INTRODUCTION AND LITERATURE REVIEW: A review of the recent literature on eating disorders, including anorexia nervosa and bulimia, reveals a remarkable silence on the utilization of hypnosis as a therapeutic tool. It is evident, for example from the book chapters by Walsh (1997) and Yager (1994), as well as journal articles devoted to eating disorders such as that of Doyle (1996), and a whole issue of the Psychiatric Clinics of North America (edited by Yager, 1996) that includes 13 scientific articles on eating disorders. In this special issue, to my surprise, the subject of hypnosis or guided imagery is not even mentioned as a viable option in the treatment of eating disorders. The publications that have appeared in the past decade on the efficacy of hypnotic techniques in the treatment of eating disorders are not even mentioned or cited; the subject of hypnosis does not exist in this special issue. This phenomenon reflects a level of ignorance on this subject reminiscent of the old adage 'The eye sees only what the mind is prepared to comprehend'; in this case, modified to 'The traditional doctor writes only about what his mind is prepared to comprehend.' Nevertheless, the effectiveness of hypnotic interventions in patients with eating disorders has been recorded in the literature over and over again since the time of Pierre Janet (1907, 1919).

Numerous publications have pointed out the usefulness of hypnosis in the treatment of patients with eating disorders. Vanderlinden and Vandereycken (1988, 1990) provide a comprehensive and excellent review of the literature on the use of hypnosis with eating disorders. Janet (1907, 1919) described how by using hypnotic techniques he was able to change the patients' dissociative, fixed ideas about eating and their body image, and to promote a general mental synthesis. Janet also used cognitive restructuring techniques that were successfully augmented by hypnosis. The hypothesis that many patients with eating disorders may suffer from dissociative episodes, has been supported by the research of Pettinati, Home and Staats (1982, 1985), as well as by Council (1986) and Torem (1986a, 1990). These studies (205) found that patients with bulimia were significantly more hypnotizable than patients with anorexia nervosa. Griffith (1989) reported the successful use of a hypnobehavioral model in the treatment of bulimia nervosa, and Gross (1984) reported the successful use of hypnosis in the treatment of patients with anorexia nervosa, thus indicating that patients bearing the diagnosis of anorexia nervosa should not automatically be ruled out as candidates for hypnotherapy. This chapter will describe specific issues involved in effective assessment of the patient with an eating disorder before the decision to utilize hypnosis is implemented. Then follows a description of a variety of hypnotherapeutic techniques and their utilization in the treatment of patients with eating disorders.

PATIENT ASSESSMENT: The comprehensive and in-depth assessment of patients with an eating disorder is of great value for understanding the underlying dynamics of the condition, the patient's character, and the crafting of an effective treatment plan. The clinical literature identifies a variety of psychodynamics attributed to the psychopathology of eating disorders such as:

1. A fear of growing up and reaching full sexual maturation (Bruch, 1973, 1974; Gross, 1984).
4. A fear of pregnancy, a fear of acting out hostile impulses as well as a need for self-punishment (Evans, 1982).
5. An unresolved past trauma (Damlouji & Ferguson, 1985; Goodwin, 1988; McFarlane, McFarlane & Gilchrist, 1988; Torem & Curdue, 1988; Goodwin & Attias, 1993).

In listening to the patient I specifically explore the possibility of ambivalence and internal conflicts regarding the eating disorder symptoms and behaviors, looking for any clues that the behaviors are ego-dystonic. In previous publications (Torem, 1989a), I have delineated the following examples of clues to an underlying dissociative mechanism in the patient's description of her symptoms:

1. 'Sometimes do not know why I do it ... I am so confused ... It is not like me.'
2. 'Whenever food is put in front of me, I automatically become frightened, like a little kid. I know I need to eat but it is like an inner voice doesn't let me touch the food'.
3. 'A part of me wants to binge and another part of me hates it and is disgusted.'
4. 'Sometimes I feel like Dr Jekyll and Mr Hyde and it's not just about eating ... I don't know myself anymore.'
5. 'Look at this body ... isn't it a shame? ... she used to be a fine attractive girl and then this awful thing happened ... she is afraid of men, all men ... she hides behind the fat.'
6. 'When I get into a binge ... it feels so strange ... as if I am in a daze ... I don't know what comes over me ... and then I feel so guilty and I want to throw up.'
7. 'Doctor, you may not believe me, but at times I don't even remember bingeing ... my husband tells me that I do ... but I can hardly remember doing it.'
8. 'I look at my body and I know the scale says I have lost more than 25 pounds but yet my body feels too fat ... I know it doesn't make sense ... it is as if I hear this voice in my head telling me I am too fat.'
9. 'You know doctor, at times I am so confused ... sometimes I feel fat and sometimes I feel skinny ... sometimes I want to eat and other times I'm afraid ... I don't know what gets into me ... I am so confused.'
10. 'Doctor, my mother says I am weird ... she thinks that I am possessed by the Devil ... that is her way of explaining my anger at myself for eating too much ... and then wanting to throw up.'

An additional method for identifying a possible underlying dissociation in patients with eating disorders is the administration of a dissociation scale. The Dissociation Experiences Scale (DES; Bernstein & Putnam, 1986), is easy to administer and has been tested for its validity and reliability in large populations (Bernstein-Carlson, Putnam, Ross et al., 1993; Putnam, Bernstein-Carlson, Ross et al., 1996). The Perceptual Alteration Scale (PAS; Sanders, 1986) is also of use since it has a special focus on eating disorders symptoms. In a recent study (Torem, Egtvedt & Curdue, 1995), a high correlation between the Eye Roll Sign (ERS) and the dissociation scores measured by the PAS indicated a possible correlation between these two measurements of dissociation. Since the capacity to dissociate is correlated with the capacity for hypnosis, the clinician may therefore learn in advance whether a certain patient may benefit from the use of
hypnotic techniques without having to use a more lengthy assessment of hypnotizability. To complement the above scales, Spiegel and Bridger's (1970) Hypnotic Induction Profile (HIP), may be used, being particularly suited to the clinical setting since it takes about 5 - 7 minutes to administer. (207)

Many patients with eating disorders feel helpless, hopeless, and ashamed of having to seek psychological help. I use the principle of ‘meeting the patient where the patient is at,’ allowing patients to talk about any subject they wish to discuss, and letting them choose the priority of their concerns, even if at first it seems only remotely related to the eating disorder. I listen to metaphors in the patient's communication, being aware that people communicate simultaneously on two levels: manifest and latent. For example, an 18-year-old adolescent girl communicates in the first session her story about the fact that the house she is living in is crumbling and needs to be renovated and remodelled, and that she is determined to find the resources to accomplish this goal. This patient is talking on a manifest level about her own house, which in reality may need to be renovated and remodeled; however, on a latent level, she may be referring to her own body that needs to be repaired and restored to health. In fact, this girl had lost many teeth due to repeated self-induced vomiting, and in addition had an electrolyte imbalance, abnormal liver functions, and esophageal bleeding, requiring immediate medical and psychiatric care. The clinician's recognition that the patient communicates about her body in a metaphorical way makes the therapist an ally with the patient's subconscious mind, and creates an ideal setting for the effective use of hypnosis to facilitate the desired change.

**THERAPEUTIC INTERVENTION WITH HYPNOSIS:** When evaluating a new patient, I listen to the patient's communication regarding dysphoric feelings of helplessness, anxiety, hopelessness, inner tension, insomnia, fear, restlessness, and so on. I introduce the idea of using hypnosis by making it relevant to the patient's presenting symptoms, saying to the patient something like this, 'Would you like to learn an exercise of how to reduce your anxiety and promote a sense of calmness and relaxation?' Patients generally respond affirmatively. I then proceed by teaching the patient a self-hypnosis exercise loaded with suggestions and images of calmness and comfort, asking the patient to select a place associated in their mind with such feelings. Some patients select a mountain trail, an inland lake or a state park, many select an ocean beach.

Most patients respond positively to this exercise which, as mentioned before, can be tailored to the patient's choice of place. At its completion, the patients have an experience of success in replacing their feelings of anxiety and restlessness with new feelings of calmness and comfort. This success makes the patient into an ally and believer in the healing powers of selfhypnotic imagery and conveys to them a sense of new hope. To facilitate yet further the experience of success, suggestions and images for ego-strengthening are added. (208)

**EGO-STRENGTHENING:** Ego-strengthening suggestions are an important part of most hypnotherapy interventions. The technique was named by John Hartland (1965, 1971), and further elaborated by Stanton (1975, 1979, 1989). In this intervention the patient follows a set of general hypnotic suggestions to promote healing, strength, a sense of wellbeing, competence and mastery. The following verbatim example may be used in patients with eating disorders:

As you are sitting here in this chair in a state of self hypnotic trance, and you allow yourself to experience such calmness and comfort, a state of inner harmony, you may allow yourself to accept, if you wish, whatever is necessary to promote your progress of healing and well-being, so you can go on with your life in a healthy, more mature and adaptive way. You learn to be free, live in the present as an effective, healthy, human being. Every day, in every
way, you are getting better and better. You become physically stronger, more alert, more wide awake, more energetic, more resourceful, trustworthy, and trusting in your own wisdom and intelligence. Yes, you deserve to live your life with respect and dignity. Yes, you deserve to experience hope, comfort and optimism. Every day in every way, your nerves become stronger, and your mood more stable and pleasant. You become more interested in what you do, and what goes on around you ... and as this happens, your mind becomes calm, serene and peaceful ... your thoughts are clear and well composed. You experience a sense of internal tranquility in total harmony with your body and as your body responds to your mind, it too becomes more calm and comfortable. Your concentration becomes focused and easy. You accept yourself with grace and with ease as a bona fide member of human society; you learn to see yourself in a positive light, developing greater confidence in your talents and skills, developing greater confidence with faith in a positive future. Now, all these may not happen quickly or rapidly. They may take some time, but only as much time as you really need for them all to take place ... they can happen as rapidly and as quickly as you need for them to happen and as rapidly as your subconscious mind wants them to happen. It is OK if you don't want them to happen too fast, only as fast as you need. Now, you may take a moment to reflect privately what your life is like with all these wonderful changes taking place. Then whenever you are ready, simply count back from three to one. At three you get ready in your own mind, and go ahead and do it now. At two with your eyelids closed, you look up, and at one let your eyelids open and let your eyes come back to focus. Your subconscious mind continues to retain all these suggestions for healing and recovering. Now, you become fully alert, awake and oriented to your surroundings, able to function safely and adaptively as you interact with the environment.

This is followed by a dialogue with the patient on practicing self-hypnosis to induce calmness and relaxation, opening one's mind to accept positive autosuggestions and imagery such as: 'everyday in every way I am getting better and better.' The patient is instructed to practice this on a daily basis and report results even if they are successful. (209)

**COGNITIVE REFRAMING AND RESTRUCTURING:** Cognitive restructuring is described in detail by the Spiegels in their book, Trance and Treatment (1978), and also by cognitive-behavioral therapists such as Meichenbaum (1977) and Kroger and Fezler (1976). In essence, the patient is taught a new way of looking at an old problem and finding new, creative solutions in situations where the patient was cognitively 'chasing his own tail,' and feeling stuck with no way out. The patient with an eating disorder is first guided into a state of self-hypnotic trance, in which the patient is highly receptive to new ideas and suggestions. Under hypnosis, the patient is asked to signify if willing to fully cooperate in this process of therapy, with the aid of ideomotor signaling. Providing the signal is in the affirmative, the therapist may proceed as follows:

As you are sitting in this chair, in this special state of extra-receptivity and self-hypnotic trance, you realize that your subconscious mind has now become your ally, and together you are making the commitment to develop a new relationship between yourself and your body. In this relationship you, in fact, vow to respect and protect your body for the rest of your life. You are learning to develop a new view of your body as a helpless little creature that is totally dependent on you to be taken care of. In fact, your body is like a precious plant through which you can experience life itself, and to the extent that you want to live your life to the fullest, you owe your body this respect and protection. You also become aware that if not for you, for your body, binge eating and purging are, in fact, a poison. (For bulimic patients. For anorexic patients, modify this statement to say: 'For your body, if not for you, self-starvation is, in fact, a poison'). You realize
that you cannot live without your body. Your body is this precious plant through which you experience life itself, so you need your body to live, and to the extent that you want to live your life to the fullest, you owe your body this respect and protection. Do you agree? [Waiting for an ideomotor signal of confirmation.] Now, these are the three principles which reaffirm your commitment to respect and protect your body for the rest of your life. This new commitment is going to be locked in from now on, and forever with the thought to binge, to purge, or to self-starve. Anytime the thought for bingeing, purging, or self-starvation arises it will be locked in with the new commitment to respect and protect your body. Since you and your subconscious have committed to support, strengthen, and empower the commitment to respect and protect your body, the destructive thoughts for bingeing, purging, or self-starvation are going to become weaker, and eventually dissipate away, as if they were never there. Are you willing to reaffirm your commitment and your vow to respect and protect your body for the rest of your life? [Wait for the affirmative response through ideomotor signaling, or in 'words. If the affirmative is yes, proceed in the following way]:

**Now, repeat after me the following statements, reaffirming your commitment as a whole person on a conscious and subconscious level:**

(a) for my body, if not for me, binging, purging, or self-starvation are, in fact, a poison [patient verbally repeats statement];
(b) I need my body to live [patient verbally repeats statement];
(c) To the extent that I want to live my life to the fullest, I owe my body this respect and protection [patient verbally repeats statement].

Now that you have reaffirmed your commitment and vow to respect and protect your body for the rest of your life, I suggest you do this exercise once every two hours...

In fact, you are going to regain a sense of mastery and control in your life as it relates to activities on your job, your plans for the future, the learning of new things, and in your relationships with other people. Now, I would like you to take a moment or so to visualize yourself as fully healed and recovered in the future. Notice the sense of joy and accomplishment as you look at your life and your healthy body. You continue your self-hypnotic exercises which you are going to do safely and comfortably on a regular basis....

This hypnotic session is followed by a discussion with the patient whereby the patient learns to avoid self-entrainment, using the principle of ‘don't think about a purple elephant.’ The patient is asked to engage in a thought exercise whereby she is asked not to think about a purple elephant. Most patients smile and report immediately that they picture a nice, big, purple elephant. The patient is then told: “you see, free people don't like to be told don't. Your subconscious mind does not incorporate the word 'don't', and only hears, 'think about a purple elephant,' and then complies appropriately. The same thing happens when you say to yourself, 'don't binge', or 'don't purge.' You are, in fact, giving yourself the suggestion to binge and to purge, and thus entrapping yourself in doing exactly what you're wishing to avoid. In this new approach any time you experience the thought to binge, purge, or use self-starvation this is your signal to engage in a state of self-hypnosis, and reaffirm your commitment and your vow to respect and protect your body for the rest of your life. So, now you focus on your vow to respect and protect your body for the rest of your life, and on your future reality of yourself living as a healthy, recovered individual.”

In a patient with anorexia nervosa an additional method of cognitive reframing is set up whereby we talk about 'gaining strength' instead of 'gaining weight.' The patient is instructed that each strength unit is equal to one pound of body weight. Since most patients with anorexia nervosa who are extremely emaciated get into treatment feeling tired and physically weak, these
presenting symptoms are capitalized on by asking them, under hypnosis, whether they would be willing to regain their strength. Most patients respond positively to such a suggestion, and this method uses the principle of 'meet the patient where the patient is at.' Meeting the patient at her level means devising a treatment plan that will be accepted by the patient with minimal resistance. The patient with anorexia nervosa, who suffers from a low body weight, tiredness and physical weakness, engages more readily and is more cooperative in activities focused on supplying her body with healthy nutrition in wholesome meals so she can regain her strength.

In this method, the patient is guided into a state of self-hypnotic trance relaxation and calmness induced in a nature scene of the patient's choice. This is followed by the use of symbolic guided imagery intended to introduce a variety of natural images communicating changes of maturation, differentiation, integration, growth, self-mastery, control, and freedom of choice (Baker & Nash, 1987). I like to use natural images of transformation such as the metamorphoses of a caterpillar (211) through a cocoon into a mature, well-differentiated butterfly. The butterfly is well differentiated sexually and can fly freely from flower to flower and choose its own mate, while the caterpillar is asexual, cannot fly (is immature) and is limited with its choices of food and resources. This has a special value for the immature adolescent patient who struggles with conflicts around gender identity. Another useful image is 'The Red Balloon Technique' (Walch, 1976) which was adapted by Hammond (1987) as an effective adjunct in helping patients to alleviate dysfunctional guilt. I also use images for gaining a sense of control and mastery by asking the patient to visualize herself driving a car, holding the steering wheel in both hands, turning to the right, or left whenever she wishes to do so, changing the speed of her travel in the car, moving forward, or reversing, and using the brakes and other control instruments in the car, based on her need and travel plans. All these are suggested in association with a sense of pleasure and self-mastery.

Another image is one of the patient remodelling and redecorating her room, the room being analogous to the patient's body. First, one imagines living in an old room where the patient feels dissatisfied, then imagery is used in which the patient visualizes the remodelling and redecorating of her room to meet her needs. Emphasis is put on the patient's choice of colours, materials, furniture, drapes, pictures, and so on. Another effective image is that of the patient adopting a puppy or kitten, perhaps a sick one from the animal shelter of the local community. Then, instruct the patient to visualize the kitten or puppy nursed into full health through the patient's commitment and dedication. The sick pet is naturally a metaphor of the patient's unhealthy body, to which they make a commitment to heal and nurse back to full physical health.

**BACK FROM THE FUTURE TECHNIQUE:** In this method, hypnotic age progression techniques are utilized as described by Yapko (1984, 1986), Erickson (1985), Frederick and Phillips (1992), and Torem (1992). Here, a discussion is held with a patient about a desired future image the patient would be interested in as representing her full recovery and reaching an ideal stage regarding personal goals, as well as body image and a state of healthy living. This is particularly important with a developing adolescent patient who is in the process of change and is generally struggling with the question of 'Who shall I become?' The patient is guided into a state of self-hypnotic trance and suggestions are structured as with the following example: ... Everyone who is committed to a process of healing and recovery has an image of the future. If you wish, you may take this very special trip in a time machine, a trip in time, into the future. Ready ... enter into your special time machine and experience yourself moving forward in time ... as you continue to mature, turning into the age of 17 [assuming the patient is 16 years old] moving forward into 18, 19, 20, 21, 22, 23, that's right and now age 25 ... By this time, you
have graduated from college and you are working in a job of your choice, gainfully employed, living in your own (212) apartment, enjoying your state of independence. You may wish to experience yourself strolling in a department store, trying on new clothes. Find yourself sitting at the counter consulting a cosmetic sales representative regarding the special colours of lipstick and other make-up items that fit your skin tone and colour. As you try these on, you look in the mirror and you see with joy how much you like your face, and the rest of your body, and yourself, and your blooming femininity presenting the young woman in you. As this goes on, you may continue to experience yourself, on a date with a young man who truly communicates uncritical acceptance of you and loves you with respect and dignity, and, if you wish, you may experience the special joy of having a date and wondering about your natural and healthy attraction to the young man that you love too, wondering about the special compatibility and chemistry that exists between the two of you, trusting the centre core of your subconscious mind that has guided you and led you to this point. On the job, you continue to excel and do what you like best, feeling a sense of self-accomplishment and self-actualization ... going to work every day with a special feeling of looking forward to the day, being assertive, appropriately so, expressing your feelings and your emotions verbally, clearly, representing your own point of view and at the same time, being flexible, adaptively so, to consider the opinions of other people, as well. Now, with a sense of wisdom, inner joy, intelligence, and special deep knowledge I'd like you to travel in the time machine to the year 1998 ... age 16 ... and bring with you back from the future, into the present, all these feelings of confidence and competence, the sense of self-actualization, the joys, the sense of contentment, the sense of maturity that you already have experienced at the age of 25, bringing these experiences with you back to 1998, into age 16, and let your subconscious mind guide you and use the special feelings, the joys, and the wisdom to guide you in the present in moving you forward, on your journey of healing and recovery. That's right, now, you don't have to remember anything that's been discussed and experienced here by you. In fact, even if you don't remember anything at all, your subconscious will continue to do all the work every minute of the hour, every hour of the day, every day of the week, every week of the month, every month of the year every year for the rest of your life. However, if you wish to remember, you may remember whatever you need to remember to continue and guide you in this special journey of healing and recovery, that's right, very good, that's right.

The patient is now encouraged to return to the alert state. This is followed by a discussion with the patient on what the patient remembered of the exercise of the future-oriented hypnotic imagery. In this modification, which I have called Back From the Future, the patient brings back from her trip to the future all the experiences that have already been accomplished in the patient's hypnotic future-oriented imagery. The patient is then given the assignment of writing in her personal journal the details of this experience of her trip to the future, and is requested to bring her completed assignment to the following session. At that time, I ask the patient to read to me her assignment and I will listen carefully to the tense the patient uses in describing her trip into the future. I have found that patients who describe their trip into the future using the past tense throughout their writing assignment usually respond well to this technique, and I use it as a positive, prognostic indicator. Many times, this has proven to be a turning point in the patient's therapy. (213)

METAPHORICAL PRESCRIPTIONS: As part of the whole treatment program my patients are given concrete assignments reinforced with hypnotic suggestions for improved therapeutic outcome. These assignments which they are asked to complete, are designed so that
the patient will metaphorically and concretely experience a feeling of success, as well as a sense of gaining mastery, control, and exercising new choices and options.

**Examples of such metaphorical prescriptions are the following:**
1. Chart a journey, on a map from point A to point B. Drive your car in confidence and safety from point A to point B. Choose two different routes; one with the expressway, and the other with a country road.
2. Redecorate your own room, or remodel the house.
3. Change the sheets and pillow cases on your bed.
4. Buy yourself a new dress/blouse and wear it.
5. Get new glasses (frames) or new contact lenses.
6. Adopt a pet: cat or dog.
7. Do a puzzle (and picture of a whole person).
8. Plant a vegetable garden, or one tomato plant. Watch it grow (be responsible for it) and develop. Pick the tomatoes only when ready.
9. Bottlefeed a small human baby, hold it and let it cling to you.

**AGE REGRESSION, ABRACCTIONS AND CATHARSIS:** This specific technique has been found useful with patients in whom the underlying dynamic for the eating disorder has been found to be related to past trauma. This can be done by using hypnosis as a diagnostic tool with the aid of such techniques as the affect bridge (Watkins, 1978; Channon, 1981) and other methods of hypnoanalytic exploration in conjunction with ideomotor signalling (Cheek & Le Cron, 1968; Barnett, 1981; Brown & Fromm, 1986). Once this has been identified, the patient can be guided with the use of age regression to the original trauma to which the eating disorder is being related. Many patients then have a chance to fully abreact emotions attached to the original trauma, and the emotional catharsis in the abreaction itself already produces some relief. At times, a significant improvement (although not a full cure) of the eating disorder symptoms is apparent. This has been described in previous publications on the special subgroup of patients with eating disorders in whom the eating disorder symptoms may be a manifestation of an underlying post-traumatic stress disorder (Torem & Curdue, 1988). To make this specific technique work, additional methods should be attached such as cognitive restructuring, and other methods which use hypnotic suggestion for personal growth, healing, recovery, letting go of the past and being liberated from the traumatic memories (Watkins, 1980). (214)

**EGO STATE THERAPY:** Ego State Therapy has become a frequent focus in the hypnosis literature (Watkins, 1984; Watkins & Watkins, 1981, 1982; Edelstein, 1982; Beahrs, 1982; Newey, 1986). Ego State Therapy is defined by Watkins and Watkins (1982) as the 'utilization of family and group treatment techniques for the resolution of conflicts between the different ego states which constitute a "family of self" within a single individual.' This method is aimed at conflict resolution and may employ any of the directive, behavioral, psychoanalytic, supportive, existential, and even relaxation and biofeedback techniques of therapy. This method of therapy concerns a notion of how much the individual's behavior is the result of dissociated ego states in a state of conflict. According to Helen and John Watkins, the experience with ego state therapy shows that activating, studying and communicating with various ego states decreases the patient's tendency to dissociate. The patient who used to dissociate and experienced these changes as 'mood swings,' 'confusion states' or 'lost time,' develops an awareness of her condition. Confusion is then replaced by greater clarity, understanding, new hope and a sense of self-mastery. The goal of ego state therapy is not total fusion of all ego states into one fully 'fused' ego, but rather an increased permeability of ego state boundries, and an improved
internal harmony resulting in better cooperation and congruence among the various ego states. Some ego states may be maladaptive; however, the strategy is not to eliminate any ego state, even if it is responsible for maladaptive behavior. Instead the strategy is to change the maladaptive behavior, and to help the ego state become more adaptive in its behaviors. In previous publications (Torem, 1987, 1989a) I have described in great detail the use of this method for the treatment of patients with eating disorders. This specific method is especially effective with patients in whom the underlying dynamic for the eating disorder is related to dissociated ego states, and who are in a state of conflict. This method also has been found useful in patients with eating disorders who had an underlying multiple personality disorder (Torem, 1990, 1993).

**ASSESSMENT OF EFFECTIVENESS:** Any treatment modality stands to be tested based on the outcome, and outcome of treatment must be compared to the natural history of the illness. There are insufficient data regarding the natural history of eating disorders. This refers to patients with anyone of the three eating disorders mentioned at the beginning of this chapter in terms of what takes place regarding the outcome of their illness when no treatment is used. This needs to be compared to a variety of treatment modalities, and when treatment interventions produce better outcome compared to the natural history of the eating disorder, such a treatment modality may be (215) considered as effective.

**The following are criteria which I use to measure the effectiveness of a specific treatment intervention:**

1. **Symptom relief:** Patients who come for treatment suffer from a variety of symptoms that can be measured and recorded with the psychiatric interview, the Mental Status Examination, and a variety of scales such as the Eating Disorders Inventory (EDI) (Garner, Olmsted & Polivy, 1983), the Zung Scale for rating Anxiety (Zung, 1971), and the Zung Scale for rating Depression (Zung, 1965). There should be an easing of these symptoms in terms of intensity, frequency, and effect on the patient's ability to function adaptively with the activities of daily living.

2. **Behavioral change:** I expect to see improvement in the patient's ability to form healthy, interpersonal relationships, their social skills, their ability to hold a job, to be gainfully employed (for adults), and perform academically (for adolescents).

3. **Improvement in self-esteem:** I expect to see a change in the patient's sense and stability of a positive self-image which can be reflected in the sentence completion test, the psychiatric interview and specific projective testing such as the Thematic Apperception Test (TAT).

4. **Body image:** The patient's body image should move from a distortion to a realistic assessment and perception of the patient's body image. This can be evaluated by the use of the Mental Status Examination (MSE), as well as the Eating Disorders Inventory (EDI), and the Draw a Person Test (DAP).

Some of these assessments may also be done with the aid of hypnoanalytic exploratory techniques such as ideomotor signaling. All of the assessments can be supplemented by data collected from close family members who know the patient prior to the treatment, during the treatment, and after the treatment intervention has been completed; this will help assess how the patient has changed. (216)