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Hypnotic Regression as an Autoethnographic Modality for Exploring Adverse Childhood Experiences as Proposed Effectors of Chronic Adult Obesity - Selected Case Studies

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Abstract

Much has been written about the aetiological role of Adverse Childhood Experiences (ACEs) in the development of chronic adult physical and emotional health problems but current screening methods utilising questionnaires and formal interviewing often fail to show consensus across populations and surveys. This paper proposes that hypnotic regression might provide an alternative approach to ACE screening through its facility in revealing unsuspected and seemingly minor ACEs, which nevertheless can go on to have long term implications for individuals' adult health. In this study seven female participants with intractable overweight volunteered to participate in a series of hypnosis sessions designed to explore for possible covert childhood or early adulthood traumatic experiences which might have contributed towards their adult obesity problems. During their hypnosis sessions all participants were seemingly able to recall and to recount, narratives of long-forgotten but intensely painful childhood experiences, traumas and family disharmony, which appeared to have provoked life-changing decisions regarding their weight, body image or eating habits, and which may then have contributed to their developing refractory obesity later in their adult

life. This study suggests that current decisions limiting the range of what constitutes ACEs may account for the differing results of previous ACEs surveys and that hypnosis might prove to be a useful tool in screening for otherwise unrecognised ACEs, thus helping to improve the specificity and sensitivity of current ACE screening programmes.

Keywords
Childhood traumas; autoethnography; hypnotic regression; refractory adult obesity

1. Introduction and Background to this Study

The increasing number of publications exploring and documenting the link between adult health problems and childhood abuse and distress clearly evidences the fact that Adverse Childhood Experiences (ACEs) can predispose to subsequent chronic refractory adult physical or emotional illness [1-7]. This study was designed to investigate the potential for hypnotic regression to be used as an autoethnographical modality for highlighting childhood traumas and ACEs which may have remained unresolved, and which may therefore be continuing to have an emotional and behavioural impact on individuals' current adult life.

Chronic refractory adult obesity was chosen in this study as an exemplar for assessing the value of hypnotic regression in detecting covert, unsuspected ACEs, for several reasons. Obesity and incipient diabetes have become increasingly major public health problems with widespread morbidity management consequences and implications [8-10]. Current efforts to deal with the rising tide of obesity problems in most countries of the world are proving less than totally successful and any new investigative approach which might help ameliorate and better manage this problem would be immensely valuable [11-14]. Furthermore, over the past decade it has become increasingly clear that adult weight, eating habits and body image problems are being widely recognised and documented as being associated with childhood personal and family trauma and other ACEs [6, 15-20].

For the purpose of this study a cohort of participants with long-term and refractory obesity were invited to undergo a series of hypnotic regression sessions which it was hoped would facilitate for them an autoethnographic exploration into their earlier or childhood life and which might reveal possible unresolved, obesity-related ACE's [21]. In this situation, transactional analysis and redecision theorists have suggested that the resulting child ego state deconfusion can lead to the healing of erroneous decisions made during traumatic childhood years [22-25]. These theories may therefore have relevance to experiences during hypnotic regression, in empowering individuals to remake or let go of unnecessary childhood protective decisions and become free to manage their adult lives in a better way. Spontaneous out of body experiences and other forms of dissociation during hypnotic regression can be similarly enlightening and empowering [26, 27]. All such autoethnographical discovering and re-discovering of the past and its previously hidden traumas and turmoil can in this way bring illumination and understanding about the past, its impact on one's present life and the freedom to change [21].

2. Participant Recruitment

Participant recruitment for this project was through an email circulation across Liverpool John Moores University campus and followed by convenience sampling through an opportunistic word of mouth ("snowballing") approach. These principally required that participants be over 18 years of age, have a history of being unable to achieve a sustained reduction in their weight after having participated in more than one weight management scheme, and have exhibited a BMI greater than 25 over the past five years. All telephone and email enquirers were sent a comprehensive four page leaflet the design and content of which had been approved by the University's Research Ethics Committee. This document discussed the nature of hypnosis and the rationale for the study and contained an invitation to attend for a face to face interview to discuss the study in more detail. From an initial 23 enquiries (22 female and 1 male), just seven female participants agreed to continue into the programme (Table 1). Ethical approval for this study was obtained from Liverpool John Moores University Research Degrees Committee (Reference SIS no. 514041) who managed and oversaw the entire project.

Table 1 Participant recruitment and outcome.

STAGE ATTAINED	REASON FOR NOT CONTINUING FURTHER	n=
Initial enquiry only	Not Appropriate	2
	Too Busy	4
	Not Known	2
Completed Forms	Too Busy	2
Attended Interview	Family Illness	1
Left Programme Before Commencing Hypnosis	Personal Health Problem	2
	Family Bereavement	1
	Work Pressures	1
Left Programme After Commencing Hypnosis	Personal Health Problem	1
Total Number of Enquirers	-	23
Participants in this Study	-	7

3. Procedure

At participants' preliminary meeting it was explained that hypnosis induction would be undertaken by the researcher, a clinical scientist, counsellor and qualified hypnosis practitioner with over 40 years of experience both as a counsellor and in using hypnosis in clinical contexts. Participants were reassured that they were free to withdraw from the programme at any point if they wished, without giving a reason for their withdrawal. Issues of confidentiality of their data and recordings of sessions were explained. Participants were also informed about the counselling

support that would be available at any point if required, ranging from informal, confidential counselling from a member of the team, the university student and staff counselling services, through to referral to independent counsellors.

Also discussed at this time was the possibility of the participant having an abreaction during one of their sessions. It was explained that this was an uncommon emotional (or physical) response which can occur during any emotional or physical therapy or research procedure, such as hypnosis, massage, acupuncture. Participants were reassured that this was a natural part of hypnotic exploration, and that if this was to happen, it could be managed and mitigated safely and calmly by the hypnotist. This initial and all subsequent discussions at the time of the hypnosis sessions were informed by the principles of a *culturally responsive relational reflexive ethics* [28].

Other than their overweight state, all of the participants going forward into this study were in good health, none reported any past or current significant health issues, nor were any on any regularly prescribed psychoactive medications (Appendix One). Emotional health screening tests indicated only mild anxiety commensurate with their concerns about their obesity problem (Table 2 and Table 3). At this point participants signed their informed consent on their copy of the information leaflet for them to retain and on the researcher's copy, and both copies of the leaflet were countersigned by the researcher. No extensive autobiographical record was obtained from participants prior to their commencing their hypnosis sessions. This was to ensure that the hypnotist as researcher could not anticipate what childhood history might be relevant in a particular participant's obesity history and thereby inadvertently induce false memories by asking leading questions and making suggestions. [29-31].

Table 2 Participant demographic information.

Participant Reference Code	Age	Height	Weight	BMI	Obesity Record		Number of Hypnosis Sessions
					Age of Onset (yr.)	Duration (yrs.)	
HP - O1	47	5' 3"	16st 9lb	41	10	37	03
MK - 02	57	5' 2''	16st 0lb	41	12	45	12
AL - 03	50	5' 3"	16st 5lb	40	10	40	14
BC - 04	40	5' 3''	14st 7lb	36	18	22	20
VS - 05	27	5' 5''	13st 3lb	27	20	7	11
BL - 06	41	5' 8''	14st 0lb	30	15	26	10
RC - 07	44	5' 2''	10st 9lb	27	11	33	10

Table 3 Participant emotional data.

Participant Reference Code	GAD-7 (i)	PHQ-9 (ii)	EEQ (iii)	ATHQ (iv)
HP - O1	12	15	14	49
MK - 03	15	14	15	34
AL - 04	7	4	12	53
BC - 06	7	14	12	59

VS - 07	10	7	16	59
BL - 08	9	6	12	57
RC - 09	6	7	15	63

(i) Generalised Anxiety Screening Questionnaire (GAD-7)
Score: 0-5 Minimal, 6-10 Mild, 11-15 Moderate, 15-21 Severe.

(ii) Stanford Personal Health Questionnaire Depression (PHQ-9)
Score: 1-4 Nil, 5-9 Mild, 10-14 Moderate, 15-19 Moderately Severe, 20-27 Severe.

(iii) Emotional Eater Questionnaire (EEQ)
Score: 0-5 Non-Emotional, 6-10 Low, 11-20 Moderate, 21-30 Very emotional eater.

(iv) Attitudes To Hypnosis Questionnaire (ATHQ)
Score Range: 7 – 98: 7- Very negative to 98- Fully positive - with regard to hypnosis.

4. Results

Despite participants' unfamiliarity with the process, all seven of the group appeared able to enter into hypnosis with ease and facility and achieve a significant depth of hypnosis. This was taken to indicate that they were both *consciously* and *unconsciously* ready to initiate exploration [16, 32, 33]. The resulting extensive verbatim recordings of participants' hypnosis sessions and between session conversations, produced a unique set of narratives of intensely personal and painful past experiences concerning their weight or body image histories and problems during their childhood and teenage years.

In response to the suggestion to go back to past traumatic times and events, all of these participants spontaneously went back to recall distressing or traumatic times, associated with their weight or body image. Participants were very surprised at just how powerful and immediate the recalling and remembering of these times felt despite these episodes having happened twenty, thirty, forty or more years earlier. They reported feeling just as sad and tearful, as frightened, or as angry, as they remembered feeling at the time. seeming to suggest these events had become embodied as Post Traumatic Stress Disorder (PTSD) links with their early years [34]. These feelings would often continue for several days or even weeks afterwards, impacting on their sleep and their dreams.

Most importantly for this study, they remembered, for the first time since their childhood or teens, the decisions they made at the time in order to manage their distress, and about how they would manipulate their weight or their body size or shape – decisions which were never subsequently revoked even into their adult lives. Despite participants' widely varying personal and family histories and the major differences in their adverse experiences and the age of onset of these, several common themes became apparent. Within this small group, five such themes seemingly came to light, with some participants recalling more than one reason why, as a child or teenager, they chose to become and subsequently to remain obese. These themes can be summarised as, using obesity, as protection, as punishment, as identity, to avert sexual pressure from others, and to cope with adverse food issues.

Using obesity as a protective psychological and emotional carapace was evidenced by participants 1 and 3 and 7, who all realised during their hypnosis sessions that they had developed a fat body to contain their insecurities and low self-worth - 'If they see me as just another fat person they will look no further and will not see the "not nice" person that I am inside'. Obesity could also

be used as self-punishment, as both participant 5 who was inappropriately blaming herself for developing a brain tumour, and participant 6 who had wanted her disabled sister to die, and then she did, discovered. Obesity as identity became evident to participant 2 who had been an obese *wife* all of her marriage and realised in hypnosis that she felt she should now continue life as her deceased husband's obese *widow*. Also by participant 4, who had been unable to have a second child in her teens but who realised for the first time during hypnosis that her abdominal obesity was a form of self-identify as a pregnant woman, one which allowed her to sensually feel like she was having a baby and which looked to others like she was.

Participants 4, 6, and 7 all became aware during their hypnotic journey, of the degree to which their becoming obese and thereby less attractive to men was the result of unconscious decisions made during the teenage years. For participants 4 and 6 this was because of previous bad experiences with male partners, and for participant 7 because of inappropriate sexual advances being made to her very early during puberty. Finally two participants became obese in their early teens but were unaware until their hypnosis sessions of the still powerful and controlling link between their past family food issues and their current adult diet and obesity. Participant 2 had difficulties coping with her parents insensitive and cavalier attitudes around eating meat and on one occasion was told she had just eaten her pet chicken for Sunday lunch. As a result, since her early teens she had eaten only junk food, had become very obese, but still had found it impossible to normalise her diet. Only during hypnosis did she realise how much her life-long aberrant diet had been determined by this episode. Similar food constraints experienced by participant 6 were related to her parents' lack of concern about providing food for her throughout her childhood. In hypnosis, she recalled powerfully being constantly hungry and searching the house for food. As soon as she was old enough she took to buying biscuits and cake, and quickly put on weight. As an adult she never could understand why she was unable to stop her addiction to cake and biscuits despite being a nutritionist but found the answer during hypnosis.

5. Discussion

The findings obtained in this study appear to reaffirm the value of hypnotic regression as an efficacious modality in screening for adverse emotional events and episodes. Conventional questionnaires and surveys no matter how carefully crafted, would be incapable of detecting the rich narrative detail revealed to and by the participants in this study [1, 3, 18, 19]. What also was different and important about this study was the apparent facility of hypnotic regression to uncover how *specific* emergency, short-term decisions made by these seven individuals during the time of their childhood aberrant experiences seemingly went on to have a hidden permanency in their lives. This study therefore appears to fully reaffirm the ability of hypnotic regression to function as a legitimate autoethnographic tool for exploring childhood and early adulthood ACEs situations, and to act as an efficacious means of obtaining covert, unconsciously stored autobiographical information [21].

6. Conclusion

This 'proof of principle' paper was not intended to propose a replacement for current ACEs screening programmes but to proffer some thoughts on how the efficacy and sensitivity of such screening programmes might be enhanced in the light of recent concerns about such screening [3,

4, 19]. There is clear evidence from other directions that childhood and later trauma can influence behaviour, personality and cognitive ability through psycho-neuro-endocrine-immune processes [34, 35] and by direct amygdala functional modulation during childhood stress [36]. This paper demonstrates the potential of hypnotic regression to function as an autoethnographical modality in the identification of such long forgotten and otherwise covert behavioural decisions. Made during traumatic times in childhood, these decisions had become part of their adult subconscious agenda, their "storied bodies and storied selves" [37].

Importantly also the findings in this study have a wider and major significance for those adults caring for their own or others' children. The malleability of childhood personality and habit forming inevitably makes children and teenagers vulnerable and susceptible to adult attitudes and idiosyncrasies and this can continue throughout the rest of their lives [38-41]. This seems especially to be the case with regard to childhood food and eating situations, perhaps because the showing and withholding of love is often demonstrated by the providing or withholding of food, and not being fed properly can feel like one is not being loved and cared for [42]. Only during hypnotic regression did the participants in this programme realise how their putting on weight to protect their vulnerability as 'unworthy or unlovable' children or teenagers had led on to their becoming obese adults.

7. Reservations

In interpreting the results accrued in this study, several important provisos need to be considered. This research was carried out with what was clearly a very small, all female, cohort of participants, self-selected in turn from a group of 22 female and 1 male enquirer. Care must be taken therefore in attempting to extrapolate its findings into the wider female, and into the male population. Additionally, the observation that all seven of these female participants seemed able to discover weight-related childhood or early adulthood emotionally traumatic episodes is not to suggest that 100% of all adult females with refractory obesity have such a childhood aetiology. As discussed above this result may be a consequence of the intuitive feelings about the causation of their obesity felt by these seven women and which acted as a trigger for their opting to enrol in this study.

No formal attempt was made to corroborate the revealed facts about participants' earlier life or childhood that appeared as part of these evoked narratives. Questions naturally arise therefore about the validity of these revealed and recounted narratives, especially in the light of the limitations widely expressed by many regarding the credibility of hypnotically obtained memories [43-47].

Throughout the generation of these participants' narratives however, the author believes that there was sufficient innate evidence attesting to their authenticity and pertinence in the documenting of participants' past ACEs and their impact on their current adult obesity. Characteristically for these seven women, it was the strength of the elicited emotions, during and between hypnosis sessions, despite the passage of years since the traumatic events, that was so significant, and which seemed to attest to the validity and veracity of the events and emotional connections evoked during participants' hypnotic regression. Between their sessions, participants frequently experienced emotional "ups and downs", often accompanied by flashbacks, memories and significant-feeling dreams, all of which could only be best explained as the signalling of subconscious processing and change [32, 48].

A decision was made at the start of this research study that there would be no weight monitoring or specific dietary advice given during the course of the hypnosis sessions, as this study was not intended to be seen as simply another fast track to becoming slim. However even during the course of their hypnosis sessions three participants did report that they had begun to lose weight as they had always hoped, to their surprise, and without really trying. A further three participants acknowledged an increased feeling of self-confidence and contentment ('I feel as if a weight has been lifted off me!') and were optimistic about the future.

Clearly regression hypnosis or any comparable autoethnographical modality would be too time consuming for large scale public health screening and population studies, but some of the findings in this study do give a hint of what significant ACEs may be being missed by existing surveys [49, 50]. Hypnosis therefore would appear to have potential in the screening of selected adult individuals with particularly serious and long-term refractory physical and mental health issues that might be ACEs related. For this purpose, such individuals may need to be referred to an external hypnotherapy based counselling service, although the establishment of an in-house, primary care service is not beyond the bounds of possibility and would make hypnosis a more approachable option for many such patients [51-53].

Appendix One – Participant Demographic and Emotional Health Data

Participant No. 1 – Aged 47, single with no children, adopted at 6 years, overweight since aged 10, current BMI of 41.

Participant No. 2 – Aged 57, widowed and deceased son, overweight since aged 12 years, current BMI of 41.

Participant No. 3 – Aged 50, married, nutrition lecturer, overweight since aged 10, current BMI of 40.

Participant No. 4 – Aged 40, single mother of one child, overweight since aged 18, current BMI of 36.

Participant No. 5 – Aged 27, married, overweight in early teens due to missed diagnosis of pituitary tumour, successful treatment but trauma of this left a legacy of 7 further years of obesity, current BMI 27.

Participant No. 6 – Aged 41, single, nutrition scientist, overweight since aged 15, current BMI of 30.

Participant No. 7 – Aged 44, married with child, overweight since 11 years. Current BMI 27.

Appendix Two – Hypnotic Protocol

This study utilised hypnotic regression as an exploratory modality, for its potential to facilitate a search for information and memories about past childhood and later, traumatic events and episodes, which may have gone on to determine and modulate an individual's response to adult situations [54-56]. The hypnotic approach and hypnosis induction scripts employed were modified from various sources [32, 57-62], from the author's professional training association, the British Society of Clinical and Academic Hypnosis (BSCAH), and from the author's personal honing and usage of visualisations developed over a 40 years professional career in hypnotherapy, and as a counsellor and clinical scientist.

Principally this approach entailed gradual relaxation through progressive physical relaxation coupled to gentle abdominal breathing. Formal induction was then induced by counting the participant down ten increasingly relaxing steps into a pre-determined 'safe place' of the participants own choosing, such as beside a gentle woodland stream, on a golden sandy beach or in a cottage garden. Participants' first three sessions were generic problem seeking and solving sessions. Depending upon what these sessions seem to indicate as possible areas and times for exploration, these were followed by more formal regression visualisations. including "the Life Story Corridor", the "Magic Flying Carpet", "Counting Down the Years", "Walking Backwards" or simply the use of the "Back" as a trigger word. Other visualisations were employed to set up an ideomotor response, for "Problem Seeking and Solving", for "Reframing", for "Ego and Life-Style Enhancement Changes", and for "Anchoring". Further details of the induction methods and of scripts utilised can be obtained from the author on request.

Each hypnosis session was preceded by a review and discussion about the participant's experience and thoughts since their previous hypnosis session, and about any unusual dreams, memories or mood changes occurring between sessions. After such discussion and an expressed willingness to continue, participants were invited to settle into a comfortable position on the couch, from which they could then allow themselves to drift into a relaxed state of hypnosis.

During their hypnosis sessions participants were observed closely in order to detect any visible signs suggestive of an emotional abreaction to their recalled memories. If they or the researcher felt this to be the case, they could use their previously agreed ideomotor response (IMR) to indicate this and be directed back to their 'safe place'. Once they were starting to feel calm, the researcher would ask if they wanted more time in their safe place in order to understand this memory, or whether they felt it was a good time to return up their steps and come out of hypnosis. After every session the researcher would associate such participants' return up their steps with their being back in the present, whilst providing post-hypnotic suggestions of being relieved to have let go of that part of their past and feeling happier and more optimistic about their future. In the event, no participant was seen to have a major abreaction and needed 'rescuing' in this way.

Once awake, participants were asked about what they saw or felt during their time in hypnosis, and their memory of and overall experience of the session. Importantly they were asked about any unexpected emotions or feelings they experienced during the session. All such conversations were recorded verbatim using a BBC quality Olympus DM670 hand-held recorder for subsequent transcription and analysis. Care was taken to ensure that participants were fully integrated back into the present before it was deemed safe for them to leave the consulting room. This was especially important if the participant was having to drive themselves home.

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Author Contributions

The author did all the research work of this study.

Competing Interests

The author has no conflict of interest to disclose.

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