of staying fat – "it's been like a comfort thing … I kinda imagine if I was pregnant … and it's made me feel happy".

DISCUSSION

Despite her being a very anxious person suffering also from agoraphobia and a fear of swallowing her tongue, the participant was able to go into a deep trance in her first session and went quickly and easily back to being 18 years old when she was living with her partner and their baby in his parent's house. She was coping poorly with being a very young mum and with feeding her baby. She remembered very clearly saying to her partner – "I said I was putting weight on. And he said don't worry I'll never leave you even if you go fat. And I did and he left me!" This was the first time she could remember her weight being a problem, as prior to this she was a slim, healthy, happy go lucky girl of 17, "not a care in the world". In subsequent sessions she went back regularly to this time which was when she also first developed her agoraphobia and her tongue problem. Between her second and third sessions she had a full two weeks she said in which she could barely stop crying.

After her third session she had a powerful dream about her deceased father who became also a surrogate father to her infant daughter after the participant's relationship with the child's father ended. Session four took her back to the problems in her relationship and she was able to see and feel how these might have impacted on her baby and now on herself. This session triggered her into deal with her hoarding of things at home and she was able to have a major clear out, which in turned allowed her to finally finish dealing with her relationship problems from that time. She was never again to regress back to this aspect

of her past life for the rest of her sessions in the project. Regression six was painful for her as she was back dealing with her difficulties in feeding her baby due to inexperience as a young mum. For session seven she was asked to go back to happier times to remember what they felt like, and promptly went back to being 17 years followed by her reliving a series of further scenes of happiness and freedom going back to wearing "red knickerbockers" at five years of age. Towards the end of this session her unconscious mind was asked if it would send a reassuring signal to the conscious mind, and as she was awakening, she saw a star.

A few days later she had a spontaneous dream about a star, followed a few days later by a longer dream in which she saw a star again but then it slowly changed into a button which very powerfully reminded her of her father who always kept a basket of buttons at home. In the eighth hypnosis session that followed she went back to being with him, the first time in these sessions, and as this session ended she once again saw a star which turned into a button. Her father was a very significant person in the participant's life, and someone with whom she needed to make peace with regarding her overweight as he did not approve of this. Throughout these sessions the participant was finding her eating habits changing to a more heathy diet although exercise was becoming difficult because of her increasing back and foot pain, and after a series of rebuilding and reorienting sessions she was beginning to feel calmer and more positive. Session fifteen was significant as she had a dramatic dream in which she saw someone jumping off a building to his death, and dreaming of death or dying is often a metaphor for the letting go of an important part of one's past life (West, 2011 p .79-80).

In her final three visualisation sessions she was able to clear out remaining problems and all of these sessions yielded positive results and left her feeling calm and at peace. In these she was able to acknowledge and become able to deal with, her regrets about not ever having had another child. The participant has also become increasingly aware, and able to vocalise, the fact that in more recent years her overweight has been serving an additional

and protective function by making her, she feels, less sexually attractive. In this way she has been able to avoid being drawn into another relationship within which her anxiety and agoraphobia, which she hides from all but her close friends, would become more evident and which would only result in a second traumatic and self-deprecatory relationship breakdown. And finally during her last session she was able to find within herself, to her surprise, the ultimate benefit of her being overweight, that it felt comfortingly like being pregnant. - “of a night it’s given me comfort … I kinda imagine if I was pregnant … and it’s made me feel happy”.

Thus it appears that this participant has had a complicated and multi-faceted relationship with her weight, both because of past connections and from current conscious and subconscious benefits. Prior to her pregnancy this participant had no problems with weight, but then she experienced the gestational weight gain associated with pregnancy which was exacerbated by her poor culinary skills as a young mother and housewife. The stress of these early months of managing with her new baby whilst simultaneously coping with living with her partner’s family and with the problems in her relationship with the father of her child, appears to have provoked an anxiety syndrome and led to weight gain (Pine, *et al*, 2001; Friedman *et al*, 2015). This coupled with her increased weight, impacted severely on her self-confidence and turned what should have been the happiest time of her life into a very unhappy period. Additionally she also felt guilty that she had let her father down by having a baby at 17 and by letting herself become so overweight. This all contrasted markedly with her time before she became pregnant, “when I was at my happiest I’d say, being in college, [or] on a night out with my friends and not a care in the world.”

The watershed between those two life experiences was of course the birth of her daughter, and sadly therefore having her daughter had become temporally and seemingly causally linked with her anxiety and with her overweight. The only way to have avoided these problems would have been to never have become pregnant, but giving up these two problems seemed to her to be tantamount to forsaking or denying her beloved daughter.

However as a result of her hypnotic explorations this participant has begun to realise consciously as well as subconsciously that it is possible for her to let go of her pregnancy- and birth- associated consequences of having been pregnant, without being disloyal to her daughter. This is a process which has already begun as evidenced within her sessions and as her dreams would appear to demonstrate.

During her time in the project this participant had several dreams which felt important, some of these involving people from her past whom she had been re-visiting in her regressive hypnosis episodes, which suggested that the hypnotically induced resolving of past problems and the releasing of past emotions were both continuing during her night time sleeping (Jung, 1961; Freud, 1976; Hartmann, 1998; Samson, 1998). She has yet to begin any consistent weight reduction programme capable of producing long-term sustained weight loss due to her current medical problems, as despite two lots of surgery and extensive investigations she still suffers considerable lower back chronic pain which requires her to walk with a stick and which is markedly reducing her mobility and severely restricting her ability to carry out even moderate exercise. Nevertheless she now has some insight into the aetiology of her weight gain and her previous inability to lose this weight and is hopefully better prepared for dealing with this once her other health problems have been resolved.

CASE STUDY FOR PARTICIPANT - VS /07

This participant was 27 years old married but with no children. Her weight had been normal and her BMI within normal limits up to her mid-teens, at which point she began to put on weight steadily and was aware of physical changes in her facial appearance. Despite frequent visits to her GP, it was not until she was 20 that she was referred to a specialist unit and was diagnosed as having a pituitary tumour with an elevated growth hormone level and acromegaly. Following cranial surgery she is now maintained on a combination of a pituitary hormone analogue and a pituitary inhibitor. The participant's current problem and reason for opting in to this project is that she would now like to start a family in conjunction with her husband but because she is anovulatory she needs to undergo In-Vitro Fertilisation (IVF) treatment in order to conceive. Unfortunately and in common with most NHS IVF units, access to such treatment on Merseyside requires that she has a BMI ideally of 30 or below.

At the time of her first approach to this project the participant's BMI ranged from 32-35, and her efforts to reduce this further, which were being thwarted by her pituitary problem, were causing her considerable distress. As a result she was struggling to control her weight and to prevent it from rising even further, as this would make it increasingly less likely that she would be allowed treatment, and additionally would further reduce her fertility and prejudice her chances of a successful IVF conception. As a result of these pressures her GAD-7 score at this time was 10/15 and her PHQ-9 score was 7/27, consistent with moderately severe anxiety and mild depression respectively. She was a moderately emotional eater scoring 16/27 on the Garaulet scale and her Spanos Attitude to Hypnosis score of 49/98 indicated good positivity regarding hypnosis. Another important element in this participant's history was that four years previously her husband had been very severely assaulted and stabbed, and was unable to work for three years, and it is only within the past year that he had become physically and psychologically well enough to resume work. The resulting loss

of income and the emotional trauma of this episode necessitated the couple giving up their house and moving in with the participant's parents; and also meant that they needed to defer for a further three years their trying for a baby until they felt that they were emotionally and financially ready for this.

The primary reason for the participant's excessive weight gain and current maintenance problem was clearly her pituitary tumour and its consequent impact on her hormone profile. However from initial discussions it was agreed that there might be other subconscious factors which were exacerbating her weight situation and the distress this was causing her, and which could be explored hypnotically. It was also felt that she would benefit from the motivational potential of hypnosis, when used in a socio-cognitive mode, to increase the efficacy of her weight management efforts as well as helping to increase her fertility. Finally the participant felt that she would benefit from the emotional support, relaxation and ego-enhancement that hypnosis could provide for her. This was the hypnotherapy plan therefore which was agreed with the participant to be applied over as many sessions as was practical within the constraints of this research project.

This participant proved to be very hypnotisable with 40 objective and subjective indices for "depth of hypnosis" criteria and 30 "content of session" indices recorded over her 15 hypnosis sessions, indicative how well and how deeply she was able to move into an efficacious trance state. This was particularly important for this participant because of her need to deal with the degree of stress and anxiety provoked by her overweight condition Comments such as:

> "I felt that I was in quite a deep state of relaxation. It was quite nice, it felt quite comforting, especially I can remember about the liquid and the soothing, it felt really comforting. … Yes, I really enjoyed that."… "Again, I really enjoyed it, as always."… "That is the first time I've relaxed, about the whole thing; so, it was nice then just to relax and try and take it in." … "I just feel brimming with confidence now, and positivity which is good because it's only ever been the negativity that stopped me" … "Ooohhh!

It was so lovely [enthusiastically]." "So, as always I've loved our session today" [Sessions 3, 5 and 12]

…all attested to how easily she was able to sink into a trance state and release tension and stresses, an important aspect and benefit of hypnotherapy. This function of her hypnosis response was noted from the very first session and continued throughout the full series, providing a supportive and restorative *leitmotif,* to the more regressive and painful therapy aspects of her ethnographic exploration. It also enabled her to learn and to put into regular practice relaxation and ego-enhancing techniques which would relieve some of the distressing tension that she was experiencing, so allowing her to focus on the other aspects of her life which needed to change. Against this background the content of her hypnosis sessions naturally changed over the course of her involvement with the project, with her early sessions designed to help her identify problems, mainly non-specific, current, anxieties, and an anxiety about feeling anxious, and later ones being more probing and targeted:

[Researcher – *Can you remember what you put in the bottle* (her problem disposal unit), *as problems?*]: "There weren't many at all, which is … I found strange, because I go through life thinking I have so many problems, and I haven't. … Time, I think I've got no time, all of the time - when I have. That was the biggest one. … Pressure, I feel constant pressure. I feel constant pressure of deadlines and targets." So I feel I can't reach the target and it's a rush to reach the target. I don't actually know why there's a rush." [Session 1]

"So I think that's why I enjoyed it … because I think without realising it … you do actually worry more than you think, so I think it was just nice just to switch off then and just relax. It was kind of reassuring that I don't have all these problems, that I thought I had. So that's what I got from today." [Session 3]

The participant was then able to use her hypnosis sessions to deal with such problems through guided visualisations which she could then put in to practice later, by herself. The resulting empowerment was apparent and highly beneficial for her in much of her day to day activities, as well as helping her to release tension and anxiety:

> "I just throughout that session give myself a pat on the back, today. It just confirmed, you know, that I'm trying my best. There's nothing more I can do. So erm, I just feel brimming with confidence now, and positivity which is good because it's only ever been the negativity that stopped me." [Session 5]
>
> "It's just nice especially to hear the words give yourself a hug, and kind of acknowledge you [participant] for getting to this point. I never, ever, ever, ever do that. … I never take that time, for myself to say, "Well done you for getting here". I just always beat myself up about things. … Most definitely, I've never thought about, like I said, I've never thought about it like that, till then, in that session. It's just like, you know, yes, there's people there supporting you but you're the one doing the work. And I don't ever think about it like that." [Session 13]
>
> "But it was nice then to just, actually take a minute to relax and think nice thoughts and positive thoughts. … Because I push it away because I'm scared. And that's the first time, and that's the first time I've actually let that thought into my mind. [Session 14]"
>
> "[Researcher - *The fact that you coped so well with that interview, that appointment, suggests that there's something happening inside*]: Definitely…I think in the past it would have [destroyed me]. Because, like I say, I've been to numerous appointments now and been told to go away and lose weight, that…I can tell you…every appointment I've come out of I've cried my eyes out, and yet at that appointment, that's the first time I've felt, I've come out of the appointment feeling stronger. … I think it's these sessions have helped definitely. Because like I say, previous, I was

coming out and crying, and yet at that appointment on New Year's Eve I just felt more determined." [Session 4]

With later sessions and with the aid of more targeted visualisations the perceived and elicited problems became more specifically pertinent to her situation and her past experience and history. She began to realise how much she has been taking the blame for the fact that they are unable to have a baby naturally because of *her* pituitary problem, which caused *her* weight increase, and which had resulted in stopping *them* from having *their* baby. Over hypnosis sessions 5 to 10 the participant became increasingly aware of her past feelings of anger and guilt about the frustrating years when inexorably she became a fat teenager due to her pituitary tumour being missed by her doctors; also the further lost years of family building years whilst having surgery and hormone replacement therapy which subsequently permanently damaged her fertility, and resulted in her current weight problem, preventing access to IVF. However even as early as her first hypnosis, when asked to go back through the past to search for contributory problems and feelings associated with her present distress, the participant became uncomfortable and restless and when asked why this might have been she replied:

"I think it's just the medical condition, again. Because I feel when growing up, with the acromegaly and not knowing I had the acromegaly, I lost a lot of confidence growing up. So again the time issue, I feel like I've missed my time. Erm, and I continuing with the rush 'cause I feel I've got the this target and this deadline to meet. I feel I'm still not having that time for me, I feel like it still passing me by." [Session 1]

In later sessions the participant became increasingly more able to regress back to revisit her teenage years, where she was able to re-experience the *feelings* of those times. By re-examining the past in this way, in a dissociative state where she is both the teenager present at the time, and the adult that she has since become, she was able to see clearly and understanding more accurately these very difficult and painful parts of her past, and to let go of the guilt feelings about what was happening then and what has happened since. This

was hinted at in her sixth session when she opened her eyes appearing very distressed and tearful saying:

> "I found that one of the most emotional session I have had up to now. Err… even shedding a tear. Er…I think it is going back and reminding yourself that you were confident and you were happy. I just find it sad that I'm struggling to get that back. Er… but I'm sure I will. … I think I just need to let go. But I can't because it's obviously a big part of my life, what happened." [became very tearful]. [Session 6]

With succeeding regression visualisations she was able to regress to specific ages, episodes, events and feelings which her unconscious mind needed her to deal with and resolve, in order to move forward in her life. In this ways he was also able to allocate some of the responsibility for the delay in their being able to start a family from herself to the consequences of the assault on her husband which had meant a delay of three years for his recovery, a resulting loss of income and the loss of the "nest" needed for raising her baby:

> "I think in previous sessions where you've mentioned about going back to feeling young and thin, but I've never actually felt it, I've never actually got to that point where I remember what I felt being like that … up until tonight. 'Cause I remember the specific age I went back to, it was 18. 'Cause it was bringing back like a birthday celebrations and things. And I think that that was when I was most confident you know. And becoming an adult but feeling like so bubbly and confident." … "I think in previous sessions where you've mentioned about going back to feeling young and thin, but I've never actually felt it, I've never actually got to that point where I remember what I felt being like that … up until tonight." [Session 9]

> "Err I've never actually listened to the question "has anything else happened in that year?". And I think finally today I've finally listened to that question. The big thing in my life that happened was with M. [husband - he was attacked and severely assaulted

and unable to work for several years in 2011] err… and where that put [us] back home with my parents where we still are now. That's a big thing because the "nesting" phase and the moving on which will be coming towards the end of this year, will be a massive thing for us moving on, and me thinking positive, and me creating my family and that nest." [Session 10]

"But it was just nice then to actually realise why I am where I'm at now , and also it was a medical condition that was preventing me from … [long pause] doing these thing that I have for so long wanted to do. I do blame myself for a lot of things that are out of my control. Especially the whole fertility thing. It's not my fault that I'm at where I'm at. But I do constantly blame myself, I realise that is what I am doing, blaming myself." [Session 10]

"[I have been thinking] it's my fault that I put weight on. I don't necessarily associate it directly to the tumour and to, 'cause to me I went so long putting the weight not knowing it was related to a tumour [that] I thinks it's that's why I do feel like the past, probably years, have been painstaking because it's took so long for it to come out. But I'm starting to feel I'm coming out the other side now." [Session 11]

The recognition and acknowledgement of how potently such past unresolved feelings were still impacting on her in the present was necessary in order for the participant to examine these from her present day adult perspective and in doing so allow them to dissipate. This process of change which is more an unconscious one than a conscious one, may or may not be perceptible at the time to the individual process, but may be reflected in spontaneous thoughts about the past and frequent unanticipated changes in mood, between sessions. This participant was able to notice a definite move towards being more positive and forward looking as her regression sessions progressed and as different regression metaphors were employed:

"[T]he thing I got from today was that I'm starting to feel that the mind's starting to catch up with the body. Just mentioning then, mind and body together, like they needed to work together. And I'm just starting to get that point now, of realising that. Because there's nothing you can't do, if you put your mind to it. So that's what I'm starting to learn." [Session 6]

"I just throughout that session give myself a pat on the back, today. It just confirmed, you know, that I'm trying my best. There's nothing more I can do … "[Telling myself] Just focus on getting you and your body back to normal" … I think that's always stuck in the back of my mind … should I be taking this time to focus on me or focus on having children. I do feel focussed now." [Session 8]

"So they are there and I know that they're there and I'm trying to push them to the back of my mind. And be positive. But like you said, that's not necessarily a good thing, pushing them to the back of your mind, you need to let them go. But that's something that I'm working on." [Session 11]

And this subconscious activity is often reflected in dream frequency and content as it was a little for this participant. However the metaphorical and allegorical nature of dreaming rarely permits any logical interpretation of such dream content:

"To be honest I don't tend to dream quite a lot, but I would say more so over the past two weeks, I have dreamt a little bit more than I would normally. Erm…they've been quite bad dreams to be honest. I think that the first night, that did stick in my memory it was something to do with Robots, robots taking over the world. Just sort of that." [Session 2]

"Monday I went to sleep and I dreamt that I'd had a child, and I was dropping the child off at the baby-sitters whilst I went to work. And to keep the child happy that I was leaving her, I was leaving the child with a load of sweets." [Session 8]

Changes and improvements in eating and exercise habits can also be an indicator of subconscious changes, and for this participant such changes were more to do with coming to terms with her weight problem and stopping blaming herself for this, rather than resulting in a major drive to lose weight. As she realised during her time in the project, her teenage weight gain was never of her own making despite the medical opinions at the time, and that because of her continuing pituitary problem, losing weight would always be a major battle. Her insight from her hypnosis sessions was that she needed to establish a comfortable and manageable routine that would enable her to maintain her current weight without any further significant weight gain, but which would at the same time give her the emotional space and energy to deal with her other problems:

> "I did mention that I gone a bit off the rails. So I reined that in, and I've lost four pound this week. And again I weren't, erm, as strict as I have been in the past on the diet this week and it seems to be working. Just letting go a little and not worrying about it every second of the day. Erm, so, it seems to be helping." [Session 3]

> "Yes, that's what I feel like. I'm getting to the point, and now I'm starting to believe more. Erm, just this week alone, being, getting back with the exercise. So there was a sense of achievement and learning, that it was me telling myself that could do it, that I done it. So I've really got something from this week." [Session 4]

> "But I'm trying me best not to let it take control, the diet. So I'm more focussing on the exercise, which I'm enjoying, rather than focussing on, "eat this, eat that" type of thing. So the weight thing at the moment is OK, it's not taking over me life, and I'm just feeling really positive. So long as I'm feeling good and I'm feeling fit and healthy, I'm not going to focus on every pound. … So I've put that out of my mind and if I lose weight I won't know it." [Session 11]

DISCUSSION

This participant had very specific needs for help with her weight management, and for which hypnosis would seem ideally suitable (Hartland, 1971; Yapko, 1995; Brann *et al*, 2012). The dual ability of hypnosis to maximise socio-cognitive motivation coupled with its potential for facilitating regression and conscious resolution of past subconscious problems, makes hypnosis an ideal tool where medical, and especially weight and eating problems are of mixed or unknown aetiology, and where anxiety or emotional distress is an additional or major factor. This participant first and foremost needed some tools to manage her anxiety about a number of life issues, and the pressure from the fertility unit to lose weight.

Very soon after commencing her hypnosis sessions, sessions one to three, this participant began to realise that she had been holding herself solely responsible for her and her partner's inability and failure to have a child together. She had started gaining weight during her mid-teens and subconsciously she was still blaming herself for having put on this weight (Koch *et al,* 2008), because of the medical opinion of her general practice advisers at that time that her overweight was entirely her own fault. By the time she was diagnosed with her pituitary tumour at 18 years she already saw herself as a culpably fat person and had set up an embedded self-denigratory, subconscious barrier about this. This feeling of self-blaming was reinforced subsequently when she had to undergo brain scans, surgery and further hormonal investigations and then commence on a problematic medication regime. In session five she was able to go back to stress of all of this and recall how she came to perceive this as her justifiable punishment for her having become obese, rather than an explanation for this. Furthermore as sessions six and seven reminded her, as a result of her tumour and its treatment she became infertile, which meant that she and her husband were going to have to employ IVF treatment to have their family, a further punishment perhaps for her getting fat, and to add further to her burden, her continued weight problem was preventing them for having this treatment – the final punishment?

In session six the participant was encouraged to go back to at time before her weight increase and tumour diagnosis to remind herself of who she really was deep inside, what she had lost, but what therefore she stands to re-gain by dealing properly with and letting go of, her past traumas. Subjectively (and objectively to the researcher) this was the most emotional session to date as she re-experienced being once again the young and happy-go-lucky teenager that she used to be. She also felt in this session that her mind and her body were at last staring to work together in harmony rather than opposition. Session nine allowed her to return to, and to acknowledge, the major impact on their family building plans, of the assault on her husband, and how this was a factor totally outside her culpability and her control, whilst in this session she was also able to see how importantly this assault had damaged the "nest" they were trying to build for their future baby. Over this participant's remaining hypnosis sessions she became far more relaxed and at ease and continued to enjoy her hypnosis, whilst continuing to explore and let go of the guilt and the shame she had felt about her weight and about its implications for their family building. She began to accept that her weight gain and the implications of this for her fertility were not her fault, nor was the delay in commencing IVF. As she relaxed she became better able to stabilise her BMI at 32, a value now acceptable to her fertility consultants. The final hypnosis session just prior to her IVF attempt was used to re-affirm the positive aspect of her progress as well as to provide her with an hypnotic fertility enhancing visualisation that she could use to optimise her uterine blood flow and increase the likelihood of her maintaining a good secure pregnancy. Subsequently she reported that against the odds she had conceived at their first IVF attempt and was pregnant.

CASE STUDY FOR PARTICIPANT - BL / 08

This participant has been ill with undiagnosed abdominal/gynaecological problems following recurrent abdominal surgery for several years and is currently regularly attending a pain management unit. Her mother and her younger (disabled) sister both died when participant was in her teens and she has a brother and her father still living. After graduating she worked abroad as a conservation biologist and a physical therapist for many years until ill health enforced her to give up this work. She has lived with her father in difficult and uncomfortable circumstances and poor accommodation until two months ago when she was able to move into a new flat which she enjoys. Her weight has been accumulating since her health started to deteriorate and she is now significantly (4 stone) over her ideal and previous weight, with a BMI of 30. The participant's GAD score was 9 and her PHQ score was 6, indicative of mild anxiety and depression, her EEQ score at 13 was suggestive of a moderately emotional eater, and her ATHQ score was 57 and compatible with a good attitude towards hypnosis.

Despite the participant's interest in health matters this project was her first contact with hypnosis. Coding of her post-hypnosis interview data indicated 35 indices of good trance depth over her 10 sessions and 69 indices of hypnotically evoked content. In her first session she was able to relax albeit with some initial anxieties about letting go, and was able to sense a number of problems around her relationships with her brother and her father. Only some of these was she able to place in her problem disposal bottle, as some unidentified people appeared to be preventing her from letting problems go. As she was returning up her steps from her beach she noticed lots of children still down on the beach:

> "But I didn't realise it at the time [starting to cry], 'cause … [long, long pause]. It's like I was a little girl, I was waving goodbye to all the children playing on the beach, with

a big kite. [can hardly talk for crying]. It's like I've never really grown up. And all the children playing on the beach I could really relate to, 'cause they've never really grown up." [Session 1]

When the participant woke from hypnosis she was crying, and continued to cry for a while. She described how towards the end of her hypnosis she:

"jerked awake [from hypnosis], I turned into a balloon … I turned into a balloon. As the balloon flew off, that's when I woke up. But I didn't feel the emotion that I'm feeling now, in that moment, you know. It was nice." [Session 1]

But once awake she became very emotional and tearful and said – "As I was just listening to you then I got into my mind "you don't trust adults."" However when asked to describe her beach scene she said:

"It was something image [sic] of an art painter, who did a lot of work on the beach in the 1920's. You know I got the feeling of what ladies wearing, you know, the big-rimmed hats and things like that, and the children in little blue short blue and white shorts. It was that kind of period, you know. I didn't recognise any faces or like that, but it was a very calm and genteel and fun and innocent." [Researcher- *The Bloomsbury Set, they did a lot of pictures, especially one called Studland Beach by Vanessa Bell, Virginia Wolff's sister. She did a painting of Studland Beach, which sounds like you are describing*]. "Yes, it was very of that period. Yet it wasn't of that period, if that makes any sense. It's only when I reflect back and look at it." [Session 1]

In this visualisation the researcher refers only to a "beach" the rest of this detailed description of the scene was provided by the participant's unconscious mind and there must therefore have been a reason for presenting such a precise metaphor-like picture. And certainly, this first session clearly had an impact on the participant as two weeks later she reported back that since this hypnosis session:

"I've been having quite a few nightmares, but I can't remember what they're about, Paul. But they've been distressing. And, and this week has been extremely, emotionally roller-coaster-ish for me. It's almost as if everything has collided all at once. I've literally been crying, burst into tears for no reason, just feeling very low, and then burst into tears again. That's just not like me really." [Pre-session 2]

The participant was reassured to hear that the emotional ups and downs of the last two weeks, and especially her nightmares, sounded like an abreaction from having disturbed the past in her first session, and that this suggests that something is coming to the surface. Coincidentally she had also noticed a slight change in her eating habits since her first session:

"The biscuit tin had been empty all week, and I did not miss eating my usual quota of biscuits**."** [Pre-session 2]

We also discussed her further thoughts on the unusual content of her first hypnosis session, and what she felt might be underlying the appearance of the children on her beach:

[Research- *Last time you became emotional, you were surprised about the children on your beach, any more thoughts about that?*] "Not really, at the same time there was an awareness that I can very easily slip into extreme childlike feelings, I can go to that moment quite easily, and become a four year old. I think it's for me a good thing, because it's like a little outlet." [R- *does that fit in with your image last time of being overweight and therefore motherly to other people, to young children? How can you be a child and also be a mother? Which do you want to be?*] "I don't wanna do that either. I tend to do that a lot though. 'Cause I'll quite understand, and I'll listen, and I give quite good advice. But at the same time it's exhausting for me. So I then regress into the childlike nature when I'm at home." [Pre-session 2]

"I'm not sexually attractive. I [don't] think. It keeps people away from me. And I can stay childlike really. Even though I can dress very feminine sometimes, and I can get

attention. I don't really want it more than someone just looking. And by going into a childlike state, you know…" [Pre-session 2]

In the subsequent session two and despite her being in pain she went deeply into hypnosis and woke up with a smile on her to report that:

"I went to the beach very quickly, and I was very present there. I slipped in there very, very easily, you know. I was back with the children again, it felt like the 1910s, 1920s, all that period dress. You know, flying the kites, there was a black and white dog, in exactly the same as last time. And then when you said go deeper and deeper, suddenly, I wasn't on the beach anymore, I was in this really grand house with this sweeping staircase with the swirls either side that goes up like that and swirls out like a big wave." [Session 2]

"I was suddenly there as you were going deeper and deeper, I could feel panic coming in. I could feel the panic coming in, I didn't know why. But I felt like I was getting close to something that was causing that panic. Just a feeling of, possibly living in that house. And then being downstairs with a … rather portly cook, and then [pause] it's kinda confusing, [pause] a sensation of wanting to shout fire. My hands felt really hot. And then, I was suddenly transported a few years later, I was on a horse galloping along the beach." [Session 2]

[Researcher- *The cook, the fire and the big house, a little like Alice in Wonderland?*]
"You see I've experienced a sensation of fire in the past, you see. And I've always had this sensation of being in a very grand house, something of the 1910, 1920s, is that, you know … But's very, very clear Paul." [Session 2]

When asked the participant how she felt on her beach, and whether she could find her problem disposal vessel and what she chose to put in it, the participant replied:

> "It makes me happy, when I'm down on the beach with the kids. And when you were going up the steps one at a time, I had already bounded up them - and I got to the top and shouted "Bye, see ye' in a couple of weeks" [Laughs]." [Session 2]

> "I didn't feel like I did a very good job, to be honest with you. But I put like, you know the fears and guilt, and, frustration, and my ill health. You know. A couple of relationships and my dad and my brother, which are actually healing anyhow, you know, things like that." [Session 2]

Discussion prior to the participant's third hypnosis session suggested that session 2 had also made an impact and had furthered the process of subconscious exploration of past events and emotions:

> "Children on the beach - That was with me the whole day after we did hypnotism last time, then it just slipped away naturally again. But it stayed very, very, very vividly in my mind through that day."[Pre-session 3]

> "I've had a few weird dreams but I can't remember them. But I remember waking up feeling a bit tearful and shocked. Err, but I can't really put my finger on what they were about. I think they might have had my ex-partner in them. You know, he was manipulating my head a little bit?" [Pre-session 3]

> "It's been a difficult few weeks, but I do feel like I've resolved a lot of problems that were going on the last few weeks. But I had to go through them, to get to the other side. I just feel a bit more positive in myself. I've resolved some of the stuff that was going on in my head. I just feel that I'm in a better place emotionally. I don't seem to be snacking as hard as I used to, which is quite a good thing for me."[Pre-session 3]

The succeeding hypnosis session 3 was the first formal regression attempt and it began with the participant going quickly and deeply into hypnosis as before, but then to inexplicably awaken after a little while, spontaneously and without instruction to do so. She exhibited

no obvious emotions during the time she was processing her regression, but suddenly in the middle of this she opened her eyes and asked had we finished. She said she heard the word “weight” and felt the need to open her eyes - “I came back into the room, you know.” I told her to go off to her same place again then spend some further time there, then brought her out of hypnosis in the usual way. This was a surprising and significant event, possible an avoidance of processing the past regarding her weight problem. She told me that she noticed that she has no pain on recovering, in contrast to her constant pain the rest of the time, and just felt very, very relaxed, however she had post-hypnotic amnesia for what I had been saying and directing, which suggests some degree of subconscious avoidance:

> “I can’t remember anything Paul. [in a surprised voice] I don’t think I went to sleep, that’s the weird thing. Because I heard the word “weight”, I think you said the word “weight” … and I woke. I can’t explain it. Something has just disappeared. I don’t recall anything at all. But I’d completely gone. But … I don’t know why, it’s weird**.** I don’t even recall getting down the steps or anything. No. I didn’t even get to the beach.” [Session 3]

I suggested that over the next two weeks the participant ask her unconscious mind to clarify for her why that had happened to her but on her return for her 4th hypnosis session she was none the wise:

> “It was kinda just a blank … you know, kinda like I went into the gap, if that makes any sense. You know the gap in between the spaces where…” [Researcher- *I’m just curious as to why the word “weight” should have brought you out*] “I think, it was weight in 2015 you said, or something like that. ‘Cause you gave a date as well didn’t ya?” [Researcher- *Well, I would have said, “ to do with the weight problem you have in 2015*”]. “Cause that’s what I heard … there the two things I heard together. That brought me out.” [Pre-session 4]

I suggested to the participant that for the mere mention of the word “weight” to bring her round and out of hypnosis in that previous session was clearly an avoidance. For some reason her unconscious mind was wanting to avoid her dealing with her weight problems but I felt that we should continue to pursue this. Hypnosis in this session was therefore a further attempt to examine weight oriented past problems using the “Walking Backwards” regression visualisation which is designed to encourage the unconscious mind to let go of current behavioural modes based upon past experiences and erroneous conclusions, and by letting go of the past and turning around, to become more forward looking and thinking. Once again this resulted in an abrupt wakening at the mention of the word “weight”, and further post-hypnotic amnesia:

> “I can’t remember anything else. Being on the lane [part of the walking backward visualisation] … “I can remember you saying walking down the lane”. … and then that’s it. Absolutely nothing. I don’t know what happened, but I came back, Like I was, a jolt, like a panic, an ! [sharp intake of breath] kind of feeling you know … and then I was like … why am I in a garden - I thought I was meant to be at the beach. I’ve got no recollection, of anything really?” [Session 4]

Significantly this point in the garden where the participant “awoke”, was the first and only point at which the word “weight” was mentioned by the researcher in this visualisation. Other than this brief movement of awareness due to the participant coming out of her deep trance, she remembered very little of quite a long and complex visualisation:

> “I remember nothing. All I remember is the bit just before, where you say about the bend And then you were saying you know about the steps again. Going up. There’s nothing in between. Just a complete blankness. But there were no thoughts either. D’you know what I mean. After I came, whatever frightened me or, brought me back, like the ! [the sharp intake of breath] then I could hear you again, and I felt like I was present again.” [Session 4]

> "I just, like I said I was walking down the path, and the next minute I was completely gone, and the next minute you were saying turn the bend, and I was back again. … I don't even remember going down to the beach, I just remember being in the country lane. And that was it. Oh, how bizarre." [Session 4]

An additional feature of session 4 hypnosis was the first appearance of a World War Two aeroplane and airman theme, which was going to figure very powerfully in latter hypnosis sessions:

> "Towards the end, you know, you said about going up the steps. … It's like it was World War Two time , and as I was going up the steps … it was almost like, the white cliffs of Dover kinda feeling. And I was standing on the top wearing 1950s clothing waving to the planes going by. So where did that come from?" [Session 4]

There was an exchange of texts between session 4 and session 5 between researcher and participant, discussing firstly how the participant sees the implications of her being overweight, and secondly the puzzle of the arousal from hypnosis brought about by the researcher's use of the word "weight" during visualisations:

> <u>Text Messages</u>:
>
> "Being fat means that I'm unattractive to opposite sex which suits me fine as I don't want anyone relying on me on a regular basis as that scares me -I feel trapped and under their control but weirdly enough the fatter I've got the more admirers I seem to have which is most odd and amusing." [Text message after session 4]
>
> *Researcher*: "I have been listening to and transcribing yesterday's post-hypnosis conversation I thought you might be interested to know that the point at which you suddenly became aware (woke up), when you were in a garden was the first and only point at which I mentioned your weight!" *Participant*: That's interesting Paul as I could have sworn you said to me that you mentioned the word weight a few times but no response from me. *Researcher*: I did indeed say that that "I mentioned the word

weight a few times but no response from me" but I have realised just today that all of these mentions were not until you were in your garden, which was a long way through the session - and that this was where you came out of trance. I did not mention weight again for the rest of the visualisation during which you were able (allowed) to stay in a trance state**."**

Discussion with the participant prior to hypnosis session 5 reaffirmed that the 1920's theme glimpsed at the end of session 4 visualisation was evidence of a major subconscious change of focus which was to dominate the participant's waking hours and her hypnosis sessions for several weeks, and which appeared to have been triggered by her hypnosis sessions:

"You know I was talking about, feeling that I been, you know, the 1920's period. I have realised Paul I've just gone so seriously in to World War One and Two, the last month or two. [Since being in this project!] And reading books on fighter planes, reading books all about the history … and watching non-stop films about being in planes and being around that period of time. And I wasn't doing that before I started doing hypnotherapy. I've been buying stuff to do with it all. It's almost like something's been triggered off." [Pre-session 5]

"But I hadn't really delved into it before hypno. I've watched ten films on World War One and Two this week, you know. And I've got tons of books on Hurricane fighters and … you know ... all books to do with that period of time. And I literally wasn't delving in that much at all until I started the hypno'." [Pre-session 5]

"So it's kinda unlocked something in me. It's unlocked a real interest as well. Which I'm really enjoying learning about. I'm not an obsessive person Paul. You know, it's intense, and a desire to absorb as much information as possible how to build a plane, how to fly a plane, what different planes do what things you know. I can tell you now what kind of planes were used at the beginning of World War Two to train the pilots,

you know. Three weeks ago I wouldn't have had a clue." [Researcher: *This has come on since you've been seeing me here?*] "Yes, yes. It's really … it's given me pleasure as well. It makes me happy." [Pre-session 5]

The visualisation used for hypnosis session 5 was the "Corridor" regression script in which the hypnotised participant pictures herself standing at the end of a long corridor with numbered doors to either side. Each of these numbered doors refers to a year in the past life of the participant, who is then encouraged to walk past each door in turn to identify doors (and years) which feel important in some way and into which she feels drawn to enter. This can be a very effective way of facilitating the exploration of an individual's past life and the procedure is usually monitored using a visible IMR signal. However on this occasion the participant became very distressed and agitated, and she began shouting out that she was not the participant and these were not *he*r doors – that she was someone else and they were *his* doors.

It was clearly important to establish what was happening for this participant, and to question the person who appeared to be speaking through her and record and transcribe what was said by this "person". In the subsequent 10 minute conversation the speaker gave his full name (but referred to as J. in this study) and that of his co-pilot, and said that he was 23 years old and had been born in Oxfordshire. The date was 25th July 1943 and he described himself as being a World War Two Spitfire fighter pilot and flight lieutenant for four years and had flown three times yesterday, but had died "in the air". By the end of this conversation the participant was feeling distressed and panicky and was having difficulty breathing with the feeling of a weight on her chest. She was quickly brought back to her beach safe place and encouraged to use her breathing and relaxation technique there, whilst being correctly and firmly re-oriented in the appropriate time and place, and subsequently brought slowly out of her trance state.

Discussion about this session was only brief as the participant was feeling quite shaken and stressed by this episode, but she did recount that during her visualisation and whilst in her corridor, there was another presence:

> "It was, like, an officer in the corridor, in uniform. And I tried to go through my doors, but they weren't any of my doors, they were his doors. I was there, but I couldn't be me. Does that make any sense at all? I could hear you asking me questions, but I was in the background, and he was in the present." [Session 5]

The participant also thought that she had heard some fighter planes flying over the building during her session and had heard someone knocking at the door:

> "Did you hear the planes going over before? (laughing)" [Researcher: *There were no planes*!] "I heard them in that corner (pointing to the window in the room behind her, and still laughing). It's very weird. That was very weird. None of that was me at all. … Did somebody knock on the door then? [Researcher: *No!*] I thought someone had really knocked on the door then" [Session 5]

Because of the unusual nature of this session the participant was contacted later in the day and again the following day to check that she was not too distressed by her experience when she reported that "I was freaked out a bit yesterday but fine now". When she presented for her hypnosis session 6 she said:

> "I was very freaked for the first 24 hours. But then I just thought, it's just my imagination, let it go. If it isn't my imagination there's nothing I can do about it anyway, let it go." [Pre-session 6]

The participant also reported that the last session surprisingly had provoked a lot of memories about her early food and eating experience, which may have given her some insight she felt into the roots of her current eating behaviour:

"But I was reminded of some of the things that went on during my childhood … that my brother and I were constantly hungry, and constantly looking in cupboards for food. And even though we knew there was no food in the cupboards. We did it all our lives, even into our teenage years. We were looking constantly for food, and both of us now have constant full larders. There's never any opportunity to not have any food in. You know, my brother exercises an awful lot though so he stays very slim, obviously I can't because of my health, so I've put the weight on." [Pre-session 6]

"Also my mum had a problem with food, mum and her family had lost her mother and father very early on and they were all put in to different orphanages. They used to get food parcels from their aunties and uncles. But the food parcels they wanted to keep for themselves as something that was theirs, but they had to share it with all the other kids in the orphanage, and it used to really upset mum." [Pre-session 6]

"We never seemed to have enough to eat and we were always looking for food, we wanted for food for ourselves. And then you look on later on in years both of us constantly have stocked larders, because we don't want to experience that sensation again. So I was wondering whether there's a connection there." [Pre-session 6]

"Mum and dad didn't cook, they went to the chippie every night. Dad was working all the time, mum was busy obviously with a very disabled child. Mum couldn't cook 'cause nobody had taught her how to cook, and dad was a man from that period, just didn't cook anyway. So chippie food was all we ate. I never eat chippie food now. So there's a food thing going on here. And it's only starting to come out a little bit more as something's triggering me to ask. It feels important to me." [Pre-session 6]

She is also coming to realise more about how her relationship with food has developed and changed over the years:

"I think food has been an issue right back early life now, I can see it quite clearly. Maybe food was a source of comfort. And I think maybe even though my diet's

changed, and I can't exercise much, and I can't have a relationship because I wouldn't allow myself to have a relationship - I think I'm having a relationship with food. I want a romantic relationship, but I will not let myself have one, I'm not well enough to do it. The relationship I can have is with food, I can feel the pleasure and the enjoyment of eating, and almost, it calms me down as well." [Pre-session 6]

"It's safety. I don't want to be attractive to anybody? And even though I'm not a mother, being fat is OK when you're a bit older 'cause it's, you know, motherly, not sexually attractive." [Pre-session 6]

Session 6 for this participant was the "Sailing Yacht" visualisation in which a sailing vessel is used to take away obsolete and sorted-out problems to be deposited deep in the ocean. This again proved problematic for the participant as she emitted several verbal outbursts, making the sound of a military trumpet, as soon as she went into hypnosis, later jerked and gulped out loud twice, gave a brief shout once and an angry "They're all going to sink" cry as her yacht was sailing away. Whilst on her beach she had again to deal with the male persona from the previous session:

"I went back to J. again. I was, I was trying very hard to suppress it from coming out. And instead of being a young boy [sic] on the beach, I was a man on the beach this time. And it was J., and I was trying to put stuff into the jar, and J. was just laughing, in my mind going "This is pointless". It was very weird. I wasn't going under [hypnosis] the way I have done in the past." [Session 6]

"There was a very strong presence of the J. character. I felt like I was battling a little bit, and I was like, in my mind I was saying, "I just wanna relax, J., just today, not today"… but it was still coming through. It seems like er …whether I'm making it up or if it's real, the person's quite angry and upset, you know. And that's not really who I am as a person." [Session 6]

> "I couldn't quite get into it, as it didn't feel like it was me going under, like I felt like the whole time I was able to go properly under 'cause .. it sounds weird this … Cause J. was in there. And it was more about him than about me. … I kept getting flashes of Spitfire engines, and when I did, I'd jerk." [Session 6]

When the participant was asked what name was on the boat as it sailed away she said with some surprise:

> "It was a bizarre name actually, it was, was, like a name for a pen. A thick pen. …Almost like a nickname. … It will come back to me…. SHARPIE!". [Researcher: *What does Sharpie mean to you, anything?*] "I don't know. I got the feeling it was a nickname to be honest with you. [Session 6]

[Sharpie is commonly known in this country as the name for a thick coloured marking pen. However a sharpie is most properly the name for a two masted, shallow drafted fishing boat originating in the New Haven, Connecticut region of Long Island Sound, United States. There is also a reference to a sharpie in a John Betjeman poem. He wrote a poem about watching a pretty girl rowing her boat down the river, and he called it a "sharpie". [in:"Youth and Age on Beaulieu River" – "Clemency the General's daughter….Soon her sharpie's rigg'd and free"]

The participant knew only of Sharpie being a type of marking pen and was very surprised and mystified to find that she had chosen a word for a type of boat as the name for her visualised boat on her beach. The presence of her male persona J. remained with her even as she was trying to climb her steps back up from her beach:

> "I felt like, when I was coming up the steps, like this … kinda weird, it was like, I was hold … I was … I didn't wanna let go of J. And J. didn't wanna let go of me. It was kinda like being pulled away." [Session 6]

Prior to hypnosis session 7 the participant reported that she was experiencing more frequent and more emotional dreaming, predominantly to do with feelings of being out of control and of being under another's control, which might indicate the processing of subconscious change prior to initiating conscious behavioural change (Freud, 1991; Jung, 1961; Hartmann, 2001; Taylor 2012):

> "I've been having some funny dreams. I don't really know… can't remember a lot of them. But I've been having dreams of losing the apartment, I've been having panic dreams about that. Almost like dreams of flying in a Spitfire [laughs], feelings of this personality coming in every so often into my feeling centre, weird dreams that have been going on all week, really. Quite consistently." [Pre-session 7]

> "I think there's a sensation of being trapped in a situation, and under somebody else's control. And not be able to keep the apartment. But I can't remember much about it, I just know it was a weird little loop again that was …reflecting back on my inability … with certain people … to be the balanced stable person that I am … something around their presence knocks me off and I become quite fearful. And when I can't communicate, to explain, I panic. I get ill, you know. And that comes around every so often. And obviously that was coming into my dreams at some point." [Pre-session 7]

Such behavioural change might be evidenced in the participant's reported reduction in her tendency to hoard food, and in her avoidance of poor quality foods:

> "I'm not food hoarding much at all. I'm not eating as much crap at all either. It just seems like I'm not consuming the extra stuff that you consume between meals as often. And that's slowly implement, slowly coming in without me thinking about it. The last few weeks, few months. And even now with Christmas coming up, I'm not desiring to go out and buy huge amounts of food to stock the cupboards. I'm even letting the cupboards get low, which is most unheard of for me. So I'm making some kind of

psychological progress without even thinking about it. If that makes any sense?**"** [Pre-session 7]

In session 7 hypnosis itself, the "Reframing" technique was used to encourage the unconscious mind to redraft a new, improved weight management "unit" to take over this role from the on. This process of identifying a part or area in the unconscious mind which takes overall charge of all that is involved in the management of a given aspect of behaviour and replacing this with an updated and better functioning one, is monitored using an ideomotor response, in this instance the participant's fingers (Yapko, 1995; Brann *et al,* 2012). The very delicate and almost imperceptible movements of her fingers on this occasion confirmed that her response was an unconscious rather than conscious action. At the end of the procedure it is usual to ask the unconscious mind if it is prepared to send a signal to the conscious mind to confirm the satisfactory completion of this exchange.

The participant appeared to be deep in hypnosis during this session except for three brief interruptions from the participant's alter ego, where, with an abrupt loud shout and a raised arm she (it) demanded "I want to talk to you". I insisted that I needed to talk to C. [participant] today about important things and not to the intruder, and that I would talk to him [her] at another time:

"I just feel like there was a constant internal struggle going on with me. Constant internal struggle going on inside. I got a real feeling, that something wants to speak … it wants to do a longer period to send me right under, so I'm not fighting with whatever's trying to come out of me, d'you get what I mean?" [Session 7]

"I feel like there's … if this person is a spirit, either of my past life or a spirit of a presence around me, I got this feeling also of a desire to keep me in this state. If that makes any sense? [This state] of being unwell, unable to move about, and fat … to keep me with them. While I'm unwell, and fat, and unable to get about … I'm not exploring this world that much. I'm living in a past I wasn't even around in. It's come

out the same time as I started doing this hypnotherapy with you and the same time as I've moved into the flat." [Session 7]

"Maybe it's the first time in my life I've been able actually to stop being fearful as much, and feel other things that are going on inside of me. And I'm in a place of safety, for the first time in a very long time." [Session 7]

When asked did she get an hypnotic signal following her "reframing" the participant replied in the affirmative, saying "I got a star, like a multi-coloured star", which was reassuring. This discussion was then followed by a conversation, an abbreviated version of which is reproduced below, about the possible nature of the participant's alter ego:

R.: We all have more than one person inside us. And different aspects of our gender come out appropriate to the situation. People will say about their friends "when he's in work he's a different person from when he's at home". So this might be a different aspect of you that's coming out?

P : It's always a male, and it's always got like a strength and purpose, and a bit angry.

R: But you have reason to be angry from your past. So it could be from your past.

P: That would fit in as well with being, choosing to be overweight, because that's a very masculine thing. Women don't choose to be overweight, men often do. They take pride in their beer bellies. And their bulk.

R: So it doesn't have to be another person. It can be another aspect of you

This explanation seemed to feel right for the participant and she went off home to consider this. Because of the Christmas period it was four weeks before hypnosis session 8 could be organised. In the interim the participant had noticed that things had calmed down somewhat regarding her intruding alter ego as she reported:

"I've noticed since we haven't done hypnotherapy sessions, the obsession with the plane's eased off, massively. I've hardly read any books on planes. And I've hardly watched any films or anything like that to do with Spitfires. I've got tons of books there but it's, it's just quietened right down. I'd be interested to see what happens now, if it comes back." [Pre-session 8]

Simultaneously with this there had come an insight about the role that food has been playing in her life from childhood, but especially over the most recent years when her weight had markedly increased, and therefore about the need for her to take back control of her eating and food habits:

"I decided to try to cut down on the consumption of chocolate and sweet stuffs in the evenings. I'm filling a hole, I don't know why I'm filling a hole you know. I'm not always eating because I'm hungry. Sometimes I am of course, but I'm trying to cut down on that now. Because there's got to be some emotional think behind it. There's a real realisation about that the last few weeks, you know." [Pre-session 8]

"It was definitely a comfort there … with the flat being quite cold, and big, and I feel like I'm rattling around in it sometimes. And there's no corner to sit in, to comfort myself, and be warm, and you know curl up. I feel like maybe I'm using sweets and stuff like that to do that. It's true, whether it's sweets or food for comfort. I do feel like I'm having a relationship with the food, and I never did all my life, until I got sick, you know. But there's definitely something, it's like replacing a sexual relationship. It's giving me some kind of endorphin rush. Just trying to adjust my eating habits somewhat. Trying to make a few changes this year, and accommodate my health." [Pre-session 8]

"I've also realised that I'm like a sponge. I soak up everybody's energies and emotional states very quickly, and I get quite unwell. It all gets piled on me. Other people can walk away from it but I absorb it. And that affects my physical state. And

I'm now starting to see quite clearly the relationship with that to food. Because when I'm really, really exhausted and distressed, and I'm around somebody who takes too much out of me … I eat. Because my system's closed down. Once I start to settle down and feel more better-sis, I eat and eat and eat. I'm now starting to see this relationship in that." [Pre-session 8]

The subsequent hypnosis session, which was planned as a re-affirmation of the "reframed" weight management part's function and a further opportunity to let go of finished with problems into her disposal bottle, proved to be a turning point in this participant's hypnotic journey. She went very quickly and deeply into hypnosis, appeared very relaxed during the session, and took a long time to re-awaken and had little recall of the visualisation – all evidence of a permitted depth of trance on the part of the unconscious mind:

"All I remember really is the part with the bottle. And it was funny 'cause I realised at that moment that I'd started to do some work on myself, 'cause I started working changing my life and recognising my patterns. And because I've been doing some work in the last three days, looking at my patterns, my own personal patterns, I was able to put things in the bottle this time, whereas in the past I haven't found many things to put in the bottle. But now I can see the patterns of behaviour that were bad for me, and the patterns of reaction that were bad for me I was putting in the bottle. And the bottle was a big glass heart." [Session 8]

"And I was shoving them all in and I was saying, you know like, I don't know, always being a sponge for other people's issues. I put that in there kind 'a thing, always putting myself out, I put that in there. Because these aren't good for my health. Any way I filled them all up and put this massive big cork stopper in it. And at one point, I don't know if you saw me jerk, I got the giggles 'cause I got the glass stopper in and I kicked. Instead of just placing it in the water, I kicked it in, and it went … woosh! … through space [laughs]. And I really got rid of it you know." [Session 8]

"I'm starting to look at the issues properly rather than just focussing the people who've been the problem. Now I'm starting to focus on my reaction to those situations. I think I'm starting to address some of my issues. Rather than saying my dad's a problem. My brother's a problem. How they speak to me is a problem in the way I react to them. So I need to learn to react in a different way." [Session 8]

The other watershed in this participant's hypnotherapy journey is the entire absence of an intervening male persona, and her freedom to be fully female:

"And this time I was a girl." [Researcher: *no sign of male intervention?*] "No, there was no boy stuff. No plane stuff. And this time I was a girl, and as I was coming up the steps, I had like a pink dress on and it was quite floaty. And as you were saying go up the steps, I was raring ready to go up the steps. And the steps were, they were not the ones they were in the past which were kind of like slate'y into the cliff. These were more like bronze'y, curved, ornate. Not ornate, natural ornate one, going up. And then when I got to the top I was wearing this pink fluffy dress, and I was dancing around. It was the first time I've been a female. In all the sessions, yer. And I was a young girl. And I was joyful" [Session 8]

The promise implied in this participant's session 8 hypnosis was clearly making itself felt as prior to session 9 the participant had a lot of news to impart about her activities and her insights in the interim:

"During the few days I was doing the silent retreat, it was to focus on myself more, than listening to other people's stuff all the time. I realised that I been stagnant for too long and it was one of the biggest problems I was having right now. Because I'm used to being very free-flowing before I got ill, and I needed to make small changes, no matter what, so at least I'm moving in some direction. I've got back to vegetarianism which is what I used to be before I got sick. I've reorganised my CD and DVD collection, which is a big thing for me as I'm not at all organised like that,

you know. And I've got rid of half of them. And I used them at lot when I was unwell as a distraction, and I feel like I don't need them anymore, so I've got rid of a lot of them." [Pre-session 9]

"I've contacted a few conservation places just to see if I can do a little bit of volunteering every so often to get me back to what I used to do. Also have quiet time, 'cause the mind's very active you know. So it's not been too bad actually, I'm nearly off of my pain medications. And this has all happened in the two weeks since I saw you last! So there's been quite a lot of changes going on, you know." [Pre-session 9]

"An absolute realisation when I was doing my silent time, is that I have some of my dad's anger in me. And it's expressed through fear. And my brother has the anger and it's expressed through anger. So we have two of my dad's two extreme emotions. I've noticed that there are emotional states, which I've done myself and I know M. (her brother) has done, slightly differently, in that all our lives growing up our emotional states were controlled, 'cause dad couldn't handle anything extreme. Especially crying or anger or feelings, like that. He would supress it down in everybody 'cause he couldn't handle it himself. It was all in him, a mirror image. Now that I can see that it's helping me work through my fears a little bit more." [Pre-session 9]

"I've had a lot of sexual dreams, you know. I've had a lot of problems sleeping that could have been because I've withdrawn off the drugs. Yes, a lot of sexual dreams. It's [long pause] it's attempts to be intimate, you know, a desire to be intimate I think, just with people I've had an attraction to over the last six months. But never really carried on or anything like that. Because I'm quite modest, even in my dreaming you know [laughs]. But it's almost like something's changing, like the lotus flower's just opening up a little bit." [Pre-session 9]

The visualisation in session 9 was a repeat of that in session 4 and was to go down to the beach safe place then into the "Walking backwards down a country lane" visualisation then

going directly into the "Walled Garden" visualisation, before returning up some "new" steps. This is designed to draw attention to any remaining misconceptions about the past and to let them go by switching from walking backwards to walking forwards, then using the fountain in the wooded garden to reflect back a correct image of the present and the future. The participant clearly went very deeply into her trance and only with great reluctance did she come back out of this at the end of the session:

> "It was very nice, I kinda, you know … the part where you go off the beach into the country lane … I must have just disappeared then. I didn't hear a single word and there were different people's faces coming into my mind. I remembered J's [her friend] face coming in, a friend of mine, and then I came back again to reality when you said about there being a wall with a door in it. So in between that period, I didn't hear anything you said at all, I just went. You know, but then since the wall, I came back again." [Session 9]

> "It was very nice that. I like the idea of looking in the pond, and seeing the reflection of the people behind me, that was nice. You know, very comforting. Yes it was good. It's definitely time for change." [Session 9]

This was the visualisation from session 4 in which the mention by the researcher of the word "weight" triggered the participant to awake with a start, but despite watching her carefully there was no visible response to "weight" on this occasion. The participant felt entirely at ease during this visualisation and found it to be peaceful and inspiring.

Session 10 began with a further update on the participant's improving emotional, family and social situations and the position regarding her involvement with World War Two and flying:

> "You know a lot of the emotional stuff that was going on for years seems to be resolving. Relationships with the family seem to be coming into a good space. I'm much stronger as a person. I'm able to be my really daft self, I'm very confident being there. It almost like people have been saying to me, the last few months, it's like

you've go to the other extreme. Your whole personality is really coming out now. You know, your sarcasm, your stupidity, your downright outrageousness, is really coming into light now. It's like you're confident even being with family members, who would normally shoot me down. So I've noticed a change in me. Quite significantly. I haven't lost any weight, I've put more weight on … but, emotionally [long pause] I feel like I'm becoming myself again." [Pre-session 10]

[Research: *No more business to do with the flying and so on? The flying side of it? The pilot?*] "It's gone really quiet. I didn't even know what you were talking about. That's the strange thing, it just went dead quiet. It was an extreme feeling for many, many months. And then that one time I came to see you and nothing happened. Complete silence. I've got books all over the place on spitfires. I still love them you know, but I'm not reacting. Maybe I have set myself free a little bit. I don't know." [Pres-session 10]

Visualisation this session was from the participant's beach safe place to a forest glade to sit on a bench and begin to heal body and mind and plan and prepare for the future aided by the power of some sunbeams, then back up some more "new" steps to a new future. In this visualisation the participant's unconscious mind provided further surprises for both the participant and the researcher:

"When I went to the bench the airman joined me. Yes, I saw the guy's face, right in front of me, with his cap on and everything. He said goodbye. He sat down and said "Goodbye C. (participant's name)" … and then all these other airmen came and joined me. And then there was like a fly-by, you know the Spitfires, and they were all saying "Bye C." and I was saying "Bye." [Session 10]

I can't really remember much more. But then as I was walking up the steps, the steps had turned to like a gold bannister. And each step had different coloured jewels in it. And as I was walking up I was saying, "Wow, that was quite unusual wasn't it. I got to

the top, and I said “Bye”. And then the fly-by went on. Definitely World War Two. The planes. And everyone was saying goodbye.” [Session 10]

[Researcher: So that’s the old life you’re saying goodbye to.] “God, yes [said surprisedly]. I see what you mean, yes.” [Session 10]

DISCUSSION

This participant was a tall athletic woman of 40 years who has struggled to maintain her weight within the normal BMI range for most of her adult life, but since becoming ill six years ago whilst working abroad, her weight has increased inexorably by four stone and now exceeds BMI 30, which she finds very distressing. Although she was able to go deeply into hypnosis in all of her ten hypnosis sessions and all sessions were productive in some way or another, they constituted three surprisingly distinct phases. Within the first four sessions the participant felt able to be herself, but in sessions five to seven she felt the controlling and dominating influence of a male alter ego, after which for the final three sessions this seem to diminish. Right from the start, in session one, the participant was able to visualise in great and precise detail, perceiving her “safe place” beach as representative of a 1920s holiday postcard with lots of young children in bathing costumes playing on the sand, she also became aware of how much her relationships with her brother and her father were problematic.

Despite the pleasant nature of this scene the participant became very tearful on awakening and her erratic emotional state persisted over the next two weeks, as she reported feeling low and bursting in to tears constantly and having frequent nightmares. This suggested that even this first session had touched upon parts of her past life that contained unresolved emotional trauma. Before her next session she discussed how she has realised how much she reverts to a childlike state as an outlet for stress and pressure from others and that this was why she became upset as she did not want to leave the children on the beach.

Sessions two and three saw her returning happily to her beach, but during her first formal regression, in sessions three and four she was provoked into an unplanned and unexpected awakening by the mention of the word “weight” suggesting that her unconscious mind was avoiding discussions about weight matters during hypnosis.

However in a text message received from the participant the day after this session she reported that it had suddenly come into her head that “being fat means that I'm unattractive to opposite sex which suits me fine as I don't want anyone relying on me on a regular basis”, and that this might be the way that her unconscious mind was avoiding dealing with her weight problem by making the word “weight” act as a trigger to wake her up from hypnosis. A significant feature also of session four was the first appearance of an RAF and World War One/World War Two theme which was to continue for the following three sessions. As the participant was walking up her steps she was surprised to find herself dressed in a 1950’s dress and a flight of fighter planes flew overhead, which was in sharp contrast to the previous 1920’s theme apparent in her first three beach scenes.

Although she was unable to account for the sudden change in the environment of her safe beach from 1920s to 1950s and the appearance of a flight of aeroplanes, the participant felt that this might be linked to the fact that since commencing her hypnosis sessions in the project she had developed an obsessive interest in World War One and Two and in all things to do with flying and fighter planes. In the brief few weeks since her first hypnosis she had acquired a large collection of films and books about the World Wars and about aeroplanes, and was watching 8-10 war or flying films each week. As result she had become very knowledgeable about all things to do with fighter planes during and between the world wars, having had little interest or knowledge in such things prior to beginning hypnosis. This major behavioural change was only brought to the attention of the researcher in the discussions prior to session five during which she did remember that in her teens she had contemplated joining the RAF but was unable to do so because of a problem with her eyesight.

Hypnosis in session five was planned as a regression using the “Corridor” visualisation in which a corridor lined with a series of numbered doors representing different years in her life, could be used by the participant’s unconscious mind to facilitate for her the exploration of her early and troubled childhood years. Instead however the dissociative process was in this session used to highlight a male alter ego of the participant who was portrayed as a World War Two Spitfire pilot who had been shot down in a raid over Germany. This alter ego was imposed on the participant in her hypnotic trance in a way that prohibited and impeded her from making her own exploration, and the resulting dissociation proved confusing and uncomfortable for her and caused her some breathing difficulties. After awaking the participant took some little time to re-associate and even next day was still a little shocked at what had happened. She was happy and eager however to continue in the project, and the researcher felt competent about managing this.

The concept of an alter ego, what Cicero referred to as “a second self, a trusted friend”, was first postulated by Weiner & Freedheim (2003), based on the work of Pederson (1994) on the decameral mind, which posits that such an inner persona might be a normal part of how we all function. The nature of hypnosis and the correlation between dissociative ability and high hypnotisability makes the discovering of such temporary, sociocognitively induced, dissociative events likely (Lynn *et al* 2012; Terhune & Cardeña, 2015), and for this reason hypnosis is regarded by many as a valid means of therapy where such is needed (Kluft, 2012e). It is unclear however whether in this case hypnotic dissociation was triggered by the participant’s current intense obsessional interest in aeroplanes and flying, or whether this latter interest was part of an overall and ongoing non-hypnotic dissociative state, a form of waking hypnosis perhaps indicative of a subconscious processing of the past induced by her hypnotherapy (Capafons, 2004a, 2004b; Alarcón & Capafons, 2006; Wark, 2011, 2015; Crabtree, 2012).

Despite this interruption the unconscious processing of past history around weight and eating appeared to be continuing so that when presenting for her next and sixth hypnosis

session the participant was bubbling over with memories, recollections and connections between her current eating behaviour and her childhood experiences of food and eating relationships, all of which were highly consistent with her current feelings about food and weight- “I think food has been an issue right back early life”. In quite a short time she had gained great insight into the nature of the relationship she has been having with food –and also felt that putting on weight was a way of protecting herself - “It’s safety. I don't want to be attractive to anybody. Being fat is OK when you’re a bit older because it’s, motherly, not sexually attractive”, a good example of the use of obesity as a defence (Faden *et al*, 2012).

The participant’s male persona or alter ego continued to make its presence felt in the session six visualisation of the “Sailing Yacht” on the beach and in the disposing of problems, with the participant feeling herself to be under pressure and to be battling against J’s presence – “It was more about him than me”. Nevertheless she was able to complete this session and picture the vessel setting sail, a yacht which she noticed bore the name “Sharpie”. Knowing this word only as the name of a brand of marking pens, the participant was very surprise to learn that this was also the name of a type of fishing boat used on the west coast of America and also mentioned in a piece of poetry by John Betjeman. The participant’s emotional state and emotional dreaming continued in the interim between this and the next session, with anxiety dreams, and waking and dreaming sensations of being trapped and under the control of others, which would seem to refer to her father and her brother, who both appeared in the participant’s first session. At the same time the participant was pleased to report continuing improvements in her food management and eating.

The following session was the “Reframing” of a new subconscious weight and eating control mechanism (Yapko, 1995; Brann *et al,* 2012), which was successfully completed despite the participant’s feeling of there being an internal struggle, and at the end of her session she recognised a reassuring signal from her subconscious mind – “I got a star, a multi-coloured star”. Post-hypnotically she was able to recognise that this inner persona, her

male alter ego, might be an expression of her inner anger and that this inner emotion was being expressed in her conscious, everyday life, as an angry, strong and heavyweight male. Reassuringly when reporting back after a longer than usual Christmas gap in her hypnotherapy, the participant presented as a very different person, more calm and self-assured, stating that her obsessional activities regarding World Wars and flying had almost totally abated. Additionally she had had further insights into the impact of food constraints in her childhood on her current eating behaviour, also how much the sensual nature of eating was a compensation for the absence of family and sexual relationships, and that eating had become an emotional energy replenishment for her to enable her to cope with other people's problems and pressures. In keeping with this behavioural watershed the ensuing eighth hypnosis session proceeded very differently from the previous three sessions. There was no interference from a male persona nor was she a boy in her visualisations, the participant was able to see herself as a very feminine girl – "I was a girl, I had a pink dress on and it was quite floaty, this pink fluffy dress and I was dancing about". She was able to successfully fill up her large, heart-shaped glass, problem disposal bottle, with all the problems she had been trying to let go of, bad behavioural and lifestyle patterns, health problems etc, and then, even before I told her to (she said with glee) she kicked this bottle powerfully into the stream and away it went.

Arriving for session nine, the participant reported further behavioural changes resulting from and reflecting subconscious changes after session eight (Taylor, 2012), including having gone on a silent retreat, reverting to vegetarianism, reorganising and rationalising her CD and DVD collections, making contacts to do some conservational volunteer work, and coming off several addictive prescription medications. She had continued to have a lot of sexual dreams - "it's almost like something's changing, like the lotus flower's just opening up a little bit." - presumably as part of reclaiming her fertility as Adler (1936), Jung (1961), Freud (1991) Cohen (1979) and Pick & Roper (2004) would all see it. A further change was that she no longer felt the need to hoard food as a protection against future food shortage

– a previous reflection of the “thrifty gene” phenomenon? (Neel, 1962; Stöger, 2008; Speakman, 2008; Carpentier, 2015).

Discussions prior to session ten hypnosis elicited the fact that a “lot of emotional stuff that was going on for years seems to be resolving” and that “relationships with family seem to be coming into a good space”. The participant’s friends have begun to comment on how she has changed back to her old self, and she says she never even thinks about wars and flying now. The final hypnosis session was a healing and rejuvenating session set in a forest glade, with sunbeams and a cleansing summer rain shower. Here she was joined briefly by the airman who said goodbye to her after which other airmen arrived to say goodbye also. On returning to her steps up from her beach she found these previously bleak steps now ornamented with a gold bannister and all bejewelled and at the top step just before she opened her eyes there was a fly-past of fighter planes with the pilots all waving and calling goodbye to her. It would seem that she now no longer has any need for this inner persona and it (he) can be let go of, as she now has all the insight and the tools to grow and move forward in her life as she chooses.

The appearance of apparently another persona within this participant is an unusual occurrence which is variously explained or accounted for by the individual having lived a previous life on earth or by the introduction of false memories, deliberately or inadvertently, by the hypnotherapist. Discussion about “previous life” events is not appropriate to this thesis but the risk of false memories being implanted needs to be considered. As Pyun (2015) and others have reported it is possible to convince a person in hypnosis that he or she has lived before or has multiple personalities, but this requires a complicated and determined effort on the part of the hypnotist as Pyun (2015) has indicated, and this certainly was not the case in this situation, with the appearance of the “airman” coming as a total surprise to both the participant and the researcher.

CASE STUDY FOR PARTICIPANT - RC / 09

This participant has a long history of being overweight since her late teens and she has had a constant struggle to maintain her BMI below 28. 2015 has been a particularly difficult year for her having suffered from major abdominal pain which only very recently has been diagnosed with endometriosis for which had surgical endometrial ablation a few months ago. Additionally, her father who was physically and emotionally abusive to her throughout her childhood, from which her mother seemed unable to protect her, died during the year from dementia. She also suffers from reactive hypoglycaemia which she says she is able to manage successfully.

At the time of her approach to the project she was 44 years old in a stable relationship with two older children from a previous marriage and a young son by her present partner. Her GAD-7 score was 6/15 indicating mild to moderate anxiety, her PHQ-9 score was 7/27 consistent with mild depression, she was a moderately emotional eater scoring 15/27 on the Garaulet scale and her Spanos Attitude to Hypnosis score of 63/98 indicated good positivity regarding hypnosis. She had had one previous brief encounter with hypnosis for anxiety which she said was not especially useful.

The participant responded well to hypnosis, as the coding analysis demonstrated, with 27 positive codings for “Depth of Hypnosis” and 16 codings for “Content of Sessions” over her ten hypnosis sessions. Within these sessions she consistently achieved a good depth of hypnosis often exhibiting the spontaneous post-hypnotic amnesia associated with a deep trance state. The participant was pleasantly surprised at how quickly, easily and deeply she was able to relax and drift off into an hypnotic trance, even during her first session, (“I do feel, really, really, really, really, relaxed and positive”), and of her lack of awareness of elapsed time whilst in hypnosis:

> "[A]t first I thought, oh, it's not going to work, so I was willing myself to just listen to your voice and the music, and then I was in the place where there was a bottle [this would be about 15 minutes into the session]. And I just kept on … it was weird … it was odd … It was like floating … couldn't see the bottle, but I knew there was a bottle there. And it was like I was floating a little bit, and then I just sank into this, like a sleep. But I could still hear what you were saying."[Session 1]
>
> [Researcher-*how long have you had your eyes closed?*] "I don't know, about 20 minutes?" [R- *It was 35 minutes*] "My gosh!" [Session 1]

The participant was able to identify successfully her bottle (problem disposal container) and to use this to let go of problems and anxieties associated with any weight and body image problems:

> [Researcher-*Can you remember anything you put into the bottle?*] "I was putting [in] negative thoughts, bad things, in the bottle. I was just trying to let go of anything negative. There wasn't just one thing, it was just a lot of things, just sort'a letting everything go. Dad died last year and obviously there's a lot of anger, he was a very nasty man." [Session 1]

During discussions prior to her second session the participant reported that since her first session she had been having spontaneous regressive thoughts and memories, as well as an unusual (for her) dream, and felt also that she had become more motivated towards weight loss:

> "When I was a lot younger, [early teens] I was very, very, very slim. I had these massive boobs. And I absolutely hated anybody looking at me figure, 'cause I felt like they were, it was vulgar. Then I remember thinking, 'cause me sister was quite fat, "I bet she doesn't worry about things like that." I think that's why I sorta let myself go. … I used to cover meself up with jumpers because I didn't want no-one to look at me." [Pre-session 2]

> "I dreamt about, which I've never dreamt about before, I dreamt about diamond bracelets and diamond rings. And I've never had them sort of materialistic dreams. … it was just weird, it was like a real, proper … in the jewellery shop, pick what you want, sort of moment. And I've never experienced that so maybe it's something that I want." [Pre-session 2]

> "I feel a lot happier, because I'm sort'a doing something about it … I feel a little bit healthier in myself, and I feel a little bit more in control. Rather than just going for the biscuits I'm saying no … and I'm eating fruit and stuff. I don't feel as hungry, which is a good thing." [Pre-session 2]

This participant's second hypnosis session was equally deep and to her surprise took her back to two episodes in her life, which appeared to have connections with her present weight problems. As with her first session, on arriving in her safe place (beach), she initially experienced feelings of being "relaxed, warm, really, really relaxed, comfortably relaxed" but when asked to identify current problems to put into her "vessel" for disposal, her feelings changed:

> "I … seemed to be somewhere with people and it did not feel comfortable … not afraid, not scared, just unsettling somehow. I'm not sure what that was about. It was a mix of places and things, like a collage you know. But to do with the past" [Session 2]

Her first regressive recall in this session took her back to her traumatic childhood experiences of her father and suggested some very early motivational reasons for a subconscious drive towards increased weight:

> "When we were little me dad, the one who died last year … he used to beat us [pause] and mum never stopped him. That upsets me. It makes me angry even now." [Session 2]

> "When I was in hypnosis just before, I was remembering how I was just a, just a … skinny little thing as a child, and I wanted to be bigger and stronger so I, I, [pause] …

could do something about being beaten by me dad. I've not thought about that for a long time, put it behind me, I suppose." [Session 2]

From this she was surprised to find her thoughts going back to her ex-husband, the father of her two grown up children, from whom she has been divorced for 20 years and about whom she very rarely thinks. She remembered having these same thoughts and feelings about being bigger and stronger, in order to deal with *his* bullying and abuse:

"I went back a bit to my ex on my beach … He was seven years older than me, but I went off with him … when I was 18 just to get away from my father. But he was also a bully and, you know. He was very possessive, and we had rows about this and I used to wish, to wish I was, well, bigger … bigger and stronger - to get back at him."[Session 2]

"It's funny isn't it how memories just seem to, to just pop into your head … I must have done more visiting than I thought, when I was, asleep on my beach [laughs]" [Session 2]

It is perhaps not too surprising that this very slim and slight young woman who was bullied by her much larger father through her childhood and then again by her male partner through her teens, ending up as a single unsupported mother, should have developed an inner emotional (if illogical) drive to have a larger, heavier and more powerful body to help her to cope with her life. The apparent validity of these revelations, and their subsequent unconscious processing, was evident from the increased amount of unfocussed dreaming about the past that the participant noted over the following two weeks, and the uncharacteristic emotional outbursts she experienced:

"I had a dream which is quite weird and it was all like … was about swimming. I was swimming with this girl I used to go to school with, then I had one about a locker, something in this locker, and I was dreaming about a caravan, I don't know why that

was. Then I dreamt that I was by a stream, and there was all these pieces of paper and I was trying to get them." [Pre-Session 3]

"I've been dead emotional because of all that. So that's … I was really angry yesterday as well. You see I don't, I have, you know, you're supposed to contain your anger and all." [Pre-Session 3]

The subsequent hypnosis session was also indicative of the participant working around a negative and frightening part of her past when she found it impossible to move forward onto her beach and into her safe place:

"That was very strange. I felt very, very relaxed … as I started to walked down my steps. But then it started to change … I started to feel anxious, and you know, like … frightened. I don't know what was making me feel …really, really … I don't think, don't remember the beach. It was all black and smoky at the bottom of the steps. Just er blackness. I, I couldn't see anything just black smoke. Strange! That's all I could see." [Session 3]

[Researcher - *how old do you think you would have been if you had walked down through that smoke to the other side?*] "Very young, [pause] I don't know, donnow why I said that … I, I think it's just association, you know, being frightened with being young, it's just you know..." [R- *How do you feel now?*] "OK, a little shaky, but OK. I wish I could remember more**."** [Session 3]

The focus of these early sessions was to identify what there might be within the unconscious agenda that might be adversely affecting this participant's weight and eating management mechanisms, and having recognised this, to remedy these. Two areas of concern appeared to have been highlighted by these sessions. Firstly, the need for this participant, as a young girl, to draw attention away from her large bust by putting on weight elsewhere around her body and making herself generally less of a sexual figure to others, especially males. Secondly, and probably more important and longstanding, was her need to be more

physically powerful and potent when in abusive relationships with others, especially other males. These protective devices were set up by the subconscious in the past to deal with past problems, but they are no longer valid or appropriate in the participant's present, hence the decision to install these needed to be reviewed and updated.

For this purpose hypnosis session 4 was the "Walking Backwards Down a Country Lane" visualisation. This is a metaphor for recognising the overly important and often inappropriately negative impact that past experiences and traumas can continue to have on present day events and living, and for making a decision to stop focussing so much on the past and letting this past remain as the sole determinant for present and future behaviour - and instead to turn around and to become more forward looking. As an additional benefit this visualisation was followed in succession by the ego-enhancement visualisation of a country garden and seeking support from others:

> "I was walking backwards, and then I can't remember nothing then. I literally must have fell into some sort of deep, deep sleep. So I don't know. I can remember you saying I was walking backwards. I realised I'd been walking backwards, that's why I was tripping up." [Session 4]

After this quite long session within which the participant went deeply into her trance, she initially said she could remember very little of her country lane or her country garden, and had felt she had gone asleep. However when I prompted her about different parts of this visualisation she began to remember more and more, and realised that she was experiencing post-hypnotic amnesia, a good indication of hypnotic depth, and was not asleep. Presumably as a resulted of this change of subconscious priorities, when she attended for her next, her 5th session, she reported that she had had a powerful dream the night before, a dream in which she dreamt that she had lost two teeth. This was a traumatic dream for her to have as she is very meticulous about her teeth:

> "I had one [a dream] last night that went on for about, I don't know, it went on for a week in the dream, which is obviously seconds. I dreamt that erm … two of me teeth had come out and I was trying to push them back in. Erm, and then erm, it just went on and on and on. And then I woke up thinking, me, me tooth's gone. 'Cause I'm very meticulous about me teeth anyway. So that was like a really odd dream." [Pre-session 5]

Such as dream about an important loss or bereavement is often a subconscious metaphor for letting go of a past aspect of our life, the bereavement of a part of ourselves which we have lived with until then. So it was a highly significant dream and very much in keeping with her previous hypnosis session about turning her back on the past. Session 5 therefore continued with the process of letting the past go, using the "The sailing boat" metaphor which employs a vessel taking her expired worries and problems out to sea for disposal. Again the depth of her hypnotic trance meant that she initially had some amnesia about the details of this and the process was thus predominantly unconscious rather than conscious. With prompting however she realised that she had heard more than she initially thought:

> "I can remember going to the top of me steps [laughs] And I just went into a coma. 'Cause I'm thinking "right I'm gonna to really concentrate now, [laughs] and I'm concentrating. I've no idea what you said, from when I was at the top of the steps, going down…. And the next thing you said about going up a different steps to the present. But I cannot remember that middle bit. So I don't know what you said to me." [Session 5]

After some prompting:

> "There was a, a yacht. Getting ready to leave. And into the yacht … problems. Something, I was dumping them into the sea. And it was going down, and an anchor or something, was it?" [Session 5]

In the interim between this and the next session the participant had a strange and water-related dream which may relate to problems around letting go of aspects of the past:

> "I dreamt I was under water on a roundabout. I was talking to this person. And they were looking, and I said "what are you looking at?" "They said we're looking at a baby piranha fish". So I'm looking at it and I can see this little piranha fish. So I said "I hope it doesn't come round here as they bite". So with that they said "On no. it's coming". So I'm swimming away, and obviously I turned round and there's the piranha, and it bit me. So I sorta woke up in the dream, and I'm looking at me bite mark, and it was a piranha bite, but obviously it wasn't. It was just an odd, odd, dream. It just kept on going on like that, this tiny little fish biting me, and it, I think it bit me behind!" [Pre-session 6]

Echoes of the expression "problems coming back to bite us" perhaps! But despite this she reported that she was feeling the benefits of what was happening in her sessions and had also noticed changes in her eating habits:

> "I've been dead calm. Really, really calm. Everything's settled down now. But I feel dead calm, dead confident. Very happy. Just me happy normal self." [Pre-session 6]

> "I don't know if you've done anything, but I noticed after we had our last session, food didn't taste the same. I was still eating obviously … but I wasn't eating stuff just for the sake of eating it. If it didn't taste nice I just was eating it. And I have sort'a slowed down, and give myself smaller portions." [Pre-session 6]

Following on from the above sessions the next stage was to help this participant to re-acquire lost or forgotten past skills, strengths and qualities which she needed to have for her better forward management of her weight and eating management. In session 6 therefore an anchoring technique in which the skills and strengths and qualities that she intuitively identified were to be anchored to her body and a signal set up to enable these to be brought into rapid use whenever she needed them – rather like a "In an emergency,

break glass" instruction (Gibson & Heap, 1991; Hartland, 1966; Brann *et al*, 2012). Using an ideomotor response of a finger movement (Hartland, 1966, Brann *et al*, 2012), the skills that she chose were "Resistance", "Confidence", "Exercise and fitness", and "Being able to make her son proud of her", and these were quickly found from within her past experience, and each anchored in turn to her wrists. She then chose a special word, a nickname for her son she later told me, which she was to use to initiate these skills as needed, until they had become automatic. This session went well and she was pleased at how promptly her four needs popped into her head without her having to think about this:

> "That was strange as I could hear you talking and me answering you, but I wasn't awake, it was really, really weird." [Session 6]

Interestingly at the end of this session the participant's unconscious mind was asked if it would send to the conscious mind a signal of reassurance about what had just been done, and after awakening the participant reported that she had seen an image of Jennifer Aniston flash into her mind. This women is someone whom she admires as a personal icon as the participant and she have had at times similar figures. This visualisation itself appears to have had an impact on the participant as when questioned prior to her session 7 hypnosis she commented that:

> "I've been quite good on the food thing. I have been really watching … not even watching what I'm eating, I'm just not running to the biscuit jar. So that's been one good thing. I still think about chocolate a lot, but I am mindful of what I'm eating." [Pre-session 7]

> "… if I start eating chocolate it just, I need to eat lots of it. And I need to just … well I haven't, I haven't been eating it. I don't remember the last time I've had a piece of chocolate, honest. I have been mindful. I've not been drinking. Well, I haven't been drinking, not so much wine, just a glass of wine. So I wasn't drinking that much." [Pre-session 7]

In session 7 itself the effectiveness of this anchoring was maximised using a visualisation known as reframing or restructuring in which the unconscious mind is asked to revise the management of an acquired habit by creating an alternative way of managing this habit or lifestyle pattern (Wolberg, 1971; Gibson & Heap, 1991; Hartland, 1966; Brann *et al*, 2012). The progress of this was monitored once again using her ideomotor response which initially was requested by the nodding of her head, but after some resistance to this, the forefinger of her left hand was used instead, and the procedure went after that with no subconsciously indicated reservations.

> "I could hear your voice, and I know that you said something about moving my head at the start. But I couldn't move my head. I felt there was a bit of grappling [sic] going on there. I did think that and when you were suggesting something about a "taking over" [I asked her unconscious mind to take control of her head and nod in response to my questions], I could feel my jaw sorta going rigid, and I felt like I was sort of arguing with something. And I tapped again [with her yes finger] I think, that was to say it didn't want to, but then it did." [Session 7]

On opening her eyes the participant looked emotional and upset, and was still deeply focussed on what she had been revisited during her hypnosis:

> "I wanted to put weight on because I was constantly getting jeered at and people you know shouting at me across the street and stuff. And I hated that, hated anyone recognising that I had the nice little figure with the massive boobs. So, I used to cover meself up with coats and stuff like that … and I think somewhere along the line I thought to me self, well "if I put a bit of weight on it's gonna …And I think that's what it was. 'Cause they were so big, I thought well, the bigger I am, the less big they're gonna be. And then, I think that sort of one of the reasons why I wasn't in control. 'Cause I think I am sort of in control as no-one going to be looking at me now." [Session 7]

Whilst the memories of these times had always stayed with her and she had always been aware of this part of her past, going back to that time in hypnosis to re-experience it and feel it strongly once again, had clearly brought back the full import of how she was felt at the time and how she coped with these past experiences.

Prior to her session 8 the participant reported that she had noticed some changes in her natural eating behaviour which pleased her:

> I've not lost a lot of weight. But my eating's been quite good, I've been quite healthy, erm, I'd say 95% healthy, 5% naughty to be honest. I've gone to 10 stone, just under 10 stone. … I'm relatively good. If I go out for a meal, I won't have a starter." [Pre-session 8]

Session 8 was then to revisit her beach to check that the new weight management part set up in her last session was working well, and to let go of any further barriers to this. She awoke brighter and happier than from her previous session, but she experienced post-hypnosis amnesia for most of the session as is often the case when the unconscious mind is working "behind the scene" to bring about change:

> "I remember going down, to the beach … and then I opened something and I put stuff in. And then [pause] I can't remember. I can't remember what I put in … I remember you talking and then I thought … you'd say something, about the new me … then said about going back up the steps, and then, I can't remember nothing [laughs]. It's weird … I can't remember walking back up the steps. … It was just weird the way, I was, I could hear what you were saying in little bits. And then, that was it. … It was weird, it was like totally relaxed. It's great isn't it?" [Session 8]

Prior to session 9 the participant confirmed that she was continuing to maintain a healthier eating and exercise regime which was encouraging, and which she felt proud of herself for achieving:

> "I've joined the swimming baths again, you know, 'cause I swim a lot. So I've joined there, and I been doing my lengths. So, I've been eating healthily, very healthily. … I'm not drinking wine at all during the week**.** But other than that I've been fairly good. I've not been eating sweets. Sometimes if my blood sugar levels goes low I go for a biscuit, but that's just one of them. But I tend to be eating lots of fruit. Preparing me meals more, I sorta know in my head what I'm going to have, and I do it. I don't think I lost that much weight, but I feel healthier." [Pre-session 9]

She also felt that other things in her life were coming together and inspiring her for the future. She said she felt different about herself, and that things which she had always be wanting to do now seem possible:

> "I'm very happy. You know, I want to move forward. I'm looking at changing my career now, because I don't want to just work in a bank forever. Erm, and I am focussing on looking forward, the Summer, I want to wear nice clothes in the Summer. I think more than anything it's more health to me. I want to be more healthy. I want to be fit, which obviously I want to exercise and all that. I just wann'er, I am looking forward to life, I am. Really, I'm looking forward to the new challenges that I'm gonn'a get as well. So I am forward thinking. And I am trying to be … well I am calmer." [Session 9]

> "So I need to get a career that I can go to a different country with. I just want to do something for myself, 'cause I've always done something for me children. And I put obstacles up in front of myself. I had a problem you know, with school. 'Because I had to work and do me mum's jobs when she was sick and that. And now I'm thinking, you know, I am quite clever, in my mind now, I do want to get a good job and earn more money. I wann'a lose weight because I've got this body for another 40 years and I want it to be a healthy body." [Session 9]

Session 9 hypnosis was for the participant to go down to safe place beach, where she was reminded of her previous anchored strengths and thanked the new installed weight management part. She then looked ahead to any future tasks or plans or events related to weight management which she needed to deal with and picture doing these in an appropriately adept manner. Then to go down to water's edge to find bottle to dispose of any remaining obstacles, barriers and problems after which to return to awake by climbing up her new steps to her new future:

> "I can remember meeting me, myself when I was a child. I left her on the beach. And I went up … the stairs had gone with the wind [laughs long time]. I can remember that. Erm … putting stuff in the bottle, and sending that off to the sea. And being, just, you know, what I was saying before myself, about starting afresh. You know, new goals and stuff, confidence to do it. Yes it was good (brightly)." [Session 9]

Clearly this participant is dealing with her problems and letting them go. This process is evident in her hypnosis sessions, as well as in her everyday behaviour:

> "But I am calmer. Even me mum says I'm calmer. I think I've let a lorr'a stuff go. An awful lot of stuff go. It was just like carrying suitcases of crap around." [Session 9]

And in her dreaming:

> "And then last night, I was dreaming, and it was a really real dream. I was on the beach as well, funnily enough, and I was walking on the beach. In the dream, it was real, it was like, I was there." [Session 9]

Prior to Session 10 she had nothing significant to report, but more acutely she had been suffering with severe food poisoning since her previous session, after having a meal out. Her hypnosis session planned as the final one was to go from her beach into a woods to a little sunlight glade by a lily pond. Here she sat on a bench and begin to heal body and mind with the aid of a summer rain storm and a sunbeam, as she planned and prepared for the future, which she found very restful:

"Ah, it was lovely that. I went into like a deep thing again … then I was on a bench, on a bench, and I can remember being on a bench, and I must have been like really deep in something then. Yes, it's nice." [Session 10]

Although she had little detailed memory of her being in the glade and of the rain, she did remember very strongly and happily experiencing three spontaneous and, for her, very powerful sensations, whilst in hypnosis. These related to her seeing a light switch and turning it on; to her reverting to an earlier session in which certain important strengths were "anchored" to her wrists; and to a "theatrical" gesture which she often makes when she feels happy and good and proud about herself. None of images these had been suggested or intended by me so they were clearly subconscious signals, but I was aware as I watched that she was moving her hands around at one stage, and at another stage moving her arms and her head:

"This light switch, I don't know if it was what you were talking about. [*Researcher - a light switch was never mentioned in this visualisation*] But there was like, I kept on seeing like a light switch, like an old fashioned light switch – up and down. And I put it on for some reason. I didn't touch it, it just went on, you know the on off. It was off and now it's gone on." [*Researcher –" I didn't mention a light switch"*]. "Did you not? 'Cause it was off! And I switched it on." [*Researcher – "That's your mind saying "right, we're on""*] "Oh is it! (in amazement). Wasn't that cool (laughs)." [Session 10]

"Then on the first one where you were doing that thing on my hands there, [*Research - This was anchoring her strengths to her wrists*] my hands were here and for some reason I was trying to grab. 'Cause I could feel my hands." [Session 10]

"And then at one point you must have said something, erm [pause] I donnow what it was … I sort of went like that you know, throw me head back [*Researcher- she demonstrated a movement which she didn't actually completely do in hypnosis*]. I do

that you know, when I'm laughing and stuff. Saying "I am the Princess" and I went like that to throw me head back like "I am the Princess". [Session 10]

These three spontaneous and uncalled-for experiences during a single hypnotic session demonstrated how effectively the subconscious mind can "hijack" the plans of the hypnotist, by giving to the conscious mind of the hypnotic subject three images, all differing markedly from those chosen by the hypnotist, but ones which it knew the conscious mind would recognise and take notice of, and appreciate their significance.

It would seem therefore at this stage that all that needed to be done to change inner subconscious motivations and agendas regarding this participants aberrant weight management had been completed. She was now "on" for effective future weight and self-image management.

DISCUSSION

During this participant's series of hypnosis sessions she was able to work through her history from a young child into her adult life, and to use her sessions to explore this journey from her now adult perspective. The participant felt very comfortable with her hypnosis sessions, going very deep right from her first session, and enjoyed the relaxation and release that these sessions usually produced. Although she frequently experienced the spontaneous post-hypnotic amnesia that deep hypnosis often produces, she was also able enjoy her visualisations and to identify problems which were readily deposited in her "bottle" and "vessel" disposal containers during her first two hypnosis sessions.

However by session two she was already regressing back very powerfully to her having suffered a long period of physical abuse from her father which her mother made no effort to prevent, and then her leaving home at a very early age only to find herself in another abusive relationship in her mid-teens, with a very possessive partner. Although she remembered as very young child being happy and of a healthy normal weight, during the times of her

being abused, recalled in sessions two and three, her weight began to increase. In hypnosis session two she re-experienced the pain and fear surrounding both relationships still, and how she used to wish she was heavier and fatter so as to be able to fight back at her abusers. It was around that time unsurprisingly that her weight inexorable began to increase.

She also has a naturally large bosom and this was exaggerated by her having a slim waist and hips. As a result her overly "sexual" figure attracted male attention during her early and mid-teens which she felt was "vulgar", and in hypnosis in session two she recalled and re-experienced how ashamed and upset she used to feel about men and boys constantly staring at her. She also recalled the many fights and rows this male attention triggered with her possessive partner who eventually told their children that she was a prostitute! She was able to recall clearly the day when she decided to try to put on weight in the hope that this would disguise her large breasts as well as making her look less attractive to other men. Eventually she later left her partner when she was 20 years and struggled to support her two children as a single mother despite her estrangement from her family, but this left her with very little time or energy to address what was by then her established weight problem.

This regressions appeared to have triggered a major change in her subconscious mind which came to a climax in session three when she was unable to find her way down her steps to her safe beach place – "I started to feel anxious and frightened. I don't know what was making me feel …don't remember the beach. It was all black and smoky at the bottom of the steps. Just blackness. I couldn't see anything just black smoke." During sessions four to five the participant had post-hypnotic amnesia and this along with her two trauma dreams, of having lost several teeth, and of being attacked by piranha fish, might indicate some subconscious processing which is substantiated by the improvements she had noticed in her mood, her eating and exercise regimes and her general optimism about her future. This culminated in her very positive final session when she realised that the light switch controlling her weight management and future life had been left off, and she had now "switched it on".

This participant's subconsciously evoked ethnography brought to light two elements from her past which would seemingly be capable of instigating a psychological basis for her adult refractory obesity. The first of these was the physical abuse and bullying that she experienced from both her father and her first male partner during her early to late teens. Such abuse has well documented as being aetiological in eating disorders and body image issues, leading to either anorexia or to overweight and obesity (Sanftner et al, 2009; Sack et al, 2010; Steinig et al, 2012; Danese & Tan, 2014; Hemmingsson, 2014; Salwen et al, 2014 Lejonclou et al, 2014; Racine & Wildes, 2015; Russell *et al*, 2016). The second emotional trigger for this participant was that during her early teens she had incurred a high degree of sexual harassment because of her noticeably large breasts which she recalled in hypnotic regression as being very distressing and embarrassing, and recalled thinking about whether putting on weight would offset this unwanted sexual attention. Such sexual harassment has been reported as engendering weight problems, both consciously and unconsciously, and amongst females especially (Buchanan, 2013; Petersen & Hyde, 2013; Groff Stephens & Wilke, 2016).

The fact that these episodes and the associated decision making regarding them, were all in the past, and that the participant had grown up and moved on in her life since then, did not mean that they were over and done with. This was apparent from the ease with which these events and memories from the past repeatedly appeared in her regression visualisations, and the strength of feeling that accompanied these subconscious revelations. This was most evident in her attempt at regression back to her teens in hypnosis session three, where the participant was unable to enter her "safe place" because she felt "anxious and frightened". Even 30 years after her father's abuse she was still only able to approach that part of her past with great trepidation. However over the succeeding series of hypnosis sessions she became increasingly comfortable about going back to her past in her regressions, and was able to use these to face up to and to let go of the past emotional traumas which seem to be at the root of her overweight problem. As she progressed

through these sessions the participant was aware of a change in her attitude towards food and towards her life in general which were very apparent to herself and to those around her were, and which allowing for the first time to begin to think about a different and more slim and healthy future for herself. As she put it she had found the switch to activate this new life and found that - “it was off! And I switched it on.”

3.2 Extraction of Codes From Participant Interviews

Tables 5. (ii) to 5. (viii) below summarise the total occurrences of coded hypnotic events recorded in each of the seven participant's total set of hypnosis interviews, when applying the coding protocol as discussed in chapter two and reiterated in table 5.1 below.

Table 5. (i) Coding Categories

CODINGS RELATING TO POST-HYPNOTIC CONVERSATIONS (EXPERIENCES DURING AND IMMEDIATELY AFTER SESSIONS)		
THEME	ASSESSMENT INDEX	CODE
Depth of Hypnosis	Prolonged time to awakening	A1
	Misjudged elapsed time during hypnosis	A2
	Exhibited or reported deep relaxation during hypnosis	A3
	Post-hypnotic amnesia regarding visualisation	A4
	Became very involved in the details of the visualisation	A5
Content of Session	Surprised at unexpected emotions during hypnosis	B1
	Surprised at or surprising content of session	B2
	Appropriate IMR response elicited	B3
	Weight/body image connection identified	*B4*
	Able to identify & deal with specific problems in hypnosis	B5
Emotion on waking	Felt relaxation or relief on awakening	B6
	Felt agitated, anxious or tearful on awakening	B7
Evidence of Regression	Generalised regressive remembering and searching	C1
	Went back to an earlier identifiable age	C2
	Went back to specific remembered event or person	C3
	Went back to specific remembered feeling	C4
	Recalled previously forgotten event, memory or feeling	C5
CODINGS RELATING TO PRE-HYPNOTIC CONVERSATIONS (EXPERIENCES OCCURING BETWEEN SESSIONS)		
THEME	ASSESSMENT INDEX	CODE
Between session Feelings and Behaviour	Unusual, emotional or seemingly significant dream(s)	D1
	Experienced surprising emotional ups and downs	D2
	Higher degree of spontaneous dwelling on the past	D3
	Spontaneous recollection of forgotten memories	D4
	Spontaneous flashbacks to past events/people	D5
	Changes in behaviour or relationships noted	D6
	Weight/body image connection or change identified	*D7*

Table 5. (ii) Participant HP/01 – Three Sessions

THEME	SPECIFIC ASSESSMENT INDEX						
	One	Two	Three	Four	Five	Six	Seven
Depth of Hypnosis	3	3	2	0	0	N/A	N/A
Content of Session	11	6	1	3	4	N/A	N/A
Emotion on Waking	N/A	N/A	N/A	N/A	D/A	3	2
Evidence of Regression	21	18	10	13	6	N/A	N/A
Between Session Events	O	2	O	2	O	0	2

Table 5. (iii) Participant MK/03 – Twelve Sessions

THEME	SPECIFIC ASSESSMENT INDEX						
	One	Two	Three	Four	Five	Six	Seven
Depth of Hypnosis	8	1	9	1	15	N/A	N/A
Content of Session	23	25	1	12	9	N/A	N/A
Emotion on Waking	N/A	N/A	N/A	N/A	D/A	8	6
Evidence of Regression	13	0	11	11	0	N/A	N/A
Between Session Events	8	1	O	0	O	1	2

Table 5. (iv) Participant AL/04 – Sixteen Sessions

THEME	SPECIFIC ASSESSMENT INDEX						
	One	Two	Three	Four	Five	Six	Seven
Depth of Hypnosis	9	4	15	1	12	N/A	N/A
Content of Session	19	17	6	4	11	N/A	N/A
Emotion on Waking	N/A	N/A	N/A	N/A	D/A	4	4
Evidence of Regression	19	21	32	34	24	N/A	N/A
Between Session Events	12	2	11	10	1O	8	7

Table 5. (v) Participant BC/06 – Twenty Sessions

THEME	SPECIFIC ASSESSMENT INDEX						
	One	Two	Three	Four	Five	Six	Seven
Depth of Hypnosis	12	1	26	1	13	N/A	N/A
Content of Session	13	19	7	16	7	N/A	N/A
Emotion on Waking	N/A	N/A	N/A	N/A	D/A	11	6
Evidence of Regression	14	17	19	19	5	N/A	N/A
Between Session Events	6	9	9	4	8	6	8

Table 5. (vi) Participant VS/07 – Fifteen Sessions

THEME	SPECIFIC ASSESSMENT INDEX						
	One	Two	Three	Four	Five	Six	Seven
Depth of Hypnosis	8	4	19	6	3	N/A	N/A
Content of Session	16	9	0	2	3	N/A	N/A
Emotion on Waking	N/A	N/A	N/A	N/A	D/A	8	1
Evidence of Regression	2	5	9	11	1	N/A	N/A
Between Session Events	4	4	0	0	0	19	1

Table 5. (vii) Participant BL/08 – Ten Sessions

THEME	SPECIFIC ASSESSMENT INDEX						
	One	Two	Three	Four	Five	Six	Seven
Depth of Hypnosis	5	0	9	13	8	N/A	N/A
Content of Session	15	26	21	2	5	N/A	N/A
Emotion on Waking	N/A	N/A	N/A	N/A	D/A	6	2
Evidence of Regression	1	4	5	10	1	N/A	N/A
Between Session Events	6	10	7	7	9	15	16

Table 5. (viii) Participant RC/09 – Ten Sessions

THEME	SPECIFIC ASSESSMENT INDEX						
	One	Two	Three	Four	Five	Six	Seven
Depth of Hypnosis	7	1	14	3	2	N/A	N/A
Content of Session	7	5	1	0	3	N/A	N/A
Emotion on Waking	N/A	N/A	N/A	N/A	D/A	5	0
Evidence of Regression	3	2	3	2	4	N/A	N/A
Between Session Events	2	3	3	1	1	5	4

Whilst there are some clear differences between participants in terms of the range and the total number of their responses recorded for these measured indices, the total number of hypnosis sessions undergone by each participant also varied greatly, from three sessions (HP/01) to twenty sessions (BC/06). In this respect these data differ from those obtained from conventional narrative case studies where individual participant's narratives can usually be compared directly and analysed accordingly. In looking at these particular seven sets of participant interviews, differences between their raw data might be accounted for by the number of sessions that they had undertaken, which will alter the nature of the relationship between the participant and the researcher, as hypnotherapy is a progressive situation and the nature of the content will vary as to what stage the participant is in, in terms of their subconscious regressive journey. Even a single recalled episode could very well influence the next three or four sessions therefore. To try to make some allowance for this and to give a better indication of the relative activities and responses of the participants during their series of hypnosis sessions and between sessions, the data from the above tables have been combined into the composite table 5. (ix), shown below.

Table 5. (ix) Comparative Frequencies of Coded Events per *Ten* Sessions

Hypnosis Coded Indices	Participant Reference Code						
	HP/01	MK/03	AL/04	BC/06	VS/07	BL/08	RC/09
A1	10	6.7	5.6	6.0	5.3	5.0	7.0
A2	10	1.0	2.5	0.5	2.7	0.0	1.0
A3	6.6	7.5	9.4	13	13	9.0	14
A4	0.0	1.0	0.6	0.5	4.0	13	3.0
A5	0.0	12	7.5	6.5	2.0	8.0	2.0
Total =	**26.6**	**28.2**	**25.6**	**26.5**	**27.0**	**35.0**	**27.0**
B1	37	19	12	6.5	11	15	7.0
B2	20	21	11	9.5	6.0	26	5.0
B3	3.3	0.8	3.7	3.5	0.0	21	1.0
B4	10	10	2.5	8.0	1.3	2.0	0.0
B5	13	7.5	6.9	3.5	2.0	5.0	3.0
B6	10	6.7	2.5	5.5	5.3	6.0	5.0
B7	6.7	5.0	2.5	3.0	0.7	2.0	0.0
Total =	**100**	**70**	**41.1**	**39.5**	**26.3**	**76**	**21**
C1	70	11	12	7.0	1.3	1.0	3.0
C2	60	0.0	13	8.5	3.3	4.0	2.0
C3	33	9.2	20	9.5	6.0	5.0	3.0
C4	43	9.2	21	9.5	7.3	10	2.0
C5	20	0.0	15	2.5	0.7	1.0	4.0
Total =	**226**	**29.4**	**81**	**37**	**18.6**	**21**	**14**
D1	0.0	6.7	7.5	3.0	2.7	6.0	2.0
D2	6.7	1.0	1.2	4.5	2.7	10	3.0
D3	0.0	0.0	6.9	4.5	0.0	7.0	3.0
D4	6.7	0.0	6.3	2.0	0.0	7.0	1.0
D5	0.0	0.0	6.3	4.0	0.0	9.0	1.0
D6	0.0	0.8	5.0	3.0	13	15	5.0
D7	6.7	1.7	4.4	4.0	0.7	16	4.0
Total =	**20.1**	**9.4**	**37.6**	**25**	**19.1**	**60**	**19**

In this table, for comparability, the frequencies of coded events for each participant have been expressed as a ratio of the number of events per ten hypnosis sessions. Looking at the data in this way the results are interesting. Despite the learning curve which would have been expected during a series of hypnosis sessions, one in which the depth of hypnosis gradually increased from session to session as the participant became more comfortable with the process and with the hypnotist, the overall depth of hypnosis (theme A1-A5) was remarkably comparable between the participant who had just three sessions (HP/01) and those who had 10, 16, and 20 sessions. Only participant BL/08 differed from the others in exhibiting greater hypnosis depth along with a greater evidence of between session changes (theme D1-D7), this being the participant who in addition experienced a major episode of prolonged disassociation. This table also demonstrates that participant HP/01 was able to exhibit more visualised content per hypnosis session (theme B1-B7) and more hypnotic regression (theme C1-C5) despite her only attending for her first three sessions. Participant AL/04 experienced more regression per session than other participants except for HP/01, whilst despite having a depth of hypnosis measure comparable to the other participants, RC/09 had a reduced amount of hypnosis content and regression.

Whilst care needs to be taken when comparing three sessions of hypnosis with sixteen or more sessions, these data appears to provide some evidence to suggest that the simple coding approach devised for this project was capable of detecting similarities and differences between individual participants in how their unconscious mind utilised hypnosis, suggesting that hypnosis may be able to reveal differences between individuals that might not be evident from the examination and analysis of standard interviewing or counselling data. Such differences may be due to the nature of the recalled material which constitutes their expressed narrative; they may arise from innate differences between the participants themselves, their psychological and emotional nature and how this interacts with the hypnotic process; or they may reflect how and where these participants are in their present lives. An important question however is whether the nature of the, as yet still poorly

understood, hypnotic phenomenon, influenced not only the way these participants narratives were revealed, but also the content and the subtle nuances of their storyline, and if so what would this suggest about how hypnosis works and also about the veracity of hypnotically recalled and recounted memories. Even whilst in hypnosis the unconscious mind continues to maintain control, acting in a selective and filtering manner to let out some but not all narrative detail and at different rates. Further research needs to be done therefore concerning the most appropriate modality for use in the examination and the analysis of the full content of hypnotically evinced material. A more formal narrative analysis of these transcibed autoethnographies, such as is utilised in the analysis of narratives from other areas of sociology, might illuminate the specific emotional characteristics of these seven participants which predisposed them to react adversly and so significantly to the childhood and later, home and social environments. However in the meantime, in order to ascertain whether in this particular coding approach, the overall participant "scores" for the major themes chosen for this analysis as shown in table 5.(i) are masking any important information about participants' more subtle use of the individual indices, the data from table 5. (ix) have been sorted in terms of the participants' ranked order for the frequency of each index. The symbol "/" indicates a large increment between adjacent participants values and "//" and "///" even larger increments.

Table 5. (x) Participants Ranked in Order of Frequency of Hypnosis Indices

DEPTH OF HYPNOSIS INDICES

A1 - PROLONGED TIME TO AWAKENING

HP RC MK BC AL VS BL

A2 - MIS-JUDGED ELAPSED TIME DURING HYPNOSIS

HP// VS AL MK RC BC BL

A3 - EXHIBITED OR REPORTED DEEP RELAXATION DURING HYPNOSIS

RC BC VS/ AL BL MK HP

A4 - POST-HYPNOTIC AMNESIA REGARDING VISUALISATION

BL// VS RC MK AL BC HP

A5 - BECAME VERY INVOLVED IN THE DETAILS OF THE VISUALISATION

MK/ BL AL BC VS RC HP

CONTENT OF HYPNOSIS SESSIONS INDICES

B1 - SURPRISED AT UNEXPECTED EMOTIONS DURING HYPNOSIS

HP// MK BL AL VS RC BC

B2 - SURPRISED AT OR SURPRISING CONTENT OF SESSION

BL MK HP// AL BC VS RC

B3 - APPROPRIATE IMR RESPONSE ELICITED

BL/// AL BC HP RC MK VS

B4 - WEIGHT/BODY IMAGE CONNECTION IDENTIFIED

HP MK BC// AL BL VS RC

B5 - ABLE TO IDENTIFY & DEAL WITH SPECIFIC PROBLEMS IN HYPNOSIS

HP/ MK AL BL BC RC VS

B6 - FELT RELAXATION OR RELIEF ON AWAKENING

HP MK BL BC VS RC AL

B7 - FELT AGITATED, ANXIOUS OR TEARFUL ON AWAKENING

HP MK/ BC AL BL VS RC

IN SESSION REGRESSION INDICES

C1 GENERALISED REGRESSIVE REMEMBERING AND SEARCHING

HP/// AL MK BC RC VS BL

C2 WENT BACK TO AN EARLIER IDENTIFIABLE AGE

HP/// AL BC BL VS RC MK

C3 WENT BACK TO SPECIFIC REMEMBERED EVENT OR PERSON

HP// AL/ BC MK VS BL RC

C4 WENT BACK TO SPECIFIC REMEMBERED FEELING

HP// AL/ BL BC MK VS RC

C5 RECALLED PREVIOUSLY FORGOTTEN EVENT, MEMORY OR FEELING

HP AL// RC BC BL VS MK

BETWEEN SESSION INDICES

D1 UNUSUAL, EMOTIONAL OR SEEMINGLY SIGNIFICANT DREAM(S)

AL MK BL/ BC VS RC HP

D2 EXPERIENCED SURPRISING EMOTIONAL UPS AND DOWNS

BL HP/ BC RC VS AL MK

D3 HIGHER DEGREE OF SPONTANEOUS DWELLING ON THE PAST

BL AL/ BC RC HP MK VS

D4 SPONTANEOUS RECOLLECTION OF FORGOTTEN MEMORIES

BL HP AL/ BC RC MK VS

D5 SPONTANEOUS FLASHBACKS TO PAST EVENTS/PEOPLE

BL/ AL BC/ RC HP MK VS

D6 CHANGES IN BEHAVIOUR OR RELATIONSHIPS NOTED

BL VS// RC AL BC MK HP

D7 WEIGHT/BODY IMAGE CONNECTION OR CHANGE IDENTIFIED

BL// HP AL BC RC MK BL

Summarised below are the findings when these coded analyses are examined alongside the narrated interview data and the subsequent outcomes for these seven participants:

PARTICIPANT HP/01

Within only three sessions this participant was able to achieve a good depth of hypnosis which was predominantly indicated by her exhibiting a prolonged time to awakening (A1) and her showing marked time distortion (A2). All indices of hypnosis content were increased (B1-B7) as were all regressional indices (C1-C5), and despite her having so few sessions there was evidence also of between session changes (D1-7). Sadly she was unable to continue in the project for long enough for these changes to become stronger and permanent.

PARTICIPANT MK/03

Indices of hypnosis depth (A1-A5) and content (B1-B7) and for regression (C1-C5) for the participant were generally all in the mid range for the cohort whilst she was starting to understand how her childhood experiences had influenced her attitude to food and eating. Between session indices for change (D1-D7) were generally low confirming the impact that her bereavements are still having on her ability to move forward in her life, and this was reflected in the increase and nature of her dreaming index (D1).

PARTICIPANT AL/04

In keeping with this participant's hypnotically revealed childhood and adulthood history of low self-image and self-regard underlying her long term weight problem, her hypnosis sessions showed a high content of regression indices with her other measures of hypnosis depth and content being within the norm for the group. Although her between session indices were average, there was an increase in those reflecting increased dreaming (D1), increased dwelling on the past (D3) and the recall of long forgotten memories (D4). These measures of subconscious processing of the past were compatible with the enlightenment she had achieved about the past emotional barriers she had set up, and with her good feelings about her new present and future as the sessions came to an end.

PARTICIPANT BC/06

This participant maintained a good depth of hypnosis throughout her hypnosis sessions which contained less then average content but a high body weight index (B4). Regression (C1-C5 and D3-D5) was maintained well throughout which was compatible with her exploring her past relationships and child rearing problems and understanding both the past and the current reasons for her weight problem. Between sessions indices for change (D6) were average and reflect her current mix of weight and chronic health problems.

PARTICIPANT VS /07

The more recent history of weight problems that this particpant had experienced was compatible with her average depth of hyposis sessions exhibiting reduced content (B1-B7) and regression (C1-C5). However the benefits that she found from the removal of guilt about her weight increase and the inspiration that she felt from her ego-enhancing visualisations, enabled her to achieve her aim of getting control of her weight and escaping from the abyss of depression into which she had fallen. This is reflected in her having a high indices for dreaming (D1) and for behavioural change (D6).

PARTICIPANT BL/08

This participant was the most unusual of the group and also the one who has made the biggest change in her cirumstances as a result of her hypnosis sessions. As would be expected by her high degree of prolonged dissociation she had unusually deep hypnosis accompanied by frequent episodes of post-hypnotic amnesia (A4), good IMR (B3) and a high facility for visualisation (A5). Her regression (C1-C5) and change (D1-D7) indices were average until the final two sessions when she began to find her life changing greatly and with more dreaming (D1), as she realise the genesis of her weight problem and could deal with this and with other outstanding matters in her life (D6, D7).

PARTICIPANT RC/09

This participant was surprised to realise how her past experiences of abuse and of sexual harassment had left her with a legacy of a high body weight. She fully enjoyed her hypnosis sessions which showed good depth (A1, A3), average regression (C1-C5) and limited content (B1-B7). Towards the end she felt more empowered as a result of her hypnosis and able to make new plans for her life and her family.

Whilst a more detailed and analytical coding approach might enable more information about individual participant's emotional processing of language and metaphors to be obtained, an approach which Smith & Sparkes (2008b, 2009) might refer to as "story analysis" rather than "storyteller", undertaking such an "analogue to digital" conversion of this "messy data" (Law, 2004) would probably lose much of the flavour of participants' hypnotic journey, and might not inform any more efficiently an understanding of the role of hypnosis as a therapy or as an ethnological narrative, nor influence the conclusions from this project.

CHAPTER FOUR - HYPNOSIS AS AUTOETHNOGRAPHY IN QUALITATIVE SOCIOLOGICAL RESEARCH

4.1 Reflection and Reflexivity in the Management of Hypnotically Acquired Autoethnographic Narrative

(i) The Telling of Stories

In socio-linguistic terms “narrative” can infer something as brief as a single paragraph or can be an extended response to an individual question. But more generally a narrative comprises a sequence of related and contingent reminisces and sub-stories linked temporally or dramatically, and delivered in order to inform, influence or entertain the reader, listener or viewer, or to facilitate a release and a relief for the recounter of the narrative (Riessman, 2008; Gubrium & Holstein, 2009; Bold, 2012). Riessman (2008) has reviewed the various properties and functions of the narrative and the stories it may contain or have described within, and lists what she sees as seven particular and overlapping functions of the narrative. These functions I would summarise as being: for a remembrance and *aide-mémoire* of the past; as a means of framing an argument or counter-argument; to justify a position; to persuade or convince; to mislead; as a means of engaging an audience and involving them in the feelings of the recounter; and for social or commercial entertainment. To this list I would add a further three important functions of storytelling, firstly as a very frequently employed tool for informing or educating others, whether directly, or indirectly through the use of metaphors and humour; secondly as an emotional and psychological therapy, and thirdly as a means of constructing one’s identity both to oneself and to others.

These two final functions I see as being particularly important in the context of the present study. Having been a counsellor for many years, increasingly I have come to appreciate

the value to those individuals with emotional or psychological stresses and problems, of their being able to recount their problems as narrative, as a means of helping themselves to understand and process these problems in a more effective way. As has been suggested by others (Fillion *et al,* 2002; Williamson, 2008; Pennebaker, 2012), I feel that the major value of the so-called "talking therapies" especially that of counselling lies in their giving clients permission for the telling of their story, the chance to recount their problems out loud, to hear it being said and to get a better and more objective grasp on this as a result (Williamson, 2008). This "saying it out loud", as a narrative, can be said in a face-to-face discussion with a counsellor or to the hypnotherapist, to an anonymous voice on a telephone helpline, to a pet dog or cat, or even to an inanimate object. There is a famous and very apposite scene in the film *Shirley Valentine* in which the eponymous star played by Pauline Collins, in the absence of anyone else to talk to, finds comfort and clarity, and self-counselling, by talking through her story to her kitchen wall (Shirley Valentine, 1989). The use of hypnosis to discover past subconscious connections which are continuing to influence our present lives, and to give voice to these, could in part therefore be seen as another archetype for the value of "saying it out loud" (Yapko, 1995; Wolberg, 1948; Brann *et al,* 2012).

Thus narrative, spoken, written or performed, would seem to be a universal means of making sense of our world and of understanding the connectedness of our lived experiences, and effective narrative self-analysis is clearly a necessary part of understanding this process. This is never truer than when exploring and examining our own past, whether through counselling, psychotherapy, neurolinguistic programming or hypnotherapy, and irrespective of what perspective on how identities are narratively constructed, is considered as the most apposite (McAdams, 2001; Smith & Sparkes, 2006, 2008a). Lieblich *et al* (1998) have discussed the degree to which such self-proclaimed life histories are highly subjective and may only represent one aspect of the truth as remembered or re-experienced by the narrator. Even within hypnotic remembering there is

always a degree of selectivity on the part of the unconscious mind determining which episodes, feelings or memories emerge, and in what sequence they emerge (Sheehan & McConkey, 1982). Much of clinical hypnosis is focussed on using the hypnotic trance state to help the individual to derive a knowledge and an analysis of the inner subconscious basis for their emotional or psychological dilemmas, with a view to engendering healing and recovery, and this will usually entail the finding and the telling of their story.

As inherent story tellers we reveal ourselves to ourselves and to others by the stories we tell, and in turn, we are and we become those stories (Lieblich *et al,* 1998; Smith, 2007; Smith & Sparkes, 2008; Edgell *et al*, 2016; Bamberg & Demuth, 2016), what Sparkes (1999) refers to as "storied bodies and storied selves" (Sparkes, 1999 p.26). The concept of an internal (morphological) structuring and embodiment of one's life story has become somewhat of a *lietmotive* for many narrative-minded sociologists, without their necessarily examining the full implications of what this entails and implies (Smith, 2007). We are very tactile beings and the touch of pleasure, pain or fear, by penetrating far beyond the carapace of our epidermal senses, can very powerfully influence prior memories or implant new ones, and teach our body seemingly (in) appropriate rules for life. In this study particularly, the physical-ness of a participant's life experiences will likely form a very powerful component of their earlier and their present life. Having perhaps lived for a greater part of this life as a fat person, their whole tactile knowledge, when showering, when walking, climbing stairs, sitting or lying down then standing erect again, when being cuddled by a partner or a child, will have been that of a bulky person. Whatever memories and thoughts they consciously have about their past experiences, will therefore be viewed very much through the veil of such tactile experience, and modulate their life narrative, as perceived both internally and externally, subjectively and objectively. Letting this history go will always be problematic.

Fortunately the dissociative state that hypnosis can induce, not only allows for the "remembering" of past tactile and other experiences but also the "re-feeling" of these, whether for good or bad – and when doing this in hypnosis the "presently knowledgeable"

adult can help the younger person to “re-learn” the meaning of such tactile experience. During the process of inducing hypnotic regression I used the various senses to facilitate recall and return to past experience, by moving the hypnotic subject from conscious “imagining” through to subconscious “re-feeling” and “re-experiencing”. This is a process where the sense of touch is most useful, where the participant can be encouraged to recall how it felt (feels) to have their hair in plaits or pony tail, how school shoes felt (feel) on their feet etc. So also is the sense of smell, the oldest of our senses and a powerfully emotionally regressive one (Shepherd, 2012), as Proust famously points out in his opus *À la recherche du temps perdu*, in which he recalls vividly how a mouthful of madeleine instantly and spontaneously took him back to his childhood days with his favourite aunt (Proust, 2014).

(ii) Hypnosis as Story Telling

In exploring the putative role of childhood and early adult life experiences and traumas in the aetiology of adult overweight and obesity, this project has generated a number of narratives the analysis of which occupied much thought and energies on the part of the researcher, not least because the range of analytical approaches available to researchers in narrative studies is probably as wide as the range and complexity of the narratives themselves being analysed. Most importantly in this project, decisions needed to be made as to which of the above functions of the narrative might be active in the vocal and emotional out-pourings of the participants, how much was genuinely accurate remembering and information, versus how much was conscious or unconscious justification and persuasion, and a need perhaps to engage the researcher’s attention, impress or entertain him.

Importantly, the production of a narrative or story is not an automatic process, with the complete story ready prepared and simply waiting in the wings to be told. Virtually all stories need to be activated, if not by the listener’s (researcher’s) questioning, then by the teller’s need to tell their story (Gubrium & Holstein, 2009). This is never more true than when these

stories have been lying in the unconscious mind for many years and are *apparently* evoked, "on demand", during a hypnosis session. As was demonstrated in most of these participants' hypnosis sessions and in the case histories compiled from them, the unconscious mind maintained overall control of each participant's hypnotherapy throughout their time in the project. Hypnotic disclosure of individual sub-stories and the overall narrative temporal storyline was thus determined by unconscious priorities, such that different sub-stories came and went and different emotions ebbed and flowed. At times sessions could be both subjectively and objectively very deep, at other times very shallow, and in many sessions the content was powerfully different from that which the researcher and the participant each expected and intended. The unconscious mind was clearly in charge and this was often reaffirmed by the associated emotional experience of the participant and their subsequent dream content.

There has been very little published literature reporting the detailed examination and analysis of an on-going series of hypnosis sessions such as was being attempted in this project. Almost exclusively textbooks and scholarly publications on hypnosis as a therapy, have in mind a pre-determined and wished for endpoint, and therefore focus on the delivery of hypnosis, detailing techniques and visualisations to be employed in various conditions and circumstances, rather than on the process of narrative evolution (Hartland, 1966, 1971; Sheehan & McConkey, 1982; Brann *et al* 2012); and with only occasional reporting of some sample generic responses from the hypnotised person. Similarly there are many hundreds of quantitative hypnosis research papers which are concerned only with the percentage success rate of hypnosis in various health and associated conditions, and which usually give only very sketchy descriptions of the hypnosis approach utilised (Lynn & Kirsch, 2006; Barabasz *et al*, 2011; Heap, 2012; Brann *et al*, 2012; Nash & Barnier, 20082; Hilgard & Hilgard, 2013; Lynn *et al*, 2014; Yapko, 2015). Exceptionally perhaps is the classic text by Wolberg (1948) in which he quotes verbatim three hypnosis case studies, but at the

expense of each study extending to 100 plus pages, and with little analysis of the text, merely allowing the words of the individuals in hypnosis to speak for themselves.

This is because as a therapy the predominant value of exploratory regressive hypnosis (especially) as with counselling (to a lesser extent) is seen to lie in the subjective "feel" of the evoked subconscious revelations, and the associated and intuitive belief in what these revelations are saying to them, on the part of the individual hypnotised or counselled client. Thus the new understanding that clinical patients and clients acquire as a result of being in a hypnotherapy situation and which may generate their "eureka" moments, becomes for them part of their new story, the story which they tell themselves and others. As the consequent healing arises predominantly from this self-revelatory insight that their hypnosis sessions facilitate, it usually requires little or no explanation or analysis by the hypnotist. Sub-conscious change, and the curative value of hypnosis, are therefore much less dependent upon the accuracy of the therapist's interpretation of these once revealed (Wolberg, 1948; Gibson & Heap, 1991; Yapko, 1995; Brann *et al*, 2012). In this respect perhaps hypnosis may differ from psychotherapy at least as delineated by Jung (1961) and Freud (1991) for whom the interpretive skills of the therapist appear to play a more major role in the restoration of their client to health and normality. By contrast the efficacy of clinical hypnosis is assessed entirely by its "cure rate", what proportion of clients get better or feel more able to move forward in their lives, rather than by quality of any thematic or structural analysis of the clients' narratives.

(iii) Story Telling as Truth Telling

The major dilemma for the researcher, as both hypnotherapist and sociologist, in this project was in assessing and demonstrating the validity of the realist stories and narratives detailed in the recorded case histories of its seven participants. This raised many problems in view of their complexity and the multi-nested nature of these narratives. At its most basic and

primary level was the need to affirm the validity of the concept that hypnosis was a modality capable of facilitating a true recall of past events and situations. Secondly was the need to answer the research question which triggered this project, whether such past events and emotions, and the connections between them, recalled through hypnosis, shed any light on the role of early life experiences in determining adult weight problems. Whether also they were indeed truly ætiological and had played and were still playing a causative role in the development and maintenance of the participants' overweight problem.

As has been discussed earlier and by many hypnosis researchers, memory recall is selective and not all that is known subconsciously can or will be recalled, and accurately so, simply on demand, and without concomitantly evoking *false* memories (Patihis *et al*, 2014; Mazzoni *et al* 2014). Fernández (2014) has posited that we all have an innate memory distortion which protects us, by reconstructing our past rather than simply preserving it, what Harris *et al* (2014) refers to as an autobiographical memory. Additionally Sheehan (1988) and Spanos *et al* (1999) have demonstrated that the "remembering" in hypnosis of events which had never actually occurred is a frequent occurrence, and Gleaves *et al* (2004), Dalenberg & Paulsen (2010); Wagstaff *et al* (2008, 2011) and Gudjonsson *et al* (2014) all accept that memory recall can generate both genuine and false memories, a mental process that appears to be a highly selective phenomenon (Painter & Kring, 2015). This would seem to be becoming even more apparent in recent years with increasing use of social media on sites such as FaceBook© and Friends Reunited© where the posting by one's peers of photographs and memorabilia of our long forgotten childhood and teenage years emphasises how much of this past we have forgotten or have misremembered.

Such past times and experiences, though forgotten, still may be impacting on our adult life and continuing to cast their invisible and imperceptible shadow on our present and our future (Siegel, 1999; Van der Kolk, 2002; 2012). The interpretation of an emerging narrative, whether evinced within hypnosis or during any type of sociological interview needs therefore to take heed of the social and emotional environment of the recounter at the time of narration,

as this can have a major influence on how the revealed story feels and has meaning. The events and emotions from her childhood and early adult life which each participant in this project had apparently elicited and recalled as a result of the hypnosis technique, could only be told to and viewed by that participant through the lens of her present adult life, with all of the obfuscation brought about by her gender, culture, professional and family roles, lived experience and social media influenced adult history as an obese woman (Striegel-Moore *et al,* 1986; Gubrium & Holstein, 2009; Sparkes & Smith, 2011).

In trying therefore to derive a measure of the validity of the narratives generated in this project, the researcher needed to appreciate that the *true and factual* past childhood history of an individual may be different from their subconsciously *remembered* history, which may in turn be different from the history *revealed* to the conscious mind by the unconscious mind during their recall sessions. This last is an important filtering step as a major role of the unconscious mind is in protecting and guiding the conscious adult mind by hiding, containing and masking painful events and memories from the past and revealing only what the unconscious mind feels the conscious mind needs to know at the time - as is frequently observed with post trauma and post road accident amnesia (Siegel, 1999; Van der Kolk, 2002; 2012; Berntsen & Rubin, 2014; Brown *et al*, 2014; Friedlander & Swash, 2016). A negative consequence of this protective concealment process is that the resulting internal tension often leads to the development of physical illness such as somatisation, conversion conditions and other psychosomatic disorders (Kradin, 2013).

Whatever is apparently brought to light for the participant as a result of any given hypnosis session has then to be *recounted* and *understood* by that individual, and its correspondence with their other sources of knowledge and with other sociological epistemologies determined. The assessing and demonstrating of the true validity of hypnotically evinced subconscious case histories, as portrayed in this project, was therefore always going to be difficult in the face of the above multiplicity of potential smokescreens, cul de sacs, stumbling blocks and impenetrables. No memory of the past can be absolutely complete,

as not all that happens in our lives goes into long term memory, a strange telephone number may be remembered only as long as it takes to dial it, then be forgotten, or misremembered 10 minutes later (Jonides *et al*, 2008). This is the difference between what Siegel (1999) refers to as the "remembered and the remembering self" (p.63). No attempt was made in this project to formally corroborate the events that participants appeared to have recalled, however all that was recalled and recounted by all participants was compatible with their associated conscious memories of times past and their present situation. The memories and recalled events in this project appeared also to be internally compatible and coherent with the emotions that were spontaneously elicited during the session and afterwards, often over a period of several sessions, as well as with participants' dreams between sessions. It was the dramatically new connections with their weight and self-image that they discovered amongst these memories that surprised them and constituted the new learning and future healing.

(iv) Placing the Researcher in the Story

Much has been written around the insider versus outsider dilemma (see Merriam, 2001; Hellawell, 2006; Dwyer & Buckle, 2009; Taylor *et al*, 2015, amongst many others) and the associated topic of the risks and the advantages of participants playing an active role in the planning and undertaking of research projects involving them (Springett & Leavey 1995; Leavey, 2003; Byrne & Ragin, 2009; Jagosh *et al*, 2012; Mayan & Daum, 2016). Because of the intuitively interactive nature of hypnosis it was impossible for the researcher to stand totally outside of the hypnosis participant's therapy and be merely a non-involved observer and recorder. This was the case in this project even though the primary role and function of the researcher, as it always is in regressive and exploratory clinical hypnosis, was to guide each participant through her various visualisations during hypnosis sessions and then to reflect back to her what she subsequently voiced about her session, what she had seen

and how it had affected her. This was an important aspect of any such therapy, encouraging reflection and reflexivity on her part as an aide to furthering her fuller understanding of her experience, whilst taking care always to avoid imposing the researcher's views and opinions on to this experience and her consequential emotions.

There were also other confounding factors which might potentially have impact to varying degrees on how each participant undertook their subconscious search, and in their free recounting of their life story, all of which needed to be taken into consideration (Purdy, 2014). Firstly there was the fact of the participants being in a research project, as opposed to the standard "commercial" therapy context. In this latter the hypnotist has been approached by and is being paid by the client, and the nature of the hypnosis contract is clear, that of a fee for a service. This is probably the usual situation for individuals seeking therapeutic help, and is certainly the case for the researcher in his clinical practice. In a research project such as this where the participant was receiving a great deal of time, attention and help with a major problem in her life, for gratis, it is possible that the *quid pro quo* for this, in the eyes of participant, might be that she feels under pressure to find something "useful" for the researcher and the project. As a counsellor and hypnotherapist with considerable clinical and therapy experience I was aware of this possibility right from the start and endeavoured to ensure that participants did not feel under such pressure and that they understood that even sessions which to them might appear unproductive could still provide useful research material. It was explained at the start of their involvement in the project, that in any series of hypnosis sessions there are occasions when nothing seemed to be happening and a session produces nothing of significance. This may represent a period of consolidation within the unconscious mind before moving on, something that Lutz *et al* (2013) have described in psychotherapy, where the apparent progress of therapy is usually intermittent rather than continuous.

Secondly there was a question about how the participants in this project saw me, both as the researcher and as the therapist, and whether my long experience as a professional

therapist and consultant in hypnosis, made me act, even unintentionally, in an authoritarian and paternalistic manner. Yapko (1995) discusses the importance of the clinical demeanour of the hypnotist and whether this tended towards an authoritarian stance or exhibited a more permissive attitude, and he appears to prefer the latter approach (p73). However there was still a possibility that I was being seen as "the boss" who needed to be impressed, and hence there was a concern on my part about whether this then disempowered the participants in some way as a result, or encouraged the elicitation of what they "thought" I was wanting them to find. Also whether my being a (non-obese) male therapist made it more or less difficult for the participant, as an obese female, possibly with self-image problems as a result, to reveal her personal past history as a young girl and to express her female emotions to me, especially over the long time scale of this project? This is critical as hypnotherapy ideally should, during the time scale of the therapy, engender an intuitive relationship of understanding and trust between hypnotist and hypnotee, as it is this relationship which supports and drives the therapy and is frequently the *raison d'être* for its therapeutic benefits (Haley, 2015; Fischer, 2016).

The intuitive relationship between hypnotist and client referred to above implies the third route whereby the researcher's presence during the hypnosis sessions is likely at times to have influenced the participants during their hypnosis. Over many years of working with hypnotherapy I have gradually come to realise how much I pick up intuitively from my clients and they pick up from me, during their hypnosis sessions. Many times I have spontaneously felt the need to change my visualisation plans mid-stream only for the person once wakened from hypnosis to comment on how appropriate what I had said to them during their hypnosis had felt. This is an unavoidable and unquantifiable consequence of hypnosis, but as with many therapies it is also an intrinsic part of their healing nature (Christensen *et al,* 2009). During the early part of this project as a scientist, I endeavoured to minimise this interaction and tried to carry out the entire project in a scientific and objective manner, treating each session and participant interaction as dispassionately as I was able and maintaining a rigid

protocol of visualisations, in order that every participant received an identical input during the process. But I began to find this very restrictive, being unable to react to the individual needs of each participant and their developing narrative, as clearly this was contrary to how such therapies ultimately work, quite unlike conventional scientific research projects (ibid).

I therefore changed my approach and returned to working more as a therapy orientated researcher, which I found that I could do without changing any of my project protocols and objectives. My past experience of working in clinical practice reminded and reassured me that it was possible to exhibit an appropriate degree of *gravitas* and professionalism whilst still being perceived as a caring and supportive therapist, and that it is the language and the tone of voice used during hypnosis which imbues the sense of reassurance and respect, and which facilitates hypnotic exploration. This is in accord with Diamond (1984) whose contention is that the hypnotherapeutic and healing process is engendered by the support, comfort and skill of the (hypno)therapist, who "becomes a benign yet strong presence to the patient's world of internal experience while somehow facing the patient's demons" [sic] (p 9). The feedback that I received from participants suggested that they felt we had worked together in this project as equals and that my appearance and manner was seen as more beneficial to them than it was inhibitory. Their maintained enthusiasm throughout the project seemed to reaffirm that they always felt in control of their own therapy despite the "being out of control" illusion which is frequently portrayed about hypnosis in the Media and the entertainment industry.

(v) Writing the Story

The final level of narrative nesting, the shaping of the outermost of the Russian dolls, is the influential nature of the researcher in selecting which of the participant's stories and how much of their narrative material to include in the final case study report. Coding and analysing of narrative data of necessity and inevitably implies selection of which data to

focus on and which to leave out from the final draft, but in such a way that the ultimately presented or published document accurately and fully illustrates what has been achieved or discovered, and without any significant omissions. Avoiding bias at this stage, whether deliberate or unconscious, arising perhaps because of a need for the researcher to demonstrate and prove the correctness and accuracy of his or her research premise(s), is critical as this could clearly undermine the validity of any piece of sociological research. Nevertheless the researcher's role in selecting and setting the boundaries of the narrative segments which are finally taken to constitute each participant's ethnography does unavoidably perhaps impose a *post hoc* shaping of this, the end product of the project (Riessman, 2008).

In the analysis of conventionally accrued narrative and its transcribing and transposition into the final ethnological product, epistemology and ontology dictate that what is *not* said and *how it is not* said can be every bit as significant as what is said and how it is said, and as such, all silences, pauses and hesitations may make a contribution towards a sociological understanding of the narrative and should be included therefore in the final analysis. A similar situation appertained in the recording and analysis of the hypnosis sessions accumulated in this project, albeit from a slightly different perspective, as at times nothing seemed to happen in a session, or what happened was very different from that which was planned to happen. Such episodes can be seen as "failed" sessions by participants or clients, and are often referred to as "resistance" by hypnosis practitioners (Wolberg, 1948; Hartland 1971; Heap & Gibson, 1991; Brann *et al,* 2012).

However from my many years of experience of using hypnosis as a therapy, I have become aware that there is a time and a tide in how hypnosis proceeds. The depth of hypnosis and the potency of the resulting visualisations will vary naturally from time to time, according to what the unconscious minds wishes to do in any given session regarding the problem under investigation, or when it is dealing with something else of more immediate importance in the rest of the participant's life. It is part of the control that the unconscious mind maintains

over the process of hypnosis and of how unconscious mechanisms work in everyday life. It is no different to when being unable to remember something important, perhaps a friend's name, despite struggling and using memory tricks, we decide that our mind is clearly too busy to deal with this right now. So we put the matter aside (to the back of our mind?), knowing that when it wishes, our unconscious mind will "pop" the name into our conscious mind later on or the next day. Where "non-typical" hypnosis sessions resulted, this was noted and referred to in the ethnological case studies in this project. But such sessions in which a participant experiences nothing of any importance or only a very shallow hypnotic trance, do not invalidate the importance of the findings in more "dramatic" sessions, on the contrary they serve only to reinforce the impact of subsequent revelations. Their unpredictable nature does however provide further evidence of a subconscious process overseeing the management of hypnosis, and re-affirms that the trance-evoked revelations in hypnosis are not merely inventions or conscious fantasies on the part of participants.

Despite the above epistemological and methodological challenges and problems, it was important that some attempt at formal narrative analysis was undertaken on the realist transcripts generated by these participants. The choice for this lay between a thematic approach which would focus on "what" was said, as opposed to a structural approach where the focus would be on "how" and "why" it was said (the "told" versus the "telling"). The former of these was felt to be more appropriate as thematic analysis retains more of biographical (ethnographical) detail of participants' interviews and avoids the fracturing that structural analysis usually entails. It also allows for longer extracts to be coded and extracted helping to preserve the *telos,* the purpose or goal of this delivered sequence of subconscious messages.

This was the approach taken by Gareth Williams (1984) in a not too dissimilar study of individuals' perception of the causation of their rheumatoid arthritis, where he felt that the biographical detail contained in their told narrative was more important than the semantic and semiotic content. Additionally like the present researcher, Williams was happy to

acknowledge his presence at the interview and analysis stages rather than trying to pretend sociological invisibility. For the present project therefore, situated as it is in a psycho-ethnographic paradigm, a thematic approach appeared to be the most fitting to bring out the essence of what takes place in an hypnotic trance, how an ethnographical picture develops over the course of the hypnosis sessions, and how the content of those sessions can be related to the physical problem under investigation in this project, that of overweight and obesity.

This is perhaps akin to that of Patton's "theory of action" (Patton, 1997) where the analytical approach is guided pragmatically by the researcher's expectations and needs within a project and such needs define the codings which in turn provide linkages between the research question(s), the analysis criteria and the overall conclusions and value of project. John Law has also written at length about the problems of trying to analyse complicated or "messy data" in sociology. In this project it would seem, trying to capture and categorise and code interviews could easily miss the point by being too constraining and influencing, hence limiting the overall result (Law, 2004). There can be difficulties in the effective coding of sighs and tears and the beaming smile of insight, in trying to convert such complex and important data into simple one word codes, and there are risks in reifying existing analytical approaches at the expense of losing the sense of narrative storyline (Smith, 2010; Frankham & Smears, 2012).

Hypnosis is a process not an end product, and the nature of hypnotherapy in this project as in any clinical hypnosis is that data are accrued and the narrative developed in an apparently non-logical order, with dis-connected past events and emotions being revealed over a series of sessions, often with some of the very earliest events in participants lives being recalled last, and with the emotions associated with them appearing before recall of the events. This is not a problem when hypnosis is being done purely as therapy as it is the end result that is of paramount importance, however for the purpose of establishing the credibility of this project the evolving nature of data accruement needed to be demonstrated.

Any analytical approach which resulted in the splitting up and recombining of conversational data because of coding requirements would have lost this sense of movement and of the gradual unfolding which is characteristic of the surreal nature of unconscious processing. An important requirement therefore of coding and of representing participants' experiences and recountings within individual hypnosis sessions, is that this picture of a gradual emergence of the narrative was retained. As a researcher in hypnotherapy my predominant concern was not with the detail of the words, phrases and even images, and in trying to analyse and interpret these. The words and images were all metaphors, were all messages, which only the individual participant's unconscious mind can truly interpret, and it is less important that I understand them than that the participant understands, and feels the enlightenment and the emotional change that they instil. Nevertheless, as with all talking therapies, discussion between participant and researcher had a useful role to play, as reflection on the part of the researcher, by encouraging participant reflexivity, can reduce the chances of either party misguidedly following blind alleys or other misinterpretations.

4.2 Hypnosis as an Ethnographical Modality

Ethnography, from its mid-18th century roots in anthropology (Vermeulen, 2008), has now in its various formats, including performance- and auto-ethnography, become a much employed and respected modality in sociological research (Seale, 2012; Clair, 2012; Hammersley, 2013). Over an almost identical time span, hypnosis has been maturing from its controversial, contentious, even disreputable beginnings as the all-pervading *Fluidum* or "animal magnetism" therapy used by charismatic 18th century German clinician Franz Anton Mesmer to explain his restoration of physical and emotional well-being in his patients (Wyckoff 1975), to become a highly regarded and researched neurological and psychological phenomenon, widely employed in health, education, sports training, dance

and drama (Ewin, 2011; Nash & Wong, 2011; Barabasz *et al,* 2011; Brann *et al*, 2012; Kradin, 2012; Heap, 2012; Yapko, 2015b ; Pekala, 2015).

Neither of these two apparently very disparate modalities had an easy gestation nor a smooth subsequent life history, with each having had its acceptance and credibility frequently challenged, and with both subsequently experiencing periods of internecine squabbling. Hypnosis is a technique which can provide a valid and intensely personal description of an individual's life and of their inner, subconscious and perhaps childhood experiences, and the information so obtained I believe, bears all of the important hallmarks of classical performance autoethnography. This study has attempted to demonstrate how the degree of their convergence and their coincidence of rationale and information accrual, supports the contention that hypnosis has many of the *sine qua non* for consideration as an ethno-sociological methodology. A more detailed examination of the historical roots, subsequent development and current status of ethnography as a sociological tool would seem to support this proposition by highlighting some of the apparent corollaries and parallels between hypnosis and ethnography as these two modalities are currently practiced.

Ethnography (from the Greek ἔθνος *ethnos* "folk, people" and γράφω *grapho* "to write") is generally regarded as deriving from the seminal work of anthropologist Gerhard Müller (1705-1783). His document on *Völker-Beschreibung*, a "description of peoples", produced as a result of the Second Kamchatka Expedition to Siberia during 1733-4, was the first to differentiate between the objective history and geography of populations and their more subjective "manners and customs", that is, between their *habita*t and their *habitus* (Vermeulen, 2008). Over the next 200 years ethnography developed as a sub-speciality of anthropology until the mid-20th century when there was an increasing realisation that ethnography could be transposed from an anthropological tool for the exploration of foreign climes and past times, to become a scholarly discipline which could be utilised to study socio-cultural phenomena nearer home. This move arose in part as a response to the informational needs of the 2nd World War and the subsequent "Cold War" (Cole, 1977) and

as a result of the work of the "Chicago School" of sociologists notably Everett Hughes (1897-1983), an American sociologist who undertook ethnographical studies of employment, occupational working conditions, and professional bodies (Hughes, 1993). Despite this extension of the range of the discipline ethnography as conventionally undertaken by both anthropologists and sociologists continued to consist of obligatory periods of qualitative research fieldwork designed to provide in-depth descriptions of real life, everyday situations (Geertz, 1973).

Nevertheless sociologists were gradually attempting to delineate the boundaries and to derive a definition of a research modality whose most significant attribute appeared to be a rejection of other more established positivist and quantitative sociological research methodologies. Current definitions of ethnography are various and elusive, describing a modality which includes elements of life history, field work, collecting of unstructured data, performance, film, interpretation, and most importantly observation both participant and non-participant, all approached from a predominantly grounded research, interpretive perspective. Observation whilst not in itself defining or being synonymous with ethnography certainly remained a prerequisite for the ethnographic approach (Atkinson and Hammersley, 1994). In contrast therefore to the original anthropological perception and application of ethnography, what Brewer (2000) refers to as "little ethnography", increasingly sociologists began to see ethnography as being any sociological research approach that did not use surveys or questionnaires as the method of data collection, in Brewer's terminology "big ethnography" (ibid). Consequently, within this wide remit and when being employed as a means of understanding contextual behaviour through the deriving of a personal narrative, hypnosis appears eminently suitable to qualify as "big ethnography" and as a methodology with a clearly ethnographic perspective.

Conventionally the term ethnography has come to refer both to the approach or method employed (the "process") as well as to the final interpreted conclusion and academic outcome (the "product"), which latter also has come to be referred to as the ethnography

(Hoey, 2014). This is appropriate as the final write up of field notes at the end of any ethnological interaction produces a particular and individualistic picture of the subject(s) of the ethnography specific to that piece of research with regard to its timing and approach. This is also very much the case with the hypnosis case study narratives included in this project the content of which would be likely to change and develop further and to feel differently, after further hypnosis sessions. Inevitably such an ethnography when written up can never be simply a perfect and fully reproducible reflection of the research data, as ethnographers are rarely content with mere dispassionate reporting of events, situations and the experiences of others. They are frequently trying also to verify an hypothesis or perhaps derive a theory. With any *reportage*, be it a newspaper article, a medical consultation, a pre-employment interview, a therapeutic hypnosis session or a formal piece of ethnological research, the interviewer or observer can hardly avoid putting their own especial gloss on what was seen, heard, recorded, transcribed and presented as the final conclusion. As a result all *etic* representations of the experiences of another individual, group or culture will differ from each other in some respects as will most *emic* representations, as Hammersley & Atkinson (1983) have discussed. To the degree that hypnosis is a profoundly personal and *emic* exploration aimed at understanding human conduct and culture set against time and relationships, it closely resembles ethnography as an embodied practice, what Conquergood (1991) refers to as an "extremely sensuous way of knowing" which "privileges the body as a site of knowing" (p.180).

Critiques of such ethnology come from two directions and highlight what are regarded by many as the two contrasting deficiencies of the ethnographic process, both of which in turn would seem to apply equally to the modality of hypnosis. Natural science or positivistic objections to ethnography frequently focus on the lack of a controlled environment which proscribes much of ethnological research from having easy and exact extrapolation into other situations. There are concerns also about the unstructured and open-endedness of most ethnographic research and the influence that the researcher can have on the observed

and recorded outcome due to their over-involvement in the research process (Brewer 2000). From a contrary direction postmodernism challenges the validity of most ethnographic research, decrying the efforts of sociological researchers both in their trying to capture the ephemeral and illusive native of the reality of everyday life, and in their claims for validity, veracity and generalisability (ibid).

As a method of data collection hypnosis has to plead guilty to both of these accusations that beset the ethnological efforts of many sociologists. Nevertheless hypnosis would seem to fulfil many of the criteria conventionally seen as defining and describing the principles and practice of ethnography including "attempting to understand human conduct as it unfolds through time and in relation to its meaning for the actors" (Conquergood, 1991, p.180), facilitating creative and imaginative thinking and theory building (ibid), and the elicitation of cultural knowledge and of an understanding of social development and interaction (Hammersley & Atkinson, 1983). During its early developmental years when ethnography was viewed primarily as an anthropological tool, the absence of formal and laborious fieldwork would have been seen as negating hypnosis as a truly ethnological modality. However as Cole (1977) has discussed this was very much the case with all sociological ethnography at that time and researchers undertaking fieldwork that did not involve the privations of working in wild and dangerous unknown lands were mocked as pseudo-ethnographers.

Since that time the increasing incorporation of an ethnographic style or approach into a multitude of sociological research projects has widened the parameters that are now seen to define "fieldwork" such that almost any specific situation which is able to be viewed by a researcher from an "outsider" perspective has the potential to be amenable to a fieldwork study. The role of the researcher as an observer and recorder of the revealed and very personal and emotional subconscious world of the participants in this study during their hypnosis sessions would seem therefore to qualify this study as a valid piece of fieldwork, and its resultant descriptions and interpretations as ethnography in its fullest sense. The

use of one-to-one interviews for the assembling and recounting of a personal narrative by an individual so as to enable an understanding of the relationship between that individual and his or her experiential culture or domestic situation, is a frequently employed and fully validated ethnological methodology (Seidman, 2013; Purdy, 2014; Olson, 2016). The hypnotically recalled and recited narratives which feature in this project would seem to fall into this same category, being personal narratives which shed light upon the experiences and responses of children and young adults growing up in family situations in which adult attitudes towards food, eating and body self-image were all prejudiced.

There are clearly limitations about the use of hypnosis as a generic sociological and ethnological modality which could make its wider application problematic. As has been discussed at several points in this thesis there is still a considerable degree of misinformation and misrepresentation amongst both the public and many professionals towards hypnosis which frequently inhibits both groups from becoming involved in the process. Although this is gradually showing improvement it is important that ethical and informed consent issues receive thorough consideration and attention where hypnosis is being considered for use in a sociological study. There can be problems also arising from the wide variation in the ability of individuals to achieve a suitable depth of hypnosis to facilitate regression and recall, a difference which is both genetic and situational (Barnier & McConkey, 2004; Entwistle & Turner, 1986: Entwistle, 1988a; Gandhi & Oakley, 2005). Fortunately this was not the case in this project as all participants were able to achieve good regression quite early on in their sessions. Undertaking hypnosis requires specific training on the part of the therapist/sociologist, appropriate facilities for managing the sessions, and can necessitate time and patience in allowing the subconscious mind to begin to reveal the details of past, forgotten and seemingly trivial events. However when used as an ethno-sociological tool hypnosis has a wide utility for the investigation of many emotional, psychological or societal problems.

Hypnosis and hypnotherapy differ greatly from other modalities usually employed for sociological data collection such as conventional one-to-one interviews and focus groups, hence the information obtained differs also both in quantity and quality, but not I believe, in principle. The unique feature of the hypnotic process as undertaken in this project was that it provided a dual element to deriving an ethnography. A primary autoethnographic narrative was evoked from within the participants through their performance of hypnosis, whilst a secondary meta-narrative could be derived through the extraction of data from the transcriptions of participants' recorded dialogues. The former autoethnographic, autobiographical experience benefitted the individual participants greatly as was clear from the interviews described in chapter three. This experience is comparable with other reports on the use autoethnography documented by Denzin (2013), Jones *et al* (2016) and many others. By contrast, the latter, extracted meta-narrative and its analysis benefitted the researcher in providing the data necessary to establish and illuminate the role of childhood and early adult experience in influencing adult refractory overweight and obesity.

In this project individual research participants have been able to explore and produce their own piece of performance autoethnography. It was their resulting free-flowing narrative, verbalised during or immediately after a dissociative, altered state hypnosis session in which regression was used to encourage the participants to revisit their past and to recall past events, traumas and feelings, which the researcher suggests most closely resembles an autoethnographic performance. By facilitating such introspection, a subsequent revelatory narrative, a personal and psycho-social biography of a particular event or period of time in an individual's life can be evoked, told in the first-person voice by the owner of that narrative. During such regressive hypnosis, the researcher had very little idea what part of the hypnotic subject's past life memories would be accessed during each session, and therefore interfered as little as possible in whatever stream of conscious was being experienced and/or expressed, either during the session, or more usually, immediately afterwards. The lack of interpretation by the research as hypnotist as the story unfolded

helped to ensure that the narrative thus elicited was wholly that of the subject of the hypnotic therapy, with all of her early life cultural, racial, religious, and gendered context and content uncontaminated as much as possible by the researcher.

There are obviously some differences between such hypnotically elicited revelations and more conventional "awake" autoethnography. The narrative so revealed under hypnotic conditions usually comes as a surprise, relating as it does to a time and a place, and events and connections, which have hitherto been withheld from the conscious mind, and with the hypnotic subject having little conscious control over this process. The exploratory and revelatory nature of hypnotic regression is more akin to, albeit a more direct and powerful version of, what happens in the counselling setting, where provoking and challenging questioning on the part of the counsellor moves the client further into his or her (recent or childhood) past life, gradually turning simply remembering and reminiscence into regression, emotional re-experience and subsequent resolution. This discovering and re-discovering of the past with its hidden nuances and previously hidden agendas, connections and imperatives can generate a free-flowing stream of consciousness. Significantly when talking about events and experiences whilst still in the hypnotic trance, the hypnotised person not only re-calls, re-enacts and re-experiences past events and traumas, but can often also talk in a child-like voice, and see events and situations from a child-like perspective, during a free-flowing stream of reminiscence (Hartland1971).

In his discussion of the cross-cultural role of performance ethnography, Alexander (2005 p. 434) refers to the action of "*stepping into someone else's voice* [his emphasis] and consequently his or her lived experience". In hypnotic regression the adult subject steps into the voice of his or her younger or child self, and the resulting dialogue between conscious and unconscious minds generates a réportage about their prior life experiences. Participants in this hypnosis project thus became able, as close as possible, to see, describe and understand their own lived experience, as it felt and was experienced at that time, in a manner which is autoethnographic. For these participants as for all individuals, such past

experience have become part of the structural interrelationship between the mind and the body, and the subconscious and the conscious, constituting the “storied bodies and storied selves” described by Sparkes (1999). Importantly also is that this new awareness and the adult judgment which is being brought to bear upon past events can put right such past emotional traumas, promoting change and healing for the adult individual.

The validity of hypnosis as a technique for exploring past events and experiences, and for revealing and resolving previously hidden ethnographic stories, has been discussed at length above, and the epistemological and heuristic problems inherent in this approach examined. Nevertheless this study does suggest that hypnosis might have a value in exploring the role of unconscious agendas in the aetiology of refractory obesity and the role of dissociative hypnosis in their identification and resolution. Hypnotic sessions appear to be able to generate autoethnographic data about the impact of early childhood experiences on subsequent eating habits, food preferences, and body size and shape, which will facilitate the refining of psychological approaches towards maximising effective weight and eating habit maintenance in this difficult to manage group of individuals (Entwistle et al. 2014).

The problems inherent in trying to use any of the conventional narrative analytical approaches to defining and refining participants’ interview data, without incurring consequential and significant loss of important aspects of the hypnotic data, has been discussed at length above. In order to address the primary premise that specific unresolved childhood emotional traumas might be capable of influencing adult obesity problems it was necessary to preserve as much of the content and the flow of the emerging narrative storyline as possible. For this reason, this thesis will be seen to be documenting a high percentage of the transposed interview data, prior to any coding process. In addition to this selected raw data however, the result of applying the coding process as described in the methodology section to these same transcripts is also documented, as an exemplar

analytical approach for examining and understanding how hypnosis was used in different ways by participants in this study to produce their respective and very individual narratives.

CHAPTER FIVE – CONCLUSIONS, DISCUSSION AND FUTURE WORK

5. 1 Introduction

In assessing and evaluating the data obtained in this project three distinct aspects of its findings needed to be considered. The first two of these aspects related primarily to the needs of the researcher. Firstly there was the question of whether the data that had been accrued supported the researcher's hypothesis that covert subconscious mechanisms and agendas arising from early life experiences including unresolved traumas, could play an aetiological role in the establishment and maintenance of long term, refractory overweight and obesity; and that hypnosis could be a useful technique with which to explore this inner story and resolve such aberrant psychological traces so as to effect a therapy and a healing. Secondly there was the researcher's need to make a case for the legitimacy of hypnosis as a tool for enabling individuals to discover their inner subconscious story, and to support the researcher's premise that hypnosis has heuristic and epistemological value as a sociological modality in ethnographic and performance autoethnographic studies more generally. As part of this also was the need to derive and examine the validity of a narrative analytical approach which could be applied to the ethnographical material emerging from this hypnosis study, one which would illuminate the differences and the communalities of process whereby individual participants' unconscious minds made use of their hypnosis sessions. Any resulting sociological acceptance and recognition might then, as a consequence, render a service to hypnosis in demystifying a frequently maligned and seemingly esoteric psychological instrument.

The third aspect to be considered in this project and one very much of an equal importance to the forgoing two aspects, was how well the researcher and the project had responded to

the need of each of its seven participants, the need for them to find and to feel some beneficially therapeutic insight as a result of their participation in this project. These seven participants, who very bravely volunteered to become involved in this project and whose hypnotically evoked autoethnographies are presented in this thesis, were fully aware of the research nature of this project when they volunteered to take part in it. Nevertheless there is no doubt that each from their personal perspective saw this also as an opportunity for them to undertake therapy for a major and apparently intractable health problem that, to varying degrees, was causing them physical, emotional and social distress. Importantly, a need and a drive that was both conscious and unconscious. Despite the primary research aims of this project, I believe that all of the participants saw their series of hypnosis sessions very much in this light. Whether or not the original premises for this study proved to be correct, all participants therefore deserved to feel that their need to benefit from their involvement with the project was as important to the researcher as was his personal need to prove his theories. It would have been disrespectful and unethical for this project to be conducted in any other manner.

Developing a mutually respectful and trusting relationship between therapist and client/patient is crucial to the efficacy of most, if not all medical and health interventions, and especially so for the so-called “natural” or “holistic” therapies, including hypnosis, as Diamond (1984), Haley (2015) and Fischer (2016) have all discussed. Predominantly these therapies produce their healing benefits by acting through the body and mind’s abilities to facilitate their own innate healing, effectively by the activation of the placebo reaction, a much undervalued and often denigrated phenomenon (Kradin, 2012). In the case of hypnosis this is potentiated by the development of an intuitive relationship between hypnotist and client which encompasses caring, support and knowledge (Diamond, 1984; Navon, 2014), and which helps to maximise the efficacy of this healing across the mind: body interface. Whilst such a personalised approach is highly appropriate for use when hypnosis is being undertaken on a case by case basis for therapy or lifestyle management

purposes, it can become difficult to establish the appropriate *milieu* for this when individuals' hypnosis session have also to comply with rigorous protocols in a research project.

This must be a dilemma which confronts most researchers when any holistic therapy is subjected to research scrutiny and explains perhaps why it can be so difficult at times to demonstrate the efficacy of many such therapies under research conditions. This certainly created a dilemma for myself, right from the start of participant involvement, in being both the researcher and the therapist. Despite many years as a counsellor and therapist my original training, profession and research experience was as a clinical scientist, hence I had a tendency to approach research from a positivist, reductionist and empirical perspective, where insider/outsider debates and similar decisions were rarely relevant. Accordingly I began this project trying to present myself as an outsider with rigid criteria to adhere to as defined by my research protocol, and who needed to take as much care as I could to avoid "contaminating" my results by becoming too involved in my participants' individual needs. Thus in this way I could ensure that each participant received the same visualisations in the same order, and that each participant by the end of the project, would have undergone an identical intervention throughout.

As described earlier I found this approach very limiting and soon abandoned it in order to be able to react to the individual needs of each participant and their developing narrative as I would if they were a patient or client. I found that my usual intuitive therapeutic approach reduced the tension for me and I suspect also for the participants. The therapeutic value of hypnosis as a healing therapy lies *a priori* in the ability of the hypnotist as therapist to help individuals to find within themselves the source of their problems and to use their discoveries to heal themselves. The hypnotist may be the touchstone to this healing, and his or her relationship with the client or patient is certainly crucial to the process, but neither the hypnotist striving for results, nor the meticulousness and insightfulness of the sociological analysis of the hypnosis process brings about the healing *per se*.

5.2 Hypnosis: Individual Therapy versus Societal Wellbeing

All seven of the participants in this project found that they were able to go into an hypnotic trance very readily right from their very first session which surprised them greatly. This was surprising to me also, as well as from a hypnosis theory point of view, as there is clear established evidence that individuals vary greatly in their hypnotisability, i.e. their susceptibility to hypnotic induction, with only between 2.5% and 15% (depending upon the criteria used to assess this) being of measurably high hypnotisability, and 10-15% showing little or no hypnotisability (Barnier & McConkey, 2004; Gruzelier, 2011). It was also surprising that all participants very readily and regularly found connections between early life events and traumas, and their current weight, eating and self-image problems, and were able to identify and describe a life narrative around such connections. Several possibly reasons could be offered to explain the consistency of these findings, (i) that I had been very fortunate in the cohort of people who chose to become enrolled as participants both in terms of their hypnotisability and their past eating traumas, (ii) that high hypnotisability, and food and eating related problems and traumas in childhood, were both universal amongst the overweight population, (iii) that these were all people who had emotional problems of other natures with which they needed to deal, and being overweight also, this gave them "permission" to volunteer into an hypnosis for weight-reduction project, (iv) that these were all people who had an inner feeling that their overweight was due to past problems and that this project might be a way of dealing with this - as a result of which they felt drawn to an hypnosis, self-exploratory therapy.

Evidence directly linking weight problems and hypnotisability is inconclusive (Stanton, 1975; Deyoub, 1979; Andersen, 1985; Jupp *et al*, 1986; Barabasz & Spiegel, 1989; Mewes *et al,* 2003) and in reality I feel that the true explanation lies between (iii) and (iv) above, and that most certainly, in this self-selected cohort, the decision to volunteer into this project was prompted by the unconscious rather than the conscious mind. My experience of working for many years with patients and clients seeking hypnosis or counselling has indicated that

there is a time and tide for subconscious decision making and processing, and that it is this which triggers the sudden desire and the drive to seek for therapy. It was also, I believe, this subconscious intention which enabled all seven of these participants to go into their hypnotic trance state so readily and so deeply, and experience their visualisations so clearly and dramatically, i.e. that this was all evidence of a subconscious need to initiate therapy and that I was being seen as the route to the resolution of their problems (Entwistle & Turner, 1986: Entwistle, 1988a; Entwistle, 1988b; Entwistle *et al*, 2014).

I am of the opinion therefore that all of these participants, even, sadly, participant HP/01 who was obliged to leave the project prematurely, were subconsciously already primed for their hypnosis at the time of their first volunteer approach, that this is why they felt drawn to volunteer, and why also they all went into trance successfully in their first session. One of the participants (AL/04) actually had a flashback to a minor childhood episode when we first spoke on the telephone several months before she commenced her hypnosis sessions. At that time, she dismissed this as coincidence and not relevant to her current weight problem, so did not mention it to me until well into her hypnosis sessions. But clearly it was relevant as it appeared promptly and very strongly in her first two regression sessions, hence so-called "waking hypnosis" had already begun for her from this first telephone conversation, if not before (Alarcón & Capafons, 2006; Wark, 2011, 2015; Crabtree, 2012).

Reference has been made elsewhere in this work to the on-going debate in academic and clinical hypnosis communities about the necessity and the wisdom of pre-testing research and clinical hypnosis candidates for their hypnotisability before commencing a research study or their treatment (Appendix D.2). Whilst Lynn & Shindler (2002), Cardeña & Weiner (2004) and Spiegel (2014) all remain committed to the imperative that preliminary hypnotisability testing is *de rigueur* for any credible research project, others including Weitzenhoffer (2000), Kuttner & Jensen (2013) and Bloom (2014) see no justification for testing in clinical use, especially as Thorne *et al* (1976), Deyoub (1978, 1979), Barber (2000), Spiegel & Spiegel (2004) and Montgomery *et al* (2011) all found little correlation between

measures of hypnotisability and clinical responsiveness and usefulness. The hypnosis quality and depth obtained in this small self-selected group of participants right from the start and their vividness of imagery during regressions and visualisations as discussed above, seem to support the contention that nothing would have been added to the project by putting participants through any of the complicated and time consuming hypnotisability screening procedures recommended by some hypnosis practitioners.

Questions naturally arise also about the validity of these revealed and recounted narratives, especially in the light of the limitations regarding the credibility of hypnotically revealed memories as discussed elsewhere and in chapter four. Although no formal attempt was made to corroborate the facts of the earlier life or childhood that appeared as part of these evoked narratives, there was nothing dramatic or historically significant in these, or reported by any of these participants, which needed to be or could be confirmed through other family members or friends. The significance of these regressively revealed events in the context of the participants' current distress and weight and body image problems, lay in bringing to conscious awareness *partially* forgotten memories and emotional traumas, and the *totally* forgotten or unrecognised connections between such episodes and their subsequent development of poor eating and weight management behaviour. Throughout the generation of these participants' ethnographies there was regular evidence pointing to the validity and veracity of the events and emotional connections being evoked.

Such evidence came from several directions I believe. Firstly there was an internal coherence about the whole story once it finally appeared in its entirety, even if the route to comprehending this story was circuitous and of an "Alice in Wonderland" nature - rather like trying to work out the storyline of a play from being given a series of individual actor's scripts in a random order. However the seeking for coherence is a common feature of narrative and can more reflect the needs of the story teller rather than constituting absolute proof of veracity (Smith & Sparkes, 2002). 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 were subjectively and objectively very genuine, and often accompanied by a "eureka" feeling that what had been disclosed should have been clear to the participant all along, and over all of the intervening years. Frequently the planned visualisation was "hijacked" by the participant's unconscious mind which had other plans for that session, and often what was visualised in a given session made no sense on its first play, but became clear on subsequent replays, a processes 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 signaling of subconscious processing and change (Brann *et al*, 2014).

Hypnosis is conventionally and commercially most frequently employed in its socio-cognitive, "non-state" mode where its main value is as a motivational tool in encouraging healthy eating and a more active lifestyle. By contrast, in this current project a more exploratory and regressive "state" approach needed to be utilised because the premise of this work was that there could be covert subconscious reasons for refractory overweight and obesity which were not amenable to standard motivational pressures. Throughout the project therefore I deliberately refrained from delivering instructional and pedagogic references to the participant's "conscious" mind about the need for them to make eating and exercise lifestyle changes. Only during hypnosis and in regression, and therefore to their "unconscious" mind, did I refer to their working towards a healthy body shape, size and weight, thus leaving it up to the unconscious mind to decide what this meant and when and how to achieve this. In taking this approach I fully realised that I and the participants might both be losing out in their not having had the benefit of any conventional hypnotic motivational pressures to modify their lifestyle so as to reduce their weight. As a consequence it was possible that participants might feel "cheated" or disappointed that I

rarely mentioned or gave instructions about eating and exercise. However my belief in there being more of a subconscious than a conscious *raison d'être* for participants enlisting in this project, and in the power of this drive, was perhaps being substantiated by their desire to continue remaining in hypnotherapy, beyond the project's formal end, even without any substantive weight reduction. Some other unconscious need that these individuals had was clearly being addressed and answered by their hypnotic sessions.

Furthermore to have focused too heavily or too frequently on weight and eating would have been to ignore the real and deeper emotional problem underlying their obesity and their need to enroll in this project, as had probably happened during these participant's previous weight loss attempts. In trying to "force" weight loss when it was very likely that there were powerful subconscious reasons for not wanting to lose weight at this point, the unconscious mind could well have backed off from therapy. This seemingly was the case with participant BL/08 who felt an overwhelming urge in two of her sessions to open her eyes, and to come out of hypnosis briefly mid-sessions on two occasions, merely at my mention of the word "weight" during her visualisations!

Nevertheless despite my avoidance of conventional motivational pressure during participants' overall hypnotherapy, all of the participants, except for the first participant with just three hypnosis sessions, reported significant changes in their attitude to food and in their eating habits. Even though such changes were usually insufficient in extent and length of time maintained, to produce substantial weight reduction, I believe that there was a motive for the unconscious mind in engendering even this temporary change, and at an early point in their therapy. My experience in using hypnosis in other fields has made me very aware of how often partial remission of client or patient's presenting problems become apparent early on in their treatment, long before a final "cure" has been achieved (Entwistle & Turner, 1986; Entwistle, 1988a; Entwistle, 1988b; Entwistle, 1989). This I believe is because the subconscious needs to ensure the continuation of the therapy once started, and that this is a follow-up of these participants' original felt drive and need to go into therapy.

The unconscious mind therefore is in effect providing a reward both to the client and the therapist to encourage both to continue with further therapy, as without such a sign of improvement both parties might lose hope and give up therapy prematurely.

All of the participants in this small group of middle aged females were experiencing considerable emotional problems, and all seven participants felt that a crisis had been reached which they attributed entirely to their being overweight, but which on subconscious exploration was found to have clear and prior non-weight antecedents. In examining the interrelationships and connections between emotional problems and obesity it can prove difficult to disentangle which is cause and which is effect. Emotional and social problems such as being too depressed or too busy can be used as excuses simply to avoid having to undertake the dietary and exercise regimes necessary to lose weight, but they can also be excuses offered to hide other deeper emotional reasons for why weight loss cannot be contemplated, reasons of which the overweight individual may not be fully and consciously aware (Metcalf *et al,* 2011: Jahromi *et al*, 2013; McBride & Cole, 2014).

Amongst this small cohort of individuals a range of childhood and early adulthood emotional and experiential factors were strongly and feelingly identified by them as being associated with their adult obesity and poor weight management. These were: guilt (MK/03, AL/04, BC/06, VS/07), dysfunctional family upbringing (HP/01, AL/04, BL/08, RC/09), poor food images as children (MK/03, BL/08), avoidance of intimate relationships (BC/06, BL/08, RC/09) and physical abuse (RC/09). Although this cohort is too small to draw any conclusions about the likely frequency of such factors in the wider obese population, these same factors are amongst those reported as being associated also with anorexia nervosa and bulimia (Carter *et al,* 2006; Castellini *et al,* 2013; Hartmann *et al*, 2013, 2014; Racine & Wildes, 2015), and adverse adult eating preferences (Russell *et al*, 2016). As this was an all-female group, no conclusion could be drawn about the value of hypnosis in the management of male obesity other perhaps than to note that, despite the large number of overweight men on the university campus, only two out of the twenty-one individuals

requesting information about the project were men and neither of these two men chose to continue into the project. This in itself may be significant as participants in this project were obviously self-selected, as will always be the case with hypnosis studies of this nature.

The primary value of hypnotic regression in dealing with unresolved traumas and emotional problems from childhood or early adulthood is that these troubled times can be revisited, seen and understood in a different light, and dismissed, all from the safety of an individual's present adult environment. Whilst the facts from the past cannot be changed, any painful or inappropriate emotional legacies from that time can be let go of, allowing new possibilities for moving forward into a different future. As psychologist, Daniel Siegel (1999) puts it:

> "Memory is more than just what we can consciously recall about events from the past. A broader definition is that *memory is the way that past events determine future function*. Memory is thus the way the brain is affected by experience and then subsequently alters its future responses. … [T]his definition of memory allows us to understand how past events can directly shape how and what we learn, even though we may have no conscious recollection of those events."
>
> (Siegel, D, 1999. The Developing Mind, New York, Guildford Press. pp. 24)

In addition to the cathartic benefits of being able to let ones-self of the hook for our own and other's past offences, misjudgments and misfeasance, hypnosis and hypnotherapy have other additional and often more immediate therapeutic merits for individuals in emotional or even physical distress. Participants in this project found a range of different benefits from their hypnosis sessions, and at different times, but all were surprised at how effective was their safe place in allowing them a temporary remission from their anxiety and stresses, when this was done by myself during their session, but also when they used self-hypnosis at home. Giving themselves permission to relax was important, as was being able to face past contentious situations and people from a safe and in-control position. Many of the

visualisations were used to help participants rebuild their confidence and strength and to rehearse dealing with future problems, whilst regression was an effective means of actually seeing from a (temporal and objective) distance how their weight had changed over the years against the background of other life events. Regression was also a way of recalling past pleasures as well as past difficulties, collecting up forgotten strengths and skills, and re-associating with the participant's slimmer, healthier body to remind themselves of how this felt and could feel again (Sparkes & Smith, 2011).

Five of the participants AL/04, BC/06, VS/07, BL/08, and RC/09, even in the absence of any weight loss, have found that their hypnosis sessions provided insights about their past which, once recognised and discussed, have triggered major improvements in their mood, life expectations and general *joie de vivre*. Amongst these changes was the letting go of a major source of guilt from the past experienced by three participants (AL/04, BC/06, VS/07); the letting go of self-disparaging thoughts and opinions about themselves (AL/04, VS/07); improvement in self-mage (HP/01, AL/04, BL/08); and starting the process of coming to terms with a disruptive family upbringing (HP/01, AL/04, BL/08, RC/09). As a direct result of their session two participants are now contemplating career changes, one is in the process of re-orientating her life and her future weight management plans, one has been able to forge a new and very much more positive relationship with her daughter, and one participant has been able to achieve a pregnancy against the odds, following IVF treatment. Participant HP/01 sadly is still struggling with her life, her weight and her poor health, and MK/03 is still trying to move on from her double bereavement. However there is reason to be optimistic regarding future weight loss from the remaining five participants as they let the traumas of the past go and feel confident and inspired about moving into a new future.

As a part of this new insight it is important that participants try to understand how the covert subconscious drivers identified by these participants have been been able to have such an impact on their eating and exercise patterns, and on their resulting weight and body size and shape for eating, without their being consciously aware of this. They did not get fat just

by thinking about it, any more than they are going to lose weight by the same thinking route, they have to adjust their calorific imput and usage accordingly. Were these participants living in a less obesogenic environment it would have made it more difficult for their subconscious weight gaining imperatives to impact on their weight, but in the UK the easy availability of high calorific foodstuffs without the need to expend calories in obtaining these, makes weight gain, rather than weight loss, the default direction for weight change unless this is carefully monitored, both consciously and subconsciously. This is in contrast to many parts of the world where food is in short supply and living requires more physical activity, and hence where weight gain is much more difficult to achieve, even in the presence of covert weight-gain imperatives, unless that is the individual can afford to pay for their excessive food and their leisure time (Addo *et al*, 2009; Simkhada *et al*, 2012).

It could be posited that there are a number of ways whereby these participants' inner agendas for driving weight gain could achieve their aim of obfuscating and disguising to the conscious mind the connections between their aberrant eating and exercise lifetyles and their increasing weight. These include reducing their conscious awareness of the true amount of their eating and reduced activity; numbing them to their increasing weight and altering body shape; and providing them with excuses for their past failures to respond efficaciously to their weight problem. Hopefully the enlightenment that these participants have experienced through hypnosis will facilitate an increase in their awareness and in their motivation, as they are going to have to change their hitherto established lifestyles in order to regain the correct balance of energy in versus energy out that they need to reduce and then maintain their weight. Ongoing therapy such as CBT and mindfulness would perhaps be an added bonus to reduce anxiety and enhance motivation (Lynn et al 2012; Mantzios & Wilson, 2015; Ciarrochi, *et a*l 2015). A further and more contentious route to engendering past subconscious weight increase in these participants could have been through the modulation of appetite and satiation hormones and other neuroendocrine pathways, as nervous and hormonal interconnections and conversations between the gut and the brain

influence appetite, absorption and the utilisation and incorporation of dietary nutrients (Harris & Mattes, 2008; Dias *et al*, 2014; Frisaldi *et al,* 2015; Zilberter, 2015). Hopefully, this process, which could have markedly increased the intake, uptake and retention of of food in these participants and hence facilitated weight increase in response to subconscious imperatives, should have been down-modulated in response to their hypnotherapeutic amelioration of past traumatic influences. This is also something which should be explored in future hypnosis and nutrition research (Holtmann & Talley, 2014; Mithieux, 2014).

For the seven individuals participating in this project and undertaking hypnosis sessions the personal benefits would seem to have been clearly established, for themselves as much as for the researcher. However overweight and obesity is not just a personal health and cosmetic problem but also a serious public health issue. Childhood obesity particularly, as well as adult refractory overweight and obesity have become major and seemingly uncontrollable epidemiological problems worldwide and especially in the UK. Within the ethical remit of this thesis therefore it needs to be considered whether, how and to what degree the results obtained with this small cohort of white, low to middle class females could be extrapolated more widely into the general population and in a manner which could have an application and an impact on the obese community. With this in mind three aspects of the findings in this project would seem appropriate for further investigation and possible extrapolation in the wider sociological-societal arena.

The first of these is the use of socio-cognitive “state” hypnosis as a sociological, diagnostic and treatment tool for the understanding, detection and management of subconsciously mediated obesity in at-risk individuals. As this is a process which entails one-to-one hypnosis sessions and which would be unsuitable for large scale group use, this highly time and staff intensive intervention should most profitably be reserved for use with specifically targeted individuals. These could be those who have severe life and health threatening obesity and who may be receiving or about to commence intensive medical or surgical interventions. Used in this way hypnosis might help to eliminate or at least reduce the

impact of adverse psychological factors such as have been highlighted in this project, and help thereby to maximise the long term benefits of these other approaches. Other individuals who may be suitable for this approach would be those who feel seriously drawn to an hypnotic intervention because of a “gut-feeling” that there is subconscious element in their failure to achieve long-term weight reduction, as I believe was very much the case with the participants in this project. Preliminary screening of all such individuals and perhaps of other interested participants from standard NHS and commercial weight and dietary management agencies would be necessary in order to identify those who might benefit most from hypnotherapy. This screening should be possible through the use of a carefully designed psychological questionnaire followed by a single exploratory hypnosis session designed to look for evidence of early childhood memories around family dysfunctionality or eating associated traumas. Any individuals whose screening results indicated the possibility of a significant subconscious basis for their weight problem could then undergo a more formal series of hypnosis sessions which would clarify more fully the nature of their problem and aid in its resolution.

The second implication of the results obtained in this project relates to the increasing incidence of obesity in children (van Jaarsveld & Gulliford, 2015; Hamilton-Shield & Sharp, 2015), which has become the focus of much concern in the UK both because of the morbidity associated with childhood overweight, and because overweight children become obese adults who go on to have obese children in turn (Berge et al, 2014; Fitzpatrick & Willis, 2015). The picture obtained from the participants in this small study and from the publications of others (Fiese & Bost, 2016: Bryjova, 2016) has highlighted how strongly the attitudes and behaviour of parents and other significant adults can engender, often unknowingly, misperceptions and prejudices within the children in their care towards food, eating and body image awareness. Furthermore these results have demonstrated how stubbornly and pervasively these consequences can remain in the unconscious minds of children only to assume potency in their adult life. Consequently those involved in the

design of public health campaigns aimed at educating parents, nursery and primary school staff and care-givers of young children about how to develop and instil heathy eating habits and food choices in the children in their care, need to be aware of the implications raised by this study.

A third consequence of the powerful influence of early life experience on adult body size, shape, eating habits and self-image relates to the interplay between our mind;body set and the outside world – the balance between the psychological, physiological and biochemical demands of Claude Bernard's *milieu intérieur* and the social, cultural, commercial and highly obesogenic environment in which we are obliged to live our lives. Maintenance of each individual's specific homeostasis requires the full integration of their body and mind facilitated by cross talk across the blood:brain barrier. The primary role of the mind in this context is to generate an equilibrium between those hormonal systems controlling satiety and hunger which will allow the development of a body shape and size which is appropriate to the physical and emotional needs of the individual and his or her idealised self-image. In evolutionary terms humans need to be appreciated as being fat mammals and this underlies our predisposition towards weight gain, rather than weight maintenance or weight loss (Wells, 2009; Power & Schulkin, 2009). Maintaining a "healthy" weight, body shape and appearance has therefore always been a struggle between our evolutionary and anthropological heritage, and our civilised and cultural needs and perceptions of body ideality.

In this respect fashion, social acceptance and public acclamation have always been more potent forces for determining body shape, size and appearance, than that of health. As Bradley (2011) has discussed, the portrayal of body shape in Roman and Greek art, even as far back as the fourth century B.C. gives clear demonstration of the mixed signals which the corpulent body could give out about the wealth, power, character and behaviour of those in the political and cultural limelight, reflecting every aspect from patrician gravitas and respectfulness, to overt disgust. Since that time images of idealised body size and shape

have fluctuated greatly over the history of western civilisation, and still do vary today across cultures and communities. The 16th and 17th century Rubenesque portrayal of large breasted voluptuous women with rounded limbs and belly and the 19th century Dickensian male corpulence both had their zenith and their decline, giving way in turn to the f*in de siècle* 19th century more moderate and slimmer body shape and size both for men and women and culminating during the early years of the 20th century in the ultimate curve-free "flapper", the "to die for" female shape of its day (Entwistle, 2000).

As the 20th century moved on, commercialisation of the female figure in the media and the increasing use of the female body as an advertising placard and a marketing tool brought further changes in subjective and objective perceptions of the idealised and iconic womanly shape (Brown, 2012). Attempts to derive current, twenty-first century idealisations of iconic feminine and masculine appearance yields conflicting results. However if the general appearance of the majority of modern-day women out socialising gives any indication of their preferred body shape and size, the body shape most frequently desired by such young and not-so young women, would seem to be the classic hour-glass figure of large breasts and rounded, curvy bottom, whilst many women and men seem happily content to give public demonstration of their high degree of overweight and obesity.

This historical overview of the ebb and flow of obesity and body imagery illustrates the major impact that culture, society and fashion can all have on a nation's weight choices. Decisions about what weight, size and shape to become are clearly being made by the young and not so young adults in responding to these trends; but are facilitated by the easy availability of cheap, high energy food and the reduction in the amount of calories expended in obtaining such food. Nonetheless the roots of such adult responses to societal pressure undoubtedly lie at least in part in their childhood and in the signals given out, perhaps unwittingly, by the nurturing adults around them. Whilst the above overview relates predominantly to white European cultures, other ethnicities and cultures have their specific conscious and subconscious, innate or learnt pressures and preferences regarding weight, size and body

image with which to conform, an example being the preference for a “thick” body type expressed by many Hispanic and Black women (Burk, 2013; Schooler & Daniels, 2014). These will result in different dilemmas for children growing up in these other cultural environment who will, knowingly or not, develop food related biases and predispositions which will continue to influencing subconsciously their lives as adults.

Thus the achieving of an ideal body size, shape and self-image is influenced strongly by environmental, social and cultural pressures but all of these have to be accommodated within the subconscious constraints determined and predicated by the sorts of nurtural experiences as were evinced by participants in this study during their hypnosis sessions. This will generate further tension and subconscious dysfunction which will add to the stress and emotional burden of achieving and maintaining an appearance appropriate for the time, the tide, the culture and the person. The study has highlighted some of the ways that parents and other supporting adults of today might be implanting adverse messages into the minds of the children in their care which will in all probability contribute to the next wave of weight and appearance trends.

5.3 The Place of Case Studies in Qualitative Sociology

In addition to investigating the diagnostic and therapeutic value of hypnosis to the individual with his or her problem of refractory overweight, it is hoped that results obtained in this project will have a wider epidemiological value for those agencies involved in the management of obesity in the medical and societal areas. For this latter aim to be the case these findings with seven individual case studies need to have some degree of extrapolation into the wider community. The various definitions of a case study have been reviewed by Berg & Lune (2012) but all entail the systematical gathering of enough information about a sampled person or setting so as to obtain sufficient rich depth of information to enable an adequate description of that person or setting. This person or setting is ordinarily selected

from a larger group of the similar and some at least of the findings of the sampled may be applicable to this larger sample, but not necessarily so. Berg & Lune also suggest that to truly be regarded a case study more than one modality should be employed in the analysis, and goes on to describe three classes of such case studies; intrinsic studies where the objective is to understand more about an individual; instrumental studies in which a methodology or a theoretical premise is under study, with the "case" being merely a "carrier" for this study; and multiple individual and distinct cases within an overall study. The present project appears to fit all three of these categories,

The nature of this study with its multiple case design of seven participants is considered by Yin (2009) as having specific advantages when compared to single case studies and multiple sampling studies. The evidence produced in a project is clearly more robust and generalizable when obtained from two or more simple case studies but the function of multiple cases is for replication only, and importantly, these multiple cases do not give a statistical increase in the reliability of each of the individual case studies. They remain independent and each has to be internally valid, and their outcomes may very well differ greatly in ways that are contradictory and reduce the validity of the whole project. Although case studies differ from surveys in not being intended to provide a benchmark for all similar individuals or group, when case studies are properly undertaken, they should not only fit the specific individuals being studied, but should also provide some general understanding about other similar individuals in similar situations (see also Smith *et al*, 2014).

Case study research using individual participants is seen by Mishler (1996) as being a fully validated form of scientific enquiry, which he feels also is capable of restoring some of the agency and human understanding to sociological research that he feels is missing from less holistic narrative studies. He cites a seminal role and contribution to the body of knowledge of individual case studies undertaken by those such as Skinner (1965), Milton Erickson (1980) and Freud (1991). Flyvberg (2006) in a passionate defence of case-study research lists what he sees as the five frequent misunderstandings about this approach:

> Misunderstanding 1: General, theoretical (context-independent) knowledge is more valuable than concrete, practical (context-dependent) knowledge.
>
> Misunderstanding 2: One cannot generalize on the basis of an individual case; therefore, the case study cannot contribute to scientific development.
>
> Misunderstanding 3: The case study is most useful for generating hypotheses; that is, in the first stage of a total research process, whereas other methods are more suitable for hypotheses testing and theory building.
>
> Misunderstanding 4: The case study contains a bias toward verification, that is, a tendency to confirm the researcher's preconceived notions.
>
> Misunderstanding 5: It is often difficult to summarize and develop general propositions and theories on the basis of specific case studies. p. 221

He then goes on to detail his refutations about each of these points, by describing how effectively, good and carefully chosen narrative case studies can allow for the exploration of the minutiae of real life situations. Such cases can facilitate hypothesis and theory building and testing, which can subsequently be extrapolated and generalised into the wider community of sociological research studies, a view strongly supported by Riessman (2008) and Yin (2009).

This is very much the case also when case studies are employed for investigating and describing health topics, as Ziebland & McPherson (2006) have shown in their valuable use of data from the DIPEx health website, where qualitative analysis of individual patients' experience of their, often rare or unusual illnesses, is being used for medical education and training. It is surprisingly therefore that this view does not appear to be universally recognised and accepted, and that the 3rd edition of the prestigious textbook Researching Society and Culture (Seale, 2012) with its 21 contributors, devotes less than 8 out of its 600 pages to the place of case studies in sociological research. Despite the encouraging opinions of authorities such as Mishler (1996), Flyvberg (2006), Yin (2009) and Berg & Lune (2012) it is clear that case study research has a long way to go to achieve the sociological status it deserves.

Whether or not these seven case studies can be replicated on a larger scale is yet to be determined, but the author believes that the preliminary findings from this project do at least

signpost some important directions for future nutrition and obesity research and practice. Firstly is the need to follow up these current participants to see what impact their hypnosis sessions have had on their future life satisfaction and on their weight and body image management, as well as repeating this current project work with a larger cohort of participants, preferably to include some men. Clearly it would be impossible to employ routinely the process used in this project on a large scale, but using the information derived from the present and any further and larger group, it might be possible to devise a screening questionnaire which could highlight those overweight individuals who need or who would benefit most for an hypnotic therapy approach in the management of their weight problem. For this purpose a more formal and detailed narrative analysis of participant interview transcriptions is planned in the hope that this will shed light on the emotional and personality constructs predisposing towards the problems highlighted in this project. There is also important work to be done in understanding the role and potential of hypnosis as a modality acting across the blood:brain barrier to modulate aberrant brain and body chemistry, as part of the short and long term management of the biochemical and physiological consequences of obesity and diabetes (Oakley, 2000; Dias *et al*, 2014; Frisaldi *et al,* 2015).

5.4 Dreams and Subconscious Messages in Hypnosis Studies

Much reference has been made in this project to the analysis of participants' dreams as part of the monitoring and determining of their subconscious activity and their therapeutic progress. Dream studies form a very major part of psychoanalysis, and the recording and interpretation of dreams figured greatly in the seminal psychotherapeutic studies of Freud (1991), Adler (1936), Jung (1961) and Lee & Mayes, 1973, as well as in the writings of most psychoanalysts (Kihlstrom & Evans, 1982; Barrett, 1992; Hartmann, 1998; West 2011; Fonagy *et al* 2012; Taylor, 2012; Llewellyn, 2013; Forrer, 2014; Steck & Steck, 2016). It is not surprising therefore that dream recording and analysis is an important aspect of

hypnosis research and practice (Wolberg, 1945: Hilgard & Nowlis, 1973; Sheehan & McConkey 1982; Brann et al, 2012). In describing the opportunities for gathering information about unconscious, Sherwin-White (2003) quotes Freud as saying "The interpretation of dreams is in fact the *via regia* [The Royal Road] to a knowledge of the unconscious" (in:*The Interpretation of Dreams*, Sigmund Freud, 1910).

Nevertheless the function of dreaming is still the topic of much debate with theories premising subconscious management and consolidation vying with those emphasising the exploratory and creative. Although the early publications of Freud and Jung were intent on finding meaning, generic or specific, in dream metaphors, as do the dream bibles, dream dictionaries, and dream guides currently published for lay use and amusement, much of the nature of dreams does not fit into such simplistic categories and would seem to have a specific metaphorical meaning and intent for the dreamer (Hartmann, 1998; West, 2011). Nevertheless, whether as a result of prompting by the hypnotist or spontaneously, the dreaming of what appeared to be significant dreams by participants between their hypnosis sessions, became a recurring and fascinating aspect of this project.

As part of hypnosis I would at times suggest towards the end of the session, that the unconscious mind might like to send to the conscious mind a signal to reassure the participant's conscious mind of the progress she is making with her exploration and therapy, and that this could be given during the course of the session, as it is ending, or at a later time perhaps in a dream. There was never any guarantee that such a signal would be given, but often there would be an immediate response within the session, sometimes a really powerful and positive response but at times a more surprising or obscure image the significance of which perhaps only later, in a dream, became clear and understandable.

Three participants especially experienced and reported an increase in their dreaming pattern during the course of this project. Participant MK/03 had a number of unusual and metaphor-like dreams about her parents, her son and her husband all of whom are deceased, which would not in itself be seen as unusual except for the surprising

juxtaposition of these dreams with unusual and spontaneously occurring experiences in her hypnosis sessions, suggesting a mirroring of one to the other. This was very reassuring if perplexing for her as she rarely dreamt about these family members other than in association with her strange hypnosis sessions. AL/04 had a recurrent and very powerful dreams about "ice" which felt very dramatic when first dreamt and which re-occurred several times in her hypnosis sessions, as well as having frequent dreams of childhood and schooldays which were clearly associated with her regression journeys. BL/08 experienced an increase in dreaming as soon as she began hypnosis and these were predominantly about being frightened or trapped or under another's control, and were prescient for her as this was this aspect of her childhood and her adult life which her regressions showed was underpinning her weight and body image problems.

There were two other dreamers whose unconscious signals in hypnosis and dreams were co-associated, the first was BC/06 whose dreams about stars and buttons frequently echoed her spontaneously occurring regression links to her father and to the "button basket" which he always kept on the sideboard of the family home when she was a child. She also had several dramatic dreams about loss including one of seeing a suicide take place. The second dreamer was RC/09 who had always been a regular dreamer, but who had some quite strange and uninterpretable metaphorical dreams during her period in the project but which appeared to have some connection with her revealed past and her process of change. The frequency with which this dreaming between sessions accompanied changes in mood, behaviour and lifestyle changes seems to confirm that the effectiveness of hypnosis extends far beyond the immediacy of simple relaxation and stress management.

CODA

What has been highlighted by this study is the major role played by parental and other adult dysfunctional relationships and behaviours in determining, albeit inadvertently, their children's relationship with food, eating and body self-image, and the subsequent impact of this on their adult resilience, motivation and self-confidence; and how this can be explored and modulated using an hypnotic intervention. There is a close and probably primeval association between food and love, the giving and receiving of love, as Shakespeare was fully aware of – ("if music be the food of love" - Count Orsino in *Twelfth Night*), hence the showing and withholding of love is often demonstrated by the providing or withholding of food, and not being fed properly can feel like one is not being loved and cared for (Hamburg *et al*, 2014). Sitting around a table sharing in the act of eating together with one's loved one or family is a very intimate act and is symbolic of the acknowledgment and the mutual sharing of love; whilst sensually luxurious food (especially chocolate) is probably the iconic present bought for one's amore or one's children as a token of such love. It is not suprising therefore that when there is a perceived lack of love, eating can become a substitute for, and a cry for love (Roth, 1993; Counihan & Van Esterik, 2012).

Six out of the seven participants in this study regressed spontaneously back in hypnosis to traumatic episodes and periods in their childhood in which secure love was missing or inadequate, and which was frequently reflected in the attitude of their parents and other responsible adults around them towards food, including the way in which this food was presented or withheld. As a result food and eating became problematic for them, for two of these participants resulting in their choosing to eat poor quality "fast" food rather than home prepared food and in hoarding and overeating because of childhood hunger fears; and for a further four participants, engendering a poor or misjudged self-image which led to their overeating for protection or for comfort. Food, eating and body image all suffered whether

or not the nurtural aberrations experienced by these women as a result of behaviour of the responsible adults around them were overtly food or eating directed.

Under such early learning situations children are relatively egocentric (Morrison & Morrison, 2006), and are liable to assume responsibility for their perceived lack of parental and other love, and feel guilty as a result (Entwistle, 1988a; 1988b). The guilt that most of these participants discovered within their self-examined past, and which they realised they had held on to 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. Closely and clearly associated with this guilt in these participants' narratives was the development of adult poor self-worth, low resilience and ego strength (Karasu, 2012; Moore & Cunningham, 2012; Wang *et al*, 2015), which would have made them more vulnerable and susceptible to stressors (Kradin, 2013). For some of these participants, the presenting themselves most obviously as an overweight person with an obese body, as a "fat woman", was both a means of containment of such painful emotions, and a way of defocussing attention from herself as a person, thus offsetting a more penetrating scrutiny which might reveal the inner, and self-perceived, "unworthy" person (Hemmingsson, 2014; Marshall, 2015). Whilst this effectively "got them off the hook", both consciously and subconsciously, about others becoming aware of their inner unworthiness and inadequacies, it also disempowered them from achieving any adequate and maintained weight reduction.

Hypnosis has a dual value in ameliorating this situation, firstly by its facility to allow exploration, discovery and resolution of these past and on-going deleterious processes which is in itself therapeutic and healing. Secondly hypnotic visualisations can expedite a rebuilding of self-worth, resilience and ego by allowing individuals to seek out the evidence of past availability of these lost and misplaced core skills and qualities, in order then to reclaim and then generalise them to their present and future lives. This self-empowerment and the letting go of guilt by making peace with their childhood traumatic past has to be the

first step to becoming a stronger and more resilient person,who is then able to understand and to change the nature of their eating behaviour. For six out of this group of seven women the process of change has already begun and all six have expressed their surprised at the powerful impact that their hypnosis sessions are already having on their lives and on their relationships with family and friends, allowing them to feel fully optimistic and postive about their future, whether or not this necessarily involves their losing weight. These paticipants' transcribed interviews have yet to be subjected to a full and conventional narrative analysis as this was not part of this particular project, however such a detailed examination needs to be done as this may reveal psychological and metaphorical variations and similarities within this group of overweight women which may shed some light on why and how their early life experiences impacted so significantly on their adult eating habits.

For the individual biographical narratives of this small cohort of overweight female participants to be regarded as providing the criteria necessary to define hypnosis as an ethnographical modality, it is necessary to demonstrate a wider applicability of hypnosis and hypnotherapy within sociology and the social world in general.

Such information would be of great value in the future development of methods for the screening and managing of such adverse psychological food and eating agendas, which could then be incorporated into generic weight management programmes. Further research into the hypnotic manipulation of the biochemical and physiological routes influencing weight gain and loss in such overweight individuals is also planned, as this will help in the correction of acquired abberant metabolic pathways. Such a multidisciplinary approach to managing overweight problems would seem to make good sense as the division between the mind and the body may be largely illusory (Kradin, 2103), and mind and body could be regarded as different hypostases, different faces, of the same essence (Augustine, 2002).

Much has been written regarding the application of theroretical models to motivating behavioural health change especially in weight management, particularly Motivational Readiness (Marcus & Forsyth, 2009) and The Transtheoretical Model (Prochaska &

DiClemente, 1983; Brug *et al*, 2005; Wu & Chu, 2015). The differential applications of hypnosis when used in its sociocognitive and its dissociative modalities could prove beneficial in such staged interventional approaches for motivating short and long term changes, and this is a further extension of this study. For the participants in this project the long term benefits of their hypnosis may not be evident or realised for some time. Nevertheless there are early signs from some of these participants of an epiphany in their lives arising from an understanding of how they have been obliged to live their lives, perhaps because of their own or others, past misjudgments and misfeasance. As a result of the enlightenment that can come from hypnotherapy, four participants are already making significant changes, one dramatically so, in how they live their lives. For six out of these seven participants, hypnosis appears to be engendering ongoing physical, emotional and psychosocial modulation which bodes well for these participants' future health and life, and which hopefully will be translatable into better weight and body image management, as and when appropriate.

As has been discussed and demonstrated by Pennebaker (1997, 2012), Singer & Blagov (2004), Woike (2008), and others, the narrating of one's personal life story, with all of its traumas and triumphs, losses and gains, achievements and *cul de sacs*, allows for a proper self-analysis and an integration of the disparate journey to their present that constitutes most people's lives. Such narration has a transformative power in bringing about reconciliation with the past, understanding of the present and planning for the future. As previously mentioned, I truly believe that a major merit of all talking therapies lies in the finding and the saying out loud of one's narrative, and the hearing of it as if from another person (or the writing, then the reading of it). This is a role for which hypnosis appears to be highly appropriate, in the health arena, in addiction management, mental health services and in sociology and ethnography in general. Hypnosis can facilitate the externalisation and objectification of our troubled histories in a way that enables a clearer understanding of

the otherwise “Tom and Jerry” fruitless internal and intercinine battles that we all have in our heads and in our minds, and which ultimately goes to support the well observed verity:

"The past is a foreign country: they do things differently there."

L.P.Hartley: *The Go-Between* (1953)

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THE USE OF HYPNOSIS AS AN AUTO-ETHNOGRAPHIC MODALITY IN THE EXPLORATION AND MANAGEMENT OF OVERWEIGHT AND OBESITY

APPENDICES

SUMMARY OF APPENDICES

Case Study from:

Unconscious Agendas in the Etiology of Refractory Obesity and the Role of Hypnosis in Their Identification and Resolution: A New Paradigm for Weight-Management Programs or a Paradigm Revisited?

Paul A. Entwistle, Richard J. Webb, Julie C. Abayomi, Brian Johnson, Andrew C. Sparkes & Ian G. Davies

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APPENDIX A

HYPNOSIS SCRIPTS EMPLOYED

APPENDIX A.(i) INDUCTION OF AN HYPNOTIC TRANCE STATE AND RECOVERY

The following hypnosis induction procedure is the author's modification of a generic induction procedure of the type used by most clinical and academic hypnotherapists, and recommended by the author's professional association the British Society of Clinical & Academic Hypnosis (BSCAH). It is a protocol which the author has employed and developed over 35 years of clinical practice. In essence the protocol consists of guided progressive physical relaxation and directed abdominal breathing potentiated by the trigger word "NOW", which together allow the hypnotic participant to move imperceptible from the wide awake state into increasing relaxation with gentle abdominal breathing, and on into an hypnotic trance. Induction is a preliminary step to subsequently moving into visualisation and other hypnosis procedures. The time scale of this sequence can be tailored to suit the setting, the hypnotic susceptibility of the individual hypnotic and his or her session to session needs, but in general is longer for the initial one to three sessions, then can be speeded up as the participant becomes increasingly accommodated to relaxing and induction, so allowing greater time for visualisations and exploration in later sessions.

A.(i) HYPNOSIS INDUCTION AND RECOVERY PROTOCOL

Induction begins:

"I would like you now to find a point somewhere on the ceiling high above your head or on the facing wall, that you can focus your gaze on …. and for the next few moments keep your gaze on that one point ….. looking forward to the time when your eyes will close, and you will drift into a beautiful relaxed state …. trusting your unconscious mind to keep you safe as you let yourself drift gently down.

As you continue to stare at that one point, I'd like you to notice how your vision is becoming hazy and blurred …. perhaps your eyelids are becoming heavy, tired and sleepy ….. but keep your gaze on that one point for a little while longer, as you listen to my voice.

I want now you to notice something else …. I want you to notice how each breath that you breathe out is helping you to feel more calm and more relaxed …. how each deep breath that you breathe out is helping you to become more sleepy, more drowsy. With each deep breath that you breathe out … from the very bottom of your stomach, you start to notice that your eyelids are becoming heavier and heavier … drowsier and drowsier.

So heavy and so drowsy that soon your eyelids will want to close. … And as your eyelids become so heavy and so drowsy … and as vision becomes so hazy and blurred … when ***you*** feel that you want to let your eyelids close, just let them close, naturally and gently. … Let everything happen naturally and gently. … And then you can let each deep breath that you breathe out, from the very bottom of your stomach help you …. to drift, and sink, deeper and further down into a beautiful, relaxed, sleepy state.

And I want you also to notice that, each time I use the word ***now*****,** how this word ***now*** helps you to feel even more relaxed … each time I use the word ***now*** this is helping you to feel even more calm … so let this word ***now*** help you … to drift even more deeply down into this beautiful, relaxed, sleepy state.

I want you ***now***, to let your thoughts focus on your feet … as you let the muscles in your feet become relaxed ... let these muscles become limp, and slack, and heavy. And as these muscles relax ***now***, and as the tension goes from them … so ***you*** are relaxing more and more, drifting down and down. And ***now***, let this feeling of relaxation spread into your legs and your thighs … ***all*** muscles relaxing. And as ***these*** muscle relax ***now,*** so ***you*** are relaxing more and more … becoming sleepier and sleepier.

And ***now***, this feeling of relaxation is spreading into your abdomen ... just feel this warm relaxed feeling spreading around your abdomen…..spreading into ***every*** muscle, ***every*** nerve, ***every*** organ, until the whole of your abdomen becomes so, ***so*** relaxed. And notice also how each deep breath that you breathe out is ***helping*** your abdomen to become totally relaxed.

And ***now***…..you can let this feeling of relaxation spread into your lower back. Just feel how the gentle pressure of the chair (or couch) under your lower back is helping these muscles

to relax….and how with each deep breath that you breathe out … you can spread this feeling of relaxation through your waist, into your upper back. Just feel also how the gentle pressure of the cushion behind your back is helping ***these*** muscles in your upper back to become relaxed. So with each deep breath that you breathe out ***now …*** the whole of your back become totally, ***totally*** relaxed, every muscle softening and letting go of its stress or tension, and just relaxing.

And ***now***…..this feeling of relaxation can spread into your chest. Just feel this same warm relaxed feeling that begins to spread across your chest, with each breath that you breathe out. With each deep breath that you breathe out, so the whole of your chest becomes totally relaxed … as you blow away all the stress and the tension in your chest muscles….. ***now*** you can spread this beautiful, relaxed feeling from your chest into your shoulders. With each deep breath that you breathe out, from the very bottom of your stomach … just feel ***now*** how those shoulder muscles are softening and relaxing, with each breath you breathe out…..that's good, that's beautiful.

And ***now***…..you can begin to move this lovely relaxed warm feeling down your upper arms … through your elbows into your lower arms…..and into your wrists…..every tendon, every nerve, every little bone in your wrists relaxing ***now***.

And ***now*** … this relaxed feeling is spreading into your hands, into the backs of your hands and the palms of your hands…..and down each and every finger and thumb. All muscles relaxing ***now***…..and as these muscles relax, and as the tension goes from them…..so ***you*** are relaxing, more and more, as you drift gently down.

And I want you ***still*** to notice***,*** how every breath is helping you to feel more calm, more relaxed…..how each deep breath that you breathe out is helping to become more sleepy, more drowsy …. how each deep breath that you breathe out ***now***, from the very ***bottom*** of your stomach, is helping you … to drift and to sink, deeper and further down, more and more into this beautiful relaxed state.

And ***now***…. let this beautiful relaxed feeling spread into your neck …. Just feel any remaining tension in your neck muscles being blown away with each deep breath that you breathe out ***now*** … letting your head sink back heavily and gratefully into your pillow. So ***now*** …. your head can sit naturally and smoothly on your shoulders, with no trace of stress or tension.

And ***now*** … let this feeling of relaxation spread to the back of your head … just feel how the gentle pressure of the pillow under your head is helping to smooth away any tension in the scalp at the back of your head … and how with each deep breath that you breathe out ***now*** you can move this relaxed feeling across to the sides of your scalp … and to the top of your scalp ***now*** … so with each deep breath that your breathe out, from the very bottom of your stomach … the whole of your scalp feels so, ***so*** relaxed, with not a trace of stress or tension.

And ***now*** … it's time to move this relaxed feeling into your face … as first your forehead begins to relax … any tension across your forehead and around your eyes ***now*** is just melting away with each breath that you breathe out … And ***now*** … this beautiful relaxed feeling can be moved down across your cheeks … to your nose and your ears ***now*** … relaxing all the time. And ***now*** you can move this relaxed and warm feeling to your mouth …

to your lips … to your tongue ***now***. And ***now***, this relaxed feeling is spreading on down through your chin … so that each and every bone and tendon and muscle in your chin is relaxing… right down to the very point of your chin … so that with each deep breath that you breathe out ***now*** … the whole of your face becomes totally, totally relaxed.

And ***now*** … this relaxed feeling is spreading in to your brain … into your mind ***now***. So that your mind and your body can relaxed together in harmony and unison ***now***.

And I want you ***still*** to notice***,*** how every breath is helping you to feel more calm, to feel more relaxed…..how each deep breath that you breathe out is helping to become more sleepy, more drowsy ... how each deep breath that you breathe out ***now***, from the very ***bottom*** of your stomach, … is helping you … at this very moment … to drift and sink, deeper and further down, more and more into this beautiful relaxed ***hypnotic*** state.

Where your whole body becomes ***totally, totally*** relaxed, ***every*** muscle, ***every*** nerve, ***every*** joint, becoming limp, and slack and ***heavy***. So heavy it feels as if your whole body is turning into ***lead***. Your limbs are so ***heavy*** you can ***hardly*** move them. You are melting away … losing the ***edges*** of your body, as you drift gently down. Like a leave falling from a tree in Autumn [alternately - like a feather falling to the ground] … drifting to and fro gently down … so you also are drifting to and fro, gently down and down into this beautiful relaxed and safe place.

And I want you ***still*** to notice how each deep breath that you breathe out is helping you ***now*** to feel, ***more calm, more relaxed***…how each deep breath that you breathe out is helping you to become ***more sleepy***, ***more drowsy***…each deep breath that you breathe out, from the very ***bottom*** of your stomach … is helping you, ***at this very moment*** … to ***drift*** and ***sink*** … deeper and further down … more and more into this ***beautiful, relaxed, HYPNOTIC state***."

[Induction of hypnosis is the first stage of each session. Once this has been achieved the participant is then taken down to their pre-selected "Own Special Safe Place", within which visualisation and therapy can take place. Recovery from hypnosis, "awakening", is predominantly done as part of the return from this Safe Place, but more generically would be brought about through the following procedure.]

"And now it is time for P. (participant's name) to awaken and continue with her day. I would like to thank the unconscious mind for all the good work it has been doing for her over the past few weeks and months in looking after her and keeping her safe, and for allowing her to relax so well today. Also for allowing me to help P. with this. Can I also ask the unconscious mind to enable P. to allow any information and emotional changes from today to be used to improve her future. … finally can I ask the unconscious mind to allow me to continue working with P. in this way in future sessions.

In a little while P. (participant's name) I am going to invite you to begin to awaken … and when your eyes do open, you will be so surprised at how good you are feeling … better than you have felt for a long, long time. Calm, relaxed, confident and optimistic. And all of these feelings are staying with you … even after you have left here …on your journey home … and in the coming days and weeks … wherever you are, at home or at work … alone or with others.

And tonight when your head touches your pillow, your mind will go back to today … to my voice and my words and the music … and you will drift off into such a beautiful, restful sleep … waking in the morning refreshed and energised to begin your day. And all of these feeling will stay with you getting better and better … stronger and stronger … with everything you do …and with every passing day. And increasingly as the days are going by … wherever you are and whatever you are doing, you will be noticing that you ***really are*** feeling more relaxed, more confident, more optimistic … nothing, no-one is worrying the same … nothing, no-one is upsetting you're the same … and your mind is ceasing churning round and round unnecessary problems … Of course, at times, things ***will*** worry you, at times, things ***will*** upset you … that's perfectly natural … ***BUT*** … nothing, no-one is worrying you ***quite*** the same … nothing no-one is upsetting you ***quite*** the same … Yes, it feels as if a weight has been ***lifted*** off you … allowing you to enjoy life more … and to be yourself more. … and these are only just a few of the many, many benefits that you are finding from this inner feeling of calmness, relaxation, confidence.

In a moment I am going to use the word ***"awaken"*** five times … and as I use that word ***"awaken"*** five times, you will slowly and naturally feel yourself awakening, as if from a beautiful relaxing sleep. As I am saying that word ***"awaken"*** five times you will start to become aware of your surroundings … lying on a couch in (current location), on (current date and time) …no part of you will be in a different place or remain in the past. ***No*** part of you will be in a different place or remain in the past. … But you may choose to keep with you anything that have learnt today that you feel will help you in your new future. With each saying of the word ***"awaken"*** you will realise more and more how much better you are feeling, ***calm***, ***relaxed***, ***confident*** and ***optimistic*** … with each saying of the word ***"awaken"*** you will realise more and more, how certain you feel that these ***good*** and ***positive*** feelings are what you will ***take away*** from here today ... what you will ***carry round*** with you in the future, and what you ***can*** and ***will use*** to build your new future … … And so…looking forward to all of these good things … on the final ***"awaken"*** your eyes will open, and you will awaken … ***feeling so, so good***.

"awaken" "awaken" "awaken" "awaken" "awaken" "

PARTICIPANT AWAKENS – SESSION ENDS

APPENDIX A.(ii) DEEPENING THE HYPNOSIS TRANCE STATE AND ESTABLISHING A PERSONALISED "SAFE PLACE"

Prior to their first hypnosis session hypnotic participants are asked to think about setting up a "safe Place" to which they could go for relaxation and respite and from where they can visualise, explore and resolve potentially painful situations and memories. Participants are asked to choose some geographical situation where they know they would feel happy and safe, preferably a chose between a garden, a country setting or a beach. This could be a real life setting that they have visited, one that they have seen pictured somewhere in a book or film, or one entirely from their imagination. Whatever their choice, this is the setting which is then suggested that they visualise in their initial hypnosis session, and which used in subsequent sessions (unless they choose to change this subsequently), and is the scene to which they go each session once relaxation and hypnosis had been induced. This safe place was always approached down a flight of steps and is the place from which they can explore the past and can experience all visualisations.

A.(ii) DEEPENING HYPNOSIS AND SETTING UP PARTICIPANTS' OWN SPECIAL SAFE PLACE

Once hypnosis has been established - visualisation begins:

"I want you ***now*** to let a picture begin to take shape in your mind's eye, as you see yourself standing on a grassy slope leading down to a beautiful garden [or little meadow or beach as appropriate, as preselected by participant]. It is a warm summer's day and you can feel the warmth of the sun on your arms and legs and the warm breeze on your face. … Above you the sky is blue with white fluffy clouds, and you can hear the sound of the birds high in the sky and the sheep on the far hills,… you can smell the flowers and shrubs at your feet [for a beach scene, the seagulls high in the sky and the smell of the salt in the sea air].

Of course, I don't know what your own special ***safe*** place is going to really look like, as it is ***your own*** special safe place … but you can certainly trust your unconscious mind to help you to picture this … but I would like to suggest that as you stand at the top of that gently, grassy slope. … that there below you is your own special ***safe*** place, waiting for you to visit it. … You are feeling very relaxed and at peace as you look down this slope to your garden [meadow or beach]. Then you notice leading down that slope between you and the garden [meadow or beach] is a flight of ten stone steps. Ten stone steps waiting to lead you down that slope to your garden [meadow or beach]. And even before you begin to walk down these steps you realise already … somehow … that walking down these steps is going to help you to feel even more ***calm*** and even more ***relaxed*** than you already are ***now***. … You also know for sure, that once you are down in your garden [meadow or on your beach], in your own special ***safe place***, you are going to feel more ***calm***, more ***relaxed*** and more ***safe***, than ever before in your life.

So I want you now to begin by stepping down on to the ***first*** of those ten steps … and just ***feel*** how good it feels, how ***calm*** and ***relaxed*** you feel even on that first step … stepping down on to the ***second*** step ***now*** you realise how ***safe*** you feel on this second step … down to the ***third*** step ***now*** and you are feeling even more ***calm*** and even more ***deeply relaxed*** … and on the ***fourth*** step so much ***safer***… ***Now*** you are stepping down on to the ***fifth*** step, you are ***half way*** down that slope and you are feeling ***so good***. Now you can see the sun sparkling off a little stream running through your garden [or meadow, or sparkling on the sea beyond your beach], as you take the ***sixth*** step down and you feel even more ***deeply relaxed*** on this sixth step … on to the ***seventh*** step ***now*** and you are feeling so very ***safe*** and ***secure***, down to the ***eight*** step feeling ***happy*** and at ***peace*** … then down to ***ninth*** step. Here you pause for a little while as you listen to the sound of the water running over the stones of the stream in your garden [through your meadow, or the sound of the surf at the water's edge beyond your beach]. One more step to go now before you will be in your garden [in your meadow or on your beach], where you ***know***, somehow you ***know*** already, that you are going to feel more ***calm***, more ***relaxed***, more at ***peace*** and more ***safe***, than ever before in your life.

And then when you are ready, just take that last step down into your garden [your meadow or onto your beach] … and just ***feel how good it feels***. How wonderfully ***calm*** and ***relaxed*** you feel … how ***safe*** you feel. Because this is your very own special ***safe place***, where nobody else can go without your permission. Your own special ***safe place*** where you will always be, totally ***calm***, totally ***relaxed*** and totally ***safe***. Your own special ***safe place*** to which you can always return whenever you need to escape from the problems and the worries of your own life. And importantly, whilst in your own special safe place you can explore your past, you can invite people in to talk to them and to resolve problems, and you can rehearse what you want to be, or where you want your life to go in the future "

[At this point any visualisations, problem searching or early life regression can be undertaking during the time spent in this special safe space, after which the participant's attention is directed back towards the steps, and they are instructed to climb these steps back to the present time, but bringing with them the knowledge and the changes that they have facilitated during their time in their special safe place.]

Awakening begins:

"And now it's time to leave your own special ***safe place*** bringing back all that you need to use in your future. But you can always return to your own special ***safe place*** whenever you wish … and this is how you do this. Whenever you wish to escape from the problems and the worries of your life, or you need to deal with some particular aspect of your present or earlier life … all you need to do to return to your own special ***safe place*** is … to settle yourself down somewhere warm and comfortable, where you will not be disturbed. Then you let your mind go back to today to my voice and my words and this music [Fairy Ring by Mike Rowlands©] and let your breathing help you to relax your body in the way that you have done today.

And then as you feel yourself relaxing with each breath, you will gradually find yourself on that grassy slope on a warm Summer day feeling very calm, relaxed and happy. There in front of you will see your ten stone steps leading down to your own special ***safe place***. When this picture is clear and strong in your mind's eye … in your own time you will be able to walk down these steps … letting each step help you to feel even more ***calm***, even more ***relaxed*** and even more ***safe …*** until you are once again down in your ***safe place***.

Here you will always feel very ***calm***, very ***relaxed*** and very ***safe***, and once in your own special ***safe place***, you will find that you will be able to deal efficiently and safely with whatever … or whoever … is troubling you. And you can remain in your own special ***safe place*** for as long as you wish, knowing that when you do choose to return up those steps, you will find that you will feel, as you will today, **calm**, **relaxed** and **safe** as your climb your steps. And on the top step your eyes will open and you will awaken feeling so **good**, better

than you have felt for a long, long time. And all of these feeling will stay with you in the coming days and weeks, as you feel better and better with each passing day."

But for today, it is time to return from your own special safe place. So when you're ready … and in your own time … you can begin to walk up your ten steps … but as you do so, I want you to notice something very interesting. As you climb up those ten steps you will begin to realise, that each of those steps is filling you with a different ***positive*** emotion, so look out for this as you climb your steps. Some steps are making you feel very ***calm*** … others are making you feel ***safe*** … on some steps you find your ***confidence*** and ***optimism*** increasing … on some steps you feel full of ***enthusiasm***, other steps are helping you to relax. These are your own special steps, so let each step fill you with its own special magic.

On the top step your eyes will open and you will awaken, feeling ***so good*** … better than you have felt for a long, long time. Calm, relaxed, confident and optimistic. And all of these feelings are staying with you … even after you have left here …on your journey home … and in the coming days and weeks. And tonight when your head touches your pillow, your mind will go back to today … to my voice and my words and the music … and you will drift off into such a beautiful, restful sleep … waking in the morning refreshed and energised to begin your day. And all of these feeling will stay with you getting better and better … stronger and stronger … with everything you do …and with every passing day. And increasingly as the days are going by … wherever you are and whatever you are doing, you will be noticing that you ***really are*** feeling more relaxed, more confident, more optimistic … nothing, no-one is worrying you the same … nothing, no-one is upsetting you the same … and your mind is ceasing churning round and round unnecessary problems … Of course, at times, things ***will*** worry you, at times, things ***will*** upset you … that's perfectly natural … ***BUT*** … nothing, no-one is worrying you ***quite*** the same … nothing no-one is upsetting you ***quite*** the same … Yes, it feels as if a weight has been ***lifted*** off you … allowing you to enjoy life more … and to be yourself more. … and these are only just a few of the many, many benefits the you will find from this inner feeling of calmness, relaxation, confidence.

PARTICIPANT AWAKENS – SESSION ENDS

APPENDIX A.(iii) PROBLEM SEARCHING AND SOLVING VISUALISATIONS

These are visualisations which provide a means for participants to search for problems both conscious and subconscious, which they are now coming to realise were never valid, or are no longer valid, and which as a result are no longer necessary in their lives, have become redundant and can therefore be disposed of. These may be personal problems, problems to do with their mind, body or emotions; problems to do with relationships, with friends, relatives or loved ones; problems from their past; problems currently active in their present lives, or worries and concerns that they have about their future. Once identified such problems and worries can be disposed of in the way directed in the following visualisations.

The first part of each visualisation is designed to provoke a searching for past and future problems which participants consciously feel may be obstructing their progress through their present life. However their main function is in prompting the unconscious mind to reveal any hidden, covert agendas, the "real", inner problems that are underlying the participant's inability to change their behaviour and to move forward in their conscious life. Having identified any such problems, if these have served their purpose and are now no longer necessary, the second stage of this visualisation allows for the disposal of these.

A.(iii) a "THE BOTTLE" PROBLEM VISUALISATION

N.B. This is the first visualisation that participants are presented with in their first session and takes place in their special safe place either by the side of their stream if they are in a garden or the country, or in a rock pool at the water's edge if they are on a beach.

Visualisation commences:

"I'd like you now to stroll about in your own special safe place, enjoying all the calmness, the beauty, the peace, and the safety of your own special safe place. Explore and enjoy being in such a special place with its little stream running past [or the waves washing up and down the golden beach] … But I'd like you now to take a walk along by the banks of the little stream [or amongst the little rock pools at the water's edge], As you do so, after a little while, you will eventually find lying by the side of the stream [at the water's edge], a very old fashioned looking, heavy, dark glass bottle, and lying beside it a heavy cork stopper. They are there somewhere, so just stroll along, enjoying your walk, until you find them. Just nod your head gently when you've found these."

[pause, whilst participant finds their bottle and stopper] .

"Good. Now this bottle has very special and useful properties, it is waterproof, shockproof, shatterproof… even ***time proof***. This bottle is your own personal problem disposal unit for you today. And whatever problems, worries or anxieties that you put into this bottle today will be removed from your life … forever. This is the chance to let go of problems that you no longer need in your life and that you and your unconscious mind would like to let go off. So I would like you now to begin to think of any problems or worries or anxieties that you realise you no longer need in your life, problems or worries that have served their purpose, are now redundant and can be let go of.

Try firstly to think about any personal problems, problems to do with your body, your mind, your emotions. Problems that you feel it is time to let go of, because you realise that you no longer need to hold on to these, they are now longer necessary in your life. Redundant problems to do with your body, your mind, your emotions. And as these come into your mind you can put them into your bottle to be disposed of. There's plenty of room, they'll all go in."

[long pause whilst this takes place]

"Good. I'd like you now to think about any problems or worries that you have, to do with relationships, with relatives, loved ones, friends or colleagues, that you feel are really needing to be finished with and should now be let go of, be disposed of. And put these into your bottle also. Problems to do with relatives, loved ones, friends or colleagues, that you don't need to hold on to any longer. Put them all in to your bottle."

[long pause whilst this takes place]

"Any problems or worries from the ***past*** now that you feel have served their purpose, that are redundant and can finally be let go of, can go into your bottle. So just go back through the past, collecting up any problems from the past that you realise you no longer need to hold on to, and put them all into your bottle to be disposed of. There's plenty of room, so put them all in, every one. All those, finished with, problems from your past that you would like to let go now can all go in your bottle, so let them all go in, now's your chance."

[long pause whilst this takes place]

"Good. Now you can look for any problems, worries or anxieties from the ***present*** that you realise you would like to let go off, that are no longer necessary, right up to this present moment in time, and they can go into your bottle, … put them all in to be disposed of."

[long pause whilst this takes place]

"And even your fears and anxieties about the ***future***, which you don't really need to hold on to, and would like to let go of, can all go into your bottle. Put them all in to be disposed of."

[long pause whilst this takes place]

"Good. Now that you have put all of, ***what used to be***, problems, worries, anxieties, into your problem disposal bottle. … You may be surprised how easy that was to do … and how already you are feeling better… Now I'd like you to push that heavy cork stopper very firmly home into your bottle. So tightly that it will never, ever come out."

[pause whilst this takes place]

"Good. Now you are going kneel down, and very gently place your bottle into the stream [into the sea], and let the current [the waves] … gently but firmly take it away, … out of sight, ... out of your mind, … out of your life for ever. You watch it bobbing along in the water for a little, but quite quickly it no longer seems important, and you turn away to continue enjoying your walk … enjoying all the calmness, the peace and the safety of your own special ***safe place***."

[Pause to allow this]

"But now it's time to leave your own special safe place for today. So when you're ready … and in your own time … you might like to walk across to where your ten steps are waiting for you. However, as you know, you can return to your own special safe place whenever you wish. And always, if you need it, … you will find waiting for you a bottle into which you can put any problem that you wish to let go of. Once at your steps you can say a thankful goodbye to you own special safe place, knowing how much good work you have done today …. Before you do so I would like to thank the unconscious mind for all the good work it has done today and for allowing me to help with this. Then when you are ready you can begin to walk up your ten steps … but as you do so, I want you to notice and remember something very interesting. As you climb up those ten steps you will begin to realise … that each of those steps is filling you with ***positive*** emotions, so look out for this as you climb your steps. Some steps are making you feel very ***calm*** … others are making you feel ***safe*** … on some steps you will find your ***confidence*** and ***optimism*** increasing … on some steps you feel full of ***enthusiasm***, other steps are helping you to relax. These are your own special steps, so let each step fill you with its own special magic.

On the top step your eyes will open and you will feel so good … better than you have felt for a long, long time. Calm, relaxed, confident and optimistic. And all of these feelings are staying with you … even after you have left here …on your journey home … and in the coming days and weeks. And tonight when your head touches your pillow, your mind will go back to today … to my voice and my words and the music … and you will drift off into such a beautiful, restful sleep … waking in the morning refreshed and energised to begin your day. And all of these feeling will stay with you getting better and better … stronger and stronger … with every passing day."

PARTICIPANT AWAKENS – SESSION ENDS

A. (iii) b "THE VESSEL" PROBLEM VISUALISATION

This is the further visualisation that participants are presented with in their second or later session and which as always takes place in their special safe place either in their garden, their country scene or on their beach. The visualisation concludes with a body and mind healing and ego enhancing visualisation, the benefits of which should be discernible at the end of the session and continue through into the days and weeks thereafter.

Visualisation commences:

"As you stand relaxing in your own special safe place, I'd like you ***now*** to let a picture begin to form in your mind's eye, as you see standing in front of, a large wooden table … a large wooden table. Let that picture of a large wooden table form very clearly and very distinctly directly in front of you. You will then start to see, standing on that large wooden table, there is a large, clear glass vessel. A large glass vessel standing on a large wooden table directly in front of you. Let that picture become very clear and very distinct in front of you.

Good. Now this glass vessel has very special and useful properties. This vessel is a problem disposal unit for you … to use … today. Whatever problems, worries, fears, anxieties, that you put into this vessel today will be out of your life …***forever***. So this is the chance, to let go of problems that you ***no longer need*** to hang on to. So I would like you now to begin to think of any problems or worries or anxieties that you realise ***you no longer need in your life*** … that have served their purpose, are now redundant and can be let go of.

Try firstly to think about any personal problems, problems to do with your body, your mind, your emotions. Problems that you feel it is time to let go of, because you realise that you no longer need to hold on to these, they are now longer necessary in your life. Redundant problems to do with your body, your mind, your emotions. And as these come into your mind you can put them into your vessel to be disposed of. There's plenty of room, they'll all go in."

[long pause whilst this takes place]

"Good … I'd like you now to think about any problems or worries that you have to do with relationships, with relatives, loved ones, friends or colleagues, that you feel are really needing to be finished with and should now be let go of, be disposed of. And put these into your vessel also. Problems to do with relatives, loved ones, friends or colleagues … that you don't need to hold on to any longer. Put them all in to your vessel."

[long pause whilst this takes place]

"Any problems or worries from the ***past*** now that you feel have served their purpose … that are redundant and can finally be let go of, can go into your vessel. So just go back through the past, collecting up any problems from the past that you realise you no longer need to hold on to, and put them all in your vessel to be disposed of. There's plenty of room, so put them all in, every one. All those, ***finished with***, problems from your past that you would like to let go now can all go in your vessel, so let them all go in, now's your chance."

[long pause whilst this takes place]

"Good … Now any problems, worries or anxieties from the ***present*** that you realise you would like to let go off, right up to this present moment in time, can go into your vessel, so put them all in to be disposed of."

[long pause whilst this takes place]

"And even your fears and anxieties about the ***future***, which you don't really need to hold on to, and would like to let go of, can all go into your vessel. Put them all in to be disposed of."

[long pause whilst this takes place]

"Good. Now that you have put into your vessel all those redundant, out of date problems, worries, anxieties, you can see them all squashed together and trapped in your vessel. You may be surprised perhaps how easy that was to do. And how already you are starting to feel a little better."

[pause whilst this takes place]

"Good. I would like you now to watch your vessel very carefully … I want you to notice something happening. … I want you to notice that your vessel is beginning to fill up, from the bottle, with a golden, shining liquid. … A golden shining liquid is gradually filling up your vessel, washing over, bathing and submerging your problems, worries and anxieties. … And as it does so, you see that your problems, worries and anxieties are just dissolving away, in this golden shining liquid. Like sugar in hot water, your problems, worries and anxieties are just disappearing, dissolving away in the golden shining liquid … right before

your eyes. Until not a trace remains, … of what used to be … problems, worries and anxieties, … just the golden shining liquid which is continuing to fill up your vessel.

And … as the vessel becomes full, … you notice that it is beginning to overflow, … and the golden shining liquid is running down the outside of the vessel … and across the table towards you, … to drip on to the flow near where you are standing. And as this golden shining liquid runs towards you across the floor … it begins to form a circle around your feet. A golden shining ***healing*** circle around your feet.

And … as this circle forms I want you to notice a new sensation. … I want you to notice that as the golden shining liquid spreads around your feet it brings with it a warm, soothing, healing sensation … which begins to spread through your feet and ankles and legs, … warming, soothing and healing as it goes. … And ***now*** this golden shining liquid is spreading into your abdomen and lower back bringing its warming, soothing, healing powers … and into your upper back and chest ***now,*** warming, soothing and healing as it goes. … And ***now***, this golden shining liquid is spreading into your shoulders … and down through your arms, hands and fingers as they begin to feel the warming, soothing and healing. … And ***now*** this golden shining liquid is spreading its soothing healing warmth into the back of your neck … into your scalp … and ***now*** the whole of your face starts to feel its warming, soothing and healing. … And even into your brain it goes … into your mind, it flows, … the soothing, healing warmth … of this golden, shining liquid.

And this is the ***proof*** … that your unconscious mind really is looking after … taking care of you … sending this golden, shining, healing liquid to help you today. And from this day onward you will continue to feel the soothing, healing, warming, power of this golden shining liquid in your life. From this day onward things are ***changing***. From this day onward ***things really are changing***. … And wherever you are going and whatever you are doing, you will continue to feel the soothing healing power of this golden shining liquid in your life. … Looking after you, taking care of you. As the days are going by, you are noticing, you are finding, that nothing, no-one is worrying you quite the same, nothing, no-one is upsetting you quite the same. So your mind is ceasing churning round and round unnecessary problems. ***Yes*** … it feels as if this golden healing liquid has lifted a weight off you … allowing you to enjoy life more and to be yourself more. And these are only just a few of the many, many benefits that you are finding from this golden shining liquid in your life.

But now it's time to leave your own special safe place for today. So when you're ready … and in your own time … you might like to walk across to where your ten steps are waiting for you. However, as you know, you can return to your own special safe place whenever you wish. And always, if you need it … you can recall this vessel and use it to dispose of your problems. You can do this by going down to your special safe place for this purpose. … Or you can even recall and used your vessel whilst just sitting at home or lying in bed. But for today, once at your steps you can say a thankful goodbye to you own special safe place, knowing how much benefit you have achieved today …. Before you do so I would like to thank the unconscious mind for all the good work it has done for you today.

Then when you are ready you can begin to walk up your ten steps … but as you do so, I want you to notice and remember something very interesting. As you climb up those ten steps you will begin to realise … that each of those steps is filling you with ***positive*** emotions, so look out for this as you climb your steps. Some steps are making you feel very ***calm*** …

others are making you feel ***safe*** … on some steps you will find your ***confidence*** and ***optimism*** increasing … on some steps you feel full of ***enthusiasm***, other steps are helping you to relax. These are your own special steps, so let each step fill you with its own special magic.

On the top step your eyes will open and you will feel so good … better than you have felt for a long, long time. Calm, relaxed, confident and optimistic. And all of these feelings are staying with you … even after you have left here …on your journey home … and in the coming days and weeks. And tonight when your head touches your pillow, your mind will go back to today … to my voice and my words and the music … and you will drift off into such a beautiful, restful sleep … waking in the morning refreshed and energised to begin your day. And all of these feeling will stay with you getting better and better … stronger and stronger … with every passing day."

So now it is time to begin to climb up your steps, and on the top step your eyes will open and you will feel so good … better than you have felt for a long, long time. Calm, relaxed, confident and optimistic. And all of these feelings are staying with you … even after you have left here …on your journey home … and in the coming days and weeks. And tonight when your head touches your pillow, your mind will go back to today … to my voice and my words and the music … and you will drift off into such a beautiful, restful sleep … waking in the morning refreshed and energised to begin your day. And all of these feeling will stay with you getting better and better … stronger and stronger … with every passing day."

PARTICIPANT AWAKENS – SESSION ENDS

APPENDIX A.(iv) ESTABLISHING AN IDEOMOTOR RESPONSE (IMR)

The ideomotor response (IMR) is used to facilitate a dialogic between the participant's unconscious mind and the hypnotist, without having to involve the conscious mind in this dialogue. It allows the hypnotist to ask direct questions of the participant's unconscious mind during hypnosis, and for unconscious mind to answer these questions, without the participant having to use speech. Whilst it is very possible participants to talk whilst in an hypnotic trance, speech requires the involvement of the conscious mind and therefore involves some lightening of the trance state. Instead, the IMR allows the unconscious mind to respond directly to questions from the hypnotist, by making minute movements of specified fingers or of the head, which the participant's conscious mind does not have to be involved in and of which he or she might in fact be totally unaware at the time of the IMR. The IMR is set up once the participant is in an hypnotic trance, and usually only after several hypnosis sessions have taken place.

A.(iv) SETTING UP AN IDEOMOTOR RESPONSE (IMR)

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P. [participant's name] over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in her life. Can I now ask the unconscious mind if it would allow me to help again today, firstly by helping P. [participant] to become even more relaxed, even more deeply asleep … and secondly by allowing a relationship to be created in which the unconscious mind can communicate directly with me using selected fingers on P's hand.

So I would like to ask the unconscious mind if today it would take control of the fingers of P's right hand, and allow these fingers to talk to me and answer questions for me today about events and feelings from P's past. Firstly I would ask the unconscious mind "Is there a "**YES**" finger in P's right hand … and if so can that "**YES**" make itself known by rising into the air to indicate a "**YES**" answer"? "

[The participant's right hand is watched carefully for even the slightest twitch, quivering or movement of the fingers. Major movements, with the whole finger rising rapidly and fully in the air, are predominantly conscious movements brought about by the participant wanting to help with the process, and this needs to be born in mind in the interpretation of subsequent answers, which may need to be ignored. Occasionally the unconscious mind will demonstrate its control by choosing to use the other hand, so both hands should be watched. If an IMR signal is given this is noted down and this finger becomes the **"YES"** finger for that session, and usually for succeeding sessions also].

"Good, now we have a **"YES"** finger, a finger to indicate a **"YES"** reply. Thank you for that. Would the unconscious mind now like to select a finger today to become the **"NO"** finger, and let that **"NO"** finger rise into the air to indicate a **"NO"** answer.""

[Again watch closely (both hands!) for a finger movement for the **"NO"** finger and when spotted this is noted] …

"Thank you, we now have a **"NO".** Now I would like to ask the unconscious mind if it would like to choose a finger to be the **"DON'T KNOW"** finger, to indicate a **"DON'T KNOW"** answer?"

[Wait again for the **"DON'T KNOW".** This often is difficult to obtain but is useful to have.]

"Thank you. Would the unconscious mind like now to choose a **"DON'T WANT TO TELL YOU"** finger, to indicate that the unconscious mind is not ready yet to answer a particular question?"

[Wait again for the **"DON'T WANT TO TELL YOU"** finger. This is also useful to have as it gives an escape route for when the unconscious mind is not yet ready to tell the participant (or the therapist) about some past event.]

If at least the **Yes** and the **NO** fingers are identified then it is possible to begin to use the IMR to solicit information from the unconscious mind. Quite frequently no clear IMR's can be elicited, in which case it is allowable to ask the unconscious mind if it would let P's *conscious* mind choose the fingers instead, and to indicate the answers by letting her become aware of a feeling or a message in her fingers. This will often be successful. Hypnosis participants at times may be totally unaware of the answers that they (i.e. their fingers) gave during IMR questioning and are surprised at what their unconscious mind had to say. Hence any results should be discussed after the session to see how these tally with their conscious remembering of past events and feelings.

APPENDIX A.(v) FOUR REGRESSIONS FOR PROBLEM SEEKING AND MANGEMENT

Age regression is used when initial problem seeking sessions have indicated the possibility of past unresolved problems being associated with participants' weight or obesity, or where participants already strongly believe this to be the case. Age regression allows the hypnotic participant to go back through their subconscious mind to earlier adult or childhood events and feelings, to discover, understand and resolve such previously covert agendas and let them go. Regression can also be used to go back to a time *before* a problem arose, to understand why this time was problem free, and to allow the participant to bring this problem free situation forward into their present life. Such regression sessions always begin in the participant's selected safe place, and are often best monitored using an ideomotor response technique (IMR).

A. (v) a REGRESSION PROTOCOL - USING THE TRIGGER WORD "BACK"

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P. [participant's name] over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again today, firstly by helping P. [participant] to become even more relaxed, even more deeply asleep … and secondly by allowing me help in directing her back through her past to look at how events from the past might be impacting still on her weight in the present.

In a moment I am going to use the word "***Back***" five times … and when I use that word "***Back***" five times, you will go back … back through the weeks, back through the months, back through the years … back to a time and a place, to people and events, to feelings and emotions, that are in some way part of the problem you are having in managing your weight and your eating in 2015. When I use that word "***Back***" five times you ***will*** go back … back through the weeks, back through the months, back through the years … back to a time and a place, to people and events, to feelings and emotions that are in some way part of the problem you are having in managing your weight and eating in 2015. I will now use the word "***Back"*** five times, and you ***will*** go back.

"***Back"…*** "***Back"…*** "***Back"…*** "***Back"…*** "***Back"***

[Participant is then left in silence to allow him or her to pay attention to whatever images may be flowing in and out of their mind's eye, but is observed continually for any indication of the emotions, tears, anxiety, smiles, tears, being experienced. If an ideomotor response has been previously established, this can be used to monitor what might be happening. It is possible to deepen the experience by repeating the regression instructions]

"I will again use the word "***Back"*** five times, and you will continue to go back.

"***Back"…*** "***Back"…*** "***Back"…*** "***Back"…*** "***Back""***

[Once it is judged that enough time has elapsed for any relevant information to be accrued in this session, the participant is brought forward out of this regression.]

"In a moment I am going to use the word ***"present"*** five times. And when I use that word ***"present"*** five times you will come forward to the present, forward through the weeks, through the months, through the years to [date and time] in [place of session], and in your own special safe place once again. No part of you will be in the past. But you will keep with you the memory and the knowledge of what you have seen and learnt from your past, for you to use in your present, to allow you to be able to manage your weight in 2015. When I use the word ***"present"*** five times you will come forward to the present, forward through the weeks, through the months, through the years to [date and time] in [place of session], and no part of you will be in the past. But you will keep with you the memory and the knowledge of what you have seen and learnt from your past, for you to use in your present, to allow you to be able to manage your weight in 2015. I will now use the word ***"present"*** five times and you will come forward to the present.

"present"… "present" … "present" …. "present" …. "present" "

[After a brief time spend re-orientating within the familiarity of their special safe place, the participant is directed to climb back up their steps in the usual way into awakeness and awareness, and can then be questioned about what they can remember of this session and about any IMR answers (if any) they produced. The participant will also be encouraged talk about what they visualised, experienced, felt and learnt from this regression.]

A. (v) b REGRESSION PROTOCOL – COUNTING DOWN THE YEARS

This regression approach (sometimes called a "Diagnostic Scan") is time consuming, especially for participants who are being regressed over many years of life experience, but it can be an effective way of targeting past problem areas and times. It requires an ideomotor response to be established at the start, in order to use this to signal those years and events which the unconscious mind records as being problematic or aetiological for the current weight problem. It is also essential to have a pen and paper to hand to record the responses.

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again today, firstly by helping her to become even more relaxed, even more deeply asleep … and secondly by allowing me help in directing her back through her past to look at how events from the past might be impacting still on her weight in the present.

Before beginning this look at past years, I would like to ask the unconscious mind if today it would take control of the fingers of P's (participant's name) right hand, and allow these fingers to talk to me and answer questions for me today about events and feelings from P's past."

[Here the "Establishing an ideomotor response (IMR) Protocol" is followed, to set up the means of responding to the hypnotist's questions. Once this has been achieved the regression can commence]

"I would like to ask the unconscious mind to take you back to the year when you were … [age] "

[This might be the age that the participant was last year, if a full regression scan is being done. Or it might be to a mutually agreed age when things first started, or appeared to have started, to go wrong for the participant regarding their weight management]

"Can I ask the unconscious mind is anything happening in ***this*** year which is connected with your present problem? If so can the unconscious mind indicate this with the **"YES"** finger"

[Pause now to allow some time for a response and then make a note of whatever happens, including any general emotional or physical response. After what is judged to be a reasonable time, move back one year, whether or not a response is obtained]

"Can I ask the unconscious mind now to take you back to the year when you were [the previous year] and ask, is anything happening in ***this*** year which is connected with your present problem? If so can the unconscious mind indicate this with the **"YES"** finger."

[This process is repeated down through the years changing the comments from time to time, referring to "teenager" or "schoolchild" and adding in age specific references such as leaving school, 18th and 21st birthdays as appropriate, to help to keep the participant to more easily orientate in each particular year… It continues right back to the year of her birth]

"Going back now to the year that you were born. Is anything happening in ***this*** year which is connected with your present problem? If so can the unconscious mind indicate this with the **"YES"** finger."

[The process is now reversed and the years are counted back up to the present age, asking a different question …]

"Can I ask the unconscious mind, in this year that you are ***born***, is anything happening to you that is particularly upsetting, or distressing or disturbing for you? If so can the unconscious mind indicate this with the **"YES"** finger."

[Next question]

"Can I ask the unconscious mind to bring you forward to the year when you are ***one*** year old and ask, is anything happening to you at one year old that is particularly upsetting, or distressing or disturbing for you? If so can the unconscious mind indicate this with the **"YES"** finger.

Coming forward to the year when you are ***two*** years old. Is anything happening at ***two*** years old that is particularly upsetting, or distressing or disturbing for you? If so can the unconscious mind indicate this with the **"YES"** finger.

Coming forward to the year when you are ***three*** years old. A toddler of ***three*** years old. Is anything happening at ***three*** years old that is particularly upsetting, or distressing or disturbing for you? If so can the unconscious mind indicate this with the **"YES"** finger.

Coming forward to the year when you are ***four*** years old. A little girl [or boy] of ***four***. Is anything happening at ***four*** years old that is particularly upsetting, or distressing or disturbing for you? If so can the unconscious mind indicate this with the **"YES"** finger.

And now you are ***five***. ***Five*** years old and starting school soon. Looking through this year, is anything happening at ***five*** years old that is particularly upsetting, or distressing or disturbing for you? If so can the unconscious mind indicate this with the **"YES"** finger.

Coming forward now to when you are ***six***. ***Six*** years old little schoolgirl [or boy]. Looking through this year, is anything happening at ***six*** years old that is particularly upsetting, or distressing or disturbing for you? If so can the unconscious mind indicate this with the **"YES"** finger.

Now you are coming forward to the year when you are ***seven***. A ***Seven*** year old schoolgirl [schoolboy]. Looking through this year, is anything happening at ***seven*** years old that is particularly upsetting, or distressing or disturbing for you? If so can the unconscious mind indicate this with the **"YES"** finger.

[This process continues upwards, changing the comments from "schoolchild" to "teenager" to "adult", and adding in age specific references such as leaving school, 18th and 21st birthdays, to help to keep the participant in each particular year. Until back to the starting point …]

"Come forward now to the year when you are … [starting point or participant's present age]', is anything happening in this year that is particularly upsetting, or distressing or disturbing for you? If so can the unconscious mind indicate this with the **"YES"** finger.

And now P. is firmly back into the present with no part of her in the past. Can I thank the unconscious mind for the good work it has done today, and ask that anything that the conscious mind has learnt today can be used to help in her present and future life."

[After a brief time spend re-orientating within the familiarity of their special safe place, the participant is directed to climb back up their steps in the usual way into awakeness and awareness, and can then be questioned about what they can remember of this session and of any IMR answers (if any) they produced; also what they visualised, experienced, felt and learnt from this regression.]

A. (v) c REGRESSION PROTOCOL – THE CORRIDOR OF LIFE

This regression ideally should be preceded by establishing an IMR, although it is possible to carry out this visualisation using oral questioning and answering.

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P. over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again today, firstly by helping her to become even more relaxed, even more deeply asleep … and secondly by allowing me help in directing her back through her past to look at how events from the past might be impacting still on her weight in the present.

Whilst P. is relaxing in her own special safe place, I wonder if her unconscious mind would like to allow a picture to begin to form in her mind's eye. A picture of her standing at the end of a long corridor. This corridor, her corridor, is pleasantly decorated and well lit, with couches and tables with magazines on them at various points along it. There is also a series of doors stretching down the corridor, each with a number clearly written on it. P. notices that the number on the first door, the one nearest to her, is the same number as her present age, and that the number on the next door is the same as the age that she was last year, and so on right down the corridor as far as she can see.

P. begins to realise that each of these numbers refers to a year in her life, and that these are the rooms in which her unconscious mind stores the memories of all that has happened to her in those years, in order to be able to go back to check out on something important from the past. This is how her unconscious mind keeps track of her developing life, keeping her safe on a daily basis by regularly referring back to earlier events and people, by remembering anniversaries for her, and also by allowing her to revisit and enjoy once again the pleasant times and feelings from her past. So P. guesses that what there is in each of the rooms behind each door might be all that happened to her in each of those particular years of her life.

It might be that you are feeling excited, at the thought that you could open any one of these doors and go back to some special day or time in your life and enjoy it all over again. Perhaps meet up with a relative or loved one from the past who has since died and re-experience how you were together. So why don't you try this, wouldn't you like to walk up your corridor to find a door with a number on it that coincides with something positive or especially lovely in your life. This might be perhaps a special birthday, or a holiday with family or friends, or perhaps some time when you felt really good and positive and proud of yourself. Then you can go into that room to see how it feels. So I would like to suggest P. that you give this a try, that you walk along your corridor, slowly pausing at each door, to find a door and a number which in some way feels positive, or that perhaps reminds you of some especially good and very positive time in your life. And when you find such a door,

to let your unconscious mind indicate this with your ***YES*** finger, and then wait outside this door."

[Wait for a YES signal, or ask "Have you found a door which feels very positive". There may be a long wait if there are lots of doors down a long corridor. If no such door is found, there may not be such a really special time, so the question is rephrased "Why not place your hand gently on each of the door handles along the corridor and see there is one that *feels friendly*, or ask your unconscious to find a *happy* door for you". Then look again for the signal or ask again "Have you found a door handle which *feels* friendly". Once such a door has been found continue …]

"Good. So now P. you are waiting outside a door which you and your unconscious mind seem to agree contains some pleasant memories, so I would like you to look carefully at the number on this door, and remember this for later. Now I don't know for certain what you are going to find when you enter this room, and neither do you, but whatever you do find and re-experience is going to relate to some very pleasant, exciting or perhaps romantic event in your earlier life, something that should make you feel good, and which will remind you of a time when you felt positive and proud of who you were. So when you are ready you can turn the handle of that door and walk boldly in to that room … and just ***feel how it feels***. [Long pause]. When you are in this important room and are able to look around and see where you are, who you are with, and what is happening, can you ask your unconscious mind to signal to me with the ***YES*** finger. This is your chance now to recall and re-experience, and ***enjoy*** once again that special time."

[Wait for a little while to allow participant to partake in this experience, observing what seems to be happening emotionally during this experience. Then continue …]

"Now it is time to say goodbye to this room and to the event and the people in it … but not to the positive feelings that you have re-discovered from that time. These good and positive feelings are yours, you are allowed to take them away with you today, and to keep them to use in some of the other rooms and situations and other years. So just before you leave check that you have them all safely with you, all of these positive feelings, emotions, qualities, skills, whatever they may be, calmness, relaxation, confidence, optimism, fearlessness, happiness, whatever you can identify … gather them all up and keep them … wherever on your person seems appropriate, whether in your mind, in your brain, in your heart, in your body, even in your pocket … but keep them all safe … as they are a very precious and important aspect of ***who*** you are. So one last look around your room, one final check that you have safely with you your positive qualities … then back into the corridor … closing the door gently behind you.

I hope you enjoyed that little adventure, and that you are now ready to explore another room along your corridor of life. Hopefully there are many more rooms along your corridor

containing good, happy and positive times, some of which you might have only a dim memory of, and some which your *conscious* mind will have forgotten completely, that's perfectly natural … but your *unconscious* mind will not have forgotten any of them … and you can always revisit these whenever you like. But that is for another time, as there isn't really enough time for this today. Besides which I think it would be useful to put some of these newly collected up positive emotions and useful skills that you have now to good use today, whilst you have them so fresh and strong … I hope you agree? So I wonder therefore whether you would like to see what problems from the past you can track down today which could be undermining your attempts to lose weight, and which you could begin to sort out today. Especially if this could help you with your weight or eating or self-image problems in the future. It would also be a good opportunity for you to put into practice the emotional and practical skills that you have recently taken back into yourself.

So I would like to ask your unconscious mind to help you today to identify what rooms there are along your corridor that are important to you today with regards to your weight and eating problems. Important because they contain times and places, events and people, feelings and emotions from the past which have continued to have an effect and an impact on your weight, your eating habits or your self-image ever since. These are the rooms that you might like to explore today with the help of your new collection of positive emotions and skills. In a moment you might like to begin again walking along the length of your corridor, starting from the door numbered with your present age … but pausing outside each of the succeeding doors in turn as you come to them, and looking up to read its number. At each door you can wait to hear from your unconscious mind, which we hope will tell you, in some way, if this is an important door for you today. I don't know how it will tell you this but you will know … the door might be a different colour, its number may be written differently, it may already be slightly ajar as if to invite you in, or it might just make you ***feel*** different. When you find such a door can you ask your unconscious mind to tell me using your ***YES*** finger. So off you go on another adventure."

[Wait and watch to see if a ***YES*** signal is delivered. This may take a while if there are a lot of doors to be examined. If there is no ***YES*** signal, then the question is rephrased "Can I ask the unconscious mind whether there were any doors that P. missed out or which were no accessible to P. today? Wait for a ***YES*** or ***NO*** signal … if ***YES***, then asked whether these doors can be accessed at a later time, eg, later today, tonight, next week, the next session or only after some other event or change has taken place. If a ***NO*** signal is given or no signal at all, this may indicate that there is no past factors relevant to the participant's current weight problem, and this needs to be explored from a different perspective. If a YES signal is given then continue …]

"So you have found a door that your unconscious mind has suggested contains information about something from the past which is relevant to your current weight problem? If this is right, please ask your unconscious mind to indicate this with ***YES*** finger."

[Wait for this signal]

"Good. Would you now like to look at the number on this door and remember this number as it might be important in the future. Now I don't know what or who you are going to find in this room once you open the door and walk in, and neither do you. But this is ***your*** room that ***your*** unconscious mind has chosen for you to see into today. Your unconscious mind would never want you to be harmed, so you can be sure therefore that there is nothing threatening in this room … only the knowledge about past events and emotions that you need to have, to understand and deal, in order for you to be able to manage your weight problem, a knowledge which you will then be able to use for your future growth and development. And remember that you are entering this room bringing with you all the emotional and practical skills sufficient for you to deal with any situation you might find there. So, in your own time, when you feel you are ready, perhaps you would you like to turn the handle of this door and walk boldly into the room beyond … and just ***feel how it feels***. When you are in this important room and are able to look around and see where you are, who you are with, and what is happening, can you ask your unconscious mind to signal to me with the ***YES*** finger."

[Wait for the ***YES*** signal, then allow time for the participant to settle in and start to understand where and when she has gone back to, and how it feels. Watching all the time for emotional turbulence and response. Check what is happening, at intervals, by asking "is the unconscious mind happy with what P is experiencing? Or "Does the unconscious mind wish P. to spend any further time in this room?" or Is there anything further that the unconscious mind wishes to show to P in the room today?" When it seems appropriate continue …]

" Now it is time for P. to leave her room, taking with her all that she has learnt from her time spent in this part of her past, and ready to use this knowledge to move forward in her life. She knows that she can always return to this room if ever she wants or needs to be reminded of this part of her life. So with one final glance around the room P can pass through the door and close this firmly behind her, knowing that she has learnt and dealt with this part of her life and can move from this. A final glance up at the number of this door and then P. can begin to walk calmly and proudly back along her corridor counting up the years as she passes the doors that are leading to her current age, to ensure that no part of her remains in the past. Almost before she realises it she is back in her own special safe place, from where in her own time she can climb up her steps and awaken, keeping with her a new knowledge for her to use for her present and her future life.

Visualisation ends …

[Once fully awake the participant can be questioned about all that she remembers about what she saw and felt in each of her two rooms.]

A. (v) d REGRESSION PROTOCOL – THE "MAGIC CARPET" TIME LINE

There are many visualisations which can help individuals to revisit their past and bring back good aspects of this to use in their present and future life. This is one I have modified to use for this overweight and obesity programme.

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P. over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again once again today, firstly by helping P. [participant] to become even more relaxed, even more deeply asleep … and secondly by allowing me to help in directing her back through her past to revisit that important time, before she developed her weight problem.

Talking now to P. - in a moment you are going to embark on a magical and exciting adventure as you start to notice a ***fascinating*** thing happening to you. As you lie relaxing on your couch you realise that you are now being carried ***gently*** and ***safely*** along on a magic carpet. This magic carpet begins to rise slowly, gently and steadily up into the warm Summer air, so that you can look down to see a lovely country lane running along below you. Looking down also you can see below you, yourself lying ***resting*** on your couch just under where you are floating. You notice also that out along your country lane below you in one direction this lane curves round out of sight, but that in the other direction you can see some of the past events in your life lined up along the lane. And you are excited to realise that this lane is the ***history*** of your life as you have lived it. So you decide to explore this lane further and to take a tour back through your life.

As you sail ***happily*** and ***safely*** along over this lane on your magic carpet, going back through your life, looking down, you see and remember and recall in turn, all the events of your life. Some of these are ***pleasant*** and you ***smile*** as you remember and feel again these good times … some of which have remained powerfully in your memory. … Others you had forgotten, and you are so ***pleased*** to have the chance to re-experience these again and to be reminded of these times. Of course there are other times that are not so pleasant, times that you remember as being perhaps sad or frightening … however you are surprised to notice that even as you re-experience them again, you don't actually feel the pain of these times any longer … not in quite the same way … nothing like as strongly as you feel the pleasures and excitements of some of the those good times. ... You realise that this is because you must have ***dealt*** with these bad times. … at the time they were occurring … and you have been able to ***let go*** of the unpleasant and painful feelings as you dealt with them,. They are no longer a factor in your life in 2015.

As you float along over your lane, from time to time, you are reminded of your weight problem. Looking down, you see and are reminded of some of the problems this has caused over the years. … You notice and realise that these events and feelings seemed to have

stayed with you. Unlike other unpleasant past events and feelings which you dealt with at the time, and which have faded away, and have become gone and forgotten. You decide that you must investigate why the weight problem and feelings have continued. Surely these should have been let go off and should have become just a memory … no longer affecting your life. … So you decide to continue your journey down your life lane to see if you can find out when and where and how your weight problems all started. You will try to find the ***last time*** the last period in your life, when you did not have a weight problem and then by going back ***before*** that time, you start to re-experience what it felt like not to have a weight problem. … You want to visit the time and the place just before your weight problem first started, be able to look into the future from there at how … and why your weight problems began to start. You are excited to see how you looked and felt about yourself when you did not have your weight problem. That way you can find the time when it all began. That way you can understand the reasons why it all began.

AND THERE IT IS!

Looking down you realise that there is where it all began. You are at a point in your lane where you can see yourself below you … looking just as you used to do before your weight began to increase, and just a little further on you can already see the changes taking place.

THIS IS SO EXCITING!

So you start to direct your magic carpet down to that important time … that last time that you did not have a weight problem. … You park your magic carpet, and step off into the lane … and ***step*** into that person standing before you … the ***you*** without a weight problem. … And just ***feel*** how it feels …once again … not to have a weight problem. Just ***feel*** how different your body feels … just feel how ***healthy*** you are feeling … just feel how ***easily*** and ***freely*** you can move around … how ***easily*** you can ***bend*** down … how much ***lighter*** you feel … how ***well*** your ***clothes fit*** you … ***eating*** is a ***pleasure*** with lots of choices … how ***relaxed*** you feel ***going out*** with friends or family for a ***meal*** … how friends and family ***admire*** your ***appearance*** … how ***relaxed*** you are in your mind … how ***proud*** and ***pleased*** you feel about ***yourself***, about your ***body***.

It would be lovely if you could take ***this*** body forward to the future … ***these*** feelings … this ***freedom*** … Would this … could this … really be possible, you wonder. … Just a little way down your road of life you can see that things are already beginning to change. Things that you realise will affect how your weight, your body, your appearance will change in the future… If only you had seen the signs then. Fortunately you ***can*** bring this ***slim, healthy, happy*** person into your future. Because … now that you can: ***see clearly*** … ***understand fully*** … ***deal appropriately*** with future problems. You can ***take control*** … ***do things differently*** ... ***change*** the ***future*** . And this will allow you to bring this slim, healthy, happy person back into your life.

So now it's time to put all these important things into practice. It is time to say a grateful goodbye to your younger self. But before your leave, you want to thank your younger self for reminding you how ***good*** and ***safe*** and ***healthy*** … how ***happy*** and ***confident*** and ***proud*** … you can feel when you don't have a weight problem. To thank this younger self for reminding you of why you started to develop a problem with your weight. And finally to ask your younger self's permission to take away with you today the good and positive

feelings that are part of not having a weight problem … to take these back to 2015 to help you deal with any future weight problems. And of course your younger self is only too happy to give you the gift of these feelings for you to use in the future.

It is a very ***different***, a ***wiser*** and a ***happier*** P. that climbs on board her magic carpet, which has been waiting patiently for you, for the return journey. And as you rise **slowly**, ***steadily*** and ***safely*** up into the warm Summer air, you wave goodbye to your younger self below, and excitedly begin your brief journey floating over your country lane as you travel through your life, back to 2015. But as you do so you have with you and inside of you … very strongly … all of the ***feelings*** and the ***experiences*** and the ***knowledge*** of what it is not to have a weight problem. Because you now ***no longer*** have a weight problem. From now onwards you are going to find it so easy to lose any unnecessary weight you have gained. The problems that became your weight problem can now be let go of or dealt with differently … and you can begin your weight loss confidently and comfortably and in your own time.

Soon you see that you are over the present time in your life. There below you is your present self, in [location] and [date]. You are totally in the present … and no part of you is in the past. But just before you come down to the ground again in 2015, you might like to confirm that you can continue into the future as this new slim, healthy, happy person. … So why not ask your magic carpet to give you a glimpse of your new slim future. Just ask it to go forward in time a little and see what you could look like at some future event, a holiday, Christmas, some family gathering. … and as you look down, there below, you can see how it could be, as there you are, part of the future, as a ***slim healthy happy*** person still. So returning to 2015 you ask your magic carpet to take you down to where you are resting on your couch. Here you step back into your present self, taking with you all the good and positive feelings that you were able to bring forward from the past … the ***good, safe*** and ***healthy*** … the ***happy, confident*** and ***proud*** feelings that you can have now … along with all of the tools you need to become that ***slim healthy happy*** person again, now that you no longer have a weight problem. And as you lie relaxing on your couch, you realise perhaps how much of an unnecessary burden you have been carrying from the past … and which has resulted in the increase in weight that you have experienced. But now things are about to change … things really are changing … and in the coming weeks you will notice more and more … that things really are changing for the better. “

[After a brief time spend re-orientating within the familiarity of their special safe place, the participant is directed to climb back up their steps in the usual way into awakeness and awareness, and can then be questioned about what they can remember of this session and of any IMR answers (if any) they produced; also what they visualised, experienced, felt and learnt from this regression.]

APPENDIX A.(vi) HABIT MODIFICATION THROUGH REFRAMING

This is one of a number of hypnotic techniques which can be used to modify or eliminate inappropriate or unwanted repetitive or habitual behavioural problems. For this reason I have adapted it to use to deal with bad eating habits and any associated behavioural patterns arising from and overeating or weight management problem. It commences once the participant is hypnotised and settled in her safe place, and it requires the prior establishment of an ideomotor response to allow questions and answers to be exchanged between the therapist and the participant's unconscious mind.

A. (vi) REFRAMING WEIGHT AND EATING MANAGEMENT HABITS

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P. over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again once again today, firstly by helping P. to become even more relaxed, even more deeply asleep … and secondly by allowing me to help her in dealing with some of the habits that are preventing her managing her weight and eating problems effectively.

I would like to ask the unconscious mind if it will allow me to talk to that part of P's unconscious mind which has been looking after and monitoring her eating habits, and when I am talking to that part in the unconscious mind, to indicate this with the ***YES*** finger."

[Wait for signal. If no signal, ask again. If still no ***YES*** signal or only a ***NO*** signal, rephrase the question eg "that part of the unconscious that takes care of her eating", or " looks after her diet". If still no response ask "would it be possible to talk to the eating and dietary part on another occasion". If a ***YES*** signal, then ask when it would be possible, "later in this session, the next session, after her holiday, in a dream", then move on to something else in this session. If a ***YES*** signal is obtained immediately then continue as …]

"I would like to thank that part in the unconscious mind that has been looking after and monitors P's eating habits, and for knowing what was necessary in the past for P. and her eating, and for all the good work it has been doing in this way for her over the past years. But today I would like to ask that part in the unconscious mind that looks after and monitors P's eating habits if it would consider the accepting a new part to do this job, in a different way, one which might be more appropriate to P's present situation. If this is acceptable to that part in the unconscious mind, would the unconscious mind indicate this with the ***YES*** finger."

[Wait for the ***YES*** signal. If this does *not* appear, ask again. If still no ***YES*** signal or only a ***NO*** signal, rephrase the question e.g. "setting up another part to *share* the role of looking after and monitoring P's eating habits", or "work alongside." If still no response or only a ***NO*** ask "would this part consider being replaced or assisted on another occasion". If a ***YES*** signal then ask when it would be possible, "later in this session, the next session, after her holiday, in a dream", then move on to something else in this session. If a ***YES*** signal is obtained, immediately then continue …]

"I would like to thank that part in the unconscious mind that has been looking after and monitors P's eating habits for being so helpful today. Now I would like to talk to the ***creative*** part in the unconscious mind, that part that creates the parts for other parts of the unconscious mind to use and which knows about new behaviours and ideas. When I am talking to the *creative* part of the unconscious mind would it indicate this with the ***YES*** finger."

[Wait for the ***YES*** signal]

"Thank you for this. Can I now ask the *Creative* part in the unconscious mind whether it would be prepared to create a range of new parts in the unconscious mind each of which could take over [or share, or work alongside with, as previously agreed] the looking after and monitoring of P's eating habits from the present time and into the future."

[Wait for ***YES*** signal. If this does *not* appear, or only the ***NO*** signal, rephrase the question, or ask about when this *could* happen and continue as appropriate. If a ***YES*** signal appears immediately then continue …]

"Thank you. Can I now ask the Creative part in the unconscious mind to create a range of new parts in the unconscious mind each of which is capable of taking over [or sharing, or working alongside with, as previously agreed] the looking after and monitoring of P's eating habits from the present time and into the future, and when these parts have been created, to signal this with the YES signal."

[Wait for the ***YES*** signal to appear, then continue …]

"Thank you, Creative part of the unconscious mind. Can I now return to that part of P's. unconscious mind which has been looking after and monitoring her eating habits up to now, and ask this part if it will accept one or more of the *new* parts made by the Creative part of her unconscious mind today to take over [or share, or work alongside with, as previously agreed] this role from the present time and into the future."

[Wait for the ***YES*** signal to appear. If the answer is ***NO***, then enquire when this new part *will* be acceptable to the existing part, eg later today, tomorrow, next week next session, after some other event or change takes place, and respond accordingly, ie. "thank you for letting such a new part take over [or share, or work alongside with, as

previously agreed] this role from later today, tomorrow, next week next session, after some other event or change takes place and into the future." Otherwise continue …]

"Can I ask is there any objection anywhere else in P's unconscious to such new parts that it has made, starting to work to look after and monitor P's eating habits in the future?"

[Wait for the ***NO*** signal. If however a ***YES*** signal appears instead then this needs to be explored in this or a later session, otherwise continue …]

"Thank you for this. So there is now a new part or set of parts working in P's unconscious mind [or sharing, or working alongside, as previously agreed] looking after and monitoring her eating habits for the future. Is this correct"

[Wait for ***YES*** signal]

"And now that this new part or parts will work in P's unconscious mind, will this now help P. to look after and monitor and develop a better eating pattern for herself for the future?"

[Wait for ***Yes*** signal, if a ***NO*** signal is given then this needs to be investigated and explored, asking what else has to change]

"Now that this new part or set of parts is working in P's unconscious mind is there any further barrier to P. being to lose weight healthily, and to her being able to develop a better eating pattern for herself for the future? Will the unconscious mind for a moment let P. look into the future to see herself using this new part to understand how it will work and how it will change her eating behaviour and other aspects of life?"

[Pause for this to happen and observe participant for any emotional change or response]

"Is there anything else that the unconscious would like to show today to P. before she returns from her safe place and awakens?"

[Respond appropriately to whatever answer is given, then after a brief time spend re-orientating within the familiarity of their special safe place, the participant is directed to climb back up their steps in the usual way into awakeness and awareness, and can then be questioned about what they can remember of this session and of any IMR answers they produced and what they visualised, experienced, felt and learnt during this process. Also how are they feeling now]

APPENDIX A.(vii) SIX LIFE-STYLE AND EGO ENHANCING VISUALISATIONS

Visualisations employing metaphors can be useful in highlighting aberrant lifestyle decisions requiring changing, and in facilitating this change. They can also be used for ego and self-confidence enhancement. Such visualisations can be generic and open-ended or can be specifically designed to suit the individual participant, occasion/session or the specific therapeutic application. The precise wording used on each individual occasion will vary as the session and the participant dictates, and also in response to evident or perceived emotional reactions on the part of the participant during the actual visualisation. Such visualisation always begin and end in the participant's hypnotic special safe place, although participants can also practice and repeat their favourite visualisation at home if they wish.

A. (vii) (a) WALKING BACKWARDS DOWN A COUNTRY LANE

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P. over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again once again today, firstly by helping her to become even more relaxed, even more deeply asleep … and secondly by allowing me to help her in dealing with some of the habits that are preventing her managing her weight and eating problems effectively.

As you are relaxing and enjoying the calmness and safety of your own special safe place, I would like you to become aware that things around you are gradually changing and you realise that you are standing in the middle of a narrow country lane. It is a warm Summer day and all around you are the sights, the sounds, the smells of the country. The sky above you is a pure, bright blue with just an occasional white fluffy cloud … and you can feel the warmth of the sun on your face and arms and feel the breeze blowing through your hair. You can hear the sound of sheep on the hills around you and of the birds in the trees in the field alongside of the lane. The verges and the hedgerows on either side of the lane are heavy with blossom, with occasional bunches of blackberries which you might like to sample… you can feel the lane under your feet, uneven with ruts and stones and tree roots.

It feels so lovely being in the country and you decide to take a walk along the lane and see what you can find. … to find out where your lane leads you to, what you can find to visit as you enjoy the walk, … so off you go, strolling slowly down your country lane to enjoy your day out"

[short pause]

"But … All is not going well, as you soon start to notice. You are finding that you keep bumping into things as you walk down your lane, … the hedges … the trees, … the fences … You keep finding yourself walking into the brambles on the hedges on either side of the lane …into the tree branches overhanging the lane … these are all ***obstacles*** that you did not see in time … there - it happens again, you have banged you head on a low branch of a tree … Just to make matters worse, you also keep ***stumbling*** over things in the lane … a large stone …***trip*** …a tree root … ***trip*** … a milestone on the grass verge, ***nearly tripped over then*** … you keep banging your feet and now you have cut your ankle. You are constantly encountering ***obstacles*** which you could easily have avoided or got around, if you had only seen them coming. And there is something else that is spoiling your walk, and that is that all the interesting things that there are to see on either side of the lane … ***you don't see*** … for some reason …***until too late***. You seem to be missing out on the adventures and the good things that are waiting for you, … the interesting little footpaths … the beautiful little cottage … the water lily filled lake … the watermill over the stream … the

wooden bench where you would have liked to have sat to admire the view … it seems that by the time you see these sights it is too late, you have already passed them. You are not having the chance to look forward to, and to enjoy the good things awaiting ahead. It is always ***too late***. You are only seeing them when it is ***too late.*** ***What a disappointment*** your walk is turning out to be. What is going wrong, you wonder.

Then … quite quickly … you realise what ***is*** going wrong. You realise that you have been ***walking backwards*** down your lovely country lane … ***walking backwards*** and ***looking backwards*** down this lovely country lane. … You don't know why this started… ***walking backwards***, just ***seemed*** to be the thing to do. How long you wonder, have you been doing this, how long have you been ***walking backwards*** and ***looking backwards.*** ***Looking backwards*** as you are ***walking backwards*** is the problem you realise. All those obstacles, the hedges, the branches, the stones in the road are only obstacles because you are looking backwards rather than looking where you are going. .You also realise that the reason you are missing out on all the interesting things that there are to see on either side of the lane is because you just … ***don't see them*** … because of course you are always … ***looking backwards.*** So can't take advantage of the pleasures of this country lane because you don't see them until you have ***passed*** them … you have already ***gone passed*** … so you have ***missed*** the turning into that interesting footpath … and ***walking backwards*** has meant that you have ***passed*** the little bridge over the stream before you realised it was there. … By the time you see these things … you have already ***walked passed*** them. ***Walking backwards*** and ***looking backwards*** means you are ***missing*** so much of your journey down your country lane. Spending too much time looking back at what has already happened and letting what has already gone by influence your journey, means that you miss so much of the pleasure of where you are in the present, and stops you being prepared for and anticipating the joys of the future. It also means that you cannot see the obstacles to avoid … until it is too late. Something just ***has*** to be done.

And so, very suddenly … and that suddenly is **NOW** … you decide you are going to ***turn around*** … ***turn around*** …You are going to ***turn around*** and start to ***walk forward***, to ***look forward. …*** And ***what a difference*** …***what a difference*** this has made. Now you can see ahead to avoid any obstacles in your lane, you can walk ***carefully*** under tree branches and ***around*** difficult parts of your path. No more are you going to walk backwards along this country lane, looking back and letting past things be more important than what is ***ahead*** of you. ***Now*** you feel much safer and more secure about your present journey down your lane … ***Now*** also you are enjoying planning each step ahead … savouring all the pleasant things around you… Now you can see the ***good*** things waiting for you … the ***exciting*** looking footpaths to left and right … the ***beautiful*** picnic places … the lake with the swans …the antique shop full of interesting things. … ***What a difference*** it has made to your walk along your country lane. ***Now*** you feel much more hopeful and excited about the future, as you can see clearly and optimistically where the rest of your journey is going to go. ***Now*** the future part of your journey is clear and visible so that you can ***look forward*** and ***walk forward*** with confidence. No longer will you walk along, looking backward and letting what has already happened determine your journey. Now you are on a ***forward looking journey.***

And so you walk off happy and contented along your country lane …for the first time for a long time being able to fully enjoy where you are and where you are going, without having to always be looking back. … You are enjoying your walk now so much that you do not

notice how far you have walked. So that quite quickly you can see that you are approaching your own special safe place … something you might have missed if you hadn't ***turned around*** and started ***walking forward***. You are so happy to arrive in your own special safe place … which feels familiar as always … **BUT** also in some magic way feels different … more ***powerful*** and ***empowering*** than usual. And after a brief stay here, you start to walk joyfully and optimistically up your ten steps, to awaken on the top step feeling so very, very happy, so very, very confident now that you will be able to avoid obstacles more reliably and be able to plan and look forward to a better future.

Ends…

A. (vii) (b) THE FOUNTAIN POOL INTHE WALLED GARDEN

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P. over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again once again today, firstly by helping P. to become even more relaxed, even more deeply asleep … and secondly by allowing me to help her in dealing with some of the habits that are preventing her managing her weight and eating problems effectively.

As you are relaxing and enjoying the calmness and safety of your own special safe place, I would like you to become aware that things around you are gradually changing and you realise that you are standing in the middle of a narrow country lane. It is a warm Summer day and all around you are the sights, the sounds, the smells of the country. The sky above you is a pure, bright blue with just an occasional white fluffy cloud … and you can feel the warmth of the sun on your face and arms and feel the breeze blowing through your hair. You can hear the sound of sheep on the hills around you and of the birds in the trees in the field alongside of the lane. The verges and the hedgerows on either side of the lane are heavy with blossom, with occasional bunches of blackberries which you might like to sample as you stroll down your country lane, enjoying all the pleasures and beauty of the day.

After a little while walking along this country lane you will find yourself walking along past a old fashioned and high, stone wall, something you might have seen around a country house or estate. You can just can just see the tops of some tall trees behind this wall, and you are curious to know what there is behind this very imposing wall. After a further distance you see that there is a heavy, metal-bound door set in to the wall, and you wonder whether it will be open. Just as you are level with this door a sudden gust of the summer breeze causes the door to open slightly as if to welcome you in, almost as if you were expected. So you push open the door a little wider and enter, into a wooded area, with tall trees and shrubs and bushes, in to what is clearly a walled garden. It is darker and more shaded out of the sunlight amidst these trees, with just the sunlight filtering through the top branches high above, but there is a clear path meandering between the trees for you to follow. After a little while you see ahead of you that the path is taking you into a clearing, and soon you emerge out into the sunlight, so bright it hurts your eyes at first. You see in front of you a beautifully well-kept green grassy lawn in the middle of which is a circular pond set within a stone wall. You wonder at first if there is any water in this, but as you approach it you realise that it is does contain a depth of surprisingly clean, clear water. This garden feels very surreal and magical, and the whole atmosphere seems so familiar and so comforting, that you are happy to sit on the wall around the pond and rest in the sunlight for a while.

There is something special also about this pond which makes you turn to look into the cool depths of its water. There as you would expect you see reflecting back at you, your own reflection, a mirror of who you feel are at this moment in your life. Of a sudden the summer breeze ripples the surface of the water and this reflection of you is lost for a moment. But then as the waters become quieter and still so the picture begins to reform. But this time a

different picture takes shape on the surface of the pond. There you are still, reflected back as before, but also ***behind*** you, you see lots of other people, the faces of other people looking over your shoulder and around you. These are all people you recognise, and they are, you realise, all people whom you love, and who love and take care and look after you. These are the people who are always on your side, who are always behind you throughout your life, watching over you whatever you are doing. Some of these faces are from the present, some from your past and some you even feel are of your future – friends, relatives, work colleagues, all those people who have been, are and who always will in the future be in your life. These are all the people behind you, watching over your shoulder. The people who ***care about you*** and ***support you***, even when you are no longer thinking about them. You are surprised how many people there are that you love and care about and who in turn are also there loving and caring about you, as they watch and encourage you in all your efforts. They are the people for whom you are going to strive to improve your life in the various ways that you know they would want you to do, and they are the people who will get so much pleasure out of what you hope to achieve in your life.

Once again the summer breeze disturbs the water's surface and the picture fades. But as the waters becomes still again so you can see a new picture forming and reflected in the pond. This time, once again, the picture is just of you, but a different you, perhaps in ways that you can't quite place at first. And then suddenly … you realise that this is the ***slim, healthy, happy person*** that you are aiming to be … this is the ***you*** that you have been striving to be … the ***slim, healthy, happy person*** and the ***real you,*** that has been waiting inside for such a long time, for the chance to re-emerge. This is the real P. and the ***person*** that all those others are going to help you to become. Looking at the ***new you*** reflected in these magic waters you can see all that you have lost but are now going to be able to reclaim, all that is within your grasp. There reflected today in your magic pond is your ***future***, and behind you are all those others seen and unseen, who are working with their love, to help you to achieve this ***future***. You can't help but smile at yourself as you see this ***you*** from the past looking back at you, and eager to take over again. And you start to think, perhaps for the first time, how you can use the power and the love of those others around to change your lifestyle, and so allow that old ***you*** from the past to become the ***new you*** of your future. ***What a revelation***.

But now, with these pictures firmly planted in your mind, you realise that it is time to begin the change that you see in that pond … so you turn to walk back across that green lawn and along the path that leads through the trees to your door in the wall. It is a ***new*** person, a very ***different*** person that walks out through that door into your country lane. A ***new*** person and a ***different*** person from the one that walked in just a little while ago … although it feels like such a long time ago because inside you so much has ***changed***, so much has ***really changed***. And you decide that you can leave this door open, because you know you will always be welcome back. Any time you wish to be reminded of all those who are behind you in your endeavours to change your life … or you want to see how much you have ***moved*** in your direction of change, to see how well the ***new slim healthy happy person*** is coming along. Then you know that you can return and use the magic waters of that pond once again. But for today I want you to continue walking along your country lane, letting what you have seen today sink in, and reassure you about what the future holds for you. After what you have seen today nothing can be the same for you. No longer can you carry on in the same way as you have been, in the same rut, letting anxieties and negative

thoughts, foolish fears and thoughts from past control your life and undermine your weight managing efforts. Things are about to change.

Ahead of you the lane bends round out of sight. I do not know what is waiting for you around that bend and neither do you, but whatever it is, it is part of what you want and need to do in your life. So with that certain knowledge, you can stroll contentedly and confidently around that bend in the road, a new person for the future … to find yourself in your own special safe place once more. Still the special safe place that you have always known, but now it feels different, even more special, even more safe, and even more positive than you last remembered it. There seems to be an excitement and an energy and a confidence about your special place now which feels very empowering. Even your ten steps seem more inspiring and uplifting.

So when you are ready, in your own time, you can begin to climb up your steps back to being wide, wide awake, and back to your future, the start of your new life.

Ends …

A. (vii) (c) THE SAILING YACHT ACROSS THE BAY

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P.over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again once again today, firstly by helping P. to become even more relaxed, even more deeply asleep … and secondly by allowing me to help her in dealing with some of the habits that are preventing her managing her weight and eating problems effectively.

As you are relaxing and enjoying the calmness and safety of your own special safe place, I would like you to become aware that things around you are gradually changing, and you realise that you are now sitting on a warm sandy beach in a small bay between two gentle grass covered headlands. The sky is blue above you with some seagulls idly drifting on the air currents rising off the sea. You can feel the warm sea breeze blowing on your face and arms, you can taste and smell the salt from the sea air, and under your body the sand is warm and soft. This is the idyllic and beautiful seaside you might have seen portrayed in galleries, or on seaside postcards, or that you might have tried to imagine and draw as a little child. There are only one or two other people sitting on the far side of your beach, and nobody is near enough to you to disturb the peace and quiet of this beautiful setting. Across the beach, down at the water's edge is an elegant sailing boat with a brightly painted hull and deck, and several cabins, all topped with a single tall mast with a flag at its very top. The whole scene feels very soothing and comforting, a picture from a fairy tale story book, something you might remember having once had read to you as a child.

Moving around on the deck of this boat are some people, taking parcels and boxes down into the cabins. You get the feeling that they are preparing the vessel to set sail. And you are correct, because as you continue watching, one of the crew leans over the side of the boat and releases the anchor from its moorings, then sets the sail to catch the wind. On the deck you can see one of your old-fashioned glass bottles such as you use to dispose of problems that you no longer need in your life. You realise that you just have time to run down to the water's edge and quickly place some further problems into this bottle for the seamen to dispose of forever into the depths, once the boat is out on the ocean. You stopper the bottle and hand it back to seaman who gives you a friendly smile, and a cheery goodbye as the boat slowly begins to move away from the shore. As the boat swings round to start its journey out across the bay, for the first time, you are able to read the name of the boat printed across the stern. You are pleasantly surprised and reassured perhaps to find that the name of this boat is in some way a familiar one, perhaps a name that is important for you. And this seems to fit in with the feeling you have, that this boat is important to you also. As it starts off on its journey, as it moves out into deeper water, it feels as if, in some magical way, this boat is going to be able to take away with it, the problems and worries and anxieties that you have had troubling you for such a long time.

So you watch with wonder as this beautiful sailing vessel heads out across the waters of the bay, pushing through the waves, its prow sending white shining sunlight diamonds of

spray high into the air. Behind, it leaves a white frothy wake of sparkling foam marking its path out across the bay, out towards the horizon, that line where the blue of the sea and the blue of the sky meet. You feel your mood lightening as this boat takes away all of your obsolete and redundant problems, out to sea and out of your life for ever, leaving you with a clean slate, a fresh new start for your fresh new life.

And now your sailing boat with its cargo of redundant problems is a long way from the beach, and already the top of the mast is nearly level with the horizon. The flag now is just a tiny handkerchief blowing gently in the sunlight. … Slowly and inevitably the boat gets nearer and nearer to the horizon, that line where the sea changes into the sky … until it actually seems to be sitting on the horizon itself. You realise that once this boat has disappeared below the horizon and is out of sight … this will mean that those problems and anxieties that you had … will be gone from you for ever. And now … gradually the boat begins to sink below the horizon … as first the hull disappears out of sight … followed by the lower and upper decks … until only the mast and the flag on its top are visible. And now there is just the flag to be seen … fluttering in the breeze … and … then … even this … disappears.

And with a deep sigh, you realise that this is the end of a chapter in your life … And the start your new life. A life free of the problems and anxieties that you have been carrying around for so long. A new life in which to use your emotional and physical skills and potential to move forward in a positive and confident manner. Standing up now, you turn around to realise that you are back in your own special safe place once more. Still the special safe place that you have always known, but now it feels different, even more special, even more safe … and also more positive than you last remembered it. There seems to be an excitement and an energy and a confidence about your special place now which feels very empowering. Even your ten steps seem more inspiring and uplifting.

So when you are ready, in your own time, you can begin to climb up your steps back to being wide, wide awake, and back to your future, the start of your new life.

Ends …

A. (vii) (d) A WALK THROUGH THE WOODS TO THE LILY POND

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P.[participant's name] over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again once again today, firstly by helping P. [participant] to become even more relaxed, even more deeply asleep … and secondly by allowing me to help her in dealing with some of the habits that are preventing her managing her weight and eating problems effectively.

As you are relaxing and enjoying the calmness and safety of your own special safe place, I would like you to become aware of something, perhaps, that you have not noticed before. Over to one side of your special safe place is the start of a little path between some shrubs which perhaps you might like to explore. So off you go. Quite quickly this path leads you into a very pretty wooded area with tall leafy trees on either side of the path, but which feels quite bright and airy, despite the trees around you. High above you can see the sunlight shining like sparkling diamonds through the leafy canopy and you can hear the sound of the summer breeze rustling these leaves, whilst at your feet the path is scattered with the fallen leaves which crunch as you walk on them. The air is perfumed by the smells of the shrubs and blossom around you and you can hear the birds calling to each other in these shrubs as you follow your little path winding to and from between the trees. It feels so good to be amongst the safety and the grandeur of this wood and you are so pleased to have spotted the start of this path from your safe place.

After you have spent a little time exploring through your woods, quite suddenly you come out into a clearing in the middle of which is a small, and very beautiful lily pond surrounded by flowers and shrubs. You decide to rest for a while by the pond and you sit on the grass leaning against a fallen branch close to the banks of the pond. In the quietness of this wooded glade you have the chance to think about your life, about how much you have to do, about the obstacles and the hurdles that seem to confront you, and whether you have the strength to tackle what lies before you in changing your future. As you are thinking this over a butterfly settles on your arm and for a short time you are able to marvel at the delicate wings and antennae of this beautiful creature, and you marvel at how, despite the butterfly's delicate and fragile structure, is able to fly fast and high into the sky, a seemingly impossible task for such an insignificant creature as this.

Then you notice across the pond there is a large frog about to jump from the bank of the pond on to the edge of a delicate, paper thin water lily leaf, barely able you feel, to support its own weight on the surface of the pond. You smile to yourself as you wait for the frog to fall right through the leaf into the water, but to your surprise the frog lands safely on this fragile surface, which clearly is strong enough to easily support the frog, as the frog well knew. How, you wonder, could such a tissue paper looking leaf, floating on the water support the weight and force of such a heavy frog landing on it. Looking around your secret grove you can see that amongst the grass and the fallen leaves, there are a number of little

green shoots, fledgling trees that have not long appeared above the ground. Looking at the towering fully grown trees around you, you realise that all of these trees will have started out as little green shots like these, in order to become the tall, strong trees that tower above you. It is surprising what time can bring about, and what can be achieved from such a small and insignificant start in life

Thinking over all of these little episodes and what they might mean to you, you lie back on the grass staring up into the tops of the trees high above you. After a while you become aware that, through a break in the clouds, a shaft of sunlight, a sunbeam, has appeared shining down into your little glade, lighting up the grassy slope quite close to where you are lying. Gradually as the clouds continue to drift gently across the sky this sunbeam begins to move until it is shining directly on to your feet … and you start to feel a beautiful ***soothing*** sensation in your feet and ankles from the warmth of that sunlight … to your amazement and delight, this sunbeam then begins to move along your legs … ***warming***, ***soothing*** and ***healing*** as it goes, until it is shining on your abdomen and your waist which also feel this same ***soothing warmth***. … And now as this sunbeam continues to move along your chest, and arms and shoulders and your face, little by little your whole body feels ***soothed*** and ***warmed*** and ***energised*** through the power of the sun's healing potential. … And now this sunbeam begins to fill your mind with beautiful and healing sensations … and you begin to understand and to see clearly how you are going to be able to ***change*** your life … and move ***forward*** into a ***happier*** and more ***positive*** future.

Looking around your little wooded glade now you realise that you have been through a very special experience, and that whatever brought you to this magical setting, was meant to happen. Now you can see clearly, understand fully and feel empowered to begin change your life … by ***letting go*** of the problems and burdens from the past that you have been carrying around for so long … by taking control of the present … using the strengths and the qualities that you possess, …and by looking forward … forward to your future. So saying thank you and goodbye to your woodland glade … and feeling excited and optimistic … you walk back along your path out of the woods to find yourself once again back in your own special safe place. Still the special safe place that you have always known, but now it feels different, even more special, even more safe, … and also more positive than you last remembered it. There seems to be an excitement and an energy and a confidence about your special place now which feels very empowering. Even your ten steps seem more inspiring and uplifting.

So when you are ready, in your own time, you can begin to climb up your steps back to being wide, wide awake, and back to your future, the start of your new life.

Ends …

A. (vii) (e) "BRAIN WASHING"

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P. over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again once again today, firstly by helping P. to become even more relaxed, even more deeply asleep … and secondly by allowing me to help her in dealing with some of the habits that are preventing her managing her weight and eating problems effectively.

As you are relaxing and enjoying the calmness and safety of your own special safe place, I would like you to become aware of something, perhaps, that you have not noticed before. Over to one side of your special safe place is the start of a little path between some shrubs which perhaps you might like to explore. Quite quickly this path leads you into a very pretty wooded area with tall leafy trees on either side of the path, but which feels quite bright and airy, despite the trees around you. High above you can see the sunlight shining like sparkling diamonds through the leafy canopy and you can hear the sound of the summer breeze rustling these leaves, whilst at your feet the path is scattered with the fallen leaves which crunch as you walk on them. The air is perfumed by the smells of the shrubs and blossom around you and you can hear the birds calling to each other in these shrubs as you follow your little path winding to and from between the trees. It feels so good to be amongst the safety and the grandeur of this woods and you are so pleased to have spotted the start of this path from your safe place.

After you have spent a little time exploring through your woods, quite suddenly you come out into a clearing in the middle of which is a small, and very beautiful lily pond surrounded by flowers and shrubs. You decide to rest for a while by the pond and you move a piece of a fallen, moss-covered branch closer to the banks of the pond to sit on. In the quietness of this wooded glade you have the chance to think about your life, about how much you have to do, about the obstacles and the hurdles that seem to confront you, and whether you have the strength to tackle what lies before you in changing your future. You realise that your first step has to be to try to let go of some of the worry and the self-reproach from your past that you have carried around for so long and that continues to burden you. As you are thinking this over you notice that you have some soil on your hands from having moved the branch, so you walk to the water's edge to wash your hands in the crystal clear water. How lovely it would be, you feel, if these problems from the past could be washed away as easily as you wash this soil off your hands.

And then as if your wish had been granted you start to feel the beginnings of a summer shower trickling down through the leaves high above you. The water is sun-warmed and refreshing as it runs gently down your face and arms and legs, until gradually your whole body becomes drenched in this beautiful cleansing rain. The water runs down to the ground at your feet taking away the tension and stresses from your body leaving your whole body refreshed cleansed and purified. Your eyes are closed as the rain runs across your eyelids, and you are aware of a picture beginning to take shape in your mind's eye. Magically you

can see that this same healing, cleansing rain is now running down over your brain. And as it does so it flows down into every cranny and crevice of your brain, washing away the dust and grime of the years, to leave your brain sparklingly clean, and bright and new again. As clean and bright and cleansed as your body. What a revelation.

But now the rain has stopped and the warmth of the sun above is drying off your clothes, your body, your brain, and filling your body and your mind with its health-giving, life-giving powers. You feel regenerated and reborn. So saying thank you and goodbye to your woodland glade … and feeling excited and optimistic about your future … you walk back along your path out of the woods, the little path between the trees which has been waiting to lead you out into your own special safe place. Still the special safe place that you have always known, but now it feels different, even more special, even more safe … and also more positive than you last remembered it. There seems to be an excitement and an energy and a confidence about your special place now which feels very empowering. Even your ten steps seem more inspiring and uplifting.

So when you are ready, in your own time, you can begin to climb up your steps back to being wide, wide awake, and back to your future, the start of your new life.

Ends …

A. (vii) (f) BUILDING AN ANCHORED RESOURCE COMPENDIUM

The visualisation is designed to help participants to find within themselves the specific skills, qualities and resources that they need, in order for them to begin to deal with their current problems. It also gives them the facility to be able to evoke and evince such resources on demand in any emergency. The technique of anchoring requires the participant to understand that during their hypnosis the hypnotist will be sitting closer to them than usual, and that from time to time will briefly take hold of one or other of their wrists. This should be explained in advance and permission should be obtained for a participant to be touched in this way during hypnosis.

Visualisation commences:

"Now that you are in your own special safe place, I would like to thank the unconscious mind for all the good work it has been doing for P' over the past few weeks. For looking after her, taking care of her, and for allowing me to help her with the problems she has been having in managing her weight. Can I now ask the unconscious mind if it would allow me to help again once again today, firstly by helping P. to become even more relaxed, even more deeply asleep … and secondly by allowing me to help her in dealing with some of the habits that are preventing her managing her weight and eating problems effectively.

As you are relaxing and enjoying the calmness and safety of your own special safe place, I would like to explain that through our lives we all acquire many skills and resources that can be useful in helping us to manage and deal with the problems and worries and anxieties that we might encounter at different times in our lives. However such skills and resources are like many of the things that we learn as we grow up. If we stop using them for any length of time, we forget how to use them. Like riding a bicycle, driving a car, even just walking, if we stop doing these things for a while, either from choice or after an accident, we forget how to do them and have to be reminded and to relearn them. Much about how the mind *and* the body work is of this nature, you use it or you lose it. So many of the skills and resources that you feel you would like to have and that you feel would help you in dealing with your current problem, whether this is your weight management or something else associated with this, you already in fact have had in the past but have stopped using. It would be useful therefore, I'm sure you would agree, to have a way of reviving and recovering these valuable tools for you to use in your everyday life, for solving your problems. This is what today's session is going to teach you how to do.

I would like you to go back to a particularly difficult time in your life, a time perhaps when your weight or eating problems, or something closely associated with this, were really, really badly affecting your life. The worse time in your life to have a weight problem, a situation when you were feeling the full effect of your weight problem on your life. I don't know when this was, or why it was so distressing for you at that time, but I would like you to think about this, go back to that time and really feel, really feel, that distress all over again. Feel all of the negative feelings that you had at that time, be there again and relive it. Can you do this,

can you find that time? When you are back there feeling it all, can you just nod your head for me."

[Wait whilst participant searches for such a time. If she cannot find a specific time then rephrase the question e.g. "can you imagine such a time in the past that might have been like that but was narrowly averted by chance?. Or perhaps a situation in the future that might yet arise where you would be in a very distressing situation because of your weight or eating problems, or because of something closely associated with your weight or eating? If so please nod your head slightly". Once such a situation can be visualised and nodded to then continue]

"Good. Thank you for that. I am now going to take hold of your ***right wrist*** and squeeze this ***right wrist*** several times, and each time a give this wrist a squeeze, I want you to notice how this pressure on your wrist makes the picture you have in mind of this difficult situation become more vivid and more strong … and how the distressing feelings that you have now to do with that time, and because of your weight or eating problems, become stronger and more powerful. Are you ready for this? Good. Here we go."

[Hypnotist squeezes participant's *right* wrist firmly six times, in two sets of three. Then releases the hold abruptly and positively]

"Very good. Now I have helped you to bind the feelings and thoughts around that very difficult and painful time and situation safely to your ***right wrist***, there they can stay until we come to deal with them in a little while. For the time being therefore you can move away from that situation and let those feelings subside, and when they have gone and you are calm again please give me a nod of your head."

[Wait for this signal]

"Now I would like you to think about the sorts of strengths, and feelings, and the skills and emotional qualities, which you feel would help you in the future, in some way, to deal with your weight and eating problem and get control of this. All the things that you feel would help you in the future, in managing the feelings that you associate with overweight and overeating. ***If only you possessed these***. If you have difficulty with we could ask your unconscious mind to help you to identify these and to let you know what ***it*** feels would help you. What does your unconscious mind suggest as the first and most important strength, or emotional skill or quality that would help you in the future in managing your weight and

eating problem. When you know what this first strength or skill is that would help you, can you tell me this - just say it quietly, when you are ready."

[Wait for participant to speak, rephrasing the question if no immediate response ... "What qualities and strengths do you think other people with weight or eating problems have, or that you have seen them using, that seem to be helpful for them in dealing with their weight problems … What qualities and strengths have you wished you had in the past which might now help you with your weight problem." If there is still no response, the hypnotist can suggest something, e.g., courage, self-belief, relaxation, calmness etc., but this is less powerful than those strengths chosen by or prompted from within the participant's unconscious mind. Whichever means are used to select the first strength, the visualisation continues …]

"Good. So you feel that [first strength – e.g. "***courage***"] would help you to cope better with your weight and eating problem? If this is the case then please nod your head gently. Thank you. I want you now to let your mind take you back through the years, as far back as you wish, to a time and a place and a situation in the past, when you realise that you did have ***courage***, when you really felt ***courageous***, perhaps even to your surprise, out of the blue, you felt and behaved and acted full of ***courage*** in some situation. So let your unconscious mind take you back to that special time when you really were the ***courageous*** person that your feel you need to be now, in the present. And when you have found that time and are back there again, please nod your head to tell me so."

[Wait for the nod. If there is no nod because this time is not found, then rephrase the question … "Why don't you instead then go back to sometime in the past when you saw another person, perhaps someone whom you admire greatly, who obviously felt and behaved and acted full of ***courage*** in some situation, and feel how she or he was feeling at that time, and how effective that feeling was. When you find such a time, then please indicate this with a nod of your head. Wait for nod then continue …]

"That's good. Now I would like you to look around at this situation, to see it very clearly and understand what is happening … finding yourself becoming fully absorbed in this situation where you or someone else is displaying ***courage***. And as you do so you will start to notice and to feel that this feeling of ***courage*** is beginning to grow more and more strongly and powerfully inside you … you are feeling all of your muscles, organs, limbs, your whole body becoming and feeling ***courageous*** … a feeling of ***courage*** is building up inside your whole body. And then you start to realise that in your mind also, you are feeling this surge of ***courage*** … you are ***feeling courageous*** … you are ***courageous*** …you are full of ***courage***, in your mind and in your body … this is your feeling, you ***are*** a ***courageous*** person … just feel it now.

And as you let this feeling build within you I am going to take hold of your ***left wrist***. [grasp the *left* wrist firmly] . As I hold your ***left wrist*** like this … just let this this feeling of courage become stronger, … and stronger … and stronger … and stronger [between each iteration of the word, release the grip slightly and then each time saying the word *stronger,* grip the wrist more firmly again, so anchoring the participant's feeling of courage to this *left* wrist]" Good. Now that feeling of courage is firmly anchored to your ***left wrist***, ready to be used when needed most."

[The hold on the wrist is released completely. The participant is then asked for another strength, or emotional skill or quality]

"Now I would like you to think about some ***other*** sorts of strengths, and feelings, and skills and emotional qualities, which you feel would help you in the future, in some way, to deal with your weight and eating problem and get control of this. Another strength or skill that would help you in the future also, in managing the feelings that you associate with overweight and overeating. ***If only you possessed this***. I would like to ask your unconscious mind to help you again now to identify a further emotional strength or skill ***it*** feels would help you. What does your unconscious mind suggest as the next most important strength, or emotional skill or quality which would help you in the future in managing your weight and eating problem. When you know what this would be can you tell me this, just say it quietly, when you are ready."

[Wait for participant to speak, rephrasing the question if no immediate response ... "What other qualities and strengths do you think other people with weight or eating problems have, or that you have seen them using, that seem to be helpful for them in dealing with their weight problems … What other qualities and strengths have you wished you had in the past which might now help you with your weight problem." If there is still no response, the hypnotist can again suggest something, e.g., courage, self-belief, relaxation, calmness etc., but this will always less powerful than those strengths chosen by or prompted from within the participant's unconscious mind. Whichever means are used to select the second strength, the visualisation continues …]

"Good. So you feel that [second strength – e.g. ***"calmness***"] would help you to cope better with your weight and eating problem? If this is the case then please nod your head gently. Thank you. I want you now to let your mind take you back through the years, as far back as you wish, to a time and a place and a situation in the past, when you realise that you did have ***calmness*** when you really felt ***calm***, perhaps even to your surprise, out of the blue. you felt and behaved and acted full of ***calmness*** in some situation. So let your unconscious mind take you back to that special time when you really were the **calm** person that your feel

you need to be now, in the present. And when you have found that time and are back there again, please nod your head to tell me so."

[Wait for the nod. If there is no nod because this time is not found, then rephrase the question … "Why don't you then instead go back to a time in the past when you saw another person, perhaps someone whom you admire greatly, who obviously felt and behaved and acted full of ***calmness*** in some situation, and feel how she or he was feeling at that time, and how effective that feeling was." When you find such a time, then please indicate this with a nod of your head. Wait for nod then continue …]

"That's good. Now I would like you to look around at this situation, to see it very clearly and understand what is happening … finding yourself becoming fully absorbed in this situation and what is happening. And as you do so you will start to notice and to feel that this feeling of ***calmness*** is beginning to grow more and more strongly and powerfully inside you … you are feeling all of your muscles, organs, limbs, your whole body becoming and feeling ***calm*** … a feeling of ***calmness*** is building up inside your whole body. And then you start to realise that in your mind also, you are feeling this surge of ***calmness*** … you are ***feeling calm***… you are full of ***calmness***, in your mind and in your body … this is your feeling, you ***are*** a **calm** person … just feel it now.

And as you let this feeling build within you I am going to take hold of your ***left wrist*** again [hypnotist grasps participant's *left* wrist firmly]. And as I hold your wrist like this … just let this this feeling of ***calmness*** become stronger, … and stronger … and stronger … and stronger [*between* each iteration of the word stronger, release the grip slightly and then on each *saying* of the word *stronger,* grip the wrist more firmly again, so anchoring the participant's feeling of ***calmness*** to this *left* wrist]. Good. Now that feeling of ***calmness*** is firmly bound to your left wrist, ready to be used when needed most."

[The hold on the wrist is released completely. This process is repeated for each emotional strength or quality that the participant identifies, or the hypnotist suggests, anchoring each one in turn to the participant's *left* wrist. Up to a maximum of six strengths. Then the visualisation continues…]

"You now have anchored safely to your ***left wrist*** all the emotional strengths and qualities which your unconscious mind has identified as being the ones which will help you in the future in some way, to deal with your weight and eating problem and get control of this, and which would help you in the future also, in managing the feelings that you associate with overweight and overeating. In a moment I am going to grasp your ***right wrist*** and this will take you back once again to all the feelings and all the memories from that **difficult** and **painful** time and that situation in the past, a time that was made so difficult due to your

weight and eating problem. [hypnotist now takes hold of the participant's *right* wrist with the his/her own left hand]. As I squeeze this right wrist six times … just feel coming back all of the difficult and painful feeling and memories from the past, that time in the past when your weight and eating problem made your life so very hard for you. [Hypnotist squeezes the *right* wrist six times, two sets of three squeezes]. Just feel those feelings getting stronger and stronger as your mind takes you back to that past time.

"BUT NOW …

[Whilst maintaining the hold on the right wrist, the hypnotist grasps the *left* wrist also and squeezes this six times (two sets of three), saying ***courage*** with each squeeze].

"Just feel how your ***courage*** starts to build as I take hold of your ***left wrist*** and squeeze this wrist six times to bring in your ***courage*** See … and how easily your ***courage starts to*** overcome the pain and distress of that past time and how those painful and difficult feelings from the past are already starting to fade away now that you have this ***courage***."

[Whilst maintaining the hold on the right wrist the hypnotist now grasps the *left* wrist and squeezes this six times (two sets of three), saying ***calmness*** with each squeeze]

"Now, just feel how your ***calmness*** starts to build as I take hold of your ***left wrist*** and squeeze this wrist six times to bring in your ***calmness.*** See … and how easily your ***courage starts to*** overcome the pain and distress of that past time and how those painful and difficult feelings from the past are already starting to fade away now that you have this ***calmness*** "

[And so on for each strengths or qualities previously identified. Both wrists are then unclasped. If necessary this procedure of linking the strengths to the *left* wrist whilst holding on to the *right* wrist can be repeated, but more quickly…]

"So whenever you are in a situation where your weight or eating problems are causing you distress, or you are in a situation where you need immediate help to manage your weight or eating such as this [here the hypnotists *left* hand grasps the participant's *right* wrist firmly] … then all the emotional strengths and skills that you need are waiting for you … all the ***courage*** that you need is available here [still keeping hold of the *right* wrist, the hypnotists *right* hand grasps the participant's *left* wrist firmly for five seconds then releases] … all the ***calmness*** that you need is available here [still maintaining hold of the *right* wrist, the hypnotists *right* hand grasps the participant's *left* wrist firmly for five seconds then releases] … all the [etc. … for all the other strengths previously described] that you need is available here."

[Release both wrists]

"So you see these strengths are all there whenever you want them, whenever you need them. However I can't always be here to hold your left wrist every time you wish to bring these into action. But you are going to use your own magic trick to bring them back whenever you need them. And this is how you can do this. I would like you to think up a signal that you can use to recall these strengths … this could be a word you say in your head, a picture that you let appear in your mind's eye or some tiny movement of a finger, a toe, your tongue … one imperceptible signal that you can give yourself whenever you feel the need to recall any or all of these strengths that you have stored within you.

So for a moment think about what signal you would like to use. I don't need to know what this signal is, but in a moment I am going to recall each of these strengths in turn by gripping your *left* wrist and each time I do this I would like you to do your signal at the same time, so that your signal becomes linked to this strength. I will now briefly hold your left wrist and say the name of each strength in turn as you to do your signal. You will find that this strength will return and stay with you even after I have let go of your wrist. Please nod your head when you have decided on your signal and you ready to proceed."

[Wait for nod, then grasp participant's *right* wrist firmly with the *left* hand and maintain hold on this the whole time. Then taking hold of the participant's left wrist with the right hand for five seconds, repeat three times over, the name of the first strength, in a calm firm manner during which the participant has time to activate her signal. Repeat this for each of the other strengths in turn.]

"Very good. Now I am going to show you how clever your signal is. I am going to hold on to your *right* wrist one final time to bring back the unpleasant and difficult memories and feelings to do with your weight and eating problems. But this time I will not say anything to you nor hold on to your *left* wrist. Instead when you are experiencing those past unpleasant memories and feelings strongly, I want you to say silently in your head the name of each strength, and then give yourself your signal, once for each of these strengths that you wish to recall. Then you are going to feel those strengths appearing one by once just as I have shown you, and as they begin to appear so you will feel those past unpleasant memories and feelings fading away, even though I am still holding on to your right wrist. You will have chased these negative feelings away from your wrist. This will prove to you how readily you can reclaim these inner resources and strengths, and how efficiently they can overcome the problems associated with your weight and with your eating. So then, whenever in the future you need help with the management of your weight or eating problems, or with any other problems, then you will be able to signal for this help to appear, ***and it will appear***.

[This is then performed and the participant watched as she carries through her signal for each strength recalled]

"I would like to thank the unconscious mind for all the good work it has done today for P. and for allowing me to help with this. I would like also to thank P herself and to invite her to return to her safe place, her own special safe place for a little while to think about what she has achieved today. Still the special safe place that you have always known, but now it feels different, even more special, even more safe, and also more positive than you last remembered it. There seems to be an excitement and an energy and a confidence about your special place now which feels very empowering. Even your ten steps seem more inspiring and uplifting.

So when you are ready, in your own time, you can begin to climb up your steps back to being wide, wide awake, and back to your future, the start of your new life." Ends …

APPENDIX B

PARTICIPANT RECRUITMENT DOCUMENTS

B.(i) Email Participant Recruitment Letter

B. (ii) Participant Information Leaflet

B.(iii) Participant Recruitment Poster

B.(iv) Participant Consent Form

HYPNOTHERAPY AS AN INVESTIGATIVE TOOL IN FACILITATING LONG TERM WEIGHT REDUCTION - SELECTED CASE STUDIES

Dear enquirer,

Thank you for responding to our recent email seeking participants interested in taking part in the above titled research project.

This is part of a longer term research study on the value of hypnosis and hypnotherapy in facilitating effective long term weight reduction and its associated health benefits. This project forms a part of a Ph.D. study being undertaken by myself, Paul Entwistle. I am a clinical scientist and counsellor and I have been using hypnosis for over 25 years as an exploratory and therapeutic tool for health management within the health service and in private practice.

The approach I am investigating with regard to hypnosis and weight-management is that, some people's long-term and repeated failures to lose weight, or to maintain a satisfactory weight after attending a weight reduction programme may be due to subconscious factors of which they may be unaware. Hypnotherapy sessions may be useful way of exploring and resolving such subconscious weight loss barriers, allowing these people to then make more effective progress with their weight management efforts.

This is an intensive programme which is explained more fully in the attached information leaflet. After you have read this you will probably have further questions to ask before making any decision to become involved in my project. If you do wish to take this further, please contact myself or my supervisor Dr. Ian Davies as indicated below, and we will do our best to answer your questions.

Kind regards, and thank you for taking an interest in our work.

Paul Entwistle

Paul Entwistle *M.Phil, Dip Couns, Dip Hypn, Chart. Scientist, Chart. Biologist* - Principal Researcher

Ph.D. Student, Faculty of Education, Community and Leisure

email: p.a.entwistle@ljmu.ac.uk t: 0151 709 3505 (Answerphone)

OR

Dr Ian G. Davies *PhD, MPhil, BSc, RNutr, PGcert* - Research Supervisor

Senior Lecturer in Nutritional Science, Faculty of Education, Community and Leisure

email: I.G.Davies@ljmu.ac.uk t: 0151 231 5290

IM Marsh Campus, Barkhill Road, Liverpool L17 6BD

HYPNOTHERAPY AS AN INVESTIGATIVE TOOL IN FACILITATING LONG TERM WEIGHT REDUCTION - SELECTED CASE STUDIES

Principal Researcher: Paul Andrew Entwistle

Faculty of Education, Community and Leisure

Introduction

You are being invited to take part in a research study to look at whether there are subconscious emotional and psychological reasons why people become overweight, or why they find it difficult to maintain a healthy weight and eating pattern after completing a successful weight reduction programme. This study will also be looking at whether hypnosis can help to reduce the impact of such emotional factors, and help with future weight reduction attempts. Before you decide whether you wish to take part in this study, it is important that you understand fully why this research is being done and what it involves. Please take time to read the following information. If any of the points below are not clear, or you would like more information, then please ask us to clarify or explain more fully.

It is important that you understand what you can expect to happen and to feel, from taking part in this research, so please take your time reading through the following sections, before agreeing to become involved. You are very welcome to take this form home with you and to discuss it with a relative or friend. We can always arrange to meet again when you have had more time to think about whether you feel happy about taking part.

1. What is this research about and why are we carrying it out?

Overweight and obesity, and the effects of excess weight on health and on life in general, are an increasing world-wide problem. However trying to lose weight, and maintain a healthy weight, with good exercise and eating habits, can all be very difficult, as you have probably already found. In the past there have been many small research studies done suggesting

that hypnosis and hypnotherapy could be helpful for some people who are in this situation. Surprisingly these early reports have never been fully followed up with proper clinical research studies. This is in contrast to many other areas of medicine, where hypnosis has become widely and successfully used, both for psychological problems such as depression and anxiety, and for physical problems such as pain relief and irritable bowel syndrome. In these conditions, hypnosis has been shown, scientifically and clinically, to be a safe procedure which is useful in producing changes in behaviour which lead on to better health.

This study is trying to answer three questions. Firstly, can subconscious emotional factors such as stress and anxiety, and traumas and problems from their past which have never been fully dealt with, be for some people, an important cause of their being overweight. Secondly, can hypnosis help in identifying such underlying psychological problems, and enable them to be dealt with in a way that stops them interfering in future attempts to lose weight. Finally, what is the best way to use hypnosis for this purpose, and to personalise hypnotherapy methods for different individuals. The primary researcher for this study is a clinical scientist, who in addition to his having worked in NHS and private biochemistry laboratories for many years, has worked for over 27 years as a hypnotherapist and as counsellor in a number of medical settings.

2. Do I have to take part?

Participation in this research study is entirely voluntary, and only you can really decide whether it is something with which you would wish to become involved. If after reading this information sheet you feel that hypnosis is not for you, then please free to say so. If however you feel you would like to take part in this study, then the arrangements for the various stages of the study will be explained to you, and you will be asked to sign a consent form, a copy of which will be given to you, plus a copy of the information sheet to keep. If you do decide to participate in the study, you remain entirely free to withdraw from the study at any point, without needing to give any explanation. Any such decision will not affect in any way your future rights and access to other treatments or services.

3. What is hypnosis, and what risks and benefits are involved?

Despite what you may have read about hypnosis in the media, or have seen or heard when hypnosis is used as a form of

‘entertainment’ on television or in the theatre, hypnotherapy is now recognised as an accepted and a safe form of medical treatment throughout the world. Aside from its use by commercial hypnotherapists and natural health clinics, many doctors, dentists, psychologists and counsellors routinely use hypnosis with patients and clients in their practices, both for relaxation and for therapy and treatment.

Contrary to popular perception, hypnosis is not about being out of control and totally unaware of what is happening to you. When hypnotised, you are not asleep, nor are you under the total control of the “hypnotist” who can make you do whatever he/she wants you to do. Even under clinical conditions hypnosis is a very natural and safe state to be in, and one that you will have already experienced spontaneously. Whenever you have become deeply engrossed in reading a book or watching a television play; or “deep in thought”, listening to a piece of music; or are “miles away” in the middle of a room crowded with people, you are in an hypnotic or trance state
Similarly, when you are doing ordinary everyday things in a daydream, without having to think about them, such as driving your car or making a cup of tea, you are in an altered state of awareness. This pleasant “day-dream” state happens to us all of the time. What turns this “day-dream” into a hypnotherapy session is the presence of the therapist who gently guides and directs your thoughts, feelings and memories to those related to the problem with which you and the hypnotherapist are wishing to deal. But even when you are deeply hypnotised and apparently unaware of things around you, as you focus on pictures and images in your “mind’s eye”, your unconscious mind is always around, monitoring what is happening in the room, and keeping you safe.

Calmness, relaxation, and feeling good and positive about yourself and about your future, are all part of what hypnosis sessions can do for you. However to achieve the maximum benefit from hypnotherapy, and to bring about the life-long changes in behaviour and health that you desire, it is often necessary also, to deal with any events and difficult times from your past which have never been fully resolved. These may be past or present relationship and family issues, bereavements, miscarriages, career problems, periods of hospitalisation, any or all of which, whether you know it or not, can be acting in your unconscious mind, to interfere with your moving forward in your life, and be stopping you achieving your goals. In going back to these events in your hypnosis sessions you are likely to feel them strongly once again, perhaps becoming weepy or frightened or angry, just as you know you would do also in everyday life, when perhaps these same memories are triggered, by an anniversary, a visit to a particular place from you past or a special piece of music.

The value of having this regression (going-back in time) experience whilst in hypnosis is that the therapist is there to gently steer you through these recalled memories in a way that allows them to be explored and then released safely, rather your being overwhelmed by them, or your simply trying to bottle them up again. Once these emotions and feelings, which really should have been dealt with in the past, are released during your hypnosis sessions, then they cease to be a factor in your life. This can only be beneficial to you in the long-term, as it "debugs" your past and frees you up for the future. But also, if the theory behind this research study is correct, it might then help you in your future attempts to lose weight and to maintain a healthy weight and lifestyle.

However, if at any time you become unhappy at aspects of the programme or you begin to feel uneasy that your hypnosis sessions are bringing up memories that you do not wish to deal with, then you will be totally free to withdraw from the study. At this time, and also at the end of the project, I will be available to provide immediate, independent and confidential counselling, followed if wished, by referral to appropriate sources of longer term help, or by referral to your GP. I have been using hypnosis in clinical arenas for many years, and have been a counsellor for many years also, so I have always had available a compendium of such agencies and support services for my clients.

4. What will happen to me if I take part?

This research study has a number of different stages, listed below, which will take place over several months. The timing of some of these stages will be determined by the nature of the research study itself, but as much as possible there will be flexibility to organise some of the stages, especially the hypnosis sessions, around the availability and convenience of the participants involved.

STAGE ONE:

At your initial discussion there will be the opportunity to ask any further questions about this study, about hypnosis in general and about how hypnosis might be useful in dealing with problem of overweight. If at this point you are happy to sign your consent form, you will be asked to fill in several brief questionnaires. One asks for some details about yourself, and your medical and weight history, one about your previous experience and knowledge (if any) about hypnosis, and two others are about your eating and habits and food choices.

Don’t worry if you are not good at filling in forms, many people are uncomfortable with complicated forms, help will be available for this if you need it. This will all take around one hour to work through.

STAGE TWO:

For your next appointment, you will be asked to bring with you some photographs or pictures about how you see yourself and your body, and how you feel about your weight and your appearance. This is called a photo-elicitation interview, it will last for one hour maximum, and I will explain to you in more detail about what will happen in this when I discuss the arrangements for this interview. I would want to make a tape recording of our conversation during this interview, and of the same process repeated at the end of your hypnosis sessions. The two recordings can then compared to see how much things have changed for you as a result of your hypnosis. I am happy to give you copies of these two recordings to keep, if you wish.

STAGE THREE:

This is when we will begin a series of eight hypnosis sessions, at approximately two weekly intervals. These will take place in a quiet room on the university campus, set aside for this purpose. As much as possible, within the constraints of the study and my own availability, these sessions will be at a time and on a day most suitable to you. These sessions will last for about 35 minutes, and each will be followed by a 20 minute discussion, which will also be recorded.

STAGE FOUR:

This is when I will repeat your photo-elicitation session, in the same as was done at stage two, but using a different set of photographs and pictures which reflect any changes that you may have noticed or experienced as a result of your hypnosis sessions. I will also ask you to repeat some of the questionnaires which you filled in at your first session (stage one). The possibility of further follow-up hypnosis sessions will be discussed with you, if you feel that you would find these useful for longer term support. But you will not be under any obligation to have these, nor even to keep in touch. However I would welcome the opportunity to keep in touch with you about how you are feeling, and about any changes that you may have become aware of in your mood or behaviour. It can often take some time for the changes produced by the

subconscious mind to begin to work, and for these changes to then become apparent to you in your everyday life.

Remember - if at any time you become unhappy at aspects of the programme or you begin to feel uneasy about how your hypnotherapy sessions are going, you will be totally free to withdraw from the study without your needing to give any in-depth reasons. However if you do wish to talk about your concerns or discomfort, then I will be available to provide immediate, independent and confidential counselling, and if you wish to arrange for you to be referred to other sources of longer term help, including if necessary your own GP.

5. Will my taking part in the study be kept confidential?

All information that you provide during this research is carefully looked after, and as much as possible identifying information is removed from any results, interview notes and audio tapes. Anything that still contains personal information about you such as, your name, age, history, will then be stored in a locked filing cabinet, or in a limited access computer with password protection, as appropriate. Only myself as the primary researcher, and the two supervisors of this research study, will ever have access to any identifying information, and all other stored results and data will have only a reference number. It is likely that some of the results of this research will be published in scientific journals or discussed at conferences on weight and obesity problems, to help other researchers working in the same field. But at no time will anything be released that could in any way identify you. Once this research is completed and the results analysed, all identifying information will be destroyed.

Contact Details of Researcher:

Paul Entwistle M.Phil., C.Biol., C.Sci. FRSM
Research Student, Faculty of Education, Health and Community, IM Marsh Campus, Barkhill Road, Liverpool, L17 6BD

p.a.entwistle@ljmu.ac.uk

Telephone: 07905 683 218 or 0151 709 3505 (Answerphone)

Or: Dr. I. Davies: 0151 231 5290 (Research Supervisor)

LIVERPOOL JOHN MOORES UNIVERSITY

Faculty of Education, Health and Community

CAN HYPNOSIS BE USED TO ACHIEVE WEIGHT LOSS?

- Are you concerned about being overweight?
- Have you regained weight after a weight loss programme?
- Has this happened more than once?
- Are you aged between 18-65?

If you've answered YES we would like to invite you to help us by taking part in a study at Liverpool John Moores University which aims to find out more about how our subconscious mind affects body weight.

For more information about this study and about taking part please contact:

Paul Entwistle:
Email: P.A.Entwistle@ljmu.ac.uk or
Telephone: Dr. I. Davies 0151 231 5290

LIVERPOOL JOHN MOORES UNIVERSITY

CONSENT FORM

HYPNOTHERAPY AS AN INVESTIGATIVE TOOL IN FACILITATING LONG TERM WEIGHT REDUCTION - SELECTED CASE STUDIES

Principal Researcher: Paul Andrew Entwistle

Faculty of Education, Community and Leisure

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, to ask questions and to have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights. ☐

3. I understand that any personal information collected during the study will be anonymised and remain confidential. ☐

4. I agree to take part in the above study, which will entail an initial interview and history taking, and the filling in of several questionnaires. This will then be followed by a longer interview during which I will discuss with the researcher a sequence of photographs which I will have been asked to provide relating to my perception of my weight and body image. This is known as a photo-elicitation interview. A similar interview with new photographs provided by myself will be undertaken after approximately 16 weeks, at the end of this study. ☐

5. I agree also to undertaking a series of eight hypnotherapy sessions, each lasting around 35 minutes, the nature of which has been explained to me. After each session there will be a 20 minute discussion about what I experienced and how it felt during each session. ☐

6. I understand that the photo-elicitation interviews and the post-hypnosis discussions will be audio recorded and I am happy to proceed on this basis. ☐

7. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised, and will not identify me in any way. ☐

8. I confirm that I am over 18 years old. I have been overweight for more than 5 years. I believe that my Body Mass Index (BMI) is over 25 and I have tried on at least two previous occasions to lose weight without any permanent success. I confirm also that I do not have any major chronic illness or recent surgery, nor am I currently under the care of a psychiatrist or mental health team. ☐

I am / am not currently attending a NHS or private weight reduction programme.

Name of Participant: Date:

Signature:

Name of Researcher: Date:

Signature

APPENDIX C

PARTICIPANT QUESTIONNAIRES

C.(i) Demographic Information

C. (ii) Generalised Anxiety Screening Questionnaire (GAD-7)

C.(iii) Stanford Personal Health Questionnaire Depression (PHQ-9)

C.(iv) Emotional Eater Questionnaire (EEQ)

C.(v) Attitudes To Hypnosis Questionnaire (ATHQ)

LIVERPOOL JOHN MOORES UNIVERSITY
INTERVIEW PROFORMA

INITIAL INTERVIEW QUESTIONS FOR PARTICIPANTS

Please note: The following information is being requested in order for me to see your overweight problem in the full context of your personal, family and medical history. You are not obliged to answer any questions about which you feel uncomfortable. As this form contains personal information about you, access to this information will be strictly limited to myself and the two supervisors of this research study. If you wish to change the information contained in this form, at a later date, you can do. At the end of this study this form will be destroyed.

-- 0 --

What age are you:

Do you have any children, and if so what ages are they:

Sons: Daughters:

Do you have any siblings, and if so what ages are they:

Male: Female:

Do you currently see yourself as being:

Normal-weight over-weight obese

Do you know what is your current:

weight height BMI

Do any other family members appear to be over-weight:

sons daughters siblings partner

Do any of your friends appear to be over-weight:

Yes No

At what age do you feel you first started to become over-weight:

Did this coincide with any significant event, change of school, marriage, having your children:

Do you have any chronic health problems:

Do you have any chronic emotional or psychological problems:

Do you have any allergies or food intolerances:

Do you know if your blood pressure is:

Normal Raised Low Don't know

Do you know if your blood cholesterol is:

Normal Raised Low Don't know

Do you take any prescription medicines, and for how long have you been taking each of these:

ANXIETY SCREENING QUESTIONNAIRE

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

STANFORD PATIENT EDUCATION RESEARCH CENTER

PERSONAL HEALTH QUESTIONNAIRE (PHQ-9) – DEPRESSION

Over the Past Two Weeks - How Often Have You Been Bothered By

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3

Emotional Eater Questionnaire (EEQ after Garaulet, 2012)

1. Do the weight scales have a great power over you - can they change your mood?

Never Sometimes Generally Always

2. Do you crave specific foods?

Never Sometimes Generally Always

3. Is it difficult for you to stop eating sweet things, especially chocolate?

Never Sometimes Generally Always

4. Do you have problems controlling the amount of certain types of food you eat?

Never Sometimes Generally Always

5. Do you eat when you are stressed, angry or bored?

Never Sometimes Generally Always

6. Do you eat more of your favourite food and with less control when you are alone?

Never Sometimes Generally Always

7. Do you feel guilty when eat "forbidden" foods, like sweets or snacks?

Never Sometimes Generally Always

8. Do you feel less control over your diet when you are tired after work at night?

Never Sometimes Generally Always

9. When you overeat while on a diet, do you give up and start eating without control, particularly food that you think is fattening?

Never Sometimes Generally Always

10. How often do you feel that food controls you, rather than you controlling food?

Never Sometimes Generally Always

INTERPRETATION

Scores: Value “0” = Never; Value “1” = Sometimes; Value “2” = Generally; Value “3” = Always.

For the clinical Practice:

Score between 0-5: You are a non-emotional eater. Your emotions have little or nothing to do in your eating behavior. You are a person with great stability with respect to your feeding behaviour. You eat when you feel hungry, regardless of external factors or emotions.

Score between 6-10: You are a low emotional eater. It is rare that you solve your problems with food. However, you feel that certain foods affect your will.

Score between 11-20: You are an emotional eater. Your responses indicate that to some extent your emotions influence your diet. Feelings and mood in some moments of your life determine how much and how you eat.

Score between 21-30: You are a very emotional eater. If you’re not careful, food will control your life. Your feelings and emotions constantly rotate around your food.

Spanos Attitudes Toward Hypnosis Questionnaire (ATHQ)

Q1: I find the whole idea of becoming hypnotized an attractive prospect

Not at all true Totally true

1 2 3 4 5 6 7

Q2: I have some apprehensions about hypnosis and being hypnotized

1 2 3 4 5 6 7

Q3: If someone attempted to hypnotize me, I would tend to hold myself back rather than let myself get carried away by the process

1 2 3 4 5 6 7

Q4: I would like to become deeply hypnotized

1 2 3 4 5 6 7

Q5: I wonder about the mental stability of those who become deeply hypnotized

1 2 3 4 5 6 7

Q6: Those who are easily hypnotizable are weak people

1 2 3 4 5 6 7

Q7: Those who can become deeply hypnotized are as normal and well-adjusted as anyone

Not at all true Totally true

1 2 3 4 5 6 7

Q8: I would not mind being known as someone who can be deeply hypnotized

Not at all true						Totally true
1	2	3	4	5	6	7

Q9: Intelligent people are the least likely to get hypnotized

1	2	3	4	5	6	7

Q10: I'm not afraid of becoming hypnotized

1	2	3	4	5	6	7

Q.11: I am wary about becoming hypnotized because it means giving up my free will to the hypnotist

1	2	3	4	5	6	7

Q12: I am totally open to being hypnotized

1	2	3	4	5	6	7

Q13: One's ability to be hypnotized is a sign of their creativity and inner strength

1	2	3	4	5	6	7

Q14: A deeply hypnotized person is robot-like and goes along automatically with whatever the hypnotist suggests.

Not at all true						Totally true
1	2	3	4	5	6	7

APPENDIX D

HYPNOSIS – HISTORY AND PHILOSOPHY

D.(i) Mesmerism to Hypnotherapy - A Brief History of Hypnosis

D.(ii) Theories and Controversies Surrounding Hypnosis

D.(iii) Hypnosis as a Blood:Brain and Mind:Body Intervention

D.(i) Mesmerism to Hypnotherapy - A Brief Historical Journey

Despite its long history and wide range of applications and uses, hypnosis still remains a much misunderstood and maligned phenomenon, and it has even been suggested by Upshaw (2006) that for many scientists and clinicians hypnosis has always been a "dirty word". In order to counter this therefore it is important for sociological researchers to have an understanding of the derivation and development of hypnosis. The roots of hypnosis lie in pre-history, with the use of trance states for healing and divination, shamanism, demonic possession and similar (Spanos & Gottlieb,1979; Hammond, 2014), all of which continue into present times as tribal rites (McClenon, 1997), Melanesian religious trance states (Stephen, 1979) spiritualism and satanic practices, all perhaps derivations of Jaynes "decameral mind" (Jaynes, 2000). The rather more formal history of hypnosis, or mesmerism as it was originally called, will be a familiar story to many people, and goes back to Franz Anton Mesmer's elucidation of "animal magnetism" as a therapeutic modality. In his famed book "*Mémoire sur la découverte du magnétisme animal*" (Mesmer, 1779), Mesmer sets out his twenty-seven propositions to explain how the heavenly bodies have influence on animate bodies through the action of a universal and all-pervading fluid he refers to as *Fluidum* or "Life Force", in a manner analogous to, but distinct from physical magnetism (Wyckoff, 1975). Mesmer also describes the various routes by which such a force impacts on individuals' physical and emotional health. The cures arising from his magnetic therapy, Mesmer insisted however, are due to his ability to induce modulations in the aberrant fluxes of this *Fluidum* within his sick patients, through his personal "magnetic" influence on their minds and bodies. His use and exploitation of the power of natural or "animal" magnetism for healing purposes, was, he insisted, very different and distinct from simply exposing patients to mineral magnetism using conventional magnets. Most importantly, as a conventionally trained doctor of medicine, he stressed that his therapy was

the result of entirely natural phenomena and not in any way supernatural or the result of divine interception (Wyckoff, 1975; Vandenberg, 2012).

Nevertheless the clinics wherein Mesmer's magnetic séances took place, with their subtle lighting, soft music and temple-like aura, and within which the magisterial and magical persona of Mesmer, in his long coat of lilac silk and wielding a long magnetic "wand", delivered his mystical passes over his convulsive and ecstatic patients, were hardly naturalistic, nor synonymous with formal medical or scientific practice of the day. A sincere man and an insightful clinician, however, he would only treat those patients whom he felt were suffering from emotional or hysterical disorders and amenable to his magnetic approach, referring on to his more conservative colleagues, those patients with more obvious organic ætiologies. Despite this, throughout his professional career, his theories and his work attracted the concerted opprobrium of medical establishments across Europe, who refused to accept his explanation for his undoubted successes in facilitating cures in seemingly impossible cases.

Individually however many physicians across Europe were in agreement with Mesmer's theories, admired and supported his work and came to him to observe and to learn about his treatment; whilst to his adoring public he was somewhere between a magician and a saint. Financially independent due to the wealth of his older wife, Mesmer could afford to devote his time to his "magnetic" clinics without the need to rely on the cultivation of a private medical practice, which infuriated much of the medical establishment of the day, but which allowed him the luxury of being able to treat many of his patients for free. Despite this he was still able to maintain an active social life, and as an amateur musician proficient in playing the glass harmonica, a series of glass tubes tuned to the musical scale, he entertained many of the famous composers of the day, including Wolfgang Amadeus Mozart and his father Leopold, Gluck and Haydn. The first performance of Mozart's operetta Bastien and Biastienne is reputed to have been given in the garden of Mesmer's villa in 1768, and as fellow members of The Freemasonry, Mozart was happy to acknowledge

Mesmer's magnetism fame in his singspiel opera The Magic Flute, despite appearing to parody his magnetic theories in his earlier opera Così fan tutte (Wyckoff, 1975 p.16).

At the time of his death in 1815 at 81, Mesmer was still a powerful voice in defence of his theory of animal magnetism, with many "magnetiser" medical disciples continuing his work, albeit with even more detractors (Wyckoff, 1975). Despite forever being portrayed as the father of hypnotism, Mesmer never actually abandoned his *Fluidum* and "animal magnetism" theories, nor ever apparently recognised or acknowledged that the cures he brought about in his many grateful patients were due to the force of his "magnetic" personality rather than to his "magnetising" ability, i.e. were psychological rather than physiological. Following the death of Mesmer, the history of "animal magnetism" continued in two contrasting directions, one leading into spiritualism, the Theosophical Society and the Christian Science movement, and the other retaining Mesmer's medical and therapy intentions (Podmore, 2011).

The continued use of Mesmer's techniques within the medical field, led in France by Joseph Deleuze (1753-1835) and Charles Lafontaine (1803-1892), and in Britain by John Elliotson (1791-1868) and James Braid (1796-1860), resulted in the gradual abandoning of the Fluidum theory and its replacement by explanations of Mesmer's trance-like state posited on attention and distraction, suggestion and imagination, and somnambulism (sleep-walking) (Gauld, 1992). Hypnosis flourished in France through the middle of the 19th century and was taken up by many psychoanalysts, notably Sigmund Freund and Carl Jung, both of whom later abandoned the practice as being too invasive. Towards the end of the century however, bitter hostility arose between Jean-Martin Charcot (1825-1893) of the Saltpêtrière Women's Asylum and Hippolyte Bernheim (1840-1919), a professor of medicine at the University of Nancy, over whether hypnosis should be used primarily for research and knowledge acquisition about brain function (Charcot), or whether its most appropriate role was in the diagnosis and remedying of patients' disorders (Bernheim). The resultant internecine battle between the Saltpêtrière School and the Nancy School brought clinical hypnosis in France into disrepute, and this coupled with its rejection by

psychoanalysts resulted in the gradual fading away of hypnosis in France as the 19th century drew to its close. It would be nearly 60 years, well into the next century before its reputation was restored (Guilloux, 2008).

None the less, outside of France, John Elliotson (1791-1868), working in London, James Braid (1795-1860) working in Manchester, and James Esdaile (1808-1859) a Scottish physician stationed in India, continued to be firm advocates for this new therapeutic technique, predominantly using it for pre-operative anaesthesia, where it proved eminently successful. However with the introduction of the chemical anaesthetic agents, nitrous oxide, ether, chloroform and ethyl chloride between 1844 and 1848, anaesthesia dramatically changed, and hypnosis, though still remaining effective, was abandoned in favour of the chemical approach. Braid however has been credited with popularising the use of the term hypnosis, and in his textbook *Neurypnology* or *The Rationale of Nervous Sleep Considered in Relation with Animal Magnetism* (Braid, 1843), he sets out his reasons for moving away from Mesmer's "animal magnetism" theory, and instead portraying hypnotism as a new and non-mystical means of treating nervous disorders (Krippner, 2014). Despite this refocussing of hypnosis giving it a more medical and scientific delineation, the British Medical Association speaking for the medical establishment as a whole, was reluctant to assign hypnosis a valid therapeutic role in compendium of medical treatments, less for its doubts about the efficacy of hypnosis and more because of middle-class Victorian England's moral attitudes towards autonomy of the individual and its concerns about the suggestible and potentially controlling nature of hypnosis (Chettiar, 2012). This reflected the debate then current in France regarding the potential danger of moral indoctrination of sick children through the application of hypnotic practices, what Rose (2011) refers to as "moral orthopedics". By contrast the spread of hypnosis into the United States of America was less that of a medical innovation and rather remained for a long time referred to as mesmerism and associated with the "quackery" of stage entertainment, charlatans,

spiritualism and subsequently the birth of the Christian Science movement (Hammond, 2014).

Nevertheless clinical hypnosis finally came of age in the 20th century, in the United States especially, where university courses were set up in medical hypnosis at the University of Wisconsin led by Joseph Jastrow (1863-1944) and Clark Hull (1884-1952). Subsequently and of major significance was the innovative work of Milton H. Erickson (1901-1980) an American clinician whose idiosyncratic approach to hypnosis with its use of metaphor and story-telling became the cornerstone for much of the clinical work currently in use in 21st century (Erickson, 1980; Lankton, 2013). Meanwhile in England, John Hartland was publishing his seminal 1966 textbook on Medical and Dental Hypnosis which, with its foreword by Milton Erickson, rapidly became the standard reference work for those working in medical and dental fields, and on which is based most of the current UK training courses in therapeutic hypnosis (Hartland, 1966). Since the latter part of the 20th century into current times, hypnosis has been adopted by psychotherapists, philosophers, sociologists and become linked to theories of mind and with mindfulness as Gruzelier (2005), Shenefelt (2011), Green *et al* (2014) and Osowiec (2014) have all described. Hypnosis has now become a valid topic of research by physicians, physiologists, neurologists, biochemists, psychologists and educationalists; a motivational tool for use in sport, dance, drama and many other areas; an alternative career choice; and as stage hypnosis, a source of entertainment in theatres, clubs and cabarets. After a long gestation and much careful nurturing, hypnosis has now acquired its ontological and epistemological credentials and has finally come of age (Weisberg, 2014; Vandenberg, 2010, 2012).

D.(ii) Theories and Controversies Surrounding Hypnosis

There have been many attempts over the past 25 years to develop a simple coherent definition of hypnosis for the benefit of clinicians, researchers and the lay public, but none have received universal acceptance or stood the test of time (Kirsch *et al*, 2011). The first attempt by The Society of Psychological Hypnosis, Division 30 of the American Psychological Association (APA) at producing such a definition of hypnosis appeared in 1993 but was immediately and universally felt to be unsatisfactory (McConkey, 2005; Elkins *et al*, 2015). After a further ten years of debate and deliberation by several different committees, the 2003 version (Green *et al*, 2005, p.262-263) appeared viz:

> Hypnosis typically involves an introduction to the procedure during which the subject is told that suggestions for imaginative experiences will be presented. The hypnotic induction is an extended initial suggestion for using one's imagination, and may contain further elaborations of the introduction. A hypnotic procedure is used to encourage and evaluate responses to suggestions. When using hypnosis, one person (the subject) is guided by another (the hypnotist) to respond to suggestions for changes in subjective experience, alterations in perception, sensation, emotion, thought, or behavior. Persons can also learn self-hypnosis, which is the act of administering hypnotic procedures on one's own. If the subject responds to hypnotic suggestions, it is generally inferred that hypnosis has been induced. Many believe that hypnotic responses and experiences are characteristic of a hypnotic state. While some think that it is not necessary to use the word hypnosis as part of the hypnotic induction, others view it as essential.
>
> Details of hypnotic procedures and suggestions will differ depending on the goals of the practitioner and the purposes of the clinical or research endeavor. Procedures traditionally involve suggestions to relax, though relaxation is not necessary for hypnosis and a wide variety of suggestions can be used including those to become more alert. Suggestions that permit the extent of hypnosis to be assessed by comparing responses to standardized scales can be used in both clinical and research settings. While the majority of individuals are responsive to at least some suggestions, scores on standardized scales range from high to negligible. Traditionally, scores are grouped into low, medium, and high categories. As is the case with other positively scaled measures of psychological constructs such as attention and awareness, the salience of evidence for having achieved hypnosis increases with the individual's score.

This version was also heavily criticised, for its length, its contradictions, its lack of coherence and its restrictive nature, but nevertheless remained as the reference definition for over 10 years. Most recently the 2014 version was produced, but only after a further two years of discussion by a cohort of clinical and scientific experts in the field of hypnosis, and which ultimately defined hypnosis as (Elkins *et al*, 2015, p. 382):

> A state of consciousness involving focused attention and reduced peripheral awareness characterized by an enhanced capacity for response to suggestion.

In the short time that this has been available for scrutiny it has already received the usual mix of opprobrium (Hammond, 2015; Lankton, 2015; Christensen & Gwozdziewycz, 2015) and praise (Barabasz & Barabasz, 2015; Barrett, 2015; Kluft, 2015; McConkey & Barnier, 2015; Pekala, 2015; Sanchez-Armass, 2015; Lynn *et al*, 2015; Yapko, 2015(a); Wickramasekera, 2015), from most of the major players in the academic, scientific and clinical hypnosis communities for whom it was intended.

The 2014 APA Committee also opted to redefined some associated terms including "hypnotic induction", "hypnotisability" and "hypnotherapy", however they acknowledged that any attempt to define hypnosis was fraught with controversy because the theoretical basIs and the true nature of the mechanisms that underlie hypnosis and the trance state are as yet not fully understood. The Committee's primary function as they saw it therefore was "to craft a concise and heuristic description to simply identify the object of interest (hypnosis) and its characteristics." (Elkins *et al,* 2015 p.6) The essential strength of the 2014 definition's simplicity the Committee felt, was that it allowed for alternative theories and other states of consciousness to be accommodated within the definition. Unfortunately this is where the difficulty in defining hypnosis lies, in the fact of there being two apparently opposing and mutually irreconcilable theoretical bases, which continue to vie for acceptance as the correct and comprehensive explanation for the phenomenon colloquially known as hypnosis, and with each having its supporters and its detractors amongst the academic and clinical communities.

Firstly of these competing theories is the “State” or dissociation theory, which sees there as being two entirely separate parts of the mind, a *conscious* part to which the subject or client has access to and control over, and an *unconscious* (or *subconscious*) part which the subject (or perhaps the hypnotist) can only access when the conscious mind has been bypassed through the induction of the trance state. In clinical and therapy situations the unconscious is seen as acting as a repository of important information which, in its withholding from the conscious mind, is thwarting the life plan of the consciously aware individual by generating emotional and physical illness states and inhibiting healing and progress. This view of two complementary divisions of the mind, with its roots in the neodissociation theory of Hilgard (1991), is the basis of the Ericksonian (Erickson, 1980) approach to therapy and underpins much of the therapeutic hypnosis described in seminal works such as those by Hartland (1971) and Rossi and Cheek (1988), as well as more recent text books by Lynn & Kirsch (2006), Nash & Barnier (2008), Heap (2012), Brann, Owens & Williamson (2012), and others, as well as being the *raison d’être* for the psychotherapy so much beloved of Freud and Jung (Fourie, 2011).

The second and alternative perspective on hypnosis, the “Non-State” or sociocognitive theory, is that the process of (hypno)therapy is facilitated entirely by and through the authoritarian personality and force of the hypnotist. The trance or relaxation state is merely perceived as a means of the subject voluntarily relinquishing control to the hypnotist so that the required suggestions or instructions can be delivered directly to the unconscious mind (where they are seen as most potent and insistent), thus bypassing the critical and defensive conscious mind. This view of hypnosis supposes that any change in behaviour or perception that happens during or as a result of hypnotherapy, is brought about by the willingness of the hypnotised subject to respond to and collude with, the wishes and instructions of the hypnotist or hypnotherapist, whose ultimate aim is to facilitate a change that both participants see as beneficial to the subject (Lynn and Green, 2011). No special *state* is seen as being hypothesised other than one in which the subject is receptive to

having his or her expectations fulfilled; and the experience of any observed hypnotic response and any resultant change is a function of this expectation and belief (Kirsch and Lynn, 1998, Pekala *et al*, 2010a, 2010b).

The strength of the intellectual and academic divide between these two theoretical standpoints, the "State" and the "Non-State" scenarios, has waxed and waned over the 200 years since Mesmer first demonstrated his "animal magnetism", with both sides claiming each scientific advance as being proof of or justification for their particular theory. The problem therefore that was presented to the 2014 APA committee in their deliberations over the formulation of a definitive description of hypnosis, was that they were required to "sit on the fence" in order to produce a definition which suited both sides of this intellectual divide. In the event they failed to achieve this primarily because their inclusion of the phrase "state of consciousness" in their definition was perceived as supporting the "state" theory of hypnosis and therefore upset those academics who see hypnosis purely as a sociocognitive (non-state") phenomenon, such as Lankton, (2015) and Christensen & Gwozdziewycz (2015) amongst others. In advance of the publication of the APA 2014 definition Wagstaff (2014) had presented a reasoned argument for the view that an altered state *should* be central to any future definition of hypnosis, an opinion echoed by Kirsch (2014) and Polito *et al* (2014), but not fully supported by others (Cardeña, 2014a: Laurence, 2014; Terhune, 2014; Woody & Sadler,2014). In support of Wagstaff (2014), and as his own response to the publication of the 2014 definition, Hammond (2015) has suggested a compromise position in that the altered "state" could and should be seen simply as a metaphor, which he feels, might make the new definition more acceptable to "non-state" hypnosis theorists.

The APA's 2004 attempt at defining hypnosis therefore needs to be set against this background of more than 30 years of debate, discussion, disagreement and disputation about hypnosis, with a major divide arising between those working in the clinical arena, using hypnosis as hypno*therapy* for investigative, diagnostic and therapeutic purposes, who predominantly will be "state" orientated; and those psychological and physiological

researchers and scientists whose remit is primarily directed towards achieving a greater understanding of the neurophysiological and neuroendocrinological processes underlying and directing hypnosis and the trance state induction, and who are more likely (but not entirely) to be "non-state" theorists. Although there are clearly many individual clinicians and scientists who are happy to work across the state/non-state divide, there is inevitably a great deal of partisanship also in such a competitively developing field.

Two decades of research on the role of attention and suggestion, both with and without hypnotic induction, and on the parameters influencing hypnotisability, has seemingly reinforced the sociocognitive concept of a process whereby cognitive, behavioural and therapeutic change takes place simply and solely because of collusion with the hypnotist or therapist. This concept however is an anathema to Rossi & Cheek (1988) whose detailed research and practice into the apparent workings and secrets of the unconscious mind has lead them to conclude that "altered behaviour derives from the life experience of the patient and not from the therapist" (p.14) and that "it is this simple but revolutionary shift from the early, error-prone authoritarian technique to Erickson's permissive and naturalistic approaches to accessing and creatively utilizing *state-dependent memory*" (p.15), [my italics], that is the therapeutic basis of hypnosis. Diamond (1984) is of a similar opinion that the hypnotherapeutic and healing process is engendered by the support, comfort and skill of the (hypno)therapist, who "becomes a benign yet strong presence to the patient's world of internal experience while somehow facing the patient's demons" (p 9). Whilst not denying the very powerful parent-like role and figure of the hypnotist, the accepted value and motivational power of transference during therapy, and the shared reward that transformation and healing offers to both therapist and subject, Diamond still sees the process of healing arising from hypnotherapy, as being more due to a psychoanalytical exploration of the subjects' unconscious mind and its contained memories and traumas, than to simple motivational instructions, no matter how potent these may be (ibid).

In his classic book on Medical and Dental Hypnosis, Hartland (1971) describes his hypnotherapy practice as a GP and a consultant psychiatrist in the same terms, and uses a mixture of suggestion, along with free-flowing exploration of unconscious past experiences, to promote healing and problem resolution, as similarly do Gibson & Heap (1991). Hypnosis in infertility situations can often result in marked enhancement of fertility, triggered (often spectacularly so) by a change brought about not just by positive suggestions about relaxing and frequency of love-making, which can in themselves be efficacious, but also to the finding of, and the dealing with, past fertility, pregnancy or relationship traumas which have apparently lain unresolved in the unconscious mind, often since early childhood, and which are serving as barriers to fertility and conception (Entwistle, 1988a; Entwistle, 1988b; Entwistle, 1990a; Entwistle, 1990b). All of these authors describe a similar picture of the unconscious mind as a repository of information not easily accessible to the conscious mind, but which has accumulated during the subject's lifetime. In addition to the multitude of safeguarding and housekeeping activities that the unconscious mind takes care of, it is hypothesised that there can be turmoil therein from past unresolved problems which, via ideodynamic (physical, physiological, hormonal and biochemical) mechanisms can bring about psychological, psychosomatic and physical disorders, resulting in overt disease and disability. Hypnosis seems able to reveal the existence of such forgotten problems to the conscious mind, and hence facilitate resolution of such hitherto barriers to health and wellbeing (Rossi & Cheek, 1988; Rossi, 1993).

However the existence of such a separate subconscious mind working behind the scenes and contactable through hypnosis is not a concept acceptable to many authoritative voices in the field of hypnotism research, and many do not consider the behavioural and sensory changes observed during trance states as being proof of such a hidden mind (Kirsch and Lynn,1998; Pekala, 2010; Pekala *et al*, 2010; Fourie, 2011; Raz, 2011a; Kirsch 2011). Fourie (2011) for one remains firmly unconvinced about the validity of this claimed dichotomy between the conscious and the unconscious mind, or that it is necessary or

appropriate to attribute hypnotically instigated behavioural change or healing, to motivations, machinations or manipulations within a hypothetical unconscious mind. In an account of a recent study on suggestion and hypnotism he expresses the (heretical?) view that there is no evidence at all for an unconscious mind, other than as a convenient label, and that this descriptively vague concept over time has undergone a process of reification into what is now seen as a semi-concrete storage area of the mind, even though there is no evidence anatomically or neurophysiologically for an "unconscious mind" (Fourie, 2011). In favour of this claim, Schweiger Gallo *et al* (2012) were able to increase hypnotisability in their subjects by prior implementation instructions, a condition which they posit is more compatible with a modifiable and sociocognitive non-state explanation, rather than a dispositional and state explanation, for hypnosis.

Although there would seem little room for manoeuvre between the above two standpoints, a paper by Lynn and Green (2011) gave some hope for annealing across the sociocognitive-dissociation divide. As these authors remind us, Woody and Sadler (2008) see the crux of this divide as being that sociocognitive theorists perceive that subjects under hypnosis feel their behaviour to be non-volitional simply because that is what they expect to feel in hypnosis and that hypnosis and hypnotherapy requires no requirement for an access to a hidden unconscious. By contrast, dissociation theorists, who hypothesise the existence of a distinct mechanism allowing discriminating between the external or internal origin of events (the conscious and the unconscious?), contend that hypnotherapy is effective because such discrimination is disrupted during the hypnotic trance state allowing information to be transferred across the interface between these two states. A route to bringing these two apparently mutually exclusive concepts together, Lynn and Green feel, is Response Set Theory (Kirsch and Lynn, 1998), which posits that volition in everyday experience is illusory, and that even seemingly voluntary thoughts, actions and behaviours carried out by the *conscious* mind are really automatic. The perceived automatic nature of ideomotor responses in hypnosis and in post-hypnotic suggestions is therefore no different

in nature from the everyday, non-hypnotic situation, and not the result of, or proof of, an altered, different, or totally distinct *unconscious* mind

Whilst this debate between the "state" and "non-state" protagonists continues, research is beginning to make much clearer the neural changes which accompany hypnosis and its concomitant psychological parameters, and Woody & Szechtman (2003), Gruzelier (2005), Naish (2010), Mazzoni *et al* (2013), Santarcangelo (2014), Landry & Raz (2015), Jensen *et al* (2015) and others, have all emphasised the importance of brain imaging techniques in hypnosis research as a route to understanding both hypnosis itself and as a tool for exploring and understanding generic brain mechanisms of consciousness. Increasingly therefore much hypnosis research has become focussed on the biochemical, neurophysiological and genetic basis of hypnosis and suggestibility, using a wide range of neuroimaging analyses (Raz, 2005; Raz, 2011b; Oakley and Halligan, 2009); EEG studies (Fingelkurts *et al*, 2007; Behbahani & Nasrabadi, 2008; Terhune *et al,* 2011; Kirenskaya *et al,* 2012a; Hinterberger *et* al, 2012; Voss *et al,* 2014); cerebral blood flow analyses (Uslu *et al* 2012); fMRI (Oakley *et al*, 2007; Derbyshire *et al*, 2004; Hoeft *et al*, 2012; Muller *et al*, 2012; Mazzoni *et al*, 2013); positron emission tomography (Rainville *et al*, 2002), as well as visual tests such as the Stroop Test, (Raz, *et al*, 2006). Such techniques are identifying many of the brain structures activated by or responsible for imagery within hypnotic and non-hypnotic states, including the hippocampus (Behrendt, 2013), anterior cingulated cortex and left dorsolateral prefrontal cortex (Gruzelier,2005; Hoeft *et al*, 2012; Wark, 2015), superior frontal cortex and thalamus (Rainville et al, 2002; Muller *et al* 2012), frontal-parietal areas (Terhune, *et al*, 2011), fronto-temporal area (Voss *et al*, 2014), amongst others.

The implications of dopamine innervation on the potentiation of the hypnotic state and on sensorimotor gating has been explored by Levin *et al* (2011) using the prepulse inhibition phenomenon, and by Raz (2005) using fMRI, and this latter has demonstrated how polymorphism of a single gene can enhance hypnotic susceptibility. The COMT gene codes for the enzyme catechol-o-metheoninytransferase, which is the rate limiting enzyme for the

metabolism of dopamine, and the gene exists in three genotypes valine/valine, methionine/methionine and valine/methionine. The heterozygous variant produces a lower level of the COMT enzyme and is associated with a higher level of hypnotisability (Raz 2005; Rominger *et al*, 2014), thus giving grounds to support a biochemical rather than a cognitive thesis for at least one aspect of the hypnosis phenomenon. This linking of biochemical fluctuations to changes in behavioural and cognitive performance may be more widespread, as Hall *et al* (2010) have identified endocrine influences on implicit motivation; suggestibility has been shown to be influenced by the oxytocin receptor gene which accounts for the modulatory role of oxytocin in allowing engagement with internal and external experiences (Bryant, *et al*, 2013); and oxytocin has been suggested as a neurobiological mediator of hypnosis and involved in attachment theory (Zelinka *et al*, 2014).

The have been very few attempts to identify correlations between neural changes and hypnotisability, but limited studies have demonstrated EEG changes in the left dorsolateral prefrontal cortex, an executive-control region of the brain linked to the depth of hypnosis (Hoeft *et al*, 2012), whilst Terhune *et al* (2011) have recorded differential frontal-parietal phase synchrony and Jensen *et a*l (2015) have observed modulated theta and gamma EEG oscillations as a functions of hypnotisability. Although dissociation is a *sine qua non* for the "state" premise for hypnosis, neither Fassler *et al* (2006) nor Dienes *et al* (2009) could identify any firm correlation between hypnotisability and dissociation. The relationship between concrete and measurable processes taking place within the brain, and behavioural and physiological changes within the mind and the body including those brought about through hypnosis, is a two way process, as events external to the brain can bring about permanent or semi-permanent structural and functional changes in brain structure and function through the process of neuroplasticity (Hartman & Zimberoff, 2011a, b; Doidge, 2015; Hope & Sugarman, 2015).

As early as 1974 Tellegen & Atkinson were identifying a trait they called "Absorption", the relinquishing of an active reality set for an experiental mental set (Tellegen & Atkinson 1974),

which correlated closely with susceptibility to hypnotic induction. This was distinct from other personality traits such as stability and introversion, and was characterised by extreme attention and absorption, and an ability to fully immerse oneself in fantasy and imagination. Attention and suggestibility are now thought to be vital determinants of what is required in order to be susceptible to becoming hypnotised as Raz (2005), Raz & Buhle (2006), Pekala *et al* (2010a, 2010b), Santarpia *et al* (2010), MacLeod (2011), Meyer & Lynn (2011), Moro *et al*, (2011), and Wyzenbeek & Bryant (2012) have all suggested. Suggestibility is closely associated with hypnotisability, and it has been suggested that many, even if not all, of the changes observed in the hypnotic state may be due solely to suggestibility (Kirsch *et al* 2007; Kirsch *et al*, 2011), and indeed in much that was written about hypnosis in the past, the two terms were regarded as interchangeable. Kirsch & Braffman (1999) have contended that hypnotisability is not the same thing as suggestibility, rather that hypnotisability is the *change* in suggestibility produced by inducing hypnosis. However despite lengthy debate and experiment it has still not been possible to define the true relationship between suggestibility and hypnotisability, in part because the measurement of each of these concepts is most usually done with reference to the other as Frischholz (2007) and Kirsch *et al* (2007) have debated. Nevertheless there is a utility and a pragmatic value in undertaking an assessment of hypnotisability because of the comparison which this enables when hypnosis is used in clinical work and research, and for the better understanding it gives of the various factors which seem to influence the ease with which an individual can move into hypnosis, the depth of hypnosis which can be achieved, and the likelihood of therapeutic benefit to be expected when working in clinical environment.

Because of this need to quantify hypnotisability a wide compendium of different scales has been devised for the assessment and quantitation of hypnotisability in the clinical and laboratory arenas as the review by Barnier & McConkey (2004) demonstrated. Some of these such as the Stanford Hypnotic Susceptibility Scale, Forms A and B (Weitzenhoffer & Hilgard,1959), the Harvard Group Scale of Hypnotic Susceptibility, Form A (Shor & Orne,

1962), the Stanford Hypnotic Clinical Scale (Morgan & Hilgard, 1978), the Hypnotic Induction Profile (Spiegel & Spiegel, 1978), the Stanford Hypnotic Arm Levitation Induction and Test (Hilgard & Hilgard, 1979) and the Elkins Hypnotizability Scale (Elkins *et al*, 2012) are premised predominantly on a "state" concept of hypnosis, whilst others including the Barber Suggestibility Scale (Barber, 1965), the Barber Creative Imagination Scale (Wilson & Barber, 1978), and the Carlton University Responsiveness to Suggestion Scale (Spanos *et al*,1983) have a more "non-state" psychometric basis (Hutchinson-Phillips *et al*, 2007). All of these individual measuring tools have their various advocates but because of their differing structures they do not all measure the same thing and therefore are not interchangeable, as an analysis by Kumar & Farley (2009) has shown, and as Barnes *et al* (2009) has demonstrated in their comparison of three frequently used hypnotisability scales, the Harvard Group Scale of Hypnotic Susceptibility, the Carleton University Responsiveness to Suggestion Scale and the Group Scale of Hypnotic Ability, where attitudes and expectancies were found to influence the measured parameters to different degrees across the scales.

Despite such disparities high hypnotisability has been found to be reliably associated with several behavioural concomitants as an extensive reviews by Lynn *et al* (2004) and Hutchinson-Phillips *et al* (2007) have shown, and in particular with having prior knowledge and expectations about hypnosis by Spanos *et al* (1983), Kirsch & Braffman (1999), (2001), Gandhi & Oakley (2005), Koep (2012) and Shimizu (2014), and with non-hypnotic suggestibility (Kirsch & Braffman, 1999; 2001). Lynn *et al* (2015) have proposed an integrated theory of effectors influencing hypnotisability including social, cultural, and cognitive factors along with positive beliefs and expectation, which is supported by observations that hypnotisability has a positive correlation with intelligence for 15-19 year old girls but a negative one with boys of the same age (Geiger *et al*, 2014); that Költő *et al* (2014) working with a Hungarian cohort could also identify gender differences with regard to individual and group hypnosis sessions, as well as a gradual increase in hypnotisability

score, in women but not men, over a 40 years span; and that Peter *et a*l (2011) found an association between hypnotisability and poor emotional attachment in adults. A small study by Naish (2013) has shown that high hypnotisability subjects can increase their ability to inhibit during hypnosis, demonstrating the interaction between hypnosis and frontal lobe activity mediated attention.

Work published by Piccione e*t al* (1989) has shown a 20 year stability of hypnotisability amongst a group of students, although this was achieved using a very selected and specialised cohort of subjects, examined and re-examined under very strict conditions by the same researchers. There have been suggestions that obese girls are more easily hypnotised (Thorne *et al*, 1978) although Spiegel & Spiegel (2004) were unable to confirm this, and also that hypnotisability has a diurnal variation (Aldrich & Bernstein, 1987; Green *et al*, 2015). Barber (2000) has suggested that there may be three distinctive types of highly hypnotisable individuals, which he named as "fantasy-prone, amnesia-prone, and positively set" subjects, and that there may be a need to tailor hypnotic induction to the specific type in order to achieve maximal depth of hypnosis. Gandhi & Oakley (2005) have demonstrated that the efficacy of a hypnotic induction can depend on the label attached to the session, and that calling a session "relaxation" resulted in a less suggestible subject than labelling it "hypnosis".

As suggested above, prior knowledge and believes about hypnosis have been shown to influence hypnotic responsiveness across many of the appropriate scales such as the Valencia scale on attitudes and beliefs toward hypnosis (Capafons *et al*, 2008a. 2008b, 2010; Carvalho *et al,* 2007), the Spanos Attitudes Toward Hypnosis Questionnaire (Spanos *et al,* 1978; Milling, 2012), and similar (Shimizu, 2014). By contrast however Accardi *et al* (2014) appear to have shown that even when hypnosis is firmly defined to subjects as being a placebo this does not compromise the induction or depth of their subsequent hypnotic state. The extensive clinical experience of the current author is that the facility for hypnotic induction and the subsequent depth of the hypnotic state can vary from occasion to

occasion within the same individual and that induct-ability tends to move in and out of ease for quite long periods of time over a prolonged series of sessions, for reasons relating to changes in subjects' life circumstances, health or emotional state. There is often a time and a tide for subconscious change to take place which cannot always be consciously influenced, neither by the subject's nor the therapist's conscious minds.

Several authorities have attempted to redefine the boundaries and the domain of hypnosis notably Zeig (2008) who favours a phenomenological and Ericksonian, "state" model; Rossi (2009) with his linking of hypnosis to psychotherapy; Crabtree (2012) who's "non-state" approach posits the need for the primary focus to be on the trance state and the role of subliminal activities and stimuli; Hope & Sugarman (2015) who's philosophical approach stresses the need for boundaries and grounding and acknowledges the work of Erickson (1980); and Rossi (1999, 2005) and Radtke & Stam (2008) who have expressed concern at the increasing exclusion of the social and the increasing dominance of the cognitive elements within the developing socio-cognitive, "non-state" approaches. Such approaches have not so far found universal favour and neither Cardeña & Terhune (2012) nor Sugarman (2015) are fully convinced or convincing that any substantial advance has been made in the psychological or philosophical understandings of hypnosis by these papers.

Hypnotic experience does not always and only take place during a conventional and enlisted, eyes-closed, trance state, as there are many other situations where absorption, attention or suggestibility quite naturally and spontaneously results in an altered awareness. Just going into a "day dream" whilst reading, listening to music or to a lecture, or in the middle of a crowd of people, or after having been involved in a traumatic experience such as car accident or terrorist attack, are all examples of what is referred to as waking or alert hypnosis. Young children spend much of their waking hours in this type of altered, hypnotic state when role playing stories or their everyday lives, with their toys. As Crabtree (2012, p.310) puts it:

> [T]he demand characteristics to which the hypnotic subject is responsive are not only those that occur in the laboratory or the consulting room. They are at work forming the individual's expectations long before he or she becomes part of those situations.

Waking hypnosis has therefore received attention from theorists of both "state" and "non-state" persuasions including Wells (1924), Kratochvil (1970), Alarcón *et al* (1999), Capafons (2004a, 2004b), Alarcón & Capafons (2006), Wark (2011, 2015), and Crabtree (2012), with a view to determining what is happening in this altered state of awareness.

Waking hypnosis has aspects in common with convention hypnosis such as identifiable neural EEG changes (Wark, 2015), but also some differing behavioural aspects (Kratochvil, 1970; Alarcón *et al* (1999), and has been employed as an exploratory tool in hypnosis research, as well as emergency hypnosis therapy for acute pain and following severe burns (Alarcón & Capafons, 2006; Lopes-Pires *et al,* 2009), in teaching (Wells, 1924), and in treating gambling addiction (LLoret *et al*, 2014). Gibbons (1974, 1976) has proposed a modified version of waking hypnosis which he named hyperempiric, derived from the Greek *empiria* (experience), to describe a relaxed aware, imagining and visualising state which could be used to modify or potentiate behaviour, but this was never developed further by Gibbons. There is still an on-going debate regarding the value and validity of testing for hypnotisability in clinical subjects and patients undergoing therapeutic hypnosis for medical and psychological problems and this is discussed in the next section.

Despite the forgoing debate and disagreement about the true nature of the hypnotic process, the clinical efficacy of hypnosis in diagnosis and treatment is firmly established and its reputation as a therapeutic tool is generally encouraging. Publications and reviews by Lynn *et al* (2000), Stewart, (2005) Oakley (2006), Raz (2007), Barabasz and Perez (2007), Mende (2009), Goldstein *et al* (2000), Oakley & Halligan (2011), Gartner *et al* (2011), Montgomery *et al* (2011), Ewin (2011), Nash & Wong (2011), Pekala (2015) Wickramasekera, I. (2007, 2010, 2015) and many others; and the plethora of academic text books (Hartland, 1971: Erickson, 1980; Rossi & Cheek, 1988; Gibson & Heap, 1991; Lynn

& Kirsch, 2006; Benham & Younger, 2008; Nash & Barnier, 2008; Barabasz *et al* (2011), Brann *et al,* 2012; Kradin, 2012; Heap, 2012; Yapko, 2015b) all attest to the clinical validity and usefulness of hypnosis in the therapeutic environment. These reflect the reports of the increasing use of alternative and complementary therapies generally (Cherniack, 2008; Hunt & Ernest, 2009; Hunt *et al,* 2010; Spinks & Mortimer, 2015; Clarke *et al*, 2015; Treister-Goltzman & Peleg, 2015).

Within the clinical field however as much as in psychological and physiological research environments debate and dichotomy surrounding "state" versus "non-state" dilemmas abound, and much of the above philosophical dilemmas and quandaries have relevance to clinical practice. A major point of contention is the question of pre-hypnosis testing for hypnotisability, seen as a basic requirement in epidemiological and research work, but for most clinical work, as an optional extra, and therefore an unnecessary luxury by some and a time wasting imposition for the client and therapist by others, most recently by clinician Peter Bloom (Bloom, 2014). In examining the clinical correlates of hypnotisability, Lynn & Shindler (2002) concluded that hypnotisability screening of clients and patients, despite its methodological limitations, can still provide clinicians with a wealth of valuable information, and they counsel for some degree of routine hypnotisability screening for clinical work, a view shared by Spiegel (2014) who makes a very strong case for this and for the simplicity and accuracy of the Hypnotic Induction Profile (HIP) test in clinical as much as in academic situations. Cardeña & Weiner (2004) has posited that an accurate evaluation of dissociation can be of value in predicting the potential efficacy of treatment and have suggested a number of approaches to assessing dissociation in children and adults.

However in their meta-analysis of hypnosis obesity trials Montgomery *et al*, (2011) calculated that hypnotisability accounted for only 6% of variance overall, and that larger values were only found in small and medium trials or in those trials on children, which therefore tended to bias the apparent benefits of suggestibility testing. These same authors questioned therefore both the need for, and the value of, pre-testing for hypnotisability in

clinical contexts, feeling that this could be counter-productive in view of the time required for such testing which was often more than was utilised for the therapy, and were concerned that patients could become irritated or worried about some of the items in testing procedures such that some “poor” responders could be put off and try less well. From an analysis of the impact of sample numbers on effect size in the ten hypnotherapy studies reviewed, the authors concluded that good validity in hypnosis trials required a minimum of 132 participants per trial, a requirement that was not met by many of the older reported trials (Ibid). Despite being one of the co-authors of the Stanford Hypnotic Susceptibility Scale (Weitzenhoffer & Hilgard, 1959), Weitzenhoffer admitted that once he began doing clinical work his opinion regarding the value of such scales changed and he stated in his textbook on hypnosis that “it remains to consider why a clinician might want to use them aside from scientific reasons for doing so. Apart from this last, there seems to be little reason for it” [sic] (Weitzenhoffer, 2000, p. 276).

Where hypnotisability testing has been used in clinical practice the benefits remain unclear. Thorne, *et al* (1976) in their small study reported that their cohort of obese patients had a higher mean score for hypnotisability on the Harvard Group Scale :A; Andersen (1985), using, arguably the more accurate Stanford Scale: C, found in their obese population that the percentage overweight was significantly related to their hypnotisability test scores; and Groth-Marnat & Schumaker (1990) working with a student population concluded that hypnotisability related to attitudes toward food intake and the fear of becoming overweight, may be one of a variety of predisposing factors in the development and maintenance of extreme attitudes towards eating and weight regulation. By contrast data from Spiegel & Spiegel (2004) demonstrated that overweight people register scores of many different levels on their Hypnotic Induction Profile (HIP), suggesting that hypnotisability, as measured by the HIP, was not a predictor of successful weight loss and that alternative approaches might suit different patients’ personalities, echoing the thoughts of Barber (2000) quoted above. Deyoub (1978, 1979) also found no significant relationship between obesity and

hypnotisability, which is related to the Creative Imagination Scale derived by Wilson & Barber (1978, p.235):

> …[to] meet the need for a nonauthoritarian scale which (a) informs subjects that they are to produce the phenomena themselves, (b) can be given with or without a trance induction, and (c) can be administered as easily to an individual or to a group.

Part of the problem may be that hypnotisability remains an elusive concept, within the clinical arena as much as in the laboratory, being variously associated with (but not always correlated with) absorption (Tellegen & Atkinson, 1974; Kirsch & Braffman, 1999); suggestibility both non-hypnotic and hypnotic (Kirsch & Braffman, 1999, 2001; Raz *et al*, 2006b; Dienes, *et al*, 2009; Milling *et al*, 2010; Santarpia et al, 2010; Wagstaff, 2012; Kirsch *et al,* 2011: Meyer & Lynn, 2011; Raz, 2011b; Schweiger Gallo (2012); expectancy (Kirsch & Braffman, 1999; Lynn & Shindler, 2002; Pekela *et al,* 2010a, 2010b; Meyer & Lynn, 2011; Schweiger Gallo, 2012; Koep, 2012: Tomé Pires *et al*, 2015); depth of hypnotic trance (Pekela et al, 2010a, 2010b; Wagstaff, 2012); dissociation (Cardeña & Weiner, 2004; Bell *et al,* 2011; Fassler *et al*, 2006) and disinhibition (Naish, 2013). The difficulty of determining what really is being tested in such circumstances is illustrated by the wide range of hypnotisability assessment tests and procedures currently available in the armamentarium of the hypnosis practitioner (Barnier & McConkey, 2004). Hence opinions continue to differ as to the relevance of, and the necessity for, pre-hypnosis screening of participants undergoing therapeutic hypnosis, as well as about the degree of correlation obtainable between measured hypnotisability and subsequent observed or subjective improvements in symptomology and clinical response (Lynn *et al*, 2004).

In the face of such practical and theoretical indecision it is easy to see why formal testing for hypnotisability in clinical and therapy situations is so rarely undertaken. However most clinical professionals do make some appraisal of the depth of hypnosis which their clients are able to achieve, as Bloom (2014) has indicated, generally from visual observation of their patient during each session, and from post-session questioning to gauge their degree

of subjective time dilation and contraction and conscious memory recall of the therapist's instructions, all of which can give some indication of the depth of the trance state. It is also the present author's experience that hypnotisability and dissociability are not totally fixed and unchangeable within an individual and are liable to variation from day to day and session to session, and that such fluctuations will inevitably be reflected in the depth of trance and the resulting therapeutic efficacy of any given therapy session. There can be a time and a tide for subconscious change to take place which cannot always be influenced by the subject's or the therapist's conscious minds, nor even by the therapist's use of the magic word "hypnosis" (Gandhi & Oakley, 2005).

The putative risks of hypnotic regression, for clinical and medico-legal purposes, evoking false memories of past childhood events and abuse was the subject of much contention during the 1990s and the early years of the 21st century, and has yet to be fully resolved (Scheflin, 1997; Patihis *et al*, 2014; Mazzoni *et al* 2014). A study by Chu *et al* (1999) strongly suggested that psychotherapy at least, is not usually associated with traumatic memory recovery due to the high degree of dissociation such childhood abuse generate, producing an amnesia for these events. Nevertheless litigation as a result of the apparent provoking of alleged recalled abuse memories by therapists can result in substantial legal claims (Appelbaum, 2001). Fernández, (2014) has discussed at length his thoughts on the possible value of and motives for the mind's repression of past memories, as a means towards creating and maintaining a smooth narrative of one's past, and posits therefore that there can be an innate beneficial memory distortion which protects us, by reconstructing our past rather than simply preserving the past. Fernández suggests that "our capacity to reconstruct our personal past in memory is different from our capacity to acquire knowledge of it through memory" (ibid p.546). Fivush & Merrill (2014) have also examined the degree to which we reconstruct and modify our remembered past, for cultural and social reasons, whilst observations by Brown *et al* (2015) have demonstrated that for many individuals, their

past false memories have been borrowed from the peers or family of the hypnotised subject, and are being “recalled”, presented and used for particular personal reasons.

The “remembering” of events in hypnosis which had never actually occurred is a frequent occurrence which can sometimes triggered, as Sheehan (1988) has demonstrated by supplying false information before and even after hypnosis, although even in the absence of such a disrupting effects and prompting, Spanos *et al* (1999) have reported 68 of 78 (90%) age-regressed participants as recalling non-existence events from their infant past, half of whom very strongly believing in the reality of their recovered ‘memories and with the classification of these experiences as memories or as fantasies not being significantly correlated with participants’ hypnotisability. Similarly Hyman & Billings (1998) found that 25% of 72 students in their study recalled false “memories” not previously remembered, however such recall was correlated with scales of dissociation and creative imagination. A study by Zelig & Beidleman (1981) found correlation between hypnotic susceptibility and strength of confidence with which hypnotised subjects remembered and believed erroneous events after hypnosis and Dasse *et al* (2015a, 2015b) reported a study indicating that the degree of hynotisability rather that of suggestibility influenced the development of false memories.

Gleaves *et al* (2004), Wagstaff *et al* (2008, 2011) and Gudjonsson *et al* (2014) all accept that memory recall can generate both genuine and false memories, and whilst Gleaves *et al* (2004) felt that the recalling of false memories could not be prevented and that the therapist could only attempt to screen them all for their veracity, Wagstaff *et al* (2008) have suggested that, if expectancy and demand criteria can provoke false memory generation, it should equally be possibly to use the phenomenon to eliminate false memories. However Painter & Kring (2015) have shown how selective the unconscious mind is in recalling memories with emotional events being remembered easier and from further back in time than neutral events

A number of publications have discussed concerns about the technical, scientific and ethical problems inherent in designing hypnosis trials, whether for clinical use or for research purposes. Iphofen *et al* (2005) have discussed at length the designing of robust hypnosis protocols which are scientifically valid whilst still respectful of individual patient's needs, feeling that conventional randomised control trials can preclude being able to work in a patient-centred, holistic manner. With this in mind Sapp (Sapp, 2004; Sapp *et al,* 2007; Sapp, 2015) has explored the problems of establishing confidence levels and power estimates in hypnosis setting, whilst Chambless & Hollon (1998), Alladin *et al* (2007) and Hutchinson-Phillips *et al* (2007) have all stressed the need for clinical hypnosis to be put on a more scientifically validated and evidence based footing. From a technical viewpoint Shenefelt (2011) and Peter *et al* (2014) have discussed the implications and validity of two popular devices employed in clinical hypnosis, these being ideomotor signaling and arm elevation respectively, as tools in the assessment and monitoring of the hypnotic trance. Whilst these phenomena are related to hypnotisability exact correlations are elusive. Frischholz (2001, 2007, 2015a, 2015b) has expressed concerns over the ethical dilemma of obtaining truly informed consent from patients prior to hypnosis therapy following recent legal contention that the informed consent form is invalid unless it identifies hypnosis as "dangerous," "experimental," and "unproven" by long-term outcome studies (ibid).

Lynn (2001a, 2001b) has also warned about the use of metaphors in age regression sessions and the danger therefore of elucidating and reifying false recalled material and "memories". However the extreme stance taken by Lynn is criticised by Kluft (2001) as being unproven and counter-productive, and by Hammond *et al* (2001) as being at best extreme and overly excessive. A series of papers by Kluft (2012a, 2012b, 2012c, 2012d) has discussed the problems of undertaking group hypnosis either for research or for training purposes, where members of the group are likely to have different hypnotisability and dissociation potentials such that some highly susceptible members of the group are may go

into a deeper trance than the others and subsequently may not be fully out of their trance state by the time that the group are sent away at the end of the session.

Nevertheless despite the above practical and theoretical problems the use of hypnosis as a therapy and treatment for a wide range of physical and emotional problems continues to flourish, both within formal medical arenas, as well as in the hands of the many private therapists and commercial agencies providing hypnosis services. The use of hypnosis and hypnotherapy in psychotherapy and medical situations generally entails the client and the therapist negotiating around whether the client's problem is best solved by "non-state" motivation hypnosis alone or by an specific mix of "non-state" suggestion and "state" dissociative psychodynamic exploration; and in general the most appropriate approach will normally become apparent during the initial history taking and assessment by the hypnotherapist.

Sociocognitive hypnosis is now widely used in medical and dental fields to facilitate invasive procedures (Kroger, 2008; Cheseaux et al, 2014); in health education and promotion as a motivational tool (Johnson & Brinker, 2001; Tramontana, 2009; Lynn *et al*, 2010; Hasan *et al*, 2014; Mohamed & Elmwafie,2014); for pain management (Ellner & Aurbach, 2009; Nash & Tasso, 2010; Kohen, 2011; Elkins *et al*, 2012; Milling, 2014; Jensen & Patterson, 2014; Syrjala *et al*, 2014; Colón & Avnet,2014; Del Casale *et al*, 2015; Artimon, 2015; Oliveira & Linhares, 2015); in infertility and gynaecology situations (Entwistle, 1988a, 1988b, 1990a, 1990b; James, 2009; McCormack, 2010; Domar & Prince, 2011; Pourhoseina & Ehsanb, 2011; Vyas *et al* 2013; Worley & Berga, 2014; Frederiksen *et al*, 2015); for bowel and gastric disorders (Hall *et al* 1967; Keefer *et al*, 2013; Schaefert et al, 2014; Berrill et al 2014); emotional and psychological disorders including depression and anxiety (Jain, 2006: Alladin, 2010; Alladin, 2014a, 2014b, 2014c; Kaiser, 2011; Airosa *et al,* 2011; Hartman & Zimberoff, 2011a, 2011b; Golden, 2012; Daitch, 2014; Gravitz & Page, 2013), insomnia (Anbar & Slothower, 2006; Farrell-Carnahan, 2010; Perfect and Elkins, 2010 Cordi *et al,* 2014; Cordi *et al*, 2015), eating disorders (Barabasz & Spiegel, 1989; Barabasz, 2007; Kraft & Kraft,

2009; Túry *et al*, 2011; Strucker, 2012; Barabasz, 2012; Roy, 2014), weight management (Entwistle *et al*, 2014; Gelo *et al*, 2014 and over 50 historical papers reviewed below in 1.6.(v)), psychiatric problems (Barabasz & Barabasz, 1996; Capafons, 1998; Oakley, 2000; Oakley, 2006; Chiu, 2009; Nash *et al*, 2009; Golden, 2012; Attewell *et al* 2012; Pyun, 2013; Hiltunen *et al*, 2013; Barabasz, 2014); Morgellons disease (Gartner *et al*, 2012), warts (Ewin, 2012), and in work with children (Brown *et al* 1997; Anbar & Slothower, 2006; Olness, 2008; Kaiser, 2011; Kohen & Kaiser, 2014; Kuttner, 2014; Oliveira & Linhares, 2015) – to give just a few examples.

Hypnosis is also increasingly being used in conjunction with other therapies such as mindfulness, meditation, acupuncture and acupressure, cognitive behavioural therapy (CBT), counselling, psychotherapy, psycho-analysis, neurolinguistic programming (NLP), and general cognitive behavioural approaches. Lynn has suggested that mindfulness might inhabit the same psychometric domain as hypnosis (Lynn *et al*, 2006;), and certainly the two have much in common with each having much to contribute to the understanding of the other, (Harrer 2009; Alladin 2014a, 2014b, 2014c; Green *et al*, 2014) and with meditation in general (Lifshitz,& Raz, 2012). A meta-analysis by Kirsch *et al* (1995) proved very positive in reaffirming the benefits of cognitive directed hypnotherapy especially for weight management, and this was welcomed by Capafons (1998) in his proposal for an awake variant of cognitive self-hypnosis, however a later paper by Schoenberger (2000) was less than fully enthusiastic. Cognitive hypnotherapy has therefore been suggested as a new paradigm for establishing hypnosis as a formalised and integrative cognitive therapy ((Barber, 2008; Alladin & Amundsen, 2011; Alladin, 2012).

Loriedo *et al* (2011) have incorporated hypnosis into their couple counselling protocol, a similar combination of therapies has been proposed by Alladin *et al* 2007 who emphasised however the need for further work to validate and evidence base hypnosis as part of this process, and by Hlywa & Dolan (2011), who saw this combination to be of value in spiritual counselling. Interestingly in their trial of treatments for adult ADHD (Hiltunen *et al,* 2013),

hypnosis was rated more successful than CBT. In a series of papers, Rossi has discussed a therapeutic hypnosis healing approach using a combination of hypnosis, and brief psychotherapy, to engender what he refers to as a creative psychosocial genomic healing experience (Rossi, 1999; Rossi, 2009; Rossi *et al*, 2011). Psychotherapy in combination with hypnosis has also been proposed by Appel (2014), whilst Hartman & Zimberoff (2011a, 2011b), Bonshtein (2012) and Wickramasekera (2015) each have their own take on the scientific and therapeutic benefits arising from the interaction between hypnosis, psychological analysis and neurochemical plasticity. Neurolinguistic programming (NLP) has been usefully employed in combination with hypnosis (Kirenskaya, 2011b), as has acupressure (Meunke & Draeger-Muenke, 2011; Gelo *et al,* 2014) and acupuncture (Lu & Lu, 2013).

Much of the therapeutic use of hypnosis however is “state” orientated and premised therefore on the implicit assumption that there is an unconscious mind at work influencing and determining the life of an individual. This inner milieu is posited as a repository of covert agendas accrued over the lifetime of that individual, often as a result of past unresolved personal traumas, which are now proving aetiological for the physical and emotional problems currently being experienced, or which may be actively impeding the individual in his or her life plans,. Access to this inner sanctum of knowledge and history through dissociative hypnosis allows these erroneous or out of date agendas to be accessed, identified and resolved facilitating the alleviation of physical and psychological symptomologies and a more appropriate progression with wished-for future life plans. Thus the seminal and idiomatic therapeutic approaches developed by Hartland (Hartland, 1971; Yeates, 2014a, 2014b) in England and Erickson (Erickson, 1980) in America continue to be the cornerstone of analytical and exploratory hypnotherapy amongst clinical hypnotists.

This interaction and interdependence of the conscious mind, the unconscious mind and the physical body, which is the basic premise of much of clinical and therapeutic (“state”) hypnosis (and of psychotherapy and psychosomatic disorders), is also the *sine qua non* of

this thesis; that decisions made as children and young adults can become internalised and lost to conscious recall, but which can nevertheless act from within the unconscious mind to influence, much later in adult life and without the individual being consciously aware of this, not just behavioural acts but additionally influence and control biochemical and physiological mechanisms leading on to heath disorders and diseases (Teicher *et al,* 2010; Webber, 2010; Kradin, 2012; Srinivasan, 2013; Van der Kolk, 2002; 2014). This has been reinforced for the present author by his many years of experience working clinically, scientifically and hypnotically in the field of unexplained infertility, where exploratory, dissociative ("state") hypnosis has been able to reveal to patients seemingly unrelated and previously unrecalled traumatic episodes from their past which when discussed and resolved, facilitated improvement in measurable fertility parameters and subsequent pregnancies (Entwistle & Turner, 1986; Entwistle, 1988a; Entwistle, 1988b; Entwistle, 1989; Entwistle, 1990a; Entwistle, 1990b; Entwistle, 1992).

Hypnosis also has now an established role in many areas of non-medical use, including sports performance enhancement (Vernon, 2009, Iglesias & Iglesias, 2011: Barker *et al*, 2013), education (Navaneedhan, 2011; Wark, 2011), forensic science (Hibler & Scheflin, 2012; Wester & Hammond, 2011; Lynn *et al*, 2015) and dance (Riley, 2012; Karageorghis *et al*, 2012), and many others. Outside of the laboratory, research and office situations, the sociocognitive mechanism of hypnosis is probably most typified by stage hypnosis, where willing volunteers seem happy to allow themselves to be taken over and ordered to behave in humorous or immoderate ways for the entertainment of their friends. During stage hypnosis the supposition of the stage hypnotist as penetrating into a protected area of the unconscious mind does not need to be made, and in fact such a circumstance needs to be avoided lest the subject inadvertently enters into a regressive state with consequent serious implications. Clearly this is a classic case of collusion between hypnotist and subject to bring about perceptual and behavioural change, without any reference to any state change or therapeutic intention.

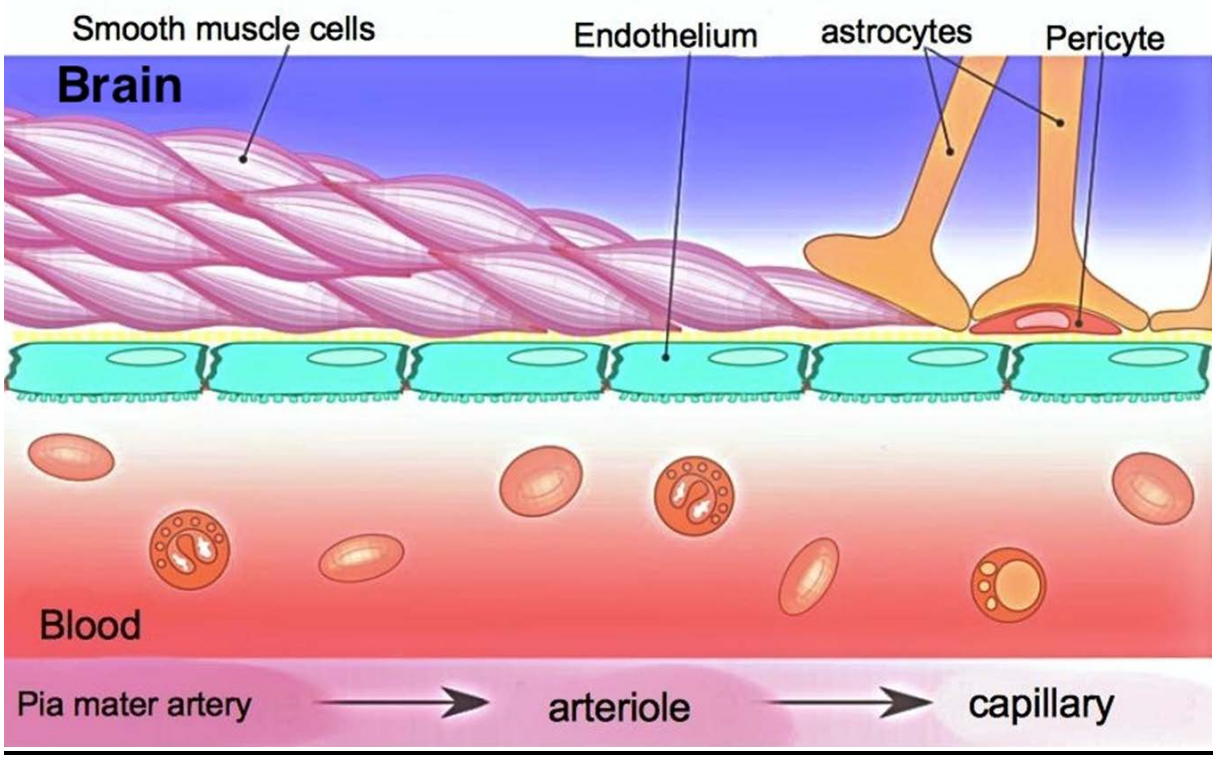
Finally in this section reference needs to be made to a paper the title of which posed the question “Does Clinical Hypnosis Have Anything to Do with Experimental Hypnosis?”, in which Heap (2011,1) suggests that:

> there is reason to question how much the clinical application of hypnosis is informed by the non-clinical scientific evidence and even whether clinicians can be said to be using hypnosis as it is now defined and understood in the academic literature.

Despite the contention of Nash & Wong (2011) that hypnosis in the laboratory can illuminate psychopathological states as detected and managed using hypnosis, Heap’s premise is that little of the research findings in the psychology, neurochemistry and neurophysiology of hypnosis has impacted on the current and every day practice of clinical hypnosis professionals, a viewpoint accepted also by Osowiec (2014), who sees only divergence between clinical and scientific hypnosis usage and practice. From a personal perspective the present author has to agree, as having originally trained in clinical hypnosis over 35 years ago and then very recently opted to retrain and update my knowledge, I have found much reassurance and comfort from the realisation that, despite the passage of time and the wealth of revelation about the scientific basis for the phenomenon that is hypnosis, my day to day, face to face work with clients and patients assumes much the same pattern as it has done over those past 30 years. The same problems and dilemmas confront me, the same methodological approaches and visualisations seem to provide the solutions, and the same philosophical issues as discussed above still remain - *plus ça change, plus c’est la même chose*, perhaps?

D.(iii) Hypnosis as a Blood:Brain and Mind:Body Intervention

Figure D. (i) SCHEMATIC DIAGRAM OF THE BLOOD-BRAIN BARRIER



Taken from: Armin Kübelbeck - http://en.wikipedia.org/wiki/File:Blood_vessels_brain_01.png

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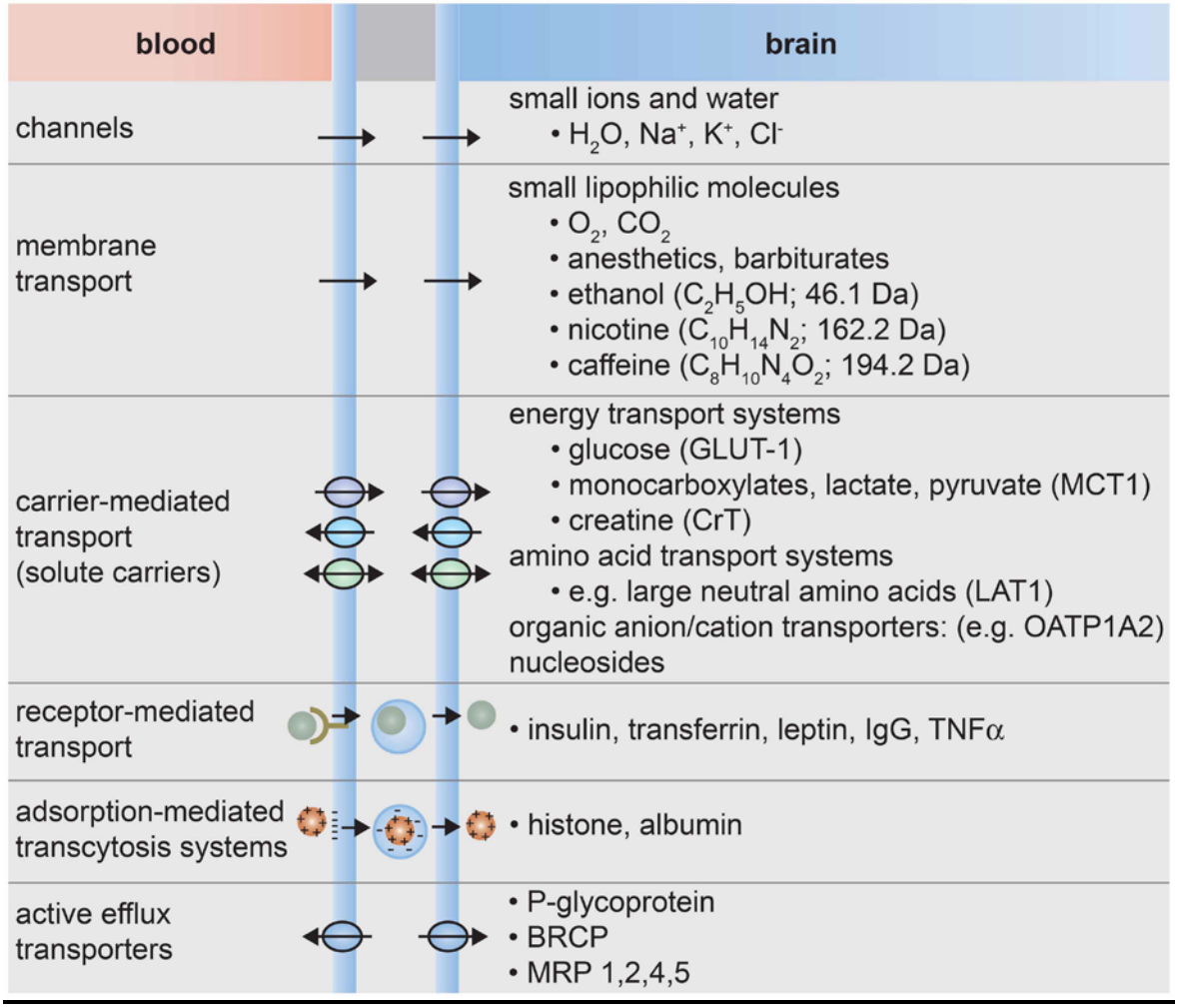
The first suggestion that there might be cellular barrier between peripheral blood and the brain tissues and fluids came from an observation by Ehrlich (1885) that injecting trypan dyes into the bloodstream of animals could vitally stain all of the organs in the body but significantly not those of the central nervous system (CNS), which he attributed to these tissues lacking a binding facility for these dyes. The functioning of this blood:brain barrier is facilitated via the endothelial cells of the CNS micro-vasculature which are unique in the body and quite unlike capillaries elsewhere, being continuous nonfenestrated vessels with tight junctions and minimal pinocytic vesicular transport properties, and which are able to

closely regulate and restrict the passage of solutes in and out of the CNS (fig D. (i)). This serves to protect the brain from access by toxic chemicals, and infective and inflammatory substances, whilst allowing egress of waste products and secretory peptides, the two processes together helping to maintain essential homeostasis within the CNS (Lawther *et al*, 2011; Bentivoglio & Kristensson, 2014; Bicker *et al,* 2104: Daneman & Prat, 2015.

Figure D. (ii)) SOLUTE TRANSPORT ACROSS THE BLOOD-BRAIN BARRIER



Taken from:

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Thus the CNS is afforded a privileged status with its own unique microenvironment and any opening up of the CNS to the rest of the body is a highly controlled and regulated process (Lawther *et al*, 2011). It is clear also that the bi-direction dynamic complexities of the blood-brain barrier makes this highly important anatomical feature rather less of a barrier, and rather more of an active interface serving as a communication and control panel between the brain (and hence the mind) and the rest of the body (fig. D. (ii)). The capillaries of the blood-brain barrier encompass around 95% of the total brain-body interface (Karamanos, 2014), but a further degree of contact exists in respect of the preservation of cerebrospinal fluid (CSF) chemistry, the normal functioning of this fluid, which bathes areas of the brain and the spinal cord, being essential in maintaining neural homeostatic activity. There therefore exists a separate, blood-CSF barrier, similar in nature to the blood-brain barrier, and this is primarily located in each of three so-called choroid plexuses, one each in the lateral ventricle (in the hindbrain), the third ventricle (in the diencephalon), and the fourth ventricle (in the telencephalon), along with some minor blood-CSF barrier activity being found in the arachnoid and arachnoid villi.

However the blood-brain and the blood-CSF barriers are not the only route for molecular movement in and out of the brain, as there are areas of the blood CNS interface which are not protected by such a barrier and where blood borne bioactive molecules can therefore diffuse freely from blood plasma into the CNS. These organs are called the circumventricular organs (CVO), and include the neurohypophysis, median eminence, area postrema, subfornical organ, lamina terminalis and the pineal gland. It in these areas that the biochemical components relevant to this project would be sensed and responded to, and which would be seen as locations and determinants of mind-body control as monitored and influenced by hypnosis. Such biochemicals include those involved in weight regulation such as amylin, ghrelin, leptin; fluid balance hormones such as angiotensin II and the natriuretic peptides; immune regulatory factors including interleukin-1 β (IL-1 β) and interleukin-6 (IL-6); and reproduction relevant hormones such as relaxin.

Through the activity of the blood-brain and blood-CSF barriers, and the circumventricular organs, the brain with its access to an individual's cognition is able to monitor the activities of the body and direct the body in turn through the hypothalamic pituitary adrenal axis, the brain-gut axis and other routes. Effectively the body hears everything the mind says and where the mind directs, the body follows. Hence a healthy mind-body set including normal emotional and behavioural activity is the corollary of an intact and healthy blood-brain interface and conversely so, as Kradin (2012) has indicated in his review of psychosomatic disorders. This inter-correlation means that physical, behavioural and emotional aspects of an individual are both controlled by, as well as influencing, the physical brain and higher cognitive centres. This allows for the positing that mental and psychological traumas can impact on the physical and emotional health of the body, and also that psychological therapies may be able to influence physical and emotional health through the same interface. Vandenberg *et al* (1966) were amongst the earliest researchers to investigate the impact of emotions and feelings on measurable biochemical parameters in their study showing that hypnosis-induced stress produced a decrease in blood glucose levels and an increase in plasma free fatty acids, and in a later paper Klein & Spiegel (1989) were able to produce modulation of gastric secretions and basal acid production under hypnosis.

Subsequent papers by Walton *et al* (1995), Oakley (2000, 2004), Wisneski & Anderson (2005), Webber (2010), Taylor *et al* (2010) and Srinivasan (2013), have all reaffirmed the interconnectedness of mind and body and of individual psychoneuroendocrine mechanism, stressing the need to develop an integrative psychophysiological approach to the study of many, if not all disease states. Oakley (2000) decries the allopathic, reductionist description of mind-body mechanisms and their molecular cross-talk as implying separate and unconnected systems, the nervous, the endocrine and the immune systems, suggesting instead that the route to a full understanding of disease states is to abandon the "systems" classification and group all neural and humoral active substances together under the generic name of "messenger molecules". Benedetti *et al* (2104) have shown that molecules

and drugs when acting as placebos and nocebos, mediate these effects by modulation of several neurochemical systems including cholecystokinin, endocannabinoids and endogenous opioids, as well as by influencing prostaglandin synthesis through the cyclooxygenase-prostaglandins pathway. Placebos and nocebos additionally have been shown to modulate anxiety through their action on β-catenin, a neural anxiolytic controller in the nucleus accumbens (Dias *et al*, 2014). In their recent review Frisaldi *et al* (2015) examined the mechanisms whereby emotional and psychological change interacts with the neuronal circuitry, have suggested that the study of placebo and nocebo effects can play a useful role in understanding such interactions between the mind and the body.

Following the seminal studies of Vandenberg *et al* (1966) and Klein & Spiegel (1989), social and psychological stress has become area of investigation for its impact across the blood-brain barrier. Neural correlates of emotional stress have been identified in the amygdala (Gianaros & Sheu, 2009; Bonaz *et al*, 2012; Martire *et al,* 2014)), nucleus accumbens (Dias *et al*, 2014), anterior cingulate cortex (Gianaros & Sheu, 2009; Zelinka *et al*, 2014; Teicher *et al,* 2014), hypothalamus (Hall *et al,* 2012; Dias *et al,* 2014; Zschucke *et al* 2015), and hippocampus and the HPA axis (Heim *et al* (2008). There is also clear evidence accumulating to implicate stress in the generation of neural inflammatory response and endothelial dysfunction (Jambrik *et al*, 2004, 2005a, 2005b; Powell *et al,* 2013; Schoen & Nowack, 2013; Tully *et al,* 2013; Kiecolt-Glaser *et al*, 2014; Morris *et al*, 2015), including granulocyte activation (Keresztes *et al* ,2007); in increasing the incidence of coronary heart disease (Gianaros & Sheu, 2009); and in skin disorders (Hall *et al*, 2012). Whilst leptin signalling to the HPA axis has been suggested as being responsible for the initiation of puberty (Bellefontaine *et al,* 2014) and may possibly be the cause of the amenorrhoea associated with anorexic states in women. Pavlov *et al* (2003) have postulated a cholinergic anti-inflammatory pathway as a primary route for generating local and systemic inflammation but Martelli *et al* (2014) have expressed doubts about this assumption. Hildebrandt et al 2000 and Stengel *et al* 2014 have independently shown that the neural

peptide, dipeptidyl peptidase IV which is associated with several different psychiatric conditions, has been found to be elevated in obese patients and is acting as a modulator of the psychoneuroendocrine pathway.

Links between dietary habits and neural and CNS changes have been identified by Martire *et al* (2014) who demonstrated that over feeding of rats reduces μ-opioid and cannabinoid-1 mRNA in the VTA and suppresses hippocampus BDNF mRNA; and by Morselli *et al* (2104) who reported that high fat diets produces inflammatory changes in the CNS. Towers & Freund (2014) have demonstrated that mechanisms active in the amygdala and the hypothalamus enable acute calorie restriction to compensate for inflammatory response as well as reducing anxiety, whilst Holtmann & Talley (2014) and Mithieux (2014) have investigated the gastric-brain axis and reported on the importance of crosstalk between gastrointestinal neurones and the brain gastroneurones and role played by the thalamus, amygdala precuneous, putamen in responding to food and modulating satiety. Work by Närvänen *et al* (1976) and Crum *et al* (2011) has shown that manipulating mind expectations of food between eating sensibly and indulgently can modulate circulating ghrelin level. Other studies have shown correlations between somatic health problems and socio-emotional disorders such as repressive modes of coping (Mund & Kitte (2012), lack of social control with agonistic striving (Ewart *et al,* 2014), numbing of feelings after a personal tragedy PTSD, or even post-exercise (Zschucke *et al,* 2015; Stoppelbein & Greening, 2015) and peer group rejection (*Zelinka et al*, 2014). An interesting observation also is that the immunomodulatory drug Fingolimod a synthetic analogue of sphingosine has been shown in the hippocampus to facilitate aversive memories (Hait *et al*, 2014).

Because of the by-directional nature of the blood:brain barrier, physical therapies can at times act to heal the mind, as mind directed therapies can heal the body, however the danger in the “bottom-up” approach to treating physical symptoms is that they may at times seemingly eradicate the presenting symptom only for it to change to a different symptom, because the original emotional pain has not been fully dealt with. Many apparently purely

physical disorders can have an emotional basis and origin as Walters (1961) and Kradin (2012) have discussed, and this is something of which we are intuitively aware. When we talk of our anger or frustration with a relative or work colleague who is giving us "a pain in the neck", or "getting our back up", we are unknowingly acknowledging how our unmanageable emotional anger state is being transferred to become a physical problem of back pain - so we in turn counter this by give them the "cold (i.e. frozen) shoulder". Similarly when we talk of our "heart ache", or about being "heart-broken", or we tell someone that "your breaking my heart" we are unconsciously transmuting our apparently inconsolable and unresolvable loss or bereavement into a physical, chest related discomfort (something easier and more acceptable to talk about perhaps?), but at the risk of potentially precipitating breathing and panic attacks and angina like heart symptoms. When our lives become too pressured and overwhelming we find that we "can't handle it" and may develop upper limb problems so that we *aren't* able to handle it, and so on. These are all metaphors of course, but this embodiment of our emotional distress intuits to our unconscious awareness of the connections between emotional problems and physical symptoms (Rossi, 2005a, 2005b; Nisenzon *et al*, 2014; Chapin *et al*, 2014).

Hypnosis is the only one of the "top-down" therapies which allows for direct manipulation of the mind:body interface when used as a tool to motivate or bring about specific changes in behaviour or in physiology and biochemistry. This is important as Münzberg *et al* (2016) have stressed the importance of the interrelationship between hedonistic and homeostatic controls of eating which would require a subconsciously directed approach to modulate. The use of hypnotic communication across the brain-gut axis has also been reviewed recently by Linden (2015). Hypnosis is also the therapy of choice when exploring for the possible psychological roots of physical problems as it allows for continuous interaction between the hypnotist and patient, facilitating the unravelling of the subconscious story, a revelatory narrative and a personal and psycho-social biography of a particular event or period of time in an individual's life which may contain information about past trauma(s)

which are underlying and continuing to affect current physical health. The use of hypnosis for the clinical management of physical symptomology in disease states is well established and many textbooks are now available describing techniques for addressing a wide range of medical and psychological conditions, from the early writings of Hartland (1971), Erickson (1980), Rossi & Cheek (1988), and Gibson & Heap (1991) to more recent texts from Lynn & Kirsch (2006), Benham & Younger (2008), Nash & Barnier (2008), Brann *et al* (2012), Kradin (2012), Heap (2012) and Yapko (2015). Despite the above wealth of clinical evidence relating clinical medicine and the psyche, Hill (2010) feels that we are only at the beginning of understanding the impact of hypnosis on biosocial phenomena.

PUBLICATION

Unconscious Agendas in the Etiology of Refractory Obesity and the Role of Hypnosis in Their Identification and Resolution: A New Paradigm for Weight-Management Programs or a Paradigm Revisited?

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Abstract

Hypnosis has long been recognized as an effective tool for producing behavioral change in the eating disorders anorexia and bulimia. Despite many studies from the latter half of the last century suggesting that hypnosis might also be of value in managing obesity situations, the efficacy of hypnotherapy for weight reduction has received surprisingly little formal research attention since 2000. This review presents a brief history of early clinical studies using hypnosis for weight reduction and describes a hypnotherapeutic approach within which a combination of instructional/pedagogic and exploratory therapeutic sessions can work together synergistically to maximize the potential for sustained weight loss. Hypnotic modulation of appetite- and satiation-associated peptides and hormone levels may yield additional physiological benefits in Type 1 and Type 2 diabetes.

Case study from above paper

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A brief vignette may help to illustrate the principle and the practice of using hypnotherapy in obesity treatment. Some years ago a patient was referred to one of the authors (PAE), seeking help with her overweight problem. This 38 year old female teacher with two children had been overweight since the birth of her first child 12 years earlier, and presented with a BMI of 34, and a history of repeated attempts to lose weight using conventional diet and exercise programmes having proved unsuccessful in reducing this. As a child and a teenager she was of normal weight and slim shape, and had never needed to worry about her eating habits or undertake any programmed exercise. Only with the birth of her first child did her weight begin inexorably to increase. On the assumption that her weight gain was simply the result of changes in eating habits and daily routine since ceasing work and becoming a mother, a simple programme of relaxation sessions coupled with hypnotherapy incorporating visualisations directed at healthy eating, exercise and a healthy lifestyle; the standard motivational, pedagogic approach of the sociocognitive hypnotist, was initiated. Quite quickly however it became apparent that there was more to this situation than merely poor eating and exercise habits. Despite insisting that she was anxious to lose weight and that she was enjoying her sessions, the young woman repeatedly forgot her appointments or cancelled them at the last minute on vague health grounds, such as headaches or stomach upsets. She also mislaid several copies of her self-hypnosis tapes provided for her to use between sessions. As a result there were often long gaps between her attendances, during which time her husband would contact the practice to apologise on her behalf and to urge the practice not to give up on her.

This was all highly suggestive of unconscious mechanisms generating an avoidance of behavioural change, it was felt, and at a case review it was explained that it might be time to move to a more exploratory approach with hypnosis sessions using age regression, to investigate whether there was some inner, unrevealed motivation for her inability to respond to simple "instructional" hypnosis. With the patient's agreement these were commenced and by the third session she was able to regress spontaneously to a previously unremembered episode when, at 6 years old, she had a bad fall at school necessitated her attending hospital for examination and suturing. The school were unable to contact her mother to accompany her, but fortunately had an emergency contact phone number for a neighbour, the mother of a classmate, who came over to the school, went with the child to the hospital, and then comforted the distressed little

girl until her mother returned from work totally unaware of what had happened to her daughter. As luck would have it, this kindly and motherly neighbour was an obese woman, in contrast to the little girl's own mother, who was of normal weight and slim. As a result the little girl came to the (fallacious) conclusion that "fat" mums are always around to look after you when you need them, whereas "slim" mums are not; and that "when I am grown up and have my own children I am going to be a "fat" mum who looks after her children and is always there when they need her". Had she been able, at the time, to verbalise this childish conclusion, to her mother, to the neighbour or to another adult, it would have been countered and would never become a future problem. But as this did not happen, the need to be fat once you become a mother, became embedded into her psyche, remaining un-recalled in her unconscious mind for 20 years, to emerge as an imperative once she had her first child. Subsequent to these sessions and their revelation, the patient was able to quickly and easily lose weight down to a BMI consistently below 23, and at the last time of contact, six years later, she had continued to maintain this weight effortlessly and confidently.