

Cognitive behavioural hypnotherapy and Obesity: A Single Case Study

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STATEMENT

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

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Abstract

This case-based research of Mrs K, a 39 year old, white woman who has been facing weight problems since the age of six sheds light on the effectiveness of a Cognitive-behavioural hypnotherapy intervention as an aid to weight loss and the enhancement of body image and satisfaction. Literature is provided to contextualise the research question and both a quantitative and phenomenological approach to conducting the research is employed in this case study. The results are also discussed from both these perspectives. The subject's body image improved over the eight session period and she was better able to understand and challenge her food cravings. At the start of the program she experienced thirty two cravings a week and by session eight they had reduced to 10. It was also found that the frequency of her five main self defeating cognitions (monitored and reported weekly on a cumulative basis) decreased from one hundred and twenty-one to eighty-two. While her actual weight-loss was not significant, the intervention assisted in her overall sense of well being facilitating self acceptance. The phenomenological section of this paper partially follows a model conceptualised by Fishman (2005), one of the leading founders of the journal *Pragmatic Case Studies in Psychotherapy* (PCSP). He advocates that as part of the study a clinical assessment and formulation be included so as to elucidate the subject's context. It was found that Mrs K had experiences in life relating to themes of unworthiness and inadequacy. These experiences could have thus impacted on her eating behaviours resulting in negative and self defeating diet patterns to develop.

Opsomming

In die enkelgevalstudie met Mev. K., 'n 39 jarige blanke vrou wat sedert sesjarige ouderdom 'n gewigsprobleem het, word die effektiwiteit van 'n kognitiewe gedragshipnoterapeutiese intervensie, met betrekking tot gewigsverlies, liggaamlike selfbeeld en satisfaksie ondersoek. Kwantitatiewe sowel as 'n kwalitatief fenomenologiese metode is gebruik om die navorsingsdata te ontleed. Tydens die agt sessies van die program het die persoon se liggaamlike selfbeeld verbeter en was daar 'n verbeterende ingesteldheid teenoor voedsel – eetlus en kon sy dit beter verstaan en beheer. Aan die begin van die intervensie het sy 32 eetbegeertes ervaar wat afgeneem het na 10 aan die einde van die program. Die frekwensie van haar vyf hoof negatiewe gedagte-patrone (weekliks gerapporteer op 'n kumulatiewe basis) het van 121 na 82 verminder. Terwyl haar fisiese gewigsverlies nie statisties noemenswaardig was nie, het haar oorkoepelende gevoel van algemene gesondheid haar selfaanvaarding gefasiliteer. Die fenomenologies-kwalitatiewe navorsingsgedeelte is gebaseer op die model van Fishman (2005), een van die stigterslede van die *Pragmatic Case Studies in Psychotherapy (PCSP) Journal*. Hy voer aan dat 'n kliniese ondersoek en formulering in die intervensie ingesluit word om sodoende die persoon se konteks beter te skets. Die volgende temas, naamlik minderwaardigheid en ontoereikendheid, is fenomenologies geïdentifiseer. Laasgenoemde belewinge (temas) het 'n negatiewe invloed op haar dieetpatroon gehad.

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To Mrs. K

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For giving me the strength and ability to think and feel.

I'd like to dedicate this research to all who struggle with weight issues. We are conditioned to believe that we are not good enough because we are fat. We become fat because we think we are not good enough. May we be allowed to enjoy food without guilt. May we know moderation. May we enjoy healthy and tasty food for all that it is meant to be - pure and simple.

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1. INTRODUCTION

The purpose of this research is to document the response of a woman struggling with obesity and body image issues to treatment based on a Cognitive-behavioural hypnotherapeutic approach. It will consider the various factors affecting such a woman's ability to lose weight within her current context. In order to understand how this study fits into the broader context of existing research, a brief overview of the relevant literature will be discussed.

In order to observe cognitive behavioural changes and gather phenomenological data this research was conducted based on a single case experimental design. Clinical case studies allow for the report of therapeutic improvements and can be used to describe certain strategies and methods applied to particular clients (Fishman, 2005; O'Leary & Wilson, 1987). The research format of this report is based on quantitative research methodology (Martin & Pear, 1978) where baseline behaviour is obtained and then measured over time as well as a qualitative phenomenological perspective of the subject's process and objective clinical assessment based on the medical model. The qualitative format of this report is largely based on the model conceptualised by Fishman (2005), one of the leading founders of the journal *Pragmatic Case Studies in Psychotherapy* (PCSP).

The first part of this paper deals with introducing and motivating the research and includes a brief introduction of the subject of this case study. The second part provides reviews of the guiding conception in the form of relevant and recent literature, in addition to an explanation of the intervention utilised, while the third part discusses the research methodology. Part four presents the results – both qualitative and quantitative – of the assessment as well as the therapy phase of the treatment. The last part discusses the interpretation of the data providing a bridge between the practice of the therapy and the existing literature.

1.1 MOTIVATION

It is evident that despite many well founded commercial weight loss programs that work based on calorie counting, abstaining from certain food type's etcetera, obesity remains a problem for many individuals in our modern society (Truby et al., 2006). The market is flooded with products and programs that proclaim results in a short space of time leaving many people disillusioned regarding weight loss (Hirsch, 1998).

Behavioural methods of weight reduction have been purported to be the most effective intervention - energy expenditure and caloric control as its most important components (Danforth & Landsberg in Greenwood, 1983). Abrahamson (1977) agrees that obesity is said to occur mostly from excessive eating and inadequate energy expenditure. Aversive techniques, covert sensitization, therapist reinforcement of weight loss as well as self-control methods have all been well researched and documented as having a positive impact on weight control (Abrahamson, 1977). Holt, Warren and Wallace (2006) suggest that adding grocery lists and meal plans to conventional behavioural treatment of obesity increases effectiveness of the program. In addition, a study by Brody, Masheb and Grilo (2005) showed that subjects diagnosed with Binge Eating Disorder (BED) preferred to be treated with cognitive behavioural therapy because it got them closer to their treatment goal (weight loss) rather than changing their perceptions of their body. Many authors agree that simply losing the weight is not enough (Avenell et al., 2004; Buckroyd, Rother & Scott, 2006; Foster et al., 2004; Masheb & Grilo, 2006; Truby et al., 2006). Maintaining the weight loss permanently remains the challenge.

While hypno-behaviour therapy has not been thoroughly researched as having an influence on the successful completion and maintenance of weight loss (Devlin, 2001), it has been found to be as beneficial as Cognitive-behavioural therapy in the treatment of Bulimia Nervosa and Anorexia with regards to modifying irrational beliefs as well as some compulsive behaviour found within these eating disorders (Vanderlinden & Vandereycken, 1988).

The role of emotions and self concept are somewhat neglected when looking at the treatment for obesity (Hutchinson-Phillips & Gow, 2005). While it is clearly evident that behavioural techniques are successful in treating obesity, there needs to be an understanding of how these emotional aspects impact both positively and negatively on weight loss. Cash (cited in Hutchinson-Phillips & Gow, 2005) purports that body image is based on a number of complex concepts including both positive and negative evaluations of one's body. According to Cash, activating events trigger internal dialogues influencing emotional states; thus putting behavioural patterns into motion. Spiegel and Spiegel (in Hutchinson-Phillips & Gow, 2005) employed the technique of reframing overeating as poisonous to the body and healthy eating as respecting the body during hypnosis. Additionally, the use of hypnosis was utilised to enhance body image and other factors affecting self esteem.

This study is interested in showing how Cognitive-behavioural hypnotherapy (CBH) may be employed to facilitate behaviour change through cognitive restructuring as well as restructuring the perception of one's body, thus influencing the subject's overall sense of self worth and well being.

1.2 BROAD AIM OF RESEARCH

The aim of this research is to ascertain the effectiveness of cognitive behavioural hypnotherapy in the treatment of obesity, that is, weight loss, by means of challenging self defeating cognitions, controlling cravings and enhancing body image.

1.3 THE SUBJECT

This case-based research design employs the unique information gathered from one individual over a period of time. It is therefore important to briefly introduce the subject.

Mrs K contacted the clinician/researcher in response to the purpose of this study which she had heard about via a colleague. She is a thirty nine year old white woman, is married with two children aged nine and five. She works in middle management at a large company and

generally enjoys a fairly good life. Mrs K has completed a Bachelor of Arts degree at university and has been working for this company for approximately ten years in various positions.

Mrs K has a history of obesity and fluctuating weight. She has made several attempts in the past to lose weight, some successful, others not.

She became aware of her predicament in December 2005 when she started snoring, something that perturbed her immensely and became consciously aware that she may be jeopardising her health. Mrs K consulted a general practitioner and ascertained that she was indeed at risk for diabetes and cholesterol problems.

Mrs K came across as a jovial woman; she has a good sense of humour and seems to be quite resilient. There were no disturbances in her mental status exam. Upon presentation Mrs K could be classified as obese based on a calculation for body mass index (BMI). She weighs ninety-five kilograms and has a height of 1.74 meters. Her BMI therefore is thirty-one. She did not meet the criteria for Panic Disorder but on occasion experiences panic attack symptoms. She has no other medical or mental health diagnosis.

2. LITERATURE REVIEW

Obesity has become one of the most common metabolic diseases in the world's developing nations. The World Health Organisation has estimated that there are over one billion overweight adults worldwide, three hundred million of them obese (Bays, 2004). Unfortunately, as children grow in this modern era they are becoming less immune to the problem of obesity. Its frequency lies within the female population of the world but the prevalence of heart disease as a result of obesity was most common amongst men (Bruch, 1974). This may have been true thirty two years ago, however, this has changed. A vast number of women are now also suffering from heart disease due to obesity and physical inactivity (Kanaya et al., 2003; Li et al., 2006).

2.1 THEORETICAL CONCEPTS

A brief description follows of five theoretical concepts that underpin the research conducted.

2.1.1 Obesity

Obesity, according to Craig (cited in Abrahamson, 1977) can be defined as an excessive amount of subcutaneous, non-essential fat. Environmental, social, psychological, physiological and modern lifestyle are factors that contribute to an overall energy imbalance that leads to obesity (Richman, Loughnan, Droulers, Steinbeck & Caterson, 2001). As it is beyond the scope of this research to address all of the above factors, psychological and physiological factors will be focussed on later in the literature review.

There is no classification of simple obesity as a disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (2000) (DSM IV – TR). Obesity is however considered a general medical condition. It is recommended that when there are significant psychological factors in the aetiology or course of a particular case of obesity, it should be noted as the presence of Psychological Factor Affecting Medical Condition. This can be indicated by means of “316- Psychological Symptoms Affecting Obesity (anxiety or depression symptoms)” or “316- Maladaptive Health Behaviours Affecting Obesity (sedentary

lifestyle and overeating)” (DSM IV-TR, 2000, pp. 732-733). This classification allows for the various factors affecting obesity to be noted, it does not however adequately encapsulate the dynamic between psychological and physical factors impacting on the person who experiences obesity as a problem.

A recognised and popular method of measuring obesity, created and employed by life assurance and health organisations, is to calculate the ratio between one’s height and weight – body mass index ($BMI = kg/m^2$). A BMI of thirty or more is an indication of obesity as well as higher medical risks. Important to note is the fact that one may weigh too much for one’s height as in the case of body builders who have lean but extremely muscular bodies (Aronne, 2002; Danowski, 1973; LeBow, 1989). More commonly however, the formula may be used for the general population where it is more than likely that one’s weight increases because of the increase in fat on the body (Aronne, 2002).

2.1.2 Hypnosis

There is general agreement that hypnosis’s precise nature is difficult to define (Heap & Dryden, 1991; Mende, 2006; Udolf, 1987). It can be described however as an altered conscious state or process involving mechanisms of attention and habituation. The involvement of attention is the outcome of hypnosis, differentiating it from other altered conscious states. According to Mende (2006), the state of hypnosis is a behavioural phenomenon, and can facilitate rapid learning, enhances memory and aids the mechanism of conditioning to be established more quickly.

Hypnosis, described as a state or process (Karle in Heap & Dryden, 1991) is readily employed in a variety of instances by a multitude of people. We need only watch musicians just before performing, sports men and women before competition and perhaps even a learned sage in meditation. These people all employ techniques to deepen their focus and concentration in order to achieve their desired goals. Araoz (in Golden, Dowd & Friedberg, 1987) mentions the necessity to demystify clinical hypnosis and make it accessible as one of the many different thinking modalities that can be learnt and applied for the enhancement of people’s lives.

2.1.3 Body Image

Grogan (cited in Bergstrom & Neighbors, 2006) characterises body image as one's perceptions, thoughts and feelings about his or her body. Two types of body image disturbance have been categorised; body-size distortion which occurs when an individual misperceives their actual body size or sees their individual body parts as larger than they objectively are. The second is characterised by body dissatisfaction, referring to the cognitive, affective or attitudinal nature of negative body image (Bergstrom & Neighbors, 2006; Viviani, 2006).

Bergstrom and Neighbors (2006) and Viviani (2006) suggest, based on studies conducted, that while women are prone to the desire to be slender, men prefer their bodies to be muscular. They also purport that an increase in negative body image raises the chance of eating disorders to develop. In a review of literature conducted by Stice and Shaw (cited in Bergstrom & Neighbors, 2006), it was found that two mechanisms exist to heighten the risk in the development of eating disorders. Firstly, body dissatisfaction causes women to diet thus creating the platform for negative eating patterns to form. Secondly, body dissatisfaction causes negative affect, increasing the risk of binge eating aimed at reducing those high levels of negative affect. While body dissatisfaction does not necessarily lead to eating disorders, it can create eating pathology in non clinical subjects (Stice & Agras cited in Farrell, Shafran & Lee, 2006).

Farrell et al. (2006) state that Cognitive-behavioural therapy (CBT) has successfully been employed as a treatment method in disorders where body image dissatisfaction occurs. They suggest though that additional research need be conducted regarding interventions specifically designed to enhance body image and include them in traditional CBT methods.

2.1.4 Self Defeating Cognitions

Cognitive therapy is based on the principle that automatic thoughts occurring in situations and are ultimately based on an individual's core beliefs about themselves and the world. These automatic thoughts influence our emotional state thus also impacting on our behaviour (Beck,

1995). According to Beck (1995), automatic negative thoughts that can be self defeating in nature are often accepted as true without evaluation or thorough reflection.

Araoz (cited in Golden et al., 1987), theorised that continuous negative self talk takes on the quality of what he calls negative self-hypnosis (NSH) – an occurrence that he suggests is at the heart of most psychological distress.

Nauta, Hospers, Jansen and Kok (2000) found that obese individuals are prone to dysfunctional cognitions concerning eating, shape and weight. Obese binge eaters were concerned more about rejection and unworthiness while non binge eaters were mainly worried about a lack of will power relating to the fear of failure.

2.1.5 Food Cravings

Food cravings have been described as an intense desire to consume a particular food or type of food that is difficult to resist (Martin, O'Neil & Pawlow, 2006). According to Yanovski (2003), food cravings are rather common – 97 percent of women and 68 percent of men in the studies conducted report having craving episodes. Literature also suggests that food cravings differ from hunger in that only that particular craved food or food type will satisfy the individual; whereas hunger may be satisfied by any number of foods (Martin et al., 2006; Yanovski, 2003). Yanovski (2003) found that there are theories suggesting that many individuals consume carbohydrates in the effort to elevate their mood. These theories postulate that food is employed as a method of self medication to ease negative affective states.

Furthermore, in a study by White, Whisenhunt, Williamson, Greenway and Netemeyer (2002), it was found that food cravings are internal states (hunger), with affective components. They were unclear at the start of the research whether food cravings were the result of biological, cognitive, learning or a combination of these factors. As cravings play a major role in the process of overeating, it is important to consider the treatment thereof when addressing eating pathology (Martin et al., 2006).

2.1.6 Weight Loss

As discussed earlier under the concept of obesity, weight is not necessarily determined by the total amount of fat on your body (Aronne, 2002; Danowski, 1973; LeBow, 1989). Weight is defined as the “heaviness of an object” (Smart, 1994, p.1349). Traditionally, weight loss programs have neglected psychological factors impacting on the individual (Buckroyd et al., 2006) and has focussed on exercise, diet, drug treatment and surgery as some of the methods employed to aid weight loss. Behavioural programs including cognitive behavioural techniques are also utilised to facilitate weight loss (Buckroyd et al., 2006; Holt et al., 2006; Richman et al., 2001). Buckroyd et al. (2006) found that their research based on CBT principles showed the effect emotional eating had on the subjects, evidenced by the weight loss. Although the losses were not significantly high, a change in attitude was noted thereby effecting change in eating behaviour.

2.2 AETIOLOGY OF OBESITY

It is suffice to say that there are a number of reasons for someone becoming obese. Following is a description of the two factors contributing to this physical state – physiological and psychological. However, as obesity is a medical condition a discussion regarding the intricacies of the biology of obesity will not be discussed here – it is beyond the scope of this research paper. Only a general understanding of its physiological aetiology can be addressed in this literature review.

2.2.1 Physiological

Literature suggests that the amount of fat cells present in one’s body could be hereditary and differs between males and females (Greenwood & Turkenkopf in Greenwood, 1983). Whitaker, Wright, Pepe, Seidel and Dietz (1997) concluded, based on their research findings, that obese children over the age of three were more at risk of becoming obese adults regardless of their parents being obese or not. The risk doubled, according to the authors, if either parent was obese. They attributed this to the possibility of the combination of shared genes as well as environmental factors. The most commonly understood reason for obesity is the discrepancy between the intake and output of energy.

Fat cells also called adipocytes and their multiplying abilities are naturally key to this discussion. In some individuals surplus calories culminate in the enlargement of adipose tissue through triglyceride storage in fat cells that already exist – called hypertrophy (LeBow, 1989). This surplus can also help to trigger new cells forming called hyperplasia. LeBow (1989) also states that adults who become fat only in adulthood suffer from fat cell hypertrophy and adults who become fat as children show fat cell hyperplasia. Most individuals can be both hypertrophically and hyperplastically obese (Greenwood & Turkenkopf, 1983; Ioffe, Moon, Connolly & Friedman, 1998; LeBow, 1989).

Weight reduction in terms of reducing adipose tissue entails diminishing the size of the fat cell and not the number of cells. This is to say then that obese people who lose the excess fat must be vigilant in maintaining a healthy fat level in their bodies to remain slim as the number of cells itself cannot be diminished (LeBow, 1989).

In 1960, Jean Mayer distinguished the difference between regulatory and metabolic obesity initiating the study of both types (Johnson & Goldstein in Greenwood, 1983). This yielded much information but confounded the investigations into the aetiology of obesity. It was concluded that obesity has a multitude of origins and entails interaction between the regulation of feeding behaviour and the physiological systems involved in metabolism. In studies conducted by Johnson and Goldstein (in Greenwood, 1983) the main tissue and cell types altered in obesity is adipose tissue, pancreas and liver. It could be said then that any disorder of the basic function of these may predispose one to obesity.

The hypothalamus has been said to be the “glucostat” of our physiological systems. The term, coined by Mayer (in Beller, 1977) explained that our body’s ability to communicate the need for nutrients particularly, glucose rested in the hypothalamus (Kalra et al. 1999). Our ability to respond constructively to this indication is what regulates the consumption of food.

2.2.2 Psychological

Psychological factors form an integral part in the aetiology of the obese person. While it is unfair to generalise that all obese people suffer from additional psychological symptoms it can be said that many individuals' body image is disturbed and the emotional sequelae filters into every facet of their lives (Bergstrom & Neighbors, 2006; Bruch, 1974; Farrell et al., 2006).

Investigators have suggested that specific family histories, precipitating factors, personality structures or unconscious conflicts can also cause obesity (Sadock & Sadock, 2002). Some individuals may overeat in response to a non specific emotional stimulus such as feeling lonely, anxious or bored while others may eat in chronic states of frustration or tension using food as a substitute for gratification in unpleasant circumstances. In some cases overeating is a symptom of an underlying psychological disorder such as depression (McReynolds, 1982).

Studies conducted by Bruch (cited in Slochower, 1983) questioned how the overeating pattern develops. She focused on the way potentially obese children were treated by their parents. Children were treated as compensatory objects unconsciously expected to fulfil their parents' wishes without due regard for the child's real needs. Furthermore, food was used symbolically rather than for nutritional purposes thus perhaps creating a learning model on which to base later eating experiences (Day, 2004).

A questionable factor in the maintenance of obesity is that of the concept of willpower (Pearson & Pearson, 1973). Many people who judge obese individuals purport that these individuals lack will power and are weak. Obese people have been on countless diets, many of them fad diets promising quick and lasting results. They stick to these for a period of time but lose faith as time progresses and are unable to maintain the diet regimen (Hirsch, 1998; Tanco, Linden & Earle, 1997). Dieting requires much control and can become an obsessive trend in one's life. The question here is not whether they have the willpower to continue with such diets, as opposed to the ability to adopt the tools to make a healthier way of living and eating part of their natural lifestyle. The continuous unsuccessful attempt at losing the fat as well as the extra fat accumulated when the diet ends and the individual goes back to their old

eating patterns is demoralising, thus further affecting their self esteem (Riva et al., 2006; Tanco et al., 1997).

It is also of concern that many obese individuals have lost or never had the ability to distinguish between true physiological hunger from psychological hunger (Pearson & Pearson, 1973). Pearson and Pearson (1973) suggest that true physiological hunger should be easy to recognise as the biological contractions of the stomach and this hunger is easy to satisfy – any food in a small quantity should suffice. Psychological hunger can also be known as cravings, however, is more complicated to satisfy. These authors propose that learning to understand your psychological hunger could be the key to enjoying food for the pleasure that it should be giving rather than being imprisoned by diets and the fear of food. They offer that cravings need not be something to avoid completely but to understand that perhaps what is sought is a sensation rather than a food. Such thinking has been backed in recent studies by Yanovski (2003) where she proposed that cravings can occur in the presence of emotional stimuli. Knowing this interaction could be instrumental in understanding your eating and perhaps more importantly your overeating patterns.

Motherhood presents as both an exciting and stressful life event and the resulting weight gain is almost inevitable. In a longitudinal (ten year) study conducted by Rooney and Shauberger (2002), it was found that women who gained more than what was recommended during pregnancy had significantly higher weight gain on their long term follow up than those who gained the recommended or less. In addition, they found that those who lost their pregnancy weight gain in the six months post partum were only 2.4kg heavier at long term follow up than women who had retained weight who were 8.4kg heavier at follow up. Gore, Brown and West (2003) found that a lack of social support as well as depressive symptoms increases the risk of postpartum weight retention.

The individual that is experiencing excessive, uncontrollable stress may be enduring both psychological and physiological factors impacting on the aetiology of obesity. Woodman (1983), explains that many eat in reaction to the anxiety created by stressful situations. Our bodies are pre-programmed to create adrenalin in the flight or fight response to stress and

anxiety as it prepares for extreme exertion. This in addition to the elevated blood sugar that becomes available as a source of muscle energy creates an opportunity for the individual who is not aware of her bodily sensations to binge. If then, this extra energy source is not utilised, it is stored as fat for later usage.

Job related stress as found by Payne, Jones and Harris (2005), has an impact on the food choices an individual makes during the day. Some people find food comforting and therefore eat more when under stress. Their findings suggest that people in jobs where there is less demand of their time but little control of their environment are more likely to express their stress reactions in terms of bad eating habits. These individuals would consume high calorie sweets and snack foods.

Binge Eating Disorder (BED), as yet not diagnosable according to the DSM IV-TR (2000, pp. 785-787) – further research in this realm is needed- shares characteristics with reports of obese individuals experience of their eating behaviour (de Zwaan, 2001). The criteria of the diagnosis includes eating very fast, eating until uncomfortably full, eating large quantities of food even when not hungry, eating alone for fear of embarrassment and feelings of disgust, depression and guilt at overeating. In reviewing literature for his article, the above author found that binge eating was associated with depression and the anxiety disorders, specifically, panic disorder, obsessive compulsive disorder and post-traumatic stress disorder.

2.3 THE EFFECTS OF OBESITY

Two of the ramifications of experiencing obesity as a problem are discussed below.

2.3.1 Physiological

The obvious effect of obesity is one that can be seen and can cause many problems in one's self-concept. The excess body fat can take its toll on the individual from a general health perspective as well. The medical profession has adequately ascertained the health risks involved in being obese. Type 2 diabetes, uterine cancer, gall bladder disease, osteoarthritis,

hypertension, coronary heart disease, breast and colon cancer are some of the most prevalent diseases associated with obesity (Aronne, 2002; Danowski, 1973; Labib, 2003).

2.3.2 Psychosocial

Psychological and social hazards of obesity can be more important to the individual than the aforementioned medical repercussions. Society and more specifically, the media seem to propagate the ideal of thinness, thus impacting negatively on individuals' self concept. Obese people are often labelled as lazy, self indulgent and gluttonous as discussed by Brownwell and Waddel (in Greenwood, 1983) and argue that the social stigma associated with obesity often precipitates a career of unsuccessful dieting. The implications therefore are a compounding effect of self deprecation and societal isolation, further increasing the likelihood of negative patterns of eating (Riva et al., 2006).

2.3 THERAPEUTIC INTERVENTIONS

The implications of the various effects of obesity warrant attention. As mentioned previously the panoply of medical ailments as well as psychological and social disturbance makes treatment of obesity a necessary component of well being. It is also understood (LeBow, 1989) that obesity itself reduces life expectancy. Life insurance studies report that as overweight increases, so does the mortality ratio (Danowski, 1973; LeBow, 1989). Of course, it should be noted that life expectancy and longevity itself is insufficient a reason to lose weight. There are a number of individuals that are fat, are happy and lead fulfilling and productive lives. Losing the fat is a choice that the individual should make for reasons that only they are to decide. If the decision is taken for the wrong reasons, maintenance of the weight loss will be difficult (Ryden et al., 2003).

We are accosted by a multitude of literature, commercial and self help programs claiming they can help in the obese individual's weight loss attempt. A number of these are offered to the public – obese, overweight or slim – as quick and easy strategies for losing weight. Despite knowing better many an individual on the diet career path may fall victim to clever marketing (Hirsch, 1998).

The market is also flooded with diet pills and drops espousing their efficacy in weight loss. What is often not stressed enough, however, is that these pills must accompany a calorie restricted diet in conjunction with exercise to maximise their effect (Avenell et al., 2004). Pharmaceutical companies are not surprisingly trying to develop a drug that may eventually make losing weight easy (Hirsch, 1998). The ultimate viability of the development of such a drug is questionable – will we be treating the symptom or the cause of the problem.

Many programs are legitimate and encourage healthy lifestyle patterns to ensure long lasting results. However, as with any health behaviour modification, motivation and commitment to one's physical and emotional health is paramount (Baban & Cracuin, 2007).

Aerobic exercise and dieting, cognitive behaviour therapy and cognitive behaviour hypnotherapy are interventions that are focussed on below. Focus is placed on aerobic exercise and dieting because it is suggested that obesity is caused by the discrepancy between energy intake and expenditure (Avenell et al., 2004; Labib, 2003; Kiernan, King, Stefanick & Killen, 2001; Volek, van Heest & Forsythe, 2005). Another understanding of the aetiology of obesity suggests that psychological approaches be adopted in order to address the long term success of weight loss (Foster et al., 2004; Ogden, 2000; Rapoport, Clarke & Wardle, 2000)

2.4.1 Energy Expenditure and Dieting

Literature surveyed by Volek, van Heest and Forsythe (2005) suggests that many combinations of diet (calorie restriction, low carbohydrate, low fat, high protein) and exercise (resistance training, aerobic exercise, weight-lifting) will lead to weight loss, but if treatment is stopped the weight is regained.

The role of increased energy expenditure while controlling calorie intake seems to have differing effects for the sexes (Kiernan, King, Stefanick & Killen, 2001). Men derive more psychological benefits by adding exercise to their weight loss regime while women seem to value the quantity of weight loss rather than how the weight was lost. While exercise and physical activity does facilitate an increase in energy, a study performed by Brownwell and

Wadden (in Greenwood, 1983), showed that perhaps it was not as much as commonly believed. They stated that one and a half hours of brisk walking or running are necessary to expend calories ingested from a chocolate milkshake. It is difficult from a motivation perspective as well as physical limitations for many obese people to undertake such physical activity. Calorie expenditure from exercise is beneficial when people are able to sum the cumulative effect of many small changes (Avenell et al., 2004).

2.4.2 Cognitive -behaviour Therapy

A comprehensive behavioural treatment program attends to the components of behaviour regulating eating habits. Such components can include stimulus control, attitude restructuring, reinforcement and slowing down the rate of eating (Brownwell & Wadden, in Greenwood 1983). Detailed inventories of the individual's eating habits are explored and old maladaptive patterns amended. Self monitoring/regulation as a procedure is paramount and is a crucial component in the successful use of CBT in the treatment of obesity.

A study conducted by Foster et al. (2004) found that CBT was effective in facilitating the restructuring of subjects' attitudes surrounding the amount of weight lost by concentrating on constructs such as body image and self esteem. Their intervention included education about the biological basis of body weight, socio-cultural pressures to be thin and accepting modest weight loss. Subjects felt satisfied with their weight at the end of treatment even though the weight loss was modest but managed to maintain and sustain better eating habits and attitudes over time.

In a comparative study of standard CBT versus a modified CBT intervention Rapoport, Clarke and Wardle (2000) found that by adding psychological strategies to promote lifestyle change in the modified CBT intervention, their subjects were better able to maintain the weight loss albeit modest – weight loss was not the goal. In standard CBT, where weight loss was the focus, the loss was greater but subjects were unable to maintain it. They argued that modest weight loss and self acceptance far outweighed in benefits to health than the constant flux in weight of repetitive dieters.

2.4.3 Cognitive-behavioural Hypnotherapy

There are a number of hypno-therapeutic approaches including traditional hypnotherapy which provides symptom relief through suggestion directed specifically to the area of need. Insight orientated approaches facilitate the uncovering and working through of unconscious material while the hypno-behavioural model uses traditional behavioural techniques such as relaxation training, the use of imagery, desensitisation and cognitive restructuring (Golden et al., 1987; Udolf, 1987).

Hypno-behaviour therapy has been found to be as beneficial as CBT in the treatment of Bulimia Nervosa and Anorexia Nervosa with regards to modifying irrational beliefs as well as some compulsive behaviour found within these eating disorders (Vanderlinden & Vandereycken, 2001). Cognitive behavioural hypnotherapy is useful for habits adopted by obese individuals (Golden et al., 1987). According to these authors, the goal of therapy is to replace unhealthy habit maintaining attitudes and behaviour with healthy constructive ones.

The effective use of cognitive behavioural hypnotherapy (CBH) (Golden et al., 1987) firstly entails identifying the subject's self defeating thoughts, attitudes and beliefs. The subjects are then taught how the regular repetition of these thoughts acts as negative self hypnosis. Araoz (cited in Golden et al., 1987; Heap & Dryden, 1991; Posthumus, 2001) argues that negative self-hypnosis (NSH) is the common denominator of all psychogenic problems. NSH consists of non-conscious, automatic negative statements and defeatist mental images. NSH, according to Araoz has three hypnotic components – 1) non-critical thinking which becomes a negative activation of subconscious processes; 2) active negative imagery, and 3) powerful post hypnotic suggestion in the form of negative affirmations.

The second fundamental element to CBH as set out by Golden et al. (1987) is cognitive restructuring. Subjects are taught how to restructure these automatic negative self defeating thoughts and to replace them with positive, constructive thoughts instead. The techniques used in CBH are discussed in the next section.

Pitler and Ernest (2005), meta-analysed six randomised control studies which compared hypnotherapy plus CBT with CBT alone and found evidence that the reduction in body weight based on hypnotherapy with CBT was very small. A further randomised control study found that hypnotherapy directed at stress reduction and energy intake had greater results for weight loss than control groups where only dietary advice was dispensed.

Literature and studies reviewed by Hutchinson and Gow (2005) revealed successful attempts at including hypnosis in a CBT intervention for the treatment of self defeating eating. In the past, the successful use of hypnosis was measured by the amount of weight lost by an individual. Current thinking, as proposed by Vanderlinden and Vandereycken (in Hutchinson & Gow, 2005), is shifting focus to creating body satisfaction and self acceptance by means of adding hypnotherapeutic techniques to the treatment of obesity.

2.5 HYPNO-THERAPEUTIC TECHNIQUES

To begin with, techniques used in hypnosis include induction and deepening techniques. Self monitoring, cognitive restructuring, imaginal rehearsal, a post hypnotic suggestion and self hypnosis are all techniques employed in the treatment of habit disorders characterised by the dysfunctional thoughts and behaviours in an obese individual (Golden et al., 1987). Metaphors add an extra dimension of the use of a subject's inner creativity. Next, these components will be discussed briefly.

2.5.1 Induction – Relaxation and Eye Fixation

Relaxation entails the subject sitting comfortably in her chair and tensing one region at a time at the suggestion of the therapist. She is asked to let go of any tension and stress she holds in these parts of her body (Udolf, 1987). Golden et al. (1987) add that suggestions about relaxation, heaviness or lightness and the use of subjects' own pleasant imagery is successful in the induction process.

The eye fixation technique (Udolf, 1987), involves the subject fixating on a spot on the wall in front of her. This should eliminate any visual distractions, causing the eyes to become tired

producing the desire for them to close. The therapist may suggest during this period that her eyes are becoming heavier and heavier and would like to shut while suggesting that the subject is going into a deep, pleasant hypnotic state.

2.5.2 Deepening Technique

The procedure involved in deepening the hypnotic state is an extension of the induction process (Udolf, 1987). Udolf (1987) and Golden et al. (1987) advocate that suggestions regarding the deepening of the hypnotic state begin soon after the initial induction technique has been used. Counting forward or backward from a number while suggesting that the subject will feel more and more relaxed and in a hypnotic state often works well (Golden et al., 1987; Udolf, 1987). These authors also suggest that combining the counting method with imagery the subject has provided adds to the effectiveness of the deepening procedure and suggesting that they have control over how fast or slow the process takes is also beneficial. According to Golden et al. (1987), relaxation imagery and suggestion also aid in deepening the hypnotic state.

2.5.3 Metaphors

Gafner and Benson (2003) describe metaphors to be rich, creative and useful ways in which to address an issue the subject is struggling with, without directly addressing it in the moment. Such metaphors can demonstrate its usefulness throughout therapy as a point of reference from which to work and build on. Siegelman (in Gafner & Benson, 2003) describes a metaphor to be an imaginative act comparing dissimilar things based on the fact that they have some underlying principle that ties them together.

According to Gafner and Benson (2003), reality is constructed through perception and categories of thought – metaphors being vital to the thought process.

2.5.4 Self Monitoring

According to Golden et al. (1987), it is advised that the subject monitor patterns of behaviour, thoughts and feelings during the day. Together they review these records and determine the situational triggers of the behaviour they wish to target.

2.5.5 Cognitive Restructuring

While insight is gained by uncovering a subject's self defeating thoughts is useful, that in itself does not automatically produce long lasting change. Two methods that aid in restructuring cognitions are discussed below.

2.5.5.1 The Two-Column Method

The client is asked to divide a page in half where in one column she places her negative thoughts while in the other her newly re-constructed positive thoughts for each negative one are recorded. These restructured thoughts are used by the therapist during hypnosis and the subject during and after self hypnosis as and when positive suggestions are required (Golden et al., 1987).

2.5.5.2 Imaginal Rehearsal

Golden et al. (1987), describe imaginal rehearsal to be a mental process where subjects imagine themselves succeeding at their target / behaviour. It can be used in preparation to cope in situations where thoughts and feelings are triggered resulting in dysfunctional behaviours. Imaginal rehearsal can also be implemented in the prevention of setbacks by anticipating the possibility of relapse and working through them during hypnosis. The authors also recommend that the positive restructured cognitions ascertained from the two-column method can be used in imaginal rehearsal to reinforce positive reactions to situations where dysfunctional behaviours may occur.

2.5.6 Post Hypnotic Suggestion

Udolf (1987) defines the post hypnotic suggestion as a suggestion given during the hypnotic state to be carried out in the wakeful state. The subject is asked to imagine a trigger situation and associate a behavioural cue with having control over such a situation. Such an example includes clenching one's fist when faced with a craving – a technique taught while in the hypnotic state.

2.5.7 Self Hypnosis

Aroz (in Golden et al., 1987; Posthumus, 2001) suggests that self-hypnosis and hypnosis facilitated by a therapist constitutes the same processes. The individual's motivation and cooperation, attitudes and expectations including her ability to allow for imaginary thinking, all play a role in the process of hypnosis. The subject utilises relaxation and other induction techniques as well as the restructured cognitions to reinforce positive self talk.

3. RESEARCH FINDINGS

Thorough research in cognitive-behaviour hypnotherapy as an intervention for obesity is lacking. The following section highlights a few studies conducted. Early studies focused on weight loss and purely behavioural therapies where as recent research has turned its focus to include more psychological factors in the treatment of eating pathology.

In 1980, three years after the original study, Hautzinger (1980) reviewed the long term benefits of the behaviour - therapeutic training program he and his colleagues conducted with 31 subjects. Of the 31 subjects only 21 were able to be rechecked and it was found that only four of the subjects' regained any weight - 4.4kg's on average. Behaviour-therapeutic methods included elements of self control – self-observation, self-instruction, self-confrontation, interruption of behavioural cues, patterns of eating behaviour alteration and self-evaluation. Hautzinger concluded that purely behavioural methods did aid in weight loss in the short and mid term. He proposed that medical and psychological methods be employed to effect long term maintenance of weight loss.

Björvell, Rössner and Stunkard (1986) investigated the eating behaviour of obese and non-obese subjects as well as the weight loss of obese individuals in a behavioural program. Two treatment and control groups were studied. They were given the Three Factor Questionnaire measuring cognitive restraint, disinhibition and hunger. The study's aim was to compare the factors between obese and non-obese subjects and to assess the relationship of these factors to weight loss. The questionnaire was administered to 88 men and women after a behavioural treatment and compared to 76 individuals in the control group - 60 were normal

weight individuals. It was found that the group receiving the most behavioural treatment showed the most cognitive restraint with regards to eating and therefore lost the most weight. There was no correlation between the disinhibition and hunger and weight change factors found in this study. The researchers were hesitant to conclude that these factors did not have a bearing on weight change in obese individuals.

Sixty-two obese women with a history of treatment failures were randomly assigned to a cognitive therapy program, a behaviour therapy weight loss program or a waiting list control group. The cognitive therapy and behavioural therapy group both consisted of two hour weekly meetings. The cognitive group was aimed at fostering insight into maladaptive behaviours, enhancing emotional well being and encouraging normal, healthy exercise and eating behaviours. Their focus differed from the behavioural group where fat reducing diets and exercise regimes were adopted. This study conducted by Tanco et al. (1997) found that subjects in the cognitive therapy program benefited significantly from a psychological perspective. Variables such as depression, anxiety and eating related psychopathology decreased while their perceptions of their self control increased. The behaviour therapy weight loss group as well as the control group did not show the same results in these variables. They also found that women in both active treatment groups lost significant amounts of weight with the behavioural treatment group losing more all together.

Marchesini et al. (2002) found in their investigation of two groups of obese individuals - 92 treated by cognitive-behavioural therapy and 76 untreated - that patients with binge eating disorder benefited more from the therapy from a psychological perspective than from weight loss. The cognitive behavioural therapy group were tasked with learning about BMI and regular weight control, calorie counting and eating diaries. The subjects also learnt how to recognise dysfunctional cognitions, learnt problem solving skills and relapse prevention. The non-binging subjects lost more weight and no positive observations were made in the control group.

Literature and studies reviewed by Hutchinson and Gow (2005) put forth the basic premise that a combination of cognitive restructuring, body image, weight and shape education, the use of imagery for desensitisation and future based behaviour change and constant proof that

change is taking place is the most effective manner in which to treat self-defeating eaters. These people have eating pathology and are not yet clinically diagnosable and categorised into an eating disorder. According to these authors, imagery and alternative therapies such as art, dance, music and drama have been employed with some success in the treatment of these individuals.

In a review of the literature, Hutchinson and Gow (2005) found that self-hypnosis, imagery and reframing were techniques employed to treat self defeating eaters with treatment ranging from six weeks to several months. Most of the information they gathered were from case studies and treatment guidelines. They found that in the past two decades more modest weight loss was reported using this method - one to one and a half pounds a week.

It is apparent that traditional behavioural methods work to facilitate weight loss. Maintenance of this weight loss proves to be more difficult though and the current understanding of obesity lends itself to an intervention that includes psychological and physiological components.

3. METHODOLOGY

This research was primarily based on the CBH process detailed by Golden et al. (1987) as discussed in the literature review. The use of metaphors in the hypnotic process was added so as to facilitate the enhancement of body image satisfaction.

The research is based on the premise that restructuring negative thoughts, decreasing cravings and enhancing body image would impact on the subject's weight loss process.

3.1 RESEARCH METHODOLOGY

The researcher utilised a quantitative and qualitative approach when conducting the research and analysing the data. Literature suggests that CBH techniques may be used to restructure thoughts and thus impact on behaviour, specifically in this case, eating behaviour. These techniques are therefore used to monitor quantitatively the frequency of cravings and self defeating thoughts as well as subjective report of body satisfaction. The researcher was interested in the impact of the entire process on the subject's phenomenological experience and also wanted to understand the subject's context, therefore including a qualitative segment to the research.

3.1.1 Research Design

3.1.1.2 Quantitative

The single case experimental design (Fishman, 2005; O'Leary & Wilson, 1987) method was employed to explore the usefulness of hypnosis in the treatment of obesity. A single case study is characterised by its behaviouristic approach but does not produce information at the expense of its personalistic quality. O'Leary and Wilson (1987) and Martin and Pear (1987) state that single case studies emphasise both experimental (empirical) and therapeutic criteria for evaluating treatment. Experimental criteria refers' to the demonstration of reliable changes that are produced due to the techniques employed. Single case studies allow clinicians to make inferences about treatment effects, thereby creating a platform for the study to be replicated.

Behaviour modification techniques such as obtaining baseline behaviour and frequency of behaviours were employed. The baseline behaviour was obtained, the treatment phase initiated, followed by the follow up phase (Martin & Pear, 1978).

3.1.1.2 Qualitative

The qualitative segment of this research was based on the outline prescribed by Fishman (2005). Firstly an individualised assessment was done yielding a formulation of what is happening in this particular case. The context in which the dysfunction operated was also obtained.

Secondly, the subject's phenomenological experience of the process was ascertained so as to attempt an understanding of the overall impact of the intervention. The subject was not a passive recipient of hypnotic suggestion but added her own creativity to the induction and deepening technique used.

3.2 THE SUBJECT

The subject was sourced via word of mouth as discussions were taking place about the purpose of this study. This study provided free therapy based on CBH to an individual who considered herself obese and struggled with body image dissatisfaction. The participant was selected because she was 1) willing to consent to the information gathered being used for research; 2) she had been experiencing obesity as a problem impacting on various aspects of her life; 3) she did not meet the criteria for Bulimia Nervosa or Anorexia Nervosa; 4) was willing to be hypnotised, and 5) had no other general medical problems. This study was conducted in line with the regulations set out by the ethics board of the American Psychological Association (APA, 2002, pp.11-12).

3.3 PROCEDURE

In conjunction with the participant's individual needs determined in the assessment the program was based on the integration of cognitive-behavioural and hypnotic techniques as set out by Golden et al. (1987).

Time was spent before and after each session discussing pertinent events of the week and its impact on the participant. For one week prior to the first session (baseline), the participant was asked to monitor the frequency of the self defeating thoughts she had. She was also asked to monitor the frequency of cravings she experienced, including how many times she was successful at controlling these cravings.

During the treatment and follow up phase, the participant was required to continue with monitoring the above variables. Records of the content of her self defeating thoughts were added in the treatment phase. She was required to continue recording the frequency of food cravings experienced during the day and whether or not she was able to curb it.

As weight loss forms part of the treatment of obesity, the subject's weight was measured by herself once a week.

The subject was required to rate herself on a scale from one to ten based on her experience of her body image – a detailed explanation of this measurement can be found in Appendix A.

The participant developed a personalised, healthy, eating plan to which she adhered during the program.

The sessions took place over a nine week period – one session per week for seven weeks and the eighth session two weeks later. The first session of the therapy process lasted for two and a half hours while subsequent sessions' duration lasted for an hour and a half to two hours. The participant could select the most convenient day and time for therapy and maintain such for continuity and reliability with regards to weight measurement as well as negative thought count.

A detailed session program follows:

Session One

The researcher conducted an assessment of the individual's specific thought patterns and emotions surrounding her weight. She was informed of the process and procedure to be followed during the program. The subject was introduced to the hypnotic techniques in order to lay a foundation on which to work during the next session.

Session Two

The subject was induced as per the literature review (relaxation and eye fixation technique). Her hypnotic state was deepened using the provided imagery. A metaphor with regards to her weight and body image was used to facilitate body satisfaction. She learnt self hypnosis during the hypnotic trance and practiced it with the aid of the researcher.

Session Three

The third session began by reviewing the subjects thought record and triggers for overeating. Negative thoughts and alternative therapeutic suggestions framed by the two column method were clarified and used during the hypnotic trance in order to restructure cognitions. The researcher introduced imaginal rehearsal.

Session Four

Session four involved teaching her the clenched fist method. Obsessive thinking and self defeating thought patterns were analysed and reconstructed. Guided imagery was undertaken in anticipation of situations in which relapse may occur.

Session Five

Session five involved rehearsal of all the methods learnt as well as some guided imagery and visualisation of the subject's end goal. Any difficulties experienced thus far were discussed and rectified during hypnosis.

Session Six

The subject practised self hypnosis and any gains made were reinforced using metaphors provided.

Session Seven

This session involved termination and summary of progress made thus far.

Session Eight – Follow Up and Termination

Session eight took place two weeks later as a follow up. Problems and gains were discussed prior to the induction of hypnosis where metaphors were used to further facilitate body satisfaction.

3.4 MEASUREMENT

The subject was required to - 1) rate her level of body satisfaction (body image) before and after each session; 2) keep a record of the frequency of her ability to control cravings; 3) keep a record of the frequency of her self defeating cognitions and 4) weigh herself weekly in the morning on the same day.

Self monitoring (Martin & Pear, 1978) was used for all four of the variables. The observations were not made directly by the researcher.

3.4.1 Body Image

Based on the literature (Bergstrom & Neighbors, 2006; Viviani, 2006), the researcher decided that when rating her body image, the subject needed to consider her feelings and cognitions towards her body. Using a 5 – point Likert Scale (Trochim, 2006) the researcher developed a scale where one meant complete discontent with body image and five indicated a positive yet realistic body image (see Appendix A). The subject was required to rate herself before and after each session. The body image rating was plotted on a graph weekly. A baseline rating in the week preceding the treatment phase was also ascertained.

3.4.2 Self Defeating Cognitions

The frequency with which self defeating cognitions occurred daily was added over a seven day period. The total number of self defeating cognitions for the week will be plotted on a graph. A baseline frequency of self defeating cognitions in the week preceding the treatment phase was also ascertained.

3.4.3 Cravings

The subject's task was to monitor daily the number of instances (Martin & Pear, 1978) her cravings occurred. The daily totals would be added over the seven day week – day one being the day of the session – providing a weekly total. The frequency with which she managed to control her cravings were also to be calculated in the same manner. A baseline frequency of cravings and ability to control cravings were collected prior to the treatment phase.

3.4.4 Weight

Weight was measured according to the standard metric unit of measurement for mass in kilograms (kg's) (Conrad & Flegler, 2006). The subject's weight was measured as a baseline measurement in the week prior to treatment commencing and then again at the same time once a week.

3.5 RESEARCHER AND CLINICIAN

The author/researcher of this paper and clinician completed a module in Hypnotherapy as well as Cognitive Behaviour Therapy as part of her training in her first year in the Masters in Clinical Psychology and Community Counselling program.

4. RESULTS

The results will first be reported empirically and will be followed by an objective formulation and process commentary by the researcher as well as the subject's phenomenological experience of the sessions and specific techniques used.

4.1 QUANTITATIVE RESULTS

The individual empirical results will now be presented. Behavioural data obtained from the single case study research design were plotted on a graph. The results are not proven statistically significant because a behavioural single-case study design was used (Martin & Pear, 1978).

4.1.1 Body Image

The graph below shows the general trend towards an increase in Mrs K's experience of body image and satisfaction. As the weeks progressed, Mrs K's rating of her body image before sessions began to increase. Mrs K's body image rating on the day of session seven dropped significantly due to a particularly bad day, she also felt nervous about the termination process. We were able to address the issue during hypnosis. The positive trend of the graph indicates that by session eight Mrs K was experiencing her body in a more positive and realistic way. A positive perception of her body began to develop as the sessions progressed, indicated by her rating before sessions. Her rating after the session was mostly higher than at the beginning (see Figure 4.1). Appendix A contains a detailed description of the criterion Mrs K was asked to consider when rating herself.

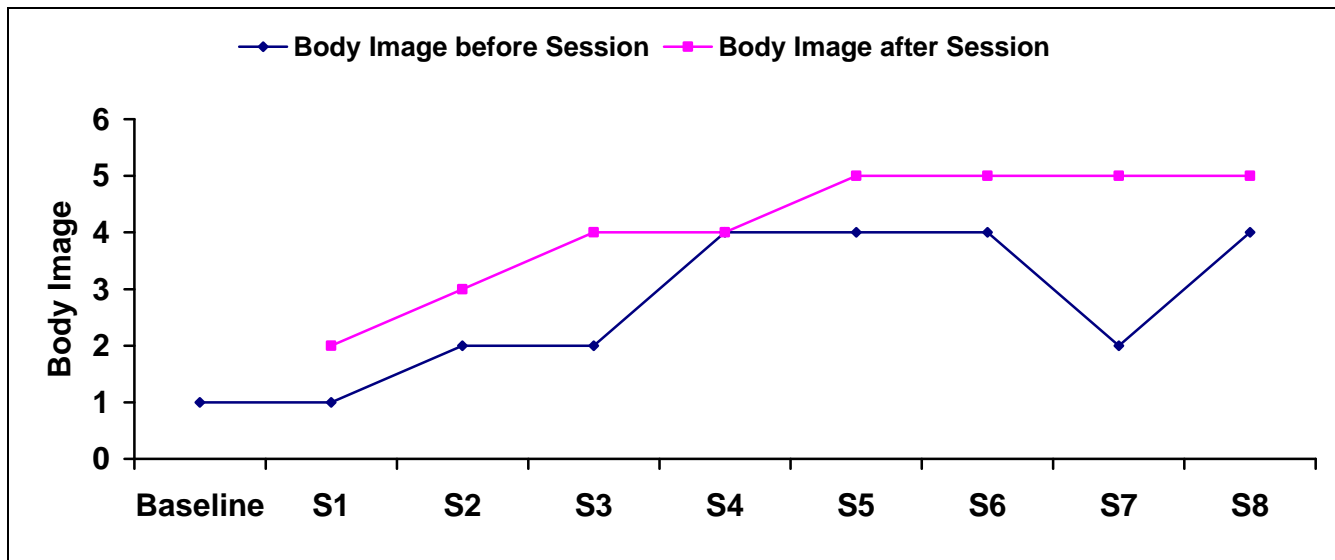


Figure 4.1 Change in body image in terms of body satisfaction over eight sessions.

4.1.2 Self Defeating Cognitions

Self defeating cognitions taking the form of negative self hypnosis can be dealt with by restructuring them into positive, more constructive thoughts aiding in the facilitation of well being.

4.1.2.1 Sample of Self defeating cognitions – Two Column Method

The two column method used in CBH requires the subject to note down their self defeating cognitions in one column while restructuring and recording them in a column to the right of the page (see Table 4.1). These new positive thoughts are suggested during hypnosis as a new way of thinking about the self as well as suggestions for imaginal rehearsal.

Table 4.1

Sample of self defeating cognitions and their positive counterparts

Self Defeating Thoughts	Therapeutic Suggestion
1. Whenever I look in the passage mirror I can't believe how bulbous and revolting I look.	1. Even though I know I need to lose weight and I feel ugly when I see myself in the passage mirror, I know I can do something about it. I am doing something about it.
2. I can't figure out why I feel so much prettier than I look.	2. I know I have nice bits on my body. I like my breasts, arms, legs and calves. Maybe my psyche instinctively knows that I am pretty but my brain is trying to trick me.
3. Scoffed about half a large slab of chocolate and I feel like a pig.	3. If this happens again I will stop and NOT admonish and recriminate myself. I will have better control the next time because I am aware that it does not agree with me or make me feel good.
4. I can't stand being this fat, how will my family accept me?	4. My husband loves me and we are intimate, he shows me affection and my children are always happy to see me.
5. I float around here at work and feel useless.	5. I have many qualities to offer this company and will find a way to feel productive. I am a capable and industrious woman.

4.1.2.2 Frequency of the Five Most Regular Occurring Self Defeating Cognitions

The subject was asked to record her self defeating cognitions during the week preceding session one. Five of her main occurring thoughts were monitored during the week between sessions. The frequency of negative thoughts was higher in the weeks preceding the technique used to reconstruct negative thoughts introduced in session three. Between week one and session one (129 self defeating cognitions) Mrs K mentioned that she had begun to get somewhat apprehensive about the process and what it entailed. Session one had a positive effect on Mrs K in that her fears were allayed and she felt somewhat empowered already – at session two, Mrs K reported a reduced frequency of the five cognitions identified. Between session two and three she reportedly became more aware of the frequency and recurrence of the negative thoughts she was automatically having (115). The two column method was introduced during session three and as Mrs K became more familiar with the technique she began to employ the method fairly successfully thus showing a positive result for reducing the frequency of destructive thoughts.

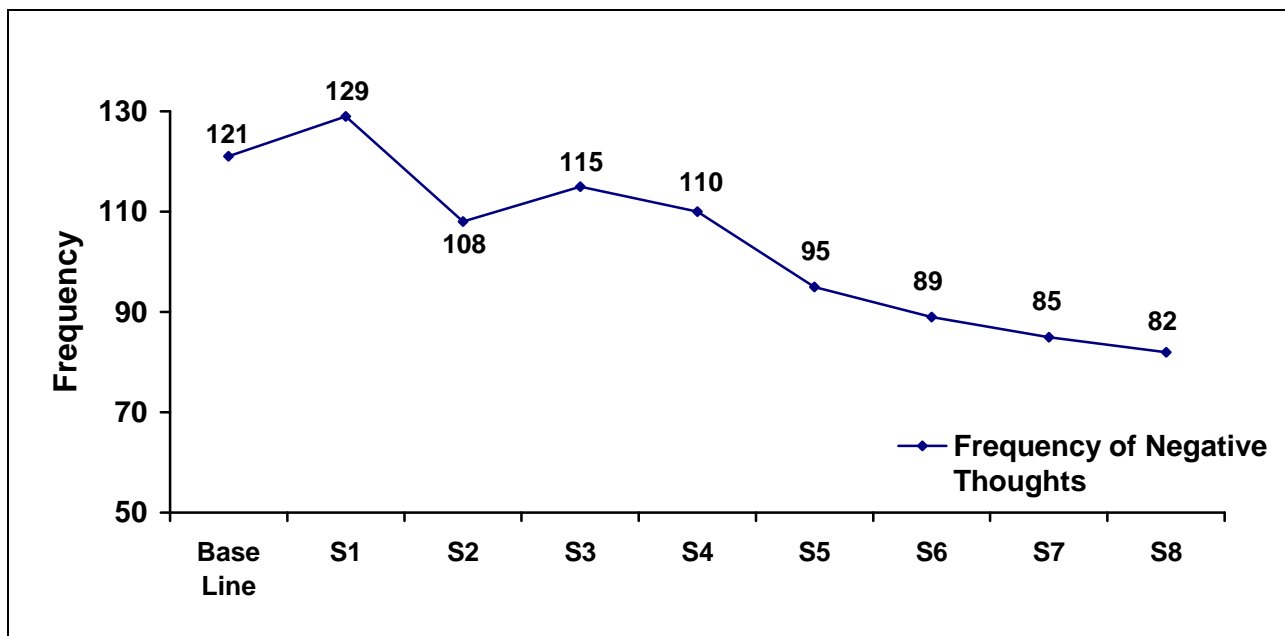


Figure 4.2 Change in the weekly frequency of the five main self defeating cognitions.

4.1.3 Food Cravings

Food cravings are internal states (hunger), with affective components and can be difficult to control if a better understanding of the affective components does not exist.

Many of Mrs K's cravings occurred in the presence of stress and anxiety at work. She was asked to record on a weekly basis the frequency of food cravings she experienced as well as her ability to control them. Mrs K reported that the number of cravings itself decreased as she grew in confidence while at the same time learning how to control these cravings. The technique employed to control cravings was introduced in session four. While there was a decrease in Mrs K's tendency to succumb to her cravings before she learnt the technique, she enjoyed more success after the clenched fist method was learnt. The graph indicates a gradual decline in the number of food cravings that Mrs K succumbed to. Mrs K reports that during the week between session six and seven she was experiencing high stress at work and was less able to control her cravings. The success of this technique however is indicated by the increase in her ability to control and stop the craving while replacing unhealthy food with healthier options.

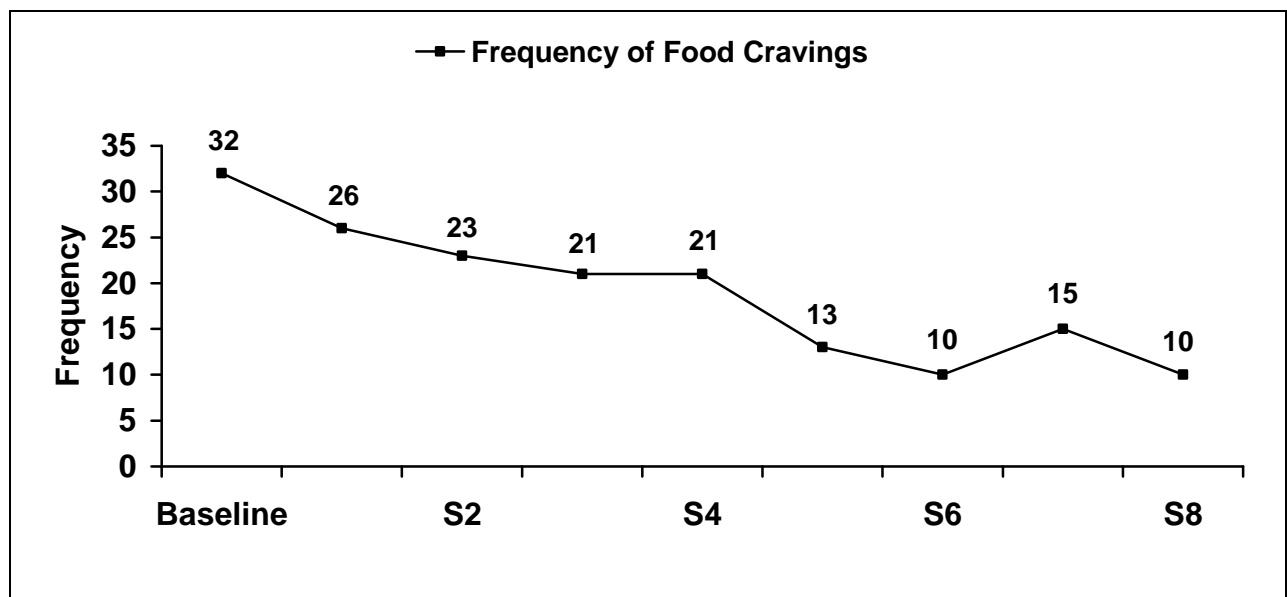


Figure 4.3 Change in frequency of food cravings and ability to control them.

4.1.4 Weight

An obvious variable in such a study would be to monitor the actual weight loss of the subject even though it was not directly targeted.

Mrs K's actual weight loss was minimal at 0.5 kg's over the total period of this study. This will be expanded on in the discussion section.

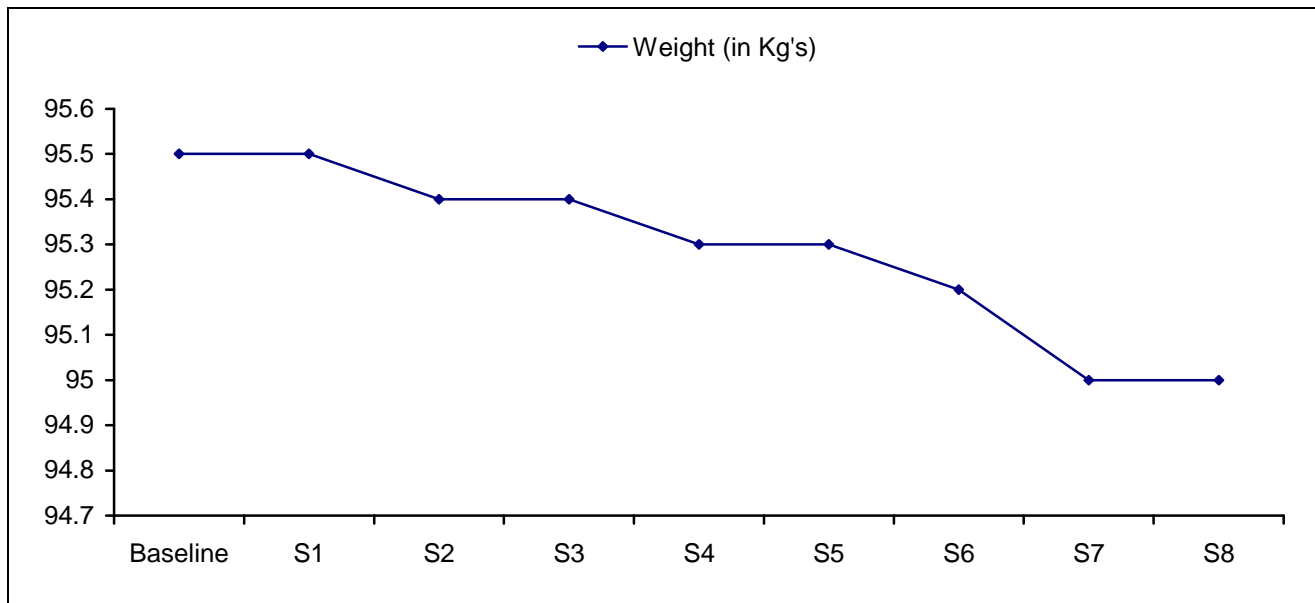


Figure 4.4 Weight change over eight sessions

4.2 QUALITATIVE RESULTS

The researcher will now report on the data collected during the clinical assessment to aid in the understanding of why obesity poses a problem for the subject. Information about the subject's family and personal history is given. An objective researcher's understanding of the process as well as that of the subject's subjective experience will be provided. Creative data generated by the subject during the eight week therapeutic period will also be reported on.

4.2.1 A clinical qualitative working image of the subject

Mrs K is an intelligent, hardworking woman who struggles with her eating habits as well as the ensuing body weight and image issues. She is a thirty nine years old white woman, is married for fourteen years and has two young daughters aged nine and five. She is a professional woman with a Bachelor of Arts majoring in Psychology and currently holds a middle management position within the human resources department in a large corporation. English is her first language. Details regarding Mrs K's history can be found in Appendix B.

There are three main themes that emerged from Mrs K's assessment including feelings of loneliness, unworthiness and fear of rejection. These themes interact and impact on her ability to respond to certain anxiety provoking life circumstances. These themes are discussed within the context of her history in the next section.

4.2.2 Formulation

Her maladaptive response to anxiety was learnt many years ago and has entrenched itself firmly in her daily living. At all significantly stressful times in her life her weight has fluctuated. Significantly, Mrs K's early experience of relocation and the ensuing feelings of dislocation have impacted on her general sense of being "good enough". She could not fit in and her response to the anxiety created by this was possibly eating – perhaps out of boredom and feeling as though she did not measure up to others' expectations.

Feeling good enough appears to be a predominant theme that is skilfully weaved into Mrs K's life story. She could have internalised her mother's musings of losing weight as a message of not being accepted and in conjunction with being in a foreign country with no friends was a precursor to the excessive need for approval that could never really be met externally. Her mother's absence could have negatively influenced her general sense of being important and loved. Also, to avoid her mother's criticism Mrs K engaged in behaviour (cooking and cleaning) that would rather illicit praise. This praise was not forthcoming however and perpetuated feelings of failure.

Mrs K relocated many times in her life and it is possible that while she has developed a good ability to cope with stressful situations in life, she has perhaps done so at the expense of her own emotional health. Not unlike many women, Mrs K has been someone who has at the detriment of herself put everything else ahead of her own needs. All of the relocations that took place were out of her control and could thus have fostered the notion that she has to 'roll with the punches' without too much consideration for herself. While this attitude can work in most aspects of life, continuous negating of one's sense of mastery over one's situation can create some dissonance resulting in anxiety.

Factors such as her daughter's accident impacted on her experience of herself as being a good mother. Feelings of inadequacy are common in mothers under normal circumstances; it would therefore make sense to hypothesise that the accident would play a major role in Mrs K's sense of competence in this regard. This could be a powerful driving force of her anxiety and thus relevant for understanding her negative eating habits especially where a predisposition to anxiety exists.

In addition to the above, Mrs K's smoking habit during the pregnancy of her second child only fuelled her sense of being a 'bad' mother. While, by her own admission, this may not have been her most sensible choice during pregnancy, there is no evidence to suggest that she is a bad mother. She addresses her children with respect, there is no foul language in the home, they are fairly disciplined, she cooks them healthy meals, takes care of them emotionally and most importantly, loves and cherishes them as individuals. As they grow up and become

more independent she understands that the responsibility to be there for them in a different capacity grows - they require more time and nurturance. While this is not something that Mrs K complains about, it could contribute to her overall sense of being cut into bits, catering to all other's needs and neglecting her own.

Her working environment most certainly contributed and currently contributes to her overall experience of self efficacy. There is little room for her to express her abilities in an environment that is constricting and almost punitive, consequently leading to feelings of worthlessness and frustration.

Mrs K's response to anxiety and frustration is to eat unhealthily and sometimes uncontrollably. She has lacked the ability to be aware of her emotional state and respond to it in a manner that is more constructive. When her environment is out of her control she responds by eating. Even though it (eating) is uncontrolled, the act of eating and food substance can give a false sense of momentary control and satisfaction. It, however, does not provide her with satiety. While she is a resilient woman, she denies her deeper feelings of loneliness, experience of loneliness and fear of rejection.

Mrs K is a strong independent woman despite her tendency to doubt herself and deny her power. She is motivated to explore this issue further in terms of what it would mean to her life if she did accept that she is "good enough". She also has the desire to lose her weight slowly and sensibly. Her family are supportive and there are structures in place at work for her to engage in physical activity that will aid in the weight loss process.

4.2.3 Therapeutic Process

Mrs K's willingness to participate in this study was an important precursor to her ability to trust the hypnotherapeutic process. She felt comfortable enough to enter the hypnotic trance (at varying levels) during this study thus enabling the clinician to use the techniques ascribed.

Mrs K was surprised at how quickly time passed while in the hypnotic state, she appeared calm and looked like she enjoyed the process. She appeared committed to the process and

her volunteering showed her willingness to change. She was a creative participant in generating imagery and metaphors to utilize during hypnosis.

4.2.4 Mrs K's Phenomenological Experience

Mrs K was on medication for panic symptoms as well as depression in November 2004 and remained on it until approximately February 2006. She became aware that she was not benefiting from the medication and felt out of control of her life. The medication was also impacting on her weight gain. For the most part, Mrs K felt as though she had spent the previous year, while on medication, in a daze, a semi conscious state and describes experiencing flat affect. She understands some of her weight gain as a general disconnect between her brain and her body thus being in complete denial of her lack of self care.

Mrs K experiences herself as disgusting at times because of the extra weight she carries. This impacts on her ability to interact with her children in an energetic manner and feels as though she may be running out of time. Apart from it being frustrating that she is not able to do more, Mrs K feels like she is failing in her duty as a mother.

The subtle effect of growing up in a home where her mother made passing comments about weight issues has manifested itself in the concept that being fat is not good enough. Mrs K experiences the ramifications of this dysfunctional foundation characterised by her inability to appreciate her body as a whole rather than just as body parts. She is inclined to meter out harsh criticism about her body. Mrs K reports this to occur mostly in stressful circumstances where people may make judgements about her abilities based on her weight. Mrs K is sometimes afraid to attract attention to herself at work because it may expose her to the scrutiny of new people who may perceive her to be lazy and stupid. She is acutely aware that people who do not know her will see a "big fat blob" and base value judgements about her personality on this.

She describes anxiety inducing times where she feels out of control of her environment and disempowered to enforce change where it is required. Her self-confidence flounders

significantly in stressful situations where her negative thought patterns surface and cloud her judgement.

Enrolling as a participant in this research assisted her to take responsibility for her health and mental well being as opposed to being a passive receiver of circumstance. She reportedly benefited from the dedicated ritual of taking two hours, once a week for herself.

Significantly, by the fifth session Mrs K had an experience that impacted positively on her general sense of well being. She described how while walking towards big reflective glass windows she saw “a big roundness” which was enshrouded by darkness. She took a moment and saw through the physical exterior towards the internal lightness both emotionally and physically. She was encouraged to hold that image and access it in moments of self doubt and negation.

4.2.4.1 Imagining a Safe Place

As part of the induction and deepening process, subjects may be encouraged to provide their own place of safety where they are guided through their imagery. Using their own creativity, something that they are familiar with creates an atmosphere of trust and ease, thereby possibly making the subject feel more comfortable with a process that may initially be anxiety provoking. The Ericksonian (Golden et al., 1987) technique can indirectly turn thoughts, ideas and images into sensory and perceptual feelings as well as alter emotional states during the hypnosis.

With minimal prompting Mrs K could utilise her creative ability to envision a safe place, a technique used to deepen the trance as well as to create a comfortable imaginary environment within which to work.

Mrs K envisioned herself in the “centre of a clearing in a forest leaning against a somewhat rough rock. There are colourful flowers growing scattered around on the soft, lush green grass. The trees create a canopy with their big green leaves and the sun shines through them. Little brown birds flutter and chirp about in the tree tops, while pretty butterflies seem to

float in front of you. It is a temperate day, not too hot and not too cold. The leaves rustling in the slight breeze add to the sense of peace and tranquillity.”

Deepening the relaxation entailed a ten step walk towards the stream in her imagery. When she was able to indicate that she had reached a satisfactory level of relaxation and calmness the clinician could work with her metaphorically.

After the first usage of this imagery, Mrs K reported that the cool, rough, granite coloured rock served as an anchoring point for her. The clinician utilised the concept of “Mother Earth” as the possible source of sacred feminine energy, something that was always available and easy to access when needed.

Mrs K accounts this process for her heightened keenness to attend the sessions. She thoroughly enjoyed her time in this space and felt at peace with her body and her life. As this imagery was used in every session, Mrs K got better at accessing it during the induction and deepening processes. It was easy for her to call upon the scene in her mind when she needed it at stressful times during the week. Her ability to imagine such a beautiful scene and draw on its positive energy injected Mrs K with new vitality and motivation to take care of herself.

4.2.4.2 Metaphors

The metaphor presents as a useful tool in the process of deepening the hypnotic state as well as in addressing existing issues indirectly. It is possible to minimise a subject’s tendency to be defensive when issues are addressed directly by using metaphors ideally provided by the subject.

4.2.4.2.1 Boxes

Mrs K was accustomed in life to suppress problem solving with the intension of dealing with them at a later stage. As she stored these problems, the container (a box) filled up eventually reaching breaking point where everything would spill out of control. As the box became

heavier, so did her physical, spiritual and emotional self. She likened this to carrying around excess baggage for fear of dealing with issues with the result of bearing a load that in fact just slowed her down.

In dealing with the initiation of letting go of certain feelings and attitudes Mrs K was keen to put these into another smaller box and throw it into the river, while watching with relief, it flow away from her. Mrs K could recall feeling emotional at the possibility that she was able to allow herself to let go of old, heavy issues that were weighing her down. The emotion was a combination of relief, grief and happiness.

4.2.4.2.2 Bandages

In addition to the above, Mrs K enjoyed using the image of herself as a mummy embalmed. It entailed the bandages rolling off her into the river as she lightened her emotional and physical burdens in her life. As the bandages were being discarded and a newer individual was being revealed she felt she had more control over her reactions to her environment. This process facilitated in a general sense of well being more often than experienced before.

This metaphor produced a similar effect to that encountered with the boxes metaphor. Mrs K's creative energy was a useful tool in this process. She had a great sense of achievement at having experienced herself as someone that could create such beautiful images. This process taught Mrs K that she had an unlimited source of inner strength that did not come at the expense of her family and lead to an overall feeling of power and worth as a woman.

5. DISCUSSION

5.1 INTEGRATION OF LITERATURE AND RESULTS

When beginning the process of weight loss, many individuals have erroneously tried to focus in on just counting calories and controlling their right to enjoy the food they desire (Martin et al., 2006; Pearson & Pearson, 1973; Yanovski, 2003). While it is not healthy to feed on junk food or the proverbial forbidden food too often, it can be said that perhaps to allow oneself the satisfaction of truly enjoying the sensation that a particular food provides - without admonishment – might go a long way in aiding in the weight loss process (Pearson & Pearson, 1973).

Mrs K is a woman, who like many, seek to find solace in food due to emotional factors (Bergstrom & Neighbors, 2006; Bruch, 1974; Farrell et al., 2006; McReynolds, 1982). While this is fine some of the time, unawareness and inability to access the understanding of her hunger has lead her to misread anxiety signals caused by internal conflict. Instead of feeding the part of her soul that requires nurturing in states of anxiety she feeds her physical body. The soul remains hungry and the body becomes bigger. One could say that Mrs K's history of constant relocation and sense of instability created a mechanism of ineffective coping to stressful situations thus influencing her eating behaviour. Her hunger for something that would soothe her translated into random binge sessions that would leave her feeling guilty and unattractive.

Since Mrs. K's obesity involves elements of emotional eating, it should make sense then that if she allowed herself time to tend to her psychological well being, she might feel in control of her experience of anxiety in her life. Anxiety that culminates from the uncertainty of the future and our abilities can be alleviated if we could begin on the journey of learning to trust ourselves (Payne, et al. 2005). We are only able to trust ourselves if we are able to sit quietly and own up to - and be proud of - who we are. This type of lifestyle is a journey and a choice. Mrs K has taken the first steps in this process and chose to learn how to change not just her physical weight, but her emotional weight too. While her working environment did not change

significantly, her feelings of worthiness in response to her actual contribution to the company improved.

Mrs K's total weight loss in this intervention was minimal but it can be argued that if the harsh negative focus on weight loss itself is minimised, as it was in this study, the impact of such an intervention could have longer term benefits. Traditional cognitive therapy as an intervention for obesity advocates that individuals strive for modest weight loss and lifestyle change including addressing emotional issues, as was found in this study (Rapoport, Clark & Wardle, 2000; Foster et al., 2004; Marchesini et al., 2002; Tanco et al., 1997). Her body image improved, thus impacting on an improved ability to accept herself. Figure 4.1 serves as a graphic representation of the possible impact of addressing two factors - namely self defeating cognitions and cravings, on Mrs K's body image. The dynamic interplay between these variables and the use of her creative imagery could explain the steady increase in the rating before each session (except for session seven) indicating a general trend towards an improved body image over time.

In addition, as discussed by Foster et al. (2004), the individual that is satisfied with their weight loss at the end of a program, however minimal, is more likely to maintain that loss over a longer period of time. Working from the perspective that it is beneficial to deal with emotional factors leading to weight gain; it is possible that addressing the individual's sense of achievement would have a positive impact in other areas of her life.

A unique feature of this study was to include positive, affirming imagery that facilitated a natural source to access when self defeating thoughts threatened to cause emotional upset. Mrs K provided rich imagery to work with during hypnosis. This was crucial to establishing good rapport and provided a foundation on which the clinician could build. Mrs K was able to internalise her positive lifestyle change over the duration of this study and felt proud of herself for making the effort to take care of herself.

In restructuring Mrs K's self defeating cognitions, she was better able to react appropriately to emotional stimuli (Buckroyd et al., 2006; Holt et al., 2006; Nauta et al., 2000; Richman et al.,

2001). This new ability to understand her reactions to her environment brought greater awareness to her own being and facilitated a turn towards a more positive appraisal of herself. The positive tendency in Figure 4.2 illustrates how her negative thoughts decreased over time.

It is difficult to determine causality in this research but an interaction between variables may be inevitable. When the two column method was introduced into the intervention and used in hypnosis Mrs K's body image rating increased further (see Figure 4.1). Her appraisal of her body began improving from the first session; it is possible however that the technique employed in session three had added benefits culminating in a cumulative effect.

Mrs K's cravings (anxiety provoked) decreased as she became more effective in her ability to deal with situations in a productive way. As in her case, she would eat or binge because she felt bad and then feel bad because she ate (de Zwaan, 2001; Martin et al., 2006). The negative cycle created began to break due to her improved body image and the implementation of positive cognitions about her abilities, especially in the work place. Figure 4.3 shows how Mrs K was better able to control her food cravings even reducing the number she experienced during the day. Even though on the day she experienced negative body image Mrs K was less able to curb her eating response, it was not at the magnitude of previous occasions prior to the beginning of this study. The ability to not succumb to all of her cravings also freed her up to enjoy her food more, thus allowing her to not feeling guilty about everything she ate.

The lack of being seen as an individual worthy of unconditional positive regard is evidenced in Mrs K's general disconnect between her actual ability and worth and her perceived faults. Rogers (1980) highlighted the role of loneliness in the development of psychopathology. Mrs K is perhaps an example of a woman who denied her feelings of loneliness in childhood in an attempt to present as a well adjusted and content child in the midst of constant flux and anxiety. She has been a woman who appears to be happy all the time when she is in fact, at times, quite unhappy. This isolation from herself and therefore others, further exacerbates feelings of loneliness. Mrs K tried unsuccessfully to sooth herself with the aid of food. This

case study shows how unconditional positive regard provided by the clinician/researcher can impact the subject on a multitude of levels. However, the unconditional positive regard Mrs K was able to access for herself during hypnosis and the interventions implemented far outweighs in significance. Mrs K experienced herself as a prized and affirmed woman during this process, something that Rogers (1980) advocates as the fundamental factor in aiding better mental health.

The minimal change in weight shows that this method of weight loss is not a quick fix but rather a slow and gradual response to changing one's cognitions, attitudes and self concept. Fortunately Mrs K was not expecting radical weight loss and remained motivated to remain in therapy because she had benefited from the other aspects that were addressed. Many women wait to lose weight before they begin feeling good about themselves. They reach a plateau in their weight loss process and misinterpret that as failure perhaps reinforcing beliefs of inadequacy, beginning the cycle of bad eating habits once again. This process presents the opposite - begin to feel good about your SELF and you may begin to lose weight.

5.2 CLINICIAN/RESEARCHER AND PARTICIPANT DYNAMIC

The single case study design requires the researcher to have a good understanding of the possible impact she could indirectly have on the subject. There is very little that can be done to control for this impact except to report in detail the researcher's and subject's understanding of the dynamic. In this case study, the researcher is also the clinician.

Initially, the clinician's belief in this approach to weight loss impacted greatly on the participant's "buy in" of the process. The clinician was able to utilise her own resources to empower the participant and her amiable nature made it easy for the participant to trust her, consequently making the induction of hypnosis unproblematic. It is important that the clinician doing such work have the resources of a healthy self concept and the ability to create an environment that is safe for the participant. Unconditional positive regard for the participant and her circumstance is crucial for the success of therapy. The atmosphere created by a clinician who is open to creativity in therapy allows for her participant to be free to express her own creativity, thus vicariously empowering her (the participant) (Gafner & Benson, 2003).

This clinician was able to provide such an environment because of her own sense of ability to do so. Watching Mrs K benefit from the process further provided encouragement, inspiration and belief in what she was doing. And, as was a pattern in this study, the positive effects gained in one area played a role in positive results in others. Mrs K therefore, observing the clinician's genuine response of appreciation for her and her improvement could internalise this positive voice and make it her own.

5.3 TRANSPORTABILITY

This process can be easily replicated at a core level. While the basic concepts are there as a guide, the clinician presents as a variable impacting on the process of therapy. Both men and women can benefit from the empowering effect it can have on individuals. People from all cultures and communities that are willing to engage with hypnotherapy can benefit from this procedure.

The strength of a single case study lies in its ability to supply data regarding behaviour change (Fishman, 2005; O'Leary & Wilson, 1987). This change does not need to be inferred from the group and adds value to the subject's life. There was evidence in this case of behaviour change in terms of cognitive restructuring and therefore a demonstration of control over cravings and negative thoughts.

5.4 LIMITATIONS

One needs to consider the possible impact of subject and researcher dynamics. It is difficult to delineate how much impact this had on the subject's overall progress during the eight week program. The process of allowing herself two hours a week to dedicate to her well being could have contributed more than anticipated.

It is important to consider the time factor in such a study. The clinician had limited time and could thus not continue beyond the eight session period. In order to see significant weight loss and other gains solidly entrenched, a considerably longer period would be needed in which to conduct the study. Furthermore, one would need to factor in a more tailored

behavioural approach to supplement the process of weight loss. This study did not concern itself excessively for controlling the subject's dietary intake and energy expenditure.

This approach (CBH) is designed to work with individuals; it should ideally not be used in the group setting (Golden et al., 1987). This dictates the amount of people it can reach at one time making it expensive to run. This precludes many South Africans from utilising such a program. It is also time consuming and requires patience from clients.

This research was highly dependant on the subject's diligent attention to recording the frequency of self defeating cognitions and food cravings. While it is not ideal that as many of the variables are subjectively recorded it could not be avoided under the circumstances of this study. It is also difficult to determine whether the weight lost was due to the varying degrees to which a woman's body fluctuates during the month.

The techniques taught to the participant required some practice of self hypnosis and imaginal rehearsal at home between sessions. Mrs K was not able to do so at a higher frequency due to time constraints. How this impacted on the overall results cannot be ascertained but it can be hypothesised that she would have achieved greater gains.

The researcher developed her own body image scale therefore its construct validity may be questioned.

The generality of the findings in this case study is difficult to determine. The purpose of this study, however, was to explore the viability of considering CBH as a treatment option for obesity. Further studies would need to be conducted to validate any findings.

The results in a single case study are presented in graph and table form. While the results in all of the variables in this study show a positive tendency they may not withstand the scrutiny of a purely quantitative approach to analysing data.

5.5 FUTURE RESEARCH

Further research is required in the realm of the impact on addressing body image as a main variable in the treatment of obesity. More validated research tools are required to affirm or challenge what was found in this study. It would be of benefit to monitor the long term effects of introducing hypnotherapy to enhance body image and self concept.

5.6 CONCLUSION

While it is clear that more time is needed than eight sessions to lose a significant amount of weight, establishing a healthy self concept through a more positive body image can benefit the individual and protect them from the many obstacles that the obese individual may encounter. The idea is to empower the individual so as to ensure maintenance of weight loss rather than providing another quick fix method that inevitably fails. This research presents a relatively novel and unorthodox approach to weight loss taking a positive stance against obesity rather than a punitive, self sacrificing one. By grappling with the notion that joy comes from experiencing one's body as a sacred entity and self acceptance is the resultant state of being, it may be possible to transform our relationship with food. A kind response to our emotional needs may facilitate more resilient individuals, depending less on extraneous resources-food in this case- to satisfy our psychological hunger.

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Appendix A

Scale for Evaluating Body Image

At the beginning of the process Mrs K was interviewed where dysfunctional thoughts and consequential emotional states were examined. The main thoughts were highlighted and utilised in her body image rating scale.

Following are the negative thoughts that were used in rating number one and two.

- a) I am fat and ugly.
- b) I waddle around like jelly.
- c) Nothing firm exists on my body.
- d) I am no good at looking after my body.
- e) All I do is overeat, I feel gluttonous.
- f) I am a bulbous human being.

The resultant emotion associated with the above thoughts was disgust and discontent with self.

Following are the positive and realistic thoughts used in rating four and five.

- a) I am overweight but something can be done to change this state.
- b) There are areas of my body that I like and appreciate as attractive.
- c) I do not have an ugly body just because it is not firm like an adolescent's.
- d) I am taking care of my psyche and soul – that feels like a positive move towards appreciating my body.
- e) I can be graceful even though I am overweight.
- f) I feel in control of my food cravings.

The resultant emotional state from having these positive thoughts was of a realistic contentment and acceptance of being overweight.

- 1 = negative feelings and thoughts towards body
- 2 = somewhat negative feelings and thoughts towards body
- 3 = neutral
- 4 = somewhat positive and realistic feelings and thoughts about body
- 5 = positive yet realistic feelings and thoughts about body

If Mrs K experienced four to six of the above thoughts and felt disgusted with herself she would choose rating number one.

If she experienced two to four of the above negative thoughts and felt disgusted with herself she would choose rating number two.

If she experienced either one negative or positive thought, Mrs K was requested to opt for a rating of number three.

If Mrs K experienced two to four of the thoughts in the positive list and felt some content with regards to her body her rating would be four.

If she experienced between four to six of the positive thoughts and had a generally realistic view of her body, she would choose a rating of five.

Appendix B

Family History

Mrs K grew up in a nuclear family consisting of both her parents and an older sister. Her parents are still married and live in Port Elizabeth. Mrs K's sister also lives in Port Elizabeth with her family comprising of her husband and two children. She describes her childhood as a pleasant one with no major trauma befalling her or her family. According to Mrs K, they generally enjoy close ties as a family and she and her sister are particularly close.

Mrs K reports that they moved frequently as a young family. The family moved to Johannesburg from PE when she was two and then to the United States when she was six. They relocated back to Johannesburg a year thereafter and back to PE when she was ten. There were no further moves until Mrs K got married.

In adolescence her relationship with her mother was somewhat strained but good overall and remembers that even though there was no financial need for Mrs K's mother to work, she did. While Mrs K did not disapprove of this, she did feel the absence of her mother during certain times of her childhood and adolescence. Mrs K feels she is better able to accept what she experienced as the somewhat selfish nature of her mother now than she could in her youth.

Mrs K reports that her father was and is a quiet man who very rarely spoke his mind or his heart. While they were not tremendously close, they did enjoy a good relationship. She describes him as being a hard worker and a traditional man in that he did what he could and needed to in order to provide for the family.

Personal History

Mrs K met her husband when she was eighteen while in her second year at university. She moved out of home at twenty one, lived in a commune with a number a girls until she and Mr K bought a house a lived together one and a half years before they got married. Mr K was told two weeks before their wedding in 1993 that he was being transferred to Cape Town. Even

though it came as a shock she was not completely averse to moving and has been living in the Western Cape since then.

She employment experience ranges from the Information Technology industry, training and development, recruitment and Human Resource consulting positions, management in both IT and HR to her current role of Talent Manager. Job satisfaction has always been of utmost importance to her. Mrs K's weight and body size has fluctuated over the years.

Mrs K describes her eating habits as unusual since approximately the age of six when the family moved to America and she "discovered the joys of watching television and eating". She reports that she became overweight and has been dealing with weight issues since then. In the year that she lived in America Mrs K had to change schools once, leaving behind the only good friend she had. This exacerbated her feeling of not belonging and fitting in and used her pocket money to purchase large quantities of sweets. Mrs K's mother was particular about the food she kept in the home – no sugary carbonated drinks or white bread for example.

Mrs K remained heavier than her peers until adolescence where she made a conscious attempt to lose weight by increasing her activity level. Her motivation at the time was allocated to a need to look slim and attractive as a teenager. She generally enjoyed being active and was therefore assisted by this to regulate her weight. While Mrs K's mother did not attempt to force her to diet or curb her eating, there were comments made about her paying attention to her eating habits.

After gaining weight at seventeen she admits to resorting to anorexic tendencies sometimes not eating for a week during her first two years at university including the use of appetite suppressants. She used to cook supper for the family in order to help out and avoid possible criticism from her mother who would admonish her if she had done nothing constructive for the afternoon. Having cooked the meal she would pretend to her family that she had indeed eaten lunch. She was on this crash diet when she met Mr K who consequently noticed her use of the suppressants, persuaded her to stop and encouraged her to eat more healthily. She maintained a healthy weight and eating pattern until they moved to Cape Town.

Mrs K's first employment in Cape Town encompassed eating unhealthy lunches provided and eating unnecessarily large meals again at supper time with her husband resulting in weight gain. She changed jobs and joined in an exercise program with a friend and colleague losing the weight. She had a miscarriage and proceeded to gain weight in excess of that lost over the period of a year once again. Dissatisfied with her body she began to diet and exercise again and after losing approximately three kilograms found out she was expecting once more.

She describes her pregnancies as uncomplicated but recalls worrying excessively. Her weight at birth was approximately one hundred and four kilograms – more than was recommended. This happened when she had her second child too. Following the birth of Mrs K's first child she enrolled into the Weigh- Less program and successfully maintained a sixty nine kilogram weight for more than two years.

Mr and Mrs K experienced trauma when their daughter nearly drowned in their swimming pool at home. Mr K was minding her while Mrs K was at work and was fortunately able to resuscitate her. While she was being supportive to her husband, Mrs K acknowledges that she was not able to deal adequately with her own feelings surrounding this incident. A year after the accident Mrs K reports that she began crying uncontrollably and started having dreams that caused her anxiety. Professional help was sought briefly. She abandoned therapy and has not been to a psychologist since then. There are times when the conditions are similar to the day of the accident Mrs K experiences flashbacks and the accompanying emotions of fear, anger and despair. This would occur mostly around the same time of year as the accident.

Mrs K moved within the company to a different role and experienced the job as excessively stressful. In response to this stress her weight increased to 75 kilograms. In conjunction with coping with a new stressful job, Mrs K fell pregnant and like her first pregnancy gained to the same amount. Once again she worried constantly and in particular this time because she has not given up smoking completely. Post-natally she became anxious, worrying about cot death and would often experience panic attack symptoms. She also experienced some depression symptoms.

During a consultation with her general practitioner while treating her eldest daughter, Mrs K's emotional state became apparent to the doctor and he prescribed a mild anti-depressant for three months that was reportedly effective.

Mrs K's weight has steadily increased since the birth of her second baby. She returned to work after maternity leave but was highly dissatisfied with her job and moved once again within the company. While this new job did afford her the opportunity to explore new avenues that added to her feelings of productivity and creativity within her career path, restructuring and management changes have impacted heavily on her. Very often she does not experience herself as a worthwhile, contributing and productive member of the department. She feels she has much to offer but is curtailed by senior management.

The family is dependant on her salary; her contribution is a large component of the combined earnings of the couple. This has been a major factor in Mrs K's reluctance to leave the company and pursue a path that is more constructive for her. Prior to beginning therapy for this study, Mrs K became aware that she uses food as a comfort and a means to fill a hole.

Mental Status Exam

- General appearance
Neatly attired, pleasant presentation, overweight.
- Facial expression and posture
Warm smile, kind facial features and seemed relaxed in her chair.
- Behaviour
Somewhat anxious characterised by foot tapping.
- Attitude
Open attitude to the process.
- Speech
Good command of the English language.

- Mood
Pleasant but stressed due to work.
- Affect
Researcher observed a slightly anxious overtone to affect.
- Thought content
Themes of unworthiness, loneliness and fear of rejection.
- Thought form
Nothing abnormal detected.
- Abnormal perceptions
None reported.
- Neuro-vegetative symptoms (eating, sleeping, energy)
Some unusual eating patterns – overeating.

No unusual sleep patterns.

Low energy due to lack of physical activity.
- Suicide and violence
No suicidal ideation or violent tendencies
- Consciousness
Normal
- Orientation
Orientated to time, place and person
- Attention
Subject was attentive throughout the interview.
- Memory (short-term, long-term)
Nothing abnormal detected.
- General knowledge
Very good

- Abstract thinking
Intact
- Insight
Fair
- Judgement
Fair