HYPNOTHERAPY AND CLIENT SUITABILITY
FOR THE TREATMENT OF OBESITY

by

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ABSTRACT

This study investigated the suitability of hypnosis for the treatment of obesity. Client suitability was assessed by six concomitant variables and one additional variable that assessed imagery activity which occurred during hypnosis treatment. The imagery assessment was done immediately following treatment.

The literature review indicated that to date only preliminary research exists on hypnosis as a treatment for obesity and that most studies have been anecdotal with little or no follow-up. The literature also revealed the need for controlled research to identify the characteristics of clients who can benefit from hypnosis treatment for obesity.

The sample consisted of 60 women between the ages of 20 and 65 who were at least 20 percent overweight and were not in another treatment program. The sample was drawn from women in Regina, Saskatchewan and surrounding communities.

The experimental groups, hypnosis plus audiotapes (Expau), hypnosis without audio-tapes (Expnau), and the control group (Expcont) were investigated on the basis of weight loss at a six month follow-up. The concomitant variables were suggestibility, as measured by the Barber Suggestibility Scale (BSS); self-concept, as measured by
the Tennessee Self Concept Scale (TSCS); quality of the families of origin, as measured by the Family History of Distress Scale (FAM), and age of obesity onset (AGE), education level (EDUC), and economic status (ECSTAT). Multi-modal imagery activity, as measured by the Representational Systems Inventory (RSI), was assessed with the two treatment groups. The dependent measure was weight loss.

Analysis of Covariance revealed a significant difference in weight loss between the treatment groups (Expau and Expnau) and the control group (Expcont) but no significant difference between the two treatment groups. It was found that none of the concomitant variables nor imagery activity contributed to the variability in weight loss at the six month follow-up. Selected case studies suggest the importance of resolution of issues stemming from the family of origin, strong personal motivation, minimal ongoing relationship problems and a readiness to work on personal issues that seem related to obesity.
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During the past forty years there has been a growing awareness that obesity has become a major problem in North America. Figures about its frequency range from 20% to 30% of the population, indicating that millions of North Americans are overweight (Bruch, 1973). The achievement and maintenance of an appropriate weight status for height, sex, age and activity throughout the life span are positive approaches to avoiding or delaying many of the health problems associated with obesity. Obese people often suffer from health problems such as arteriosclerosis, diabetes, hyperlipidemia, gall bladder disease, colitis, hernia, hypertension, cirrhosis of the liver, as well as psychological feelings of inadequacy and low self esteem (Mitchell, Rynberger, Anderson & Dibble, 1976). Mitchell further contends that inappropriate weight during childhood and adolescence appears to be associated not only with physical problems but also with problems of psychosocial development, and the obese adult in our society faces numerous social pressures and prejudices.

As the awareness of the obesity problem has grown, so has the search for viable treatment methods. An early review of the treatment evaluation literature by Feinstein (1960) indicated that successful weight reduction involves the interaction of three sets of factors: the client himself; the therapeutic relationship between client and
therapist; and the dietary program. According to Feinstein (1960), the client himself and the therapeutic relationship appeared to be the most significant factors while the type of energy-restricted diet program was of lesser significance in promoting successful weight reduction. Feinstein (1960) further contends that an external source of motivation may be the decisive factor in assisting the majority of obese clients to lose weight. The external source of motivation for many obese individuals is an ongoing therapeutic relationship with a clinician.

Bruch (1973) reinforces many of Feinstein's conclusions and further points out that there is no one aspect more important in weight loss than the client's motivation for losing weight. Bruch (1973) also finds that obese people seem to be unable to differentiate sensations of hunger from other unpleasant bodily sensations such as fear or anxiety. They seem to have an external rather than internal locus of control.

Kline (1976) reports that no single concept or theory will explain the myriad of ramifications involved in the understanding and treatment of obesity. He concludes that in the final analysis, obesity usually stems from a lack of self-control and a lack of sensory discrimination. He suggests a weight loss program which teaches clients to learn to manage the deprivation behavior and the stress reactions which occur as a result of initially being deprived of the reward of eating.
Garfield and Bergin (1978) report that the behavioral techniques of Ferster et al (1962), Stuart (1967), Mahoney (1976), and Mahoney and Mahoney (1976) can be useful and even an important component of weight loss therapy but they are not sufficient. Except where they have been supplemented by other therapeutic strategies, they have not been consistently powerful. Coupar and Kennedy (1980) recommend a combination of group sessions and individual sessions to provide both the therapeutic effect of group reinforcement and the opportunity for individualized therapy.

Wolman (1982) points out that obese clients often try to lose weight by going on various diets and by participating in a variety of weight-loss programs. Sometimes they lose weight in a relatively short period of time, but most clients regain their weight very quickly. In many cases it seems that the clients consciously like the idea of losing weight but unconsciously they fear the consequences of being slim. Wolman (1982) feels that for many obese clients the excess weight is a choice defence mechanism and if eliminated, the client is forced to face his/her problems directly. Some clients may unconsciously fear the possibility of social-sexual pressures which may accompany slimness, others may equate stress reduction with food and still others may turn to food when starved for affection. It is an assumption in the present study, that many obese subjects have unconscious reasons for becoming and remaining obese.
In spite of a conscious desire to become slim (Bruch, 1973; Feinstein, 1960; Kline, 1976; Mitchell, 1976; Wolman, 1982), the limited and often temporary success of the various therapeutic approaches to obesity suggest a need to more closely examine weight loss from the perspective of unconscious motivations underlying the obesity symptom. It is assumed in this study, that obesity resulting from unconscious motivation can best be treated by gaining access to the unconscious issues which prompt over-eating behavior in the obese subject.

A specific method for uncovering unconscious motivations for symptomatic behavior was developed by Cheek (1968) and is now a familiar component of hypnotherapy treatment (Udolf, 1981). Cheek recognized that clients respond verbally and nonverbally in hypnosis and he discovered that the verbal responses were often accompanied by incongruent nonverbal responses. By teaching hypnosis subjects to develop a specific nonverbal finger for yes and specific finger signals for no and I don't know, he was able to incorporate what he called the ideomotor response technique into hypnotherapy. Once the subject has been inducted, the therapist can ask for the correct ideomotor response to questions concerning the unconscious motivations for over-eating. If a subject indicates that there are unconscious reasons for her obesity, the therapist can use the same
ideomotor response technique to uncover the specific current or historical issues involved (Cheek, 1968).

Udolf (1981) points out that one of the least effective uses of hypnosis, and the one most commonly used by therapists treating clients for obesity, is direct suggestion, or symptom removal. This approach ignores the possibility of unconscious motivational factors which, when brought to awareness with hypnosis provide the client the opportunity to make informed choices. Kline (1980) indicates that once unconscious motivations have been uncovered, clients can be assisted with hypnosis, to alter undesirabe behavior patterns through cognitively induced changes in perception, sensation, and the effective utilization of imagery.

It is quite clear from the literature (Bruch, 1973; Feinstein, 1960; Garfield & Bergin, 1978; Mahoney, 1976; Stewart, 1967) that the success of the varied approaches to weight loss has been limited and often temporary. It is also evident, as Cheek (1968), Klein (1980), and Wolman (1982) have found, that unconscious motivations are part of the obesity problem for some people and that hypnosis can be a valuable means of uncovering these motivations. Hanley (1967) reports that hypnosis can be a useful form of weight loss therapy following the uncovering activities. Mott and Roberts (1979) conclude that there is evidence that hypnosis may have a role in the treatment of obesity. However, well
designed research studies are needed to establish the extent of its usefulness, the most effective methods of using hypnosis in the treatment of obesity and to identify the type of client who is most responsive to such methods.

**Nature of the Study**

The present study is based on the assumption that hypnosis treatment programs can play an important role in the effective treatment of obesity. Mott and Roberts (1979) in their review of the literature on hypnosis and obesity call for future studies to include objective measures of hypnotizability and correlation of hypnotizability scores with various indices of outcome. The literature on hypnotizability (Barber, 1980; Deckert, 1963; Deyoub, 1979; Diamond, 1977; Edmonston, 1967; Hilgard, 1979; Hoen, 1978; Perry, 1977; Weitzenhoffer, 1980) reflects a degree of uncertainty and contention among researchers of this phenomena. It is not yet clear if a hypnotizability score is a valid predictor of outcome in hypnosis programs for weight loss and therefore a measure of the subjects' hypnotizability is included in this study to further investigate this issue.

Mott and Roberts (1979) also suggest that outcome be evaluated in terms of a measure of self-concept. Bruch (1973) and Wolman (1982) indicate that self-concept may be a significant indicator of successful weight loss in that persons with higher self-concept scores may have greater
motivation to lose weight than persons with lower self-concept scores. A measure of self-concept is included in this study as an concomitant variable to determine if the level of one's self concept can be used as a reliable predictor of successful weight loss. Mott and Roberts (1979) propose that education level and socio-economic status are variables that may influence outcome. Wolman (1982, p. 153) proposes that the prevalence of obesity is greatest among the lower socio-economic levels and among people with lower levels of education. Whereas level of education and socio-economic status are definitely useful variables for predicting the probability of an obesity problem, it has yet to be shown that these two variables are useful predictors of outcome in weight-loss programs. For this reason education level and socio-economic level are included as concomitant variables in this study.

Mott and Roberts (1979) suggest the evaluation of outcome on the basis of the age of obesity onset. Bruch (1973) contends that obesity can be either developmental or reactive. She describes developmental obesity as a result of family and developmental issues in the home. Obesity is then viewed as a symptom of problems within the family of origin. She describes reactive obesity as occurring primarily in adults in response to traumatic environmental circumstances. Bruch (1973) considers developmental obesity to be more complex than reactive obesity and therefore possibly
more difficult to treat. Bullen (1964) found that disturbances in the family of origin, characterized by poor sociability among family members and much fighting among siblings, was a situation common among obese teenage girls. These findings suggest that the age of obesity onset and a measure of the quality of the family of origin have potential as predictors of outcome and are therefore included as concomitant variables in this study.

The role played by a subject's imaginative and fantasy productions during hypnosis has long been of interest to researchers (Deckert & West, 1963; Hilgard, 1975; Sheehan, 1979). In recent years, several studies (Bowers, 1978; Coe, 1980; Crawford, 1978, 1979) found significant correlations between the vividness of visual imagery experienced by subjects during guided imagery activities and hypnotic susceptibility. There has been relatively little research, however, on the relationship between treatment outcome and imagery vividness experienced by subjects in modes other than the visual mode. Tellegen and Atkinson (1974) found that absorption in imagery correlates consistently with hypnotizability but the work of Bandler and Grinder (1975, 1981) indicates that efforts to measure the quality and characteristics of imagery should incorporate all of the sensory modes. Meichenbaum (1978, p. 392) emphasizes that as a client's imagery changes his internal
self-talk also changes resulting in an alteration of the meaning attributed by the client to an experience. Bandler and Grinder (1981) contend that imagery is the vehicle that people use to represent the world and their experiences in the world. They suggest that we use a representational system consisting of the visual, kinesthetic, olfactory, auditory and gustatory senses and that it is misleading to consider only the visual mode when assessing the quality and characteristics of a subject's imagery experience. To properly measure absorption in imagery, the measuring instrument should include items from each of the sensory modes, (Bandler & Grinder, 1981). Such an instrument would enable the researcher to better assess the role of imagery absorption as a predictor of outcome in a hypnosis treatment program.

Group treatment of obese individuals provides a number of advantages such as mutual support, positive expectations and a degree of social pressure (Mahoney, 1976; Wollersheim, 1982). Group members can profit not only from the suggestions of the therapist but also from the experiences of other group members. However, it is important (Mahoney, 1976; Kline, 1976) to provide time within the group setting for the individual group members to express specific needs and for the therapist to provide some individualized instruction. Group hypnosis for obesity encompasses the benefits of the group setting for weight loss programs
(Mahoney, 1976; Wollesheim, 1982) and the benefits of increased hypnotic responsiveness that occurs in groups when highly responsive subjects are used to demonstrate hypnotic phenomena (Kline, 1976; Erickson, 1960, 1976; Perry, 1977) to other group members. Induction time is often reduced and the confidence of the group is enhanced when they see and accept the responsiveness of fellow group members (Perry, 1977). It is important however to provide time, in group hypnosis programs, for individual inductions and explorations. Any uncovering work must be done on an individual basis (Erickson, 1976) as the therapist will be unable to provide adequate attention and support during a group uncovering activity. Kline (1982) feels that the weight loss suggestions provided in a group hypnotherapy program should consist of the general group oriented suggestions about quality and quantity of food, exercise, self-monitoring and also, specific suggestions designed for specific group members and their unique needs. The benefits of group treatment for weight loss are such that the group model is considered the model of choice (Wollersheim, 1982) and is used in this study.

In the hypnosis literature the term heterohypnosis is used to described a therapist employing hypnosis with a client and autohypnosis is the term used for self-hypnosis. The view is often expressed (Udolf, 1981) that all hypnosis is self-hypnosis because it is the subject's imagination that produces all of the effects. Ruch (1975) supports the notion that active self-hypnosis is the primary phenomenon
and that heterohypnosis is in effect, a case of guided self-hypnosis. Fromm (1975) notes that until quite recently most of the research in hypnosis has been heterohypnosis with very little research on the nature and role of self-hypnosis. She found that a major advantage of using self-hypnosis as a supplement to therapy was that the subject was always attuned to her own responses during induction and therefore suggestions could be optimally timed. She also found that after two or three weeks most subjects reported that self-hypnosis took too much effort and was dropped. Udolf (1981, p. 264) outlines the possible advantages of incorporating some form of self-hypnosis regime into treatment programs. He indicates that self-hypnosis is a way of focusing on the client the prime responsibility for progress in her own therapy while fostering in her a sense of self-mastery and independence. He also speculates that self-hypnosis may be of value to the client who, following treatment, needs a method to avoid the re-establishment of old behavior patterns. Self-hypnosis can serve as a wedge in a former eating pattern and provide the client the time to consider consciously the options available to her (Spiegel, 1974).

Since there is ample clinical evidence that confirms self-hypnosis as a valuable therapeutic aid (Ruch, 1975; Barber, 1979; Fromm, 1979) self-hypnosis, as a supplement to in-session treatment, is incorporated in this study. As indicated by Fromm (1975) most clients lose interest in
self-hypnosis after a few weeks and therefore it has been recommended (Aja, 1977; Araoz, 1982; Fromm, 1979, Udolf, 1981) that some of the advantages of self-hypnosis can be attained by providing the subjects with an audio-tape for home use. Udolf (1981, p. 268) indicates that the tapes should be tailor-made for the induction requirements of each subject, and ideally they should be made during an actual hypnotic session with the subject so that suggestions may be timed in response to the subject's reactions. It may be that in the treatment of obesity with hypnosis, the added component of self-hypnosis via audio-tapes will result in greater weight loss than that obtained by subjects who are not provided with audio-tapes.

**Purpose of the Study**

The principal purpose of this study was to compare the effectiveness of a hypnotherapy program for weight-loss which utilizes audio-taped suggestions following the treatment period, the same hypnotherapy program without the audio-tapes and a control group. The hypnotherapy program is identical in content and time duration for both treatment groups (Appendix E). The audio-tapes are prepared for the subjects in the first treatment group immediately following the completion of their hypnotherapy program. Each tape is twelve to fifteen minutes long and consists of a personalized induction incorporating the appropriate representational
systems for each subject as used by Erickson (1976) and formalized by Bandler and Grinder (1981). The weight loss suggestions on each tape are the same for each subject and incorporate suggestions for gradual, healthy weight loss with increasing self-esteem and the achievement of the desired body image (Appendix 1). The subjects using the audio-tapes were asked to use them once per day during the six-month follow-up period and to tabulate actual usage.

The secondary objectives of this study were to identify characteristics of client suitability for this type of hypnotherapy program. The data from which conclusions will be drawn are the following: (a) Demographic Data: i) Level of Education, ii) Socio-economic Status; (b) Symptom Data: i) The Barber Suggestibility Scale, ii) The Tennessee Self Concept Scale, iii) The Representational Systems Inventory, iv) The Family of Origin Inventory, and v) The Age of Obesity Onset.

Definition of Terms

The following terms are defined in accordance to their usage in this study.

Obesity - As yet there is no universally accepted definition of obesity and the existing definitions range from the very simple to the very complex. In this study, obesity is defined as a measured weight of 20 percent or more above the ideal weight provided on the height and weight actuarial data of Metropolitan Life (1960).
**Hypnosis** - As is the case with obesity, no universally accepted definition of hypnosis exists. Debate continues over a number of concepts involved in hypnosis including the basic issue of the trance state (Barber, 1979). However, Fromm and Shor (1979) have compiled the most commonly accepted concepts of hypnosis from which a meaningful definition can be constructed. In this study, hypnosis is defined as the development of a cognitive skill which enables the client to utilize unconscious mental functioning and unconscious mental resources.

**Hypotheses to be Tested**

**Hypothesis 1:** There will be a statistically significant effect in measured weight loss between the two experimental treatments and the control group at a six-month follow-up with the hypnotherapy groups (with and without audio-tapes) showing the greater weight loss.

**Hypothesis 2:** There will be a statistically significant difference in measured weight loss between the two treatment groups with the hypnotherapy plus audio-tape group showing the greater weight loss.
Hypothesis 3: There will be a statistically significant predictable relationship between measured weight loss and the scores on the Representational Systems Inventory which measures multi-modal imagery absorption for the two experimental groups.

Hypothesis 4: There will be a significant predictable relationship between measured weight loss and suggestibility as measured by the Barber Suggestibility Scale.

Hypothesis 5: There will be a significant predictable relationship between measured weight loss and self-concept as indexed on the Total Positive Scale of the Tennessee Self Concept Scale.

Hypothesis 6: There will be a significant predictable relationship between measured weight loss and the level of distress in the subjects' families of origin as measured by the Family History of Distress Scale.
Hypothesis 7: There will be a significant predictable relationship between measured weight loss and adult or childhood onset of obesity, between measured weight loss and the reported levels of education and finally, between measured weight loss and family income.

Rationale for the Hypotheses

Evidence has accumulated (Bruch, 1973; Feinstein, 1960; Kline, 1976; Hanley, 1967; Mitchell, 1976; Wolman, 1982) which indicates that many obese people have unconscious motivations for overeating. Treating the obesity symptom directly without identifying and understanding the unconscious motivational factors will result in short term benefits at best (Wolman, 1982).

Hypnosis is a cognitive skill which enables subjects to relax, focus on inner feelings, recall past experiences and suspend the critical reality-testing activities of the conscious mind (Orne, 1959). The suspension of critical thinking is what Orne called trance logic. In an altered state, subjects become more responsive to suggestions because they temporarily suspend the reality-testing that is so apparent in the conscious state. Consequently, hypnotic subjects can learn to trust their unconscious experiences (Erickson, 1976) and respond, through verbal or ideomotor
movement, to the uncovering suggestions of the therapist (Cheek, 1968). In this manner, hypnotic subjects can identify and understand, from a current perspective, their formerly unconscious motivations for overeating. Understanding the circumstances which originally resulted in maladaptive eating patterns, provides the subjects with a foundation for the development of alternative coping skills and healthy eating patterns. At this point, in the therapy process, the therapist develops and presents suggestions for more functional ways of dealing with the stresses of living and for healthy weight loss (Kline, 1976). The suggestions include specific directions for wise dietary choices, minimal feelings of deprivation and a growing sense of confidence.

Indirect metaphorical suggestions tend to bypass any conscious or unconscious resistance that might arise in the subjects when direct suggestions are used (Erickson, 1976). North American culture tends to emphasize the value of independence and therefore many subjects will resist suggestions that are presented in an authoritarian manner (Udolf, 1981). It can also be assumed (Erickson, 1976) that people make what seems to be the best choices available to them at any given time. If a person chooses to use food as a replacement for denied affection or for any other reason, direct suggestions will confront unconscious resistance from
the subject. Carefully chosen metaphors and suggestions buried in seemingly innocent stories can bypass this form of resistance (Alman, 1978; Bandler & Grinder, 1975, 1981; Erickson & Rossi, 1976). Once subjects have learned how to enter an altered state with the assistance of a therapist, they can then be taught how to experience and utilize self-hypnosis.

Research is needed (Mott and Roberts, 1979) to evaluate the effectiveness of hypnotherapy treatments for weight loss and to identify client variables that correlate with significant weight loss.

Clinical evidence (Ruch, 1975; Barber, 1979, Fromm, 1979) points to the potential value of self-hypnosis as a supplement to in-session treatment for obesity. Since there is often a motivational problem that seems to limit the use of self-hypnosis (Fromm, 1975) it has been recommended (Aja, 1977; Araoz, 1982; Fromm, 1979; Udolf, 1981) that subjects be provided with audio-tapes to more easily facilitate the potential benefits of self-hypnosis.

Current evidence (Hilgard, 1975; Shor, 1979; Tellegen & Atkinson, 1974) suggests that absorption in imagery is an important component of positive outcome in hypnotherapy. The degree of absorption in metaphorical imagery experienced by clients may prove to be a useful predictor of outcome.
The issue of suggestibility or hypnotizability has been studied extensively (Barber, J., 1980; Barber, T., 1979; Hilgard, 1975; Perry, 1977) and yet there is, at present, no conclusive evidence indicating if suggestibility is a stable personality characteristic or a situational variable (Udolf, 1981). Further research evidence is needed to confirm or disconfirm the value of suggestibility measures as predictors of outcome.

The self-concept of obese subjects has been identified as an important component in an overall understanding of obesity (Bruch, 1973; Wolman, 1982). Mott and Roberts (1979) recommend the evaluation of outcome including measures of self-concept and body image. Bruch (1973) and Bullen (1964) have indicated that the quality of family of origin relationships, which play an important role in the development of self-concept, seem to influence the development of obesity among adolescent girls. Obese girls tend to come from dysfunctional families (Bullen, 1964). An evaluation of outcome including current self-concept and the quality of relationship within the family of origin will provide a more ecologically complete view of the subject's responses to treatment.

Olefsky (1980) advocates that the age of obesity onset be included in future weight loss research since adults do not produce new adipose tissue and therefore
weight loss may be easier for obese subjects who put on the weight as adults. No studies to date have considered this variable and Mott and Roberts (1979) recommend its inclusion in future studies.

Stunkard (1976) suggests that socio-economic status may be a factor to consider in weight loss studies leading Mott and Roberts (1979) to recommend the inclusion of some measures of socio-economic status in future research.

Significance of the Study

Over the years, many varied and often complex theories regarding the nature and etiology of obesity have developed resulting in a variety of treatment procedures and commercial diets. Almost all of the investigations of the hypnotic treatment of obesity have been of an anecdotal nature, with little attention paid to issues such as treatment components or subject characteristics which may be related to weight loss (Wadden & Flaxman, 1981). Although hypnosis has been suggested for years as a treatment for obesity there is no clinical research which clearly substantiates this view.

Since obesity is recognized (Mitchell et al. 1976) as a major physical and psychological health problem among North Americans and since present weight loss programs are able to demonstrate only limited success (Garfield & Bergin, 1978), an effective form of brief therapy could be a useful
therapeutic tool in the continuing struggle to achieve long-term weight loss for obese clients.

Hypnosis has been shown to be an effective form of brief therapy (Hartland, 1971) and if successfully used with obese clients it could facilitate a greater utilization of therapist time and provide an effective means to sustain weight loss which is the major challenge in the treatment of obesity today.

Mott and Roberts (1979) point out that this type of research is urgently needed now because of the prevalence of the problem of obesity and the tendency of its sufferers to be exploited by extravagant claims of commercialized clinics.

Delimitations of the Study

This study was done with obese women between the ages of 20 and 65 years of age who responded to newspaper advertisements in Regina, Saskatchewan and surrounding communities. Implications for all obese people in Saskatchewan urban centers are only applicable to the extent that the sample is typical of urban Saskatchewan obese women.

Only two men responded to the newspaper advertisement for this project and therefore implications arising from this study are limited to the female gender. As in earlier studies (Wadden & Flaxman, 1981) the researcher is also the therapist.
Hypnosis Background

The hypnotic phenomena, in one form or another, has been a part of many cultures for centuries. Until 1930 the research in hypnosis was somewhat less than scientific, consisting primarily of clinical observation and often involving unjustified claims. Clark Hull was the first to use the Null Hypothesis model in hypnosis research. This model, although it has limitations for psychotherapy research (Garfield & Bergin, 1978), provided a procedure for dealing in a systematic and quantitative fashion with much of the otherwise confusing variability inherent in human responses.

Lorge (1936) indicated that the responsiveness of subjects in hypnosis was largely a factor of how the subjects perceived the operator. The more the operator was perceived to be "expert" and "prestigious" the more readily the subjects seemed to respond to his/her suggestions. White (1941) and Brenman and Gill (1947) found that subjects seem to wish to please the operator and they strongly recommend the use of an unhypnotized control group for hypnosis research as a result.

Erickson (1944) emphasized the importance of verbal imagery and the careful choice of wording as well as very careful attending to nonverbal communications by the operator.
Jennes (1944) found that subjects who were capable of experiencing vivid imagery made better subjects than those who were less capable of experiencing vivid imagery. Arnold (1946) found a positive relationship between vividness of imagery and hypnotic depth which was confirmed by Richardson (1969, 1972).

Following World War II, a vast increase in the number of research projects conducted on hypnosis in psychotherapy occurred. Erickson (1952) emphasized a humanistic approach to suggestion, rejecting the more commonly used mechanistic approach which used repetitious implanting of direct suggestions. Erickson (1952) felt it was necessary to know the client as well as possible and to utilize the client's personal experiences and modes of imagery in the hypnosis sessions. He would interweave two or more suggestions through thematic imagery and since he believed that a deeply hypnotized subject is more literal in his interpretation of suggestions, Erickson would very carefully choose wording that maintained and amplified the theme being used.

Orne (1959) conceptualized what he called "trance logic" which has become a common term in hypnotherapy. This concept is based on the assumption that there is a hypnotic trance state, and when in that state, a subject does not attempt to differentiate between hallucination and reality. This means that a subject can accept suggestions without the usual reality testing and evaluating that takes place in
the waking state. As is often the case in hypnosis research, no conclusive evidence exists that shows beyond doubt that "trance logic" is a valid concept even though clinical observations seem to support such a concept.

Haley (1958) in co-operation with Milton Erickson, focused on the formulation of hypnotic speech, extending to minute details of wording. Haley (1958) treated hypnotic communication from an interactional standpoint, emphasizing the double bind aspects of the hypnotist's language. Haley's efforts made it quite clear that hypnotherapy is a form of communication that requires considerable skill and conscious choice of terminology, variation of voice tone and awareness of nonverbal communication on the part of the hypnotherapist.

T.X. Barber began to develop an alternative paradigm to the traditional paradigm in 1957. Since that time, Barber has called into question the existence of a "trance state" postulating that responsiveness to suggestions for limb rigidity, anesthesia, hallucination, age regression and amnesia is due to the positive attitudes, motivations, and expectancies of the subject which allows him/her to think with, and vividly imagine, those things that are suggested. Barber (1979), by focusing on the literature that failed to show differences of significance and giving only passing acknowledgement to the literature that did, is able to construct a reasonable case for his alternative paradigm.
However, Barber is also unable to provide convincing evidence and the trance versus nontrance issue has not been resolved. Barber (1979) and Sabrin and Coe (1972) do, by their efforts, force the supporters of both sides of this issue to seek greater clarity of concepts and the employment of better experimental designs.

Cheek (1959) in his studies of pain control and unconscious perceptions of sounds, popularized finger signalling as a means of communicating with the subject during hypnosis. He found that the use of a "yes" finger, a "no" finger and an "I don't know" finger required less effort on the part of the subject than verbal communications. This form of ideomotor responding also adds to the communication and relationship aspect of hypnotherapy as opposed to the active-passive dyad and is firmly based on the assumption of a trance state.

Recent Major Trends

In a review of the literature on hypnosis between 1965 and 1975, Hilgard (1975) identified the trends of research that dominated that decade. The first trend was the ongoing controversy of the trance concept maintained primarily by Barber (1965) and Sabrin and Coe (1972). The evidence in this controversy increasingly favored the trance phenomenon, but the differences were not great and the theoretical problems were not simple, so that by 1975
no definitive conclusions had been obtained.

The second major trend identified by Hilgard (1975) was the issue of the role played by the subject's imaginative and fantasy productions. After making a very comprehensive survey of the literature, Deckert and West (1963) concluded that the correlation of any personality trait, including imagination and fantasy, with hypnotizability could not be shown at that time. Hilgard (1975) reported a low but positive relationship between hypnotizability and the ability to experience imagery. In a more recent review Sheehan (1979) concluded that as yet, there is no unequivocal evidence to confirm or disconfirm a correlation between hypnotizability and imagination and therefore further research needs to be done to clarify this potentially important issue.

The third trend that Hilgard (1975) identified was very closely related to the second and involved the degree of absorption in imagery that subjects were able to experience. Until it can be shown with more certainty that the ability to experience imagery correlates positively with hypnotizability the findings on absorption (Tellegen & Atkinson, 1974) are less meaningful than they could be.

The work of Erickson (1979) and Bandler & Grinder (1981) indicates that efforts to measure quality and characteristics of imagery should incorporate more than just the visual component of imagery. Bandler & Grinder (1981) have
identified what they call, representational systems, which are the visual, kinesthetic, auditory, olfactory and gustatory modes of experiencing. They have demonstrated that most people have a dominant representational system through which they interpret their experiences and when a client is taught to use all of his/her representational systems imagery activities are more complete and more intense.

To add some support to the imagery relationship Hilgard (1975) provided a fourth trend in research which is that of brain psychophysiology. It seems that hypnotic responsiveness is associated with a preference for right hemisphere function in well lateralized right-handed subjects. This finding is coherent with the role of the right hemisphere in imagination (Bakan, 1970).

Research Issues

The 1970's brought a vast expansion in hypnosis research. Many of the issues discussed by Hilgard (1975) continue to be unresolved even today. Hypnotizability is one such issue. Whereas a number of authors (Shor & Orne, 1962; Weitzenhoffer and Hilgard, 1962; Tart, 1963; O'Connell, 1964), have taken the position that only a portion of the population is able to experience hypnosis and that the depth of the experience is correlated with outcome; other authors have questioned this assumption from various perspectives (Barber, 1964; Barrios, 1973; Sabrin and Coe, 1972;
Erickson, 1976). As discussed earlier the trance issue, or non-issue, depending on one's stance, calls into question the concept of depth. If, as Barber (1964) contends, there is no trance state, then trance depth becomes meaningless and one must focus on the level of motivation in the subjects.

As Erickson (1976) has so frequently demonstrated, hypnotizability seems to reflect individual differences in that a given induction method may work with one subject but not with another. Erickson (1976) sought to personalize the induction to incorporate phrases and suggestions that reflected the personal experiences and perspectives of each individual subject. The resistant subject, that is the person who wants to experience hypnosis but seems unable to do so, often becomes quite receptive when the therapist goes with the resistance (Haley, 1968) giving the subject permission to resist and thereby freeing the subject to experience the desired state. It would seem that a group or standardized approach to hypnosis is bound to reveal subjects who "are unable to experience" this phenomena just as a standardized form of any therapy will reveal nonresponsive subjects. Shor (1979) points to this situation as a major problem in hypnosis research. The researcher is caught between the need to be objective and the need to create expectancy and a facilitative relationship with the subjects. Sheehan (1979) acknowledges the aspect of individual differences which makes traditional research seem inadequate.
The traditional model of selecting a sample from a population and applying a standard hypnotic treatment to that sample does not account for individual differences adequately and does not account for interaction between the therapist and each subject. By its very nature the selection process eliminates those subjects who do not respond to the traditional measurement devices such as the Stanford and Harvard Scales. On the other hand if a researcher wishes to remain within the bounds of the traditional research model and yet accommodate the resistant client he/she will have to vary the induction procedure and the suggestion format. This variation could contaminate the research design in that there is no longer procedural consistency. Garfield and Bergin (1978) make reference to this dilemma when discussing research in the broad area of psychotherapy. They feel that the traditional research model does not allow for the fact that people are active information processing beings. They suggest a task analysis model based on the step by step analysis of individual therapy sessions in a clinical setting avoiding the use of volunteers from university classes. Such an approach means that data concerning method, in-session activity, and outcome must be built from carefully monitored clinical settings with individual subjects. Such a model is very time-consuming, expensive and possibly inconvenient for clinicians. However, the present research on hypnotherapy and psychotherapy in
general is not producing the concrete results that most had hoped for during the last two decades.

In the early 1960's a number of hypnotic susceptibility scales were developed that are currently in general use today. They include the Standford Hypnotic Susceptibility Scale, Forms A and B (Weitzenhoffer and Hilgard, 1959) and Form C (Weitzenhoffer and Hilgard, 1962); the Harvard Group Scale of Hypnotic Susceptibility (Shor and Orne, 1962), a group administered adaptation of the Standford Scale, Form A and the Barber Suggestibility Scale (Barber, 1965). The Stanford and Harvard scales are based on the assumption that there is a measurable hypnotic state. These scales consist of a brief attempted induction of hypnosis, followed by a number, usually twelve, of simple tests of the kinds of behavior that are believed to be characteristic of hypnotized subjects. The persons who pass anywhere from seven to twelve of these items are considered susceptible to hypnosis. Hilgard (1962) proposed that subjects should pass ten of the twelve items in order to be included in a research study. He pointed out that only about fifteen percent of subjects would score ten or higher. Even if one lowers the acceptable score to seven only about fifty-five percent of subjects will pass (Hilgard, 1962). This greatly reduces the generalizability of a study in that the sample is no longer representative of any large population (Levitt and Chapman, 1969).
The Barber Suggestibility Scale (Barber, 1965) is based on the assumption that there is no trance state and consists of eight items: arm lowering, arm levitation, hand lock, thirst hallucination, verbal inhibition, body immobility, post-hypnotic-like response and selective amnesia. Barber (1965) found that he obtained comparable responses to these eight items when using the traditional trance induction and when using task motivational instructions. The Barber Scale correlates substantially with the Stanford Hypnotic Susceptibility Scales (Ruch, Morgan and Hilgard, 1974).

Hypnotizability or suggestibility remain contentious issues even today with most clinicians claiming that hypnosis is a learned skill which can be developed and refined by a client working with a skilled practitioner (Stolar, 1975; Diamond, 1977; Perry, 1977). In experimental hypnosis however, these scales provide the uniform measurement necessary for more objective evaluation, but even Weitzenhoffer (1980) who coauthored the Stanford Suggestibility Scale, has recently raised questions about this struggle for objectivity.

J. Barber (1980) points out that susceptibility scales consistently employ a direct, if not authoritarian, approach to the subjects and direct suggestions are usually used in the resulting studies. Barber (1977) found that there was no difference in the ability of subjects to respond to suggestions when the hypnotic induction technique was naturalistic and indirect. Alman (1979) reports similar
findings and views hypnosis as a skill which can be learned with training and experience.

The issue of self-hypnosis has not received the same attention from researchers as has hetero-hypnosis. However, there appears to be a growing interest in this area (Shor and Easton, 1973; Fromm, 1974, 1975; Brown, 1974; Brown and Fromm, 1978; Oberlander, 1974, 1978; Ruch, 1975; Johnson and Weight, 1974; Boxer, 1978; Hurt, 1978). Self-hypnosis has been used extensively in therapy, especially for controlling somatic pain and reducing anxiety. The implicit assumption is that hetero-hypnosis and autohypnosis are so similar that the client can be taught to utilize this skill without the continuous aid of a practitioner. There is however no definitive documentation that this is so. In heterohypnosis the subject's ego, while listening to the hypnotist's voice is said to divide into an experiencing part and observing part (Hilgard, 1979). In self-hypnosis it would seem that the ego would have to split into three parts: instructing, observing and experiencing functions. Whereas there is as yet no satisfactory evidence that this process takes place there is ample clinical evidence that has more than confirmed its promise as a valuable therapeutic aid (Ruch, 1975; Barber, 1979; Fromm, 1979).

To date there has been little research done in the area of self-hypnosis and even less research incorporating the utilization of audio-tapes. Self-hypnosis is generally
accepted as a potentially valuable therapeutic aid (Ruch, 1975; Barber, 1979; Fromm, 1979) that places the prime responsibility of progress on the client. However, Fromm (1975) found that many clients reported losing interest in self-hypnosis after a few weeks because they had to take the time and effort to induce an altered state before giving themselves suggestions. Spiegel (1974) indicated that self-hypnosis is a valuable aid in altering eating patterns by providing an opportunity for the client to pause and focus on the goal and the behavior choices available. It has been recommended (Aja, 1977; Araoz, 1982; Fromm, 1979; Udolf, 1981) that to increase the probability of clients using self-hypnosis, an audio-tape be provided to the client for home use. Udolf (1981, p. 268) indicated that the tapes should be tailor-made for each client thereby maximizing the induction effect and the quality of weight-loss suggestions. Araoz (1982) feels that audio-taped inductions and suggestions can be a valuable self-help component in treatment but there have been no formal evaluations done on the effectiveness of audio-tapes as a supplement to in-session treatment. Fromm (1979) believed that there is a definite need for such evaluation in the next decade.

What we find then, in hypnosis research, as in other areas of psychotherapy, is that the issue of how people change is very complex. We have been unable, to the present time, to be precise enough to identify each step of
the process. The result is a number of theories that consider the hypnotic phenomena from various perspectives. The clinician experiences often startling and exciting phenomena in the clinic setting that the researcher is often unable to replicate in the laboratory. J. Barber (1977) for instance, claimed close to 100% success with his rapid induction method and was able to see the results in dental patients who are able to tolerate the discomfort of dental work without artificial pain control. Hilgard (1979) insisted that he was unable to replicate Barber's method in the laboratory setting which points to the unique problem of hypnosis research. Part of the hypnotic experience seems to be based on expectancy and the laboratory hypnotist, in order to avoid experimenter bias, has to refrain from reinforcing this expectancy. In seeking objectivity it seems that some aspects of hypnotic potential are lost but by totally abandoning objectivity the merits of the scientific method are lost. It is a fine line indeed that must be pursued between these two extremes.

Clinical Issues

In recent years growing attention has been given to rapid induction techniques. Cheek and LeCron (1968) described a method using a mild startle effect but it was Erickson (1964) and Hartland (1972) who were the strongest proponents of rapid induction. Hartland (1972) claims that trance
induction can occur in less than sixty seconds. It is a surprise technique which leads the subject in an unobjectionable way to develop trance behavior before resistances can be developed. The basic rationale rests on the nonverbal establishment of behavior outside of consciousness. The subject's arm is gently picked up at the wrist by the therapist and held in a horizontal position. The therapist slowly releases contact until it seems apparent that the arm will remain elevated without any further physical support. Then it is suggested that the eyes may close and the body relax. As Erickson (1964) points out, it will occasionally become apparent that calatepsy will not develop and that arm heaviness exists instead. Following the concept of going with the resistance the therapist then calmly changes tactics letting the arm fall into the subject's lap and congratulates him/her on how well relaxation is beginning. Either way the therapist is able to use the response to suggest induction with resulting success. Hartland (1972) points out that this method greatly shortens the induction time although it is a prestige technique. Hartland claims that he rarely uses a longer more formal technique. More recently Joseph Barber (1977) reported success in 100% of 100 dental patients although these patients were initially given a standard induction which took up to twenty minutes. It would seem that if subjects are motivated, have a high degree of expectancy and view the therapist as "expert",...
rapid inductions can be successful and very time saving.

A trend in hypnotherapy that has been receiving attention in recent years is the inclusion in post-hypnotic suggestions of self-concept statements. Hartland (1971) analyzed post-hypnotic suggestions and concluded that they all tended to strengthen the subject's self-confidence. Since then a number of authors have reported that self-concept can be improved through the use of post-hypnotic suggestions (Gorman, 1973; Jabush, 1976; Susskind, 1976). It would seem that the inclusion of self-esteem suggestions have a positive effect on the subject's perception of self and this alteration may positively influence the specific therapeutic outcomes of hypnotherapy.

One of the values of hypnosis has been its brevity thus reducing the expense to the client and the utilization of therapist time. Hartland (1971) stated that four sessions of post-hypnotic suggestions would be sufficient to result in changes in perception of improvement as measured on a debriefing questionnaire. A number of investigators have conducted studies using only one session of hypnotic induction and suggestion (Dhanens & Lundy, 1975; Hoen, 1978; Liebert, Rubin and Hilgard, 1965; London, Covant and Davidson, 1966). If one is to consider the individual differences of subjects, it would seem that Erickson's (1976) method of indirect inquiry would be more useful. After getting some background information from the subject, Erickson would tell the
subject that other people with similar concerns had ben­
fitted from hypnosis. He would say that some needed only a
short time to benefit and some needed a longer time.
Erickson would watch for a non-verbal response in the form
of a headnod or some verbal response to these two alterna-
tives. He would base his expectations of therapy duration
upon the subject's response.

If suggestions have an emotional content, it seems
that their effectiveness is enhanced (Cheek and LeCron,
1968; Coe, Baugher, Krim and Smith, 1976; Erickson, 1976).
When suggestions are combined with a permissive format and
expressed indirectly such as, "you can really enjoy remembering
to forget what you need to remember to forget", emotional
suggestions reduce resistance and provide additional motivation
for the subject to experience and possibly benefit from
hypnosis.

The clinical work and writing of Milton Erickson
has done much to encourage an awareness of communication
skills, resistance techniques, rapid inductions, indirect
suggestion, and the extensive use of imagery. The more
recent clinical evidence suggests that permissive imagery is
most effective when associated with the personal background
of the subject and includes an emotional component. The
next decade should see considerable research in the area of
imagery. Current research suggests that the more vividly
one is able to experience imagery the more one is able to
experience hypnosis (Sheehan, 1979). It is not yet clear, however, which various cognitive functions are involved and there is growing recognition of the need for greater specificity in indentifying the various types of imagery. Current research suggests that if analogies and imagery are closely related to the desired outcome so that suggestions can be incorporated permissively into the imagery, the desired goal is more likely to be reached than if the imagery and analogies are less closely related to the subject's concern or goal (Araoz, 1982).

**Hypnosis and Obesity**

Although hypnosis has for many years been suggested as a treatment modality for obesity, there is no clinical research which clearly substantiates this view. The literature dealing with hypnosis for weight reduction consists primarily of anecdotal reports and studies of selected cases. Mott and Roberts (1979), in their review of the obesity and hypnosis literature, indicate that although there is evidence that hypnosis may have a role in the treatment of obesity, well-designed research studies are needed to establish the extent of its usefulness and the most effective methods of using hypnosis with the different types of obesity. The literature is dominated by anecdotal reports rather than experimental approaches and very few articles report follow-up data.
Hershman (1955) describes a technique whereby the client enters trance and then visualizes himself in a theatre where he sees an actor experiencing sadness and dissatisfaction. In a second theatre the client imagines an actor experiencing happiness, contentment and peace of mind. Adherence to the diet will allow a fantasy of the pleasant scene while breaking the diet will result in the negative scene. Only four case histories are presented but they do show significant weight loss over a period of one to four years.

Winkelstein (1959) reported treating a group of 42 female clients with group hypnosis incorporating suggestions about the type of diet as well as special problems manifested by individuals. The average weight loss was 27 pounds after four months but no information regarding age of onset of obesity or other weight history was noted.

Erickson (1960) utilized an individualized approach with direct intervention on the current behavior patterns of the individual. He reported maintained weight loss but provided only three case studies.

Glover (1961) reported the use of suggestions for decreased appetite, eating slowly and increased self-confidence with a group of overweight nurses. Average weight loss for these subjects was thirty pounds at a four month follow-up.

Wollman (1962) employed a traditional group hypnotherapy paradigm and asked the clients to imagine, as a
motivational factor, a desired weight and body image. He also suggested grace be used at mealtime that included a phrase about becoming uncomfortable if overeating.

Brodie (1964) used an analogy between obesity and cancer suggesting that clients accept that it will take months to remove the fat cancer. He included suggestions for eating slowly like a gourmet, minimal consumption of carbohydrates and increased exercise. He also taught autohypnosis to his clients and they used it three times daily. No follow-up data was provided.

Hanley (1967) used specific suggestions such as becoming satiated easily but he gave special attention to relapse and discouragement. He notes that initial successes tend to be superficial and at a point of relapse, deeper issues often emerge which may require specific therapy.

Kroger (1970) used a variety of hypnotic techniques including sensory imagery conditioning, teaching the client to develop glove anaesthesia then to transfer the anesthesia to the stomach to reduce hunger pains. He also recommended use of autohypnosis eight or ten times a day.

Wick, Sigman and Kline (1971) reported two separate approaches to weight reduction using hypnosis. The first approach employs the exploratory techniques of Cheek and LeCron (1968) to uncover the issues underlying the weight problem. The second approach is a re-education program using suggestions for deprivation feelings.
Tilker and Meyer (1972) trained a female college student in hypnosis to associate nausea with nondiet foods such as ice cream or cake. A nine month follow-up indicated that she had maintained her weight loss but Garfield and Bergin (1978) contend that such case studies using nauseating imagery are not supported in controlled outcome research.

Stanton (1975) saw clients individually for four weekly hypnotic sessions in which suggestions were given for reduced appetite as well as ego enhancing instructions that weight loss would be successful. Follow-up data were available from only ten of the clients but after two years, all of them weighed less than at the beginning of treatment and were within a few pounds of their target weight. Stanton (1976) reported that clients who pay a fee for treatment show a significantly greater weight loss than a comparable no-fee group.

Kline et al (1976) reported that obese people are highly sensitive to external stimuli but relatively insensitive to internal signals. Cohen and Alpert (1978) support this finding and pointed out that obese clients may require more extensive training in hypnotherapy than more internally sensitive clients.

Thorne, Rasmus and Fisher (1976) tested 258 overweight girls on the Harvard Group Scale of Hypnotic Susceptibility and found that scores were significantly higher than other groups reported in the literature. Deyoub (1978)
found no significant relationship between suggestibility as measured by the Barber Suggestibility Scale and the degree of obesity in a sample of overweight females. Wadden and Flaxman (1981) also report no relationship between hypnotic suggestibility, as measured on the Barber Suggestibility Scale, and weight loss.

Aja (1977) used a group approach with auxiliary self-hypnosis and reported a mean loss of 9.5 pounds on a six month follow-up, but no information was provided regarding other patient characteristics. Deyoub (1979) reported positive results using group hypnosis for weight loss and also recommends further clarification of the role of hypnotizability in hypnosis studies on obesity.

Kline (1980) reported that the greatest significance of experimental work with hypnotherapy and obesity may well be to give an indication of how behavior patterns can be altered and shaped through cognitively induced changes in perception, sensation, and the effective utilization of imagery.

Mott and Roberts (1979) expressed concern that most hypnotherapy and obesity studies had little or no follow-up. Garfield and Bergin (1978) have indicated that a follow-up of six months or more is sufficient to show a trend since most subjects who regain their weight begin to do so within six months. Mott and Roberts (1979) point to the need for correlations of hypnotizability scores with various indices
of outcome and they recommend that outcome should be evaluated in terms of self-concept, age of obesity onset, education level and socio-economic level. They feel that although clinical reports suggest that hypnosis has a place in weight control programs, if and how it may be useful needs to be evaluated by controlled research studies.

**Obesity Etiology**

Kline (1976) indicates that no single concept or theory will explain the myriad of ramifications involved in the understanding and treatment of obesity. Basically however, when caloric intake exceeds expenditure, the extra calories are stored as fat tissue.

Olefsky (1980) points out that the regulation of eating behavior is incompletely understood. To some extent, appetite is controlled by discrete areas of the hypothalamus where there is a feeding center and a satiety center. The cerebral cortex receives positive signals from the feeding center that stimulate eating and the satiety center modulates this process by sending inhibitory impulses to the feeding center. Several regulatory processes have been proposed as modulators of these hypothalamic centers. The satiety center may be activated by the surges in plasma glucose and or insulin that follow a meal. Meal-induced gastric distention is another possible inhibitory factor. The total fat tissue mass may also influence the activity of the hypothalamic
centers. Ultimately, the cerebral cortex controls eating behavior and impulses from the feeding center to the cerebral cortex are only one input. Psychological, social and genetic factors also influence food intake. In many obese subjects these influences are overriding in that obese subjects usually respond to external cues such as time of day, social setting, and smell or taste of food to a greater extent than do non-obese subjects.

Olefsky (1980) states that physical activity clearly modulates overall caloric balance and obese people tend to be less active than non-obese people but decreased physical activity is unlikely to be an important cause of major weight gain. There may also be a role of genetic influences in obesity but it is difficult to evaluate because of compounding social and cultural factors. In rare cases obesity can result from physical disorders such as Cushing's Disease, hypothyroidism and insulinoma but such cases are rare indeed. Any subject taking part in a weight loss program however should have a medical check-up to be certain that one of these rare disorders is not involved.

Olefsky (1980) reports that the human organism produces new fat-cells during childhood and adolescence but an adult becomes obese only on the basis of an increase in fat-cell size. Thus, overnutrition during the early years leads to a permanent change in fat-cell number and an increase in fat-cell size; later nutritional alterations
influence only cell size. Thus weight reduction programs may be more successful with subjects who experienced weight gain as adults rather than during childhood.

Bruch (1973) considers obesity from two different perspectives, one being developmental and the other reactive. She feels that developmental obesity begins in early childhood and is a response to dysfunctional family relations often resulting in the child developing a sense of rejection and a distorted body image. Reactive obesity, on the other hand, is viewed as occurring primarily in adults in response to stressful environmental circumstances. Bruch (1973) feels that not dealing with the underlying issues will result in short term benefits only.

Wolman (1982) points out that obese children tend to develop an extremely poor self concept and body image which would seem to result in quite different long-term effects than those manifested in an individual whose body was not deviant during childhood and adolescence but who became obese after marriage, childbirth or at some point in middle age.

Rothman and Becker (1970) reported cases of obesity in children following the death of a parent, hospitalization of the mother, parental divorce, desertion by the father, the child's hospitalization, and being sent away to boarding school. Again a sense of rejection or abandonment seems often to lead to the use of food as an emotional form of compensation.
Many obese adults have a low self-concept which may result from a combination of childhood experiences and the social expectations of thinness leading to a state of depression and the choice of self-punitive eating behaviors (Wolman, 1981). One of the problems that prevents greater certainty in such a conclusion is that to date there is very little information available on obese people who may in fact be happy and well adjusted. It does seem apparent however that psychological and social issues often play a role in the obesity problems. Herman and Mack (1975) point out that many obese people find conscious restraint to be very fragile and vulnerable to influences which lead to increased eating. Without considering the psychodynamic issues, many of which may operate out of awareness, sustained weight loss seems to be a very elusive goal.

Obesity Treatment Evaluations

Whereas there is no clear evidence to indicate definitively that one specific treatment mode is more successful than others in treating obesity, there are some definite patterns. The behavioral approach is often recommended (Mahoney, 1976; Olefsky, 1980) but it is by no means considered sufficient treatment. Craddock (1973) is notable for having devoted many years to obesity in a medical practice, and he has repeatedly indicated the importance of a wide-ranging approach.
Garfield and Bergin (1978) reviewed twenty-nine weight loss studies between 1970 and 1976. The follow-up periods ranged from four weeks to two years. Thirteen of the studies used follow-up periods of three months or less but their review indicates that a minimum follow-up period of six months is desirable. They suggest the use of each subject as his/her own control.

Ferster (1962), Stuart (1967), Stunkard and Mahoney (1976) have shown that behavioral techniques can be useful but Garfield and Bergin (1978) point out that behavioral techniques may be an important therapeutic component of weight loss programs but they are not sufficient except where they have been supplemented by other therapeutic strategies.

Most of the behavioral literature cited above was completed in the early or mid-1970's. At that time, the behavioral treatment of obesity was a relatively new venture and, as a result, long-term follow-up data were not available. Long term follow-up data has become more available in recent years and the results have tended to be disappointing. Abramson (1982) concludes that the long-term effectiveness of behavioral treatments has not been demonstrated and attempts to prolong the duration of weight loss by adding booster sessions have been successful only while the booster sessions continued. Abramson (1982) feels that truly effective treatment will require a greater understanding of
the behavioral, cognitive, social and physiological factors contributing to obesity.

In their work with obese adults, Mahoney and Mahoney (1976a, 1976b) have used an apprenticeship format in which clients develop progressively more complex problem solving skills. Obesity problems are likened to the research scientist's problems and the same skills are deemed beneficial. Thus in the "personal science" approach to adjustment (Mahoney, 1977), subskills are integrated into a basic seven step sequence: specify the general problem; collect information; identify causes of patterns; examine options; narrow options and experiment; compare data; extend, revise or replace. In the various stages of problem solving the client develops skills such as self-monitoring, means-ends thinking and rehearsal of possible options. Mahoney (1977) states that this method allows for the uniqueness of individual clients in that the focus is on helping the individual to discover and implement whatever strategies are effective in a given situation.

Kline (1976) reports on a program which teaches clients to learn to manage the deprivation behavior and stress reactions which occur as a result of initially being deprived of the reward of eating. The goal of this method is self-direction and self-mastery. Kline (1976) also reports that dieting does not result in depression but often reduces anxiety and depression during the period of successful weight loss.
Kline (1976) also indicates that starvation diets can be dangerous and usually fail because hunger pangs do not decrease and much of the weight loss during such a diet is protein and water. Bergin and Garfield (1978) found that nauseating imagery provided with or without hypnosis has often been reported in case studies but its value has not been supported in controlled outcome studies.

Olefsky (1980) reports on a number of medical treatments for obesity such as drug therapy and surgery. He points out that surgery is used only with a small minority of extremely obese clients. Drug therapy is used infrequently because of the problem of drug abuse and because drugs do not treat the underlying eating disorder. Olefsky (1980) also points out that exercise is helpful in a weight loss program but moderate exercise burns fewer calories than many obese clients like to believe. He points out that little evidence exists to support the claim that, calorie for calorie, one type of diet will lead to greater weight loss than another. Diets deficient in any major class of foodstuff are to be avoided. He concludes that weight loss is not the real therapeutic problem. The real problem is that almost all obese clients eventually regain their weight and therefore an effective means to sustain weight loss is the major challenge in the treatment of obesity today.
From the psychoanalytic perspective, weight loss is considered incidental to the psychoanalytic process. Obese clients are expected to focus on psychodynamic issues and the client's obesity is considered symptomatic of these issues (Rand and Stunkard, 1977). For this reason obese clients in psychoanalysis are different from obese clients in most other programs. The client enters psychoanalysis for an emotional disorder but there is, at present, no indication that obese people in general are more or less emotionally disturbed than the general population (Wolman, 1982). Given the probable differences between obese psychoanalytic subjects and the general population of obese subjects, Rand and Stunkard (1977) report that weight losses and maintenance of these losses among obese psychoanalytic clients were better than losses in most traditional weight reduction programs. During treatment the obese clients showed marked improvement in psychopathology. Emotional crisis of many kinds were associated with weight gain and food had symbolic importance to obese clients in that they tended to turn to food as a replacement for unavailable intimacy.

Motivation is an important component of any weight loss program and a group setting can often provide a form of mutual support and encouragement for each client (Kline, 1982). Many commercial weight loss programs however use a group setting so that pressure can be placed on the clients who are not doing well (Wollersheim, 1982). Success by some
group members can be a motivational factor for other group members but when a client is purposefully identified as a failure, as is often done in commercial programs, the group setting then becomes a negative factor. Group size is usually six to eight clients to allow optimum time for individual needs although Deyoub and Wilke (1980) used a group of seventeen subjects. In most weight loss programs the economic costs to the subjects are reduced as a result of a group setting.

Since inactivity is often a characteristic of obesity, regular exercise is often incorporated directly or indirectly in weight loss programs (Wolman, 1982). However, the more overweight the subjects, the more difficult it usually is to sustain enthusiasm for an exercise program. It would seem that a sensible, regular exercise program designed to meet the needs of each subject could add a useful component to most weight loss programs but the evidence indicates that long term weight loss is not a simple issue and seems to involve psychodynamic and social factors as well as the more obvious physiological factor.
CHAPTER III
METHODOLOGY

Subjects

The sample consisted of female subjects who responded to a newspaper announcement for a weight loss program. There were 60 subjects between 20 and 65 years old, all of whom were without medical problems contraindicating weight loss and who were not enrolled in any other weight reduction program. All subjects came from Regina, Saskatchewan and surrounding area.

Procedures

Assignment to Groups

For the purpose of this study one control and two treatment groups were established with 20 subjects in each group. Expnau received hypnosis followed by the home use of an audio-tape during the six month follow-up period. Expanau received hypnosis only and the Expcont control group received no treatment. All subjects in Expnau and Expcont control group received treatment from the same therapist. The subjects were randomly assigned to group Expnau, Expanau and Expcont. The subjects in the control group were placed on a waiting list for treatment after the six month follow-up.
Pretesting Procedures

Prior to active involvement in treatment, the subjects were asked to present a medical statement from a physician indicating that they were without medical problems contraindicating weight loss. All subjects understood that they were not to take part in any other weight loss program during their participation in this study. Furthermore, they were asked to sign a consent form agreeing to participate in the study and the six month follow-up. Immediately prior to treatment the subjects were weighed and measured for height. All subjects were weighed and measured without shoes, with indoor clothing and on the same scale. Each subject in the three groups then completed the Barber Suggestibility Scale, the Tennessee Self Concept Scale, the Family History of Distress Scale, and the intake form for onset of obesity data. Expau and Expnau completed the Representational Systems Inventory and all groups were weighed immediately upon completion of the treatment period. After six months the treatment groups were interviewed and their weights were recorded as were the weights of the subjects in the control group. The subjects in the control group had been placed on a wait-list for the follow-up period.
Treatment Procedures

The two treatment groups met for one six-hour session with the researcher during which time the intake information was gathered, the pretesting was done and the remainder of the time was devoted to an introduction to the principles of hypnosis. This session was designed to remove any fears, doubts or misconceptions the subjects may have had concerning hypnosis, and to teach the subjects how to experience the hypnotic state.

Subjects in Expau and Expnau met with the therapist for two three-hour group sessions each week for four weeks totalling 24 hours. The subjects in Expau all had available, through purchase or loan, tape recorders to facilitate the use of a prepared audio-tape following treatment.

In the standard therapy procedure each subject was given a hypnotic induction which involved focusing on a spot or object until the eyes became heavy and closed. The next step was to use progressive relaxation suggesting that the subject systematically relax her muscles beginning with the muscles in the forehead, around the eyes, around the mouth, the jaws, the neck and then each muscle group throughout the body. A deepening exercise was used in the third step as each subject, depending upon her preferences, was guided down a staircase, escalator or elevator to a deeper state of relaxation. In some cases the subjects found a floating,
drifting imagery to be more applicable for them. The fourth stage consisted of Hartland's (1971) ego-enhancing suggestions which emphasize a growing sense of optimism, confidence and self-mastery. The fifth stage of the hypnosis sessions employed the indirect method of suggestion used by Erickson (1976). This method utilizes fables, imagery based on the personal experiences of the subject, reminders of how the subject learned to talk, to walk, to read and to forget certain fears and habits as she grew older. This method also includes the desired body imagery and accompanying improved feelings of self-esteem with suggestions to match weight goals with expectations. The sixth stage of hypnosis was the suggestions of alertness, growing confidence, optimism and a count-out from 5 to 1 (Appendix E). This format was used initially but in subsequent sessions the induction format was replaced with a rapid induction (Hartland, 1972).

The audio-tapes were prepared for each subject in Expau by recording a personalized induction followed by standardized suggestions. The tapes were approximately 12-15 minutes long and the subjects were asked to listen to the tapes once every day during the six month follow-up period. Each subject was requested to keep a written record of her use of the audio-tapes during the six months following treatment (Appendix I). There was no contact with the three groups during the follow-up period.
**Instruments**

The measurements of the independent variables were obtained from the Barber Suggestibility Scale, the Tennessee Self Concept Scale, the Family History of Distress Scale, the Representational Systems Inventory, age of obesity onset, level of education, socio-economic status. The dependent variable was measured weight loss.

**The Barber Suggestibility Scale**

The Barber Suggestibility Scale was administered to each subject prior to treatment (Appendix A).

The Barber Suggestibility Scale consists of eight standardized test suggestions and each subject is assessed individually on objective and subjective responses to all eight items. The eight items are as follows: Arm lowering (the subject's right arm is heavy and is moving down); Arm levitation (the subject's left arm is weightless and is moving up); Hand lock (the clasped hands are welded together and cannot be taken apart); Thirst hallucination (she is becoming extremely thirsty); Verbal inhibition (her throat muscles are rigid and she cannot speak her name); Body immobility (her body is heavy and she cannot stand up); Post hypnotic-like response (when she hears a click postexperimentally, she will cough automatically); and selective amnesia (when the experiment is over she will not remember one specific text suggestion).
The subject received a maximum objective score of eight points (one point for each of the eight test suggestions) if: the right arm moves down four or more inches; the left arm rises four or more inches; the subject tries to, but fails to unclasp her hands; she shows swallowing, moistening of lips, or marked mouth movements and states postexperimentally that she became thirsty during the test; she tries but does not succeed in saying her name; she tries but does not succeed in standing fully erect; she coughs or clears her throat when the cue is presented postexperimentally; and she does not refer to the critical item during the postexperimental interview but recalls at least four other items and then recalls the critical item when told, "Now you can remember."

In addition to the objective scores the subject also receives a maximum subjective score of twenty-four points (one to three points for each of the eight items) if she states, during the postexperimental interview, that she actually experienced each of the suggested effects and that she did not respond overtly to the test suggestions simply to follow instructions or to please the experimenter.

The Barber Suggestibility Scale is significantly correlated with the Stanford Hypnotic Susceptibility Scale, Form A at .62 and .78 for the objective and subjective portions, respectively (Ruch, Morgan, and Hilgard, 1974).
The Tennessee Self Concept Scale

The Tennessee Self Concept Scale was administered to each subject prior to treatment (Appendix B).

The Tennessee Self Concept Scale consists of 100 self-description items, of which 90 assess the self-concept and 10 assess self criticism. For each item the respondent chooses one of five response options labelled from "completely false" to "completely true". Fourteen scores are derived from these items and are reported in the profile sheet. The essential qualities of self evaluation are: identify, self-satisfaction, behavior, physical self, moral-ethical self, personal self, family self, and social self. Each of these aspects of the self receives a subscore based on relevant items. In addition, major additional scores are derived: Total Positive score, reflecting the overall level of self-esteem; Variability scores, reflecting the amount of consistency from one area of self perception to another; and Distribution score, a measure of extremity response style.

Reliability coefficients ranging from .60 to .92 are reported by the author with the majority being in the high .80's. Bentler (1972) states in Buros Seventh Mental Measurements Yearbook that though little information on internal consistency is presented in the manual, large correlations obtained between scale scores and other measures such as MMPI scales suggest that internal consistency coefficients would be quite high.
Suinn (1972) in Buros *Seventh Mental Measurements Yearbook*, reports that cross-validation data strongly suggest that the empirical scales do a competent job of aiding in group discrimination. He concludes his review by stating that the Tennessee Self Concept Scale ranks among the better measures of self concept.

**The Family History of Distress Scale (FAM)**

The FAM scale was administered to each subject prior to treatment (Appendix C).

The FAM scale is a subtest from the Marital Satisfaction Inventory which was developed by Douglas K. Snyder in 1975. The FAM scale consists of 15 items reflecting the degree of disharmony in the marriages of the respondent's parents and extended family. Item content is organized along five factors: (1) parent's marriage dominated by discord, (2) reports of an unhappy childhood, (3) eagerness to leave home prior to marriage, (4) lack of closeness among family members, and (5) marital disruption among the extended family.

The FAM scale is based on the premise that either unresolved conflicts evolving from the family of origin or the absence of adequate parental models could contribute to current relationship difficulties and emotional problems.

Low scores on FAM (below 45T) reflect a family of origin characterized by warmth and harmony. Parents are
unlikely to have had frequent disagreements and are described as having provided positive models for expressions of affection and resolution of differences.

Moderate elevations (45-60T) indicate significant distress in the parent's marriage. With elevations above 60T disruption in the family of origin is extensive. Individuals scoring high on FAM are likely to have experienced considerable alienation from parents, siblings, or both.

Test-retest reliability coefficients are reported by the author of the Marital Satisfaction Inventory and the .94 reliability coefficient for the FAM scale is the highest of all the subscales. The author reports that elevated scores on FAM are predictive of current relationship and emotional dysfunction.

The Representational Systems Inventory

The Representational Systems Inventory was administered to each subject in Expa and Expnau following the one month treatment period (Appendix D).

The Representational Systems Inventory was developed by the researcher as a means of assessing the subject's degree of absorption in imagery activities suggested during the hypnotherapy treatment program. Tellegen and Atkinson (1974), Hilgard (1975), and Sheehan (1979) indicate that the more vividly one is able to experience imagery the more one is able to experience hypnosis. Bandler and Grinder (1981)
point out that people seem to process information through the visual, auditory, kinesthetic, olfactory and gustatory channels. They refer to these channels as representational systems as they are the systems used to represent experiences. They conclude that most people tend to use the visual, auditory or kinesthetic channel in their imagery activities. It seems that one means of assessing the subjects' absorption in imagery activities is to construct the evaluation instrument on the basis of representational systems. The Representational Systems Inventory, constructed for the purposes of this study, consists of 30 items reflecting the degree of imagery absorption experienced by the subjects in three representative imagery activities from the hypnotherapy program.

Item content is organized on the basis of visual, auditory and kinesthetic experiences. For each item the respondent chooses one of four response options labelled from "not true" to "completely true." Four scores are obtained, one for each of three imagery activities, and one cumulative score. The minimum score for each subtest is ten and the maximum score is forty. The minimum cumulative score is forty and the maximum cumulative score is 120.

The Representational Systems Inventory is based on the premise that the higher a subject scores on this inventory the more vividly that subject is able to experience
imagery. As the literature suggests (Tellegen and Atkinson, 1974; Hilgard, 1975; Sheehan, 1979; Bandler and Grinder, 1981) the more vividly one is able to experience imagery the more one is able to experience hypnosis.

A reliability coefficient of .92 was obtained from a test-retest method of analysis conducted on twenty-two female patients in a hospital weight loss program.

Onset of Obesity

As part of the intake information each subject was asked to indicate if her obesity problem developed prior to, or following, her eighteenth birthday in line with the recommendation of Mott and Roberts, (1979).

Level of Education

As part of the intake information each subject was asked to indicate the number of years of formal education she received (Mott & Roberts, 1979).

Socio-economic Status

As part of the intake information each subject was asked to indicate her level of family income (Mott and Roberts, 1979).
Weight

Each subject was weighed prior to treatment and at the follow-up. The same balance scale was used for all subjects for the pretreatment post-treatment measures and all subjects were weighed in indoor clothing after the removal of their shoes. Each subject was measured for height at the time of the initial weigh-in to facilitate the identification of an ideal weight for each subject.

Design

The data were gathered on the assumption that each variable would provide some unique information for a more comprehensive understanding of the treatment of obesity with hypnosis.

The data were gathered and recorded by the researcher assisted by a qualified dietician from the Plains Hospital in Regina, Saskatchewan. The data from the pre and post measures were gathered by the researcher and put into usable form for computer analysis.

Subject names were recorded to facilitate the follow-up but were not included in the final report to ensure their confidentiality.

The data recorded and analyzed from the two treatment groups include the following independent variables: The Barber Suggestibility Scale; The Tennessee Self Concept Scale; The Family History of Distress Scale; Age of Obesity Onset; Level of Education; and Economic Status. The data
recorded and analyzed from the control group includes the above mentioned variables with the exception of the Representational Systems Inventory which was administered to Expau and Expnau. The dependent variable is measured weight loss from the three groups.

Expau and Expnau were identical in content and duration (Appendix E). All subjects were weighed following the treatment period. For the six month follow-up period, subjects in Expau were provided with audio-tapes (Appendix I), were instructed to listen to them once daily and were instructed to keep a record of actual usage (Appendix J). There was no contact with the three groups during the follow-up period.
Table 1

Data Collection Sequence

<table>
<thead>
<tr>
<th>I. Pre-treatment Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concomitant Variables</td>
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<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Dependent Variable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Treatment Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Post Treatment Measure of Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV. Follow-up Period of Six Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Expau</td>
</tr>
<tr>
<td>Expnau</td>
</tr>
<tr>
<td>Expcont</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>V. Follow-up Measure of Weight</th>
</tr>
</thead>
</table>
Statistical Analysis

The descriptive statistics derived from the data are displayed in Table 2. Included in these statistics are means of all the variables. The raw scores for all subjects are displayed in Appendix K.

The inferential statistics will be derived from an analysis of covariance at the .05 level of significance.

The initial weights of the 54 subjects in this study ranged from a minimum of 133 pounds to a maximum of 295 pounds. It is assumed that this variation in initial weight may result in weight loss becoming a function of initial weight (Olefsky, 1980). A weight loss of 30 pounds may seem more attainable to a subject who initially weighs 160 pounds than to a subject who initially weighs 270 pounds. On the other hand, a subject who weighs 270 pounds may be able to lose 30 pounds with greater ease than a subject who weighs 160 pounds. The three groups were compared for weight loss and on the basis of the concomitant variables listed in Table 1. The analysis of covariance combines the advantages of regression analysis and analysis of variance.
CHAPTER IV
 RESULTS

The results obtained in the investigation of the hypotheses are reported in this chapter. The inferential statistics are derived from an analysis of covariance at the .05 level of significance.

It should be noted that six subjects failed to return for the weigh-in at the follow-up resulting in each treatment group consisting of n = 17. Twenty control group subjects all returned. Consequently there is a total of 54 subjects in the study.

A summary of means and standard deviations for eleven variables from the three groups is provided in Table 2. Two analyses of covariance were performed on one-month and six-month weight loss with seven covariates, in order to assess the effects of experimental treatments Expau and Expnau.

Table 2
Summary of Means and Standard Deviations of 11 Variables by 3 Groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Expau Mean</th>
<th>Expau SD</th>
<th>Expnau Mean</th>
<th>Expnau SD</th>
<th>Expcont Mean</th>
<th>Expcont SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Wt.</td>
<td>215.99</td>
<td>34.19</td>
<td>184.76</td>
<td>29.23</td>
<td>175.79</td>
<td>40.13</td>
</tr>
<tr>
<td>1 Mo. Loss</td>
<td>6.53</td>
<td>1.05</td>
<td>8.00</td>
<td>0.97</td>
<td>+ 1.50</td>
<td>0.95</td>
</tr>
<tr>
<td>6 Mo. Loss</td>
<td>17.82</td>
<td>2.73</td>
<td>17.12</td>
<td>2.54</td>
<td>0.50</td>
<td>2.45</td>
</tr>
<tr>
<td>BSS</td>
<td>14.79</td>
<td>7.80</td>
<td>11.71</td>
<td>7.24</td>
<td>16.39</td>
<td>5.32</td>
</tr>
<tr>
<td>FAM</td>
<td>44.29</td>
<td>12.55</td>
<td>51.06</td>
<td>11.41</td>
<td>48.55</td>
<td>12.81</td>
</tr>
<tr>
<td>Age</td>
<td>1.65</td>
<td>0.58</td>
<td>1.69</td>
<td>0.58</td>
<td>1.50</td>
<td>0.52</td>
</tr>
<tr>
<td>TSSCS</td>
<td>321.99</td>
<td>38.60</td>
<td>325.47</td>
<td>34.26</td>
<td>335.99</td>
<td>39.54</td>
</tr>
<tr>
<td>ECON STAT</td>
<td>34.41</td>
<td>14.58</td>
<td>33.53</td>
<td>14.38</td>
<td>26.50</td>
<td>8.72</td>
</tr>
<tr>
<td>EDUC</td>
<td>13.76</td>
<td>0.21</td>
<td>13.00</td>
<td>0.16</td>
<td>13.38</td>
<td>0.22</td>
</tr>
<tr>
<td>RSI</td>
<td>92.71</td>
<td>19.60</td>
<td>90.76</td>
<td>22.08</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tape Use</td>
<td>45.65</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

67
Table 3 provides summary results of the regression analysis including regression coefficients, their corresponding t-values and significant P-values of seven concomitant variables of the three groups Expau, Expnau and Expcont.

Table 3

Regression Coefficients and their Corresponding T-Values of Seven Concomitant Variables of Three Groups: Expau, Expnau and Expcont

<table>
<thead>
<tr>
<th>Concomitant Variables</th>
<th>Reg Coeff One Month Wt Loss</th>
<th>Std</th>
<th>Err</th>
<th>T-Value</th>
<th>Reg Coeff Six-Month Wt Loss</th>
<th>Std</th>
<th>Err</th>
<th>T-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orig. Wt.</td>
<td>-0.013</td>
<td>0.016</td>
<td>0.016</td>
<td>-0.784</td>
<td>-0.023</td>
<td>0.042</td>
<td>-0.564</td>
<td></td>
</tr>
<tr>
<td>BSS</td>
<td>-0.114</td>
<td>0.087</td>
<td>-1.320</td>
<td>0.368</td>
<td>0.223</td>
<td>1.634</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAM</td>
<td>-0.157</td>
<td>0.063</td>
<td>-2.506**</td>
<td>0.016</td>
<td>0.163</td>
<td>0.100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGE</td>
<td>-1.206</td>
<td>1.138</td>
<td>-1.059</td>
<td>-0.380</td>
<td>2.964</td>
<td>-0.128</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TSCS</td>
<td>-0.005</td>
<td>0.016</td>
<td>-0.294</td>
<td>0.080</td>
<td>0.041</td>
<td>1.939</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ECSTAT</td>
<td>-0.105</td>
<td>0.048</td>
<td>-2.211*</td>
<td>-0.090</td>
<td>0.124</td>
<td>0.725</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDUC</td>
<td>-0.108</td>
<td>0.271</td>
<td>-0.399</td>
<td>-0.312</td>
<td>0.705</td>
<td>-0.443</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* for P < .025
** for P < .01

It seems that none of these variables contributed significantly to variability in weight loss at six months; but the family of origin (FAM) and economic status (ECSTAT), did predict the variability in the initial weight loss significantly at P < .01 and .025, respectively. This finding appears to indicate that subjects who reported disruption in their families of origin and who reported a currently low family income expected a simple solution to a complex problem.
Wolman (1982) indicated that for many obese people excess weight is a choice defence mechanism and if eliminated, they are forced to face their problems directly. It is possible that these subjects made such a discovery during the follow-up period.

Two more analyses of covariance were carried out with Expau and Expnau. The measure of the Representational Systems Inventory was available only to the subjects in Expau and Expnau and therefore the main focus of this analysis was to determine if the Representational Systems Inventory contributed significantly to the variability in overall weight loss. Table 4 provides a summary of the analysis including regression coefficients and their corresponding t-values of eight concomitant variables of the two groups Expau and Expnau.

Table 4

Regression Coefficients and their Corresponding T-Values of Eight Concomitant Variables of Two Groups: Expau, Expnau

<table>
<thead>
<tr>
<th>Concomitant Variables</th>
<th>Reg Coeff One Month Wt Loss</th>
<th>Std Err</th>
<th>T-Value</th>
<th>Reg Coeff Six-Month Wt Loss</th>
<th>Std Err</th>
<th>T-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orig.</td>
<td>-0.005</td>
<td>0.023</td>
<td>0.194</td>
<td>-0.033</td>
<td>0.070</td>
<td>-0.471</td>
</tr>
<tr>
<td>BSS</td>
<td>-0.141</td>
<td>0.104</td>
<td>-1.357</td>
<td>0.319</td>
<td>0.311</td>
<td>1.025</td>
</tr>
<tr>
<td>FAM</td>
<td>-0.187</td>
<td>0.081</td>
<td>-2.324**</td>
<td>0.125</td>
<td>0.240</td>
<td>-0.522</td>
</tr>
<tr>
<td>AGE</td>
<td>-1.179</td>
<td>1.475</td>
<td>-0.800</td>
<td>-0.687</td>
<td>4.403</td>
<td>-0.156</td>
</tr>
<tr>
<td>RSI</td>
<td>0.052</td>
<td>0.040</td>
<td>1.281</td>
<td>0.173</td>
<td>0.121</td>
<td>1.436</td>
</tr>
<tr>
<td>TSCS</td>
<td>-0.010</td>
<td>0.024</td>
<td>-0.429</td>
<td>0.068</td>
<td>0.071</td>
<td>0.961</td>
</tr>
<tr>
<td>ECSTAT</td>
<td>-0.123</td>
<td>0.054</td>
<td>-2.273*</td>
<td>-0.142</td>
<td>0.162</td>
<td>-0.879</td>
</tr>
<tr>
<td>EDUC</td>
<td>-0.140</td>
<td>0.361</td>
<td>-0.389</td>
<td>-0.947</td>
<td>1.077</td>
<td>-0.879</td>
</tr>
</tbody>
</table>

* for P <.025

** for P .01

df = 24
As can be seen in Table 4, the Representational Systems Inventory did not contribute significantly to the variability in weight loss at one month or at six months. As was noted in Table 3, family of origin and economic status had an initial influence on weight loss but was not significant after six months.

Table 5 provides a summary of the adjusted means for weight loss by the three groups after the one month treatment period and after the six-month follow-up period. Adjusted mean weight losses of both experimental groups (Expau and Expnau) are clearly shown to be greater than the control group, $t_s(44) = 7.529$ and $6.256, \ p_s < .0001$, for one-month and six-months weight loss, respectively. The two experimental groups are shown to be not different from one another.

Table 5

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Standard Error</th>
<th>Group Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>One Month Loss</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expau</td>
<td>17</td>
<td>1.046</td>
<td>-6.75$^a$</td>
</tr>
<tr>
<td>Expnau</td>
<td>17</td>
<td>0.974</td>
<td>-8.31</td>
</tr>
<tr>
<td>Expcont</td>
<td>20</td>
<td>0.952</td>
<td>+1.95</td>
</tr>
<tr>
<td><strong>Six Months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expau</td>
<td>17</td>
<td>2.725</td>
<td>-19.29</td>
</tr>
<tr>
<td>Expnau</td>
<td>17</td>
<td>2.537</td>
<td>-18.26</td>
</tr>
<tr>
<td>Expcont</td>
<td>20</td>
<td>2.478</td>
<td>+1.73</td>
</tr>
</tbody>
</table>

$^a$The two specific contrasts made are shown in Appendix L
This finding, which confirms the primary hypothesis, indicates that hypnosis is a useful treatment for weight loss. Mott and Roberts (1979) expressed concern that there was little or no research evidence available to support even the primary issue of hypnosis as an effective treatment for obesity.

The hypothesis that there would be a statistically significant difference in weight loss between Expau and Expnau at the six-month follow-up period was not supported. The calculated F did not exceed the tabled value of F at the .01 or .05 levels of significance (Appendix L). This result indicates that the use of audio-tapes did not have a meaningful influence on the weight loss efforts of the subjects in Expau. The mean for tape usage during the six-month follow-up period was 45.65 times. It appears that participation in the hypnotherapy program was the important factor in the weight loss efforts of both groups. Whereas Araoz (1982) and Fromm (1979) had speculated on the potential of tapes for weight loss, it seems that Erickson (1976) was correct in stating that the tapes cannot adequately provide the human element of live therapy sessions.

The hypothesis that the Representational Systems Inventory would show statistical significance as a predictor of weight loss was not supported. This result does not support the views of Bandler and Grinder (1975, 1981). However only three imagery activities from the hypnotherapy program were evaluated with the Representational Systems
Inventory and in future research possibly a greater number of imagery activities need to be evaluated. There was a trend of greater weight loss with higher scores on the Barber Suggestibility Scale but this trend was not sufficient to result in statistical significance.

The hypothesis that the Barber Suggestibility Scale would show statistical significance as a predictor of weight loss was not supported. This result however, supports the findings of Deyoub (1978) and Wadden and Flaxman (1981). There was also a trend of greater weight loss with higher scores on the Barber Suggestibility Scale but this trend was not sufficient to result in statistical significance.

The hypothesis that scores on the Tennessee Self Concept Scale would be a significant predictor of weight loss was not supported. The speculations of Bruch (1973) and Wolman (1982) that self-concept may be a predictor of weight loss were not supported by these results.

The hypothesis that there would be a statistical difference in weight loss among the subjects on the basis of the Family History of Distress Scale was not supported at the six-month follow-up. The suggestion of Bullen (1964) that family of origin could be a predictor of weight loss was not the case in this study.

The hypothesis that stated there would be a statistically significant difference in weight loss on the basis of age of obesity onset, education level and economic status was not supported. Mott and Roberts (1979) indicated
that these three variables be included in weight loss research but they were not significant in this study.

Ten subjects were selected for discussion to provide additional understanding of the dynamics involved in their weight loss efforts. Five of the subjects achieved their weight loss goals and five did not.

The successful subjects reported previous achievements in career and educational endeavors, a willingness to explore and resolve weight related issues, a supportive family environment and the motivation that seems necessary to lose weight.

The five subjects in the case studies who did not succeed in losing the weight they had hoped to lose, reported extensive family and marital problems that seemed to force weight loss into a secondary position. Their unresolved problems were ongoing and they seemed unable to resolve those problems within the limited time provided. These subjects reported difficulty in focusing on weight loss suggestions or in maintaining the initiative to work at their weight problem within the context of their disruptive environments.

A detailed description of the selected case studies is placed in Appendix M for interested readers.
CHAPTER V
DISCUSSION AND SUMMARY

The hypotheses that were explored in his study are discussed in this chapter. The ten case studies presented earlier are also discussed.

All of the subjects were weighed at the outset of the program, at the conclusion of the treatment program and at the six month follow-up. Significant differences were found between the treatment groups and the control group after one month and after six months. Since the treatment provided Expau and Expnau was identical it was necessary to measure the weight lost by the two treatment groups during the treatment period so that statistical effects of the tapes during the 6 month follow-up period could be clearly established.

The hypotheses that there would be a statistically significant difference in weight loss among the three groups at the six month follow-up was supported. As expected the subjects in the two treatment groups lost significantly more weight than the subjects in the control group. This result provides support for the use of hypnotherapy as a treatment for obesity and provides a basis for further study.

The hypothesis that there would be a statistically significant difference between the two treatment groups was
not supported. The mean weight loss for the Expau (17.82 pounds) and for the Expnau (17.20 pounds) indicates that the tapes had minimal influence on weight loss. It is interesting to note however that the two subjects in the non-tape group who lost the most weight during the follow-up period made and used, their own audio-tapes. In the follow-up interviews these two subjects reported that they recorded some of the inductions that had been used by the therapist during the treatment program then chose suggestions and imagery from the program that they felt best fit their needs. They then recorded their own 15 to 20 minute tapes and used them often but did not record actual usage. The literature (Araoz, 1982; Fromm, 1979) indicates the potential value of audio-tapes. The element of client motivation to use the tapes and the impact of repeated suggestions are the two components that were being evaluated by including the tape variable. The subjects were requested to use the audio-tape every day for 180 days and the mean of actual use was 45.64 times. The non-significance of tape use explains the finding for the second hypothesis and indicates that other aspects of the treatment program can be credited with the weight loss results that were achieved. In this study, audio-tapes were not a significant factor in the final outcome.
Whereas the statistical analysis did not support the hypothesis that there would be a statistical difference in weight between subjects who scored higher and lower on the Representational Systems Inventory, an examination of the data initiates some interesting speculations. Erickson (1976) spent most of his life developing techniques of indirect suggestion through pacing, voice inflection, stories, metaphors and carefully chosen sentence structure. Whereas most hypnotherapists used formal inductions and gave direct suggestions in the form of commands, Erickson seemed to induce clients to change by using unexpected and uncommon techniques. Bandler and Grinder (1975) arranged to spend considerable time observing Erickson at work and discussing his methods with him. They were able to apply their skills in linguistics and communication to an organized analysis of Erickson's therapy techniques. They discovered that Erickson paid close attention to the manner in which a client described her experiences. They noted that if the client tended to describe her experiences visually Erickson would respond with visual metaphors and stories while pacing his phrases slightly slower than the client's rate of breathing. He would very gradually shift his descriptive terminology from the visual mode to another mode, such as the kinesthetic, and the client would invariably go into an altered state. This method led Bandler and Grinder to speculate on the modes of communication that are available to clients and
through which they represent their experiences. They speculated that each person has a dominant mode of experiencing and that the frequent use of a single mode, such as the visual mode, can limit one's understanding of a situation as well as limit the response choices that one perceives to be available. Bandler and Grinder (1975) developed a set of labels that generally coincide with the five senses and used these labels to identify the modes of experiencing that people utilize. They used the title Representational Systems under which are placed the visual, kinesthetic, auditory, olfactory and gustatory modes of experiencing. Bandler and Grinder (1975) employed the metaphor of a perceptual map to describe the function of each mode, implying that a person experiences the world on the basis of her perceptual map. They emphasize that "the map is not the territory" and like the analogy of the blind men and the elephant, a limited perception of any given situation can result in a reduction of perceived options. Erickson (1976) suggested that people who can learn to utilize more than just one or two modes of experiencing are open to a greater variety of options when faced with problem situations. Even in their most recent work, Bandler and Grinder, (1981), speculate on this untested hypothesis, but are unable to provide more than single case examples to support their contentions. A review of the scores on the Representational Systems Inventory obtained by the subjects who lost 15 or
more pounds in the present study, gives some support to the contention of Bandler and Grinder (1975, 1981). It is not possible to conclude in this study that high absorption in multi-modal imagery, as indicated by the scores on the Representational Systems Inventory, is a significant characteristic for all subjects who lost weight in the hypnotherapy program, but it does appear to be an important characteristic of the subjects who lost the most weight. It is possible that the ability to become absorbed in multi-modal imagery is an important component in the mosaic of characteristics found in successful weight loss subjects, but this characteristic requires further study with a more refined instrument.

A further review of the data from this selected group indicates that the subjects who scored highest on the Representational Systems Inventory lost more than twice as much weight as the mean weight lost by the entire sample, giving further credence to the potential importance of high absorption in multi-modal imagery among successful weight losers. It would seem that additional research on absorption in multi-modal imagery is warranted. Possibly greater emphasis needs to be placed on determining if the ability to become deeply absorbed in multi-modal imagery is an inherent characteristic, as Hilgard (1979) contends for suggestibility, or whether it is a teachable skill as Erickson (1976) and Bandler and Grinder (1981) contend.
The Barber Suggestibility Scale and the Tennessee Self Concept Scale did not reveal statistical significance as predictors of weight loss but the trend from these two instruments indicates that higher scores correspond to greater weight loss. Perhaps a measure of suggestibility that incorporates indirect suggestion needs to be developed since the current suggestibility measures use only direct authoritative suggestions. The mean score of the Tennessee Self Concept Scale is 348 and the mean score obtained by the subjects in this study is 323. The lowest scores were obtained on the Physical-self sub-test. These two variables may provide useful information in future research if more refined instruments can be developed to assess their significance.

The Family of Origin instrument provided results indicating that Family of Origin was not significant as a predictor of weight loss. Bruch (1973) and Bullen (1964) tentatively indicated that the quality of interpersonal relationships in the family of origin seemed to be a factor in the development of obesity among adolescent girls. Like the findings of Bruch (1973) and Bullen (1964), the results of this study provide the basis for no more than speculation. Family of Origin may, as Bruch (1973) and Bullen (1964) suggest, be a factor in the development of obesity but seems to be less reliable as a predictor of successful weight loss. It is the view of the researcher, based on the
experiences of the subjects in this study, that measures of the quality of relationships in the family of origin need to be supplemented by measures of how well the resulting issues have been resolved. Many of the subjects who lost little weight reported current unresolved issues such as marital discord or loneliness which seemed to result in sessions of overeating. It would be interesting to pursue the possible relationships among the quality of families of origin, current unresolved issues and the impact of hypnotherapy on issue resolution and weight loss.

Education level, economic status and age of obesity onset were not significant predictors in this study. Mott and Roberts (1979) reported that these variables had not been used in the studies that they reviewed and felt that possibly their inclusion in future research would provide some meaningful information which could be implemented in hypnotherapy programs for weight loss. Their speculations were not supported in this study. It is the opinion of the researcher that in future research, the age of obesity onset should include the circumstances experienced by the subjects at the onset of obesity rather than just age of onset.

Implications

The results of this study support the findings of Kline (1976), who reported that no single concept or theory
will completely explain the myriad of ramifications involved in the understanding and treatment of obesity. Treatment with hypnosis produced significant results in this study but identifying the subjects with characteristics that result in success was more difficult.

Tape recorded suggestions do not appear to provide the reinforcement or motivational component that was considered possible by Fromm (1979). Whereas some of the subjects who enjoyed extensive weight loss used the tapes provided and others made their own, some subjects lost considerable weight without tapes and still others had limited success with tapes. It might be interesting, in future research, to pre-screen group members on the basis of the characteristics shared by the successful subjects in this and other studies and then create a group which uses tapes and a group which does not. In this way it might be possible to gain further understanding of the possible value of tapes with a specific type of subject.

The capability of extensive absorption in multimodal imagery, though not significant in this study, does seem to be an important characteristic of successful subjects in this type of hypnotherapy program. Over the years the indirect suggestions so skillfully utilized by Erickson have often resulted in dramatic observable changes in many clients, but it was not until Haley (1958) and later Bandler and Grinder (1975, 1981) began focusing on the specific
communication techniques of Erickson that definite patterns began to emerge. Once these patterns were identified it was possible, as Bandler and Grinder did, to review transcripts, tapes, and live sessions of Erickson's work to study the variety of ways that he worked with the representational systems of his clients. However, until research was conducted on the impact of using a representational systems approach, it was possible to attribute much of Erickson's success to his unique character. It was necessary to remove the potentially confounding component of an internationally acknowledged therapist before further evaluating the impact of multi-modal imagery on the client change.

The results of this study lend only speculative support to the claims of Bandler and Grinder (1975, 1981) but the measurement of absorption in multi-modal imagery is a somewhat global approach that should be considered only as a first step. Only a sample of the imagery from this treatment program was used to measure absorption and it is possible that imagery absorption is at least partially influenced by the content of the imagery activity. It seems probable also that subjects may become highly absorbed in an imagery activity and yet that particular imagery activity may have little or no impact on weight loss. Others in the field (Hanley, 1967; Kline, 1976; Wolman, 1962) have reported on the importance of subjects visualizing a desirable body image that will provide an achievable goal toward which they
can direct their efforts. Whereas it remains important to determine the significance of absorption in multi-modal imagery, a next logical step seems to be an identification of the most effective imagery activities that result in the greatest weight-loss for the greatest number.

Another aspect of representational systems, or multi-modal imagery, that has not been fully explored is Erickson's (1976) contention that gradually moving a subject from her dominant mode of imagery to other modes helps to induce an altered state of consciousness. It also seems (Bandler & Grinder, 1981) to provide the subject with a new perspective of a familiar problem and may result in an awareness of previously unconsidered options. Erickson continually challenged his clients with indirect suggestions which implied that more options were available than the client realized. The statement, "It's not what you don't know that causes you problems, it's what you know that isn't so that causes problems," often aroused curiosity in Erickson's clients and led to their exploration of the limitations they placed on themselves by maintaining a rigid view of their situation. Bandler and Grinder (1981) made reference to the same concept when they emphasized that the map is not the territory. It would seem that future studies could be designed to refine the global consideration of multi-modal imagery absorption to consider the potential of more specific aspects of this hypnotherapy technique.
The more practitioners move away from the direct authoritarian type of suggestions in hypnotherapy the less applicable measures of direct suggestibility seem to become (Barber, 1980; Wadden & Flaxman, 1981; Weitzenhoffer, 1980). The Barber Suggestibility Scale, which correlates substantially with the Stanford Hypnotic Susceptibility Scales (Ruch, Morgan & Hilgard, 1974), was not significant as a predictor of outcome in this study. It seems appropriate in future studies where indirect suggestions are used, to assess suggestibility with an instrument that utilizes indirect suggestion and multi-modal imagery.

Self-concept was not a significant predictor of outcome in this study but this result may reflect the difficulties inherent in attempting to measure such a broad concept. Possibly a more precise focus on motivation and readiness to work on personal issues would provide more valuable information. Many of the subjects seemed to enter the hypnotherapy program with a sense of dissatisfaction about their lives. They seemed to focus this sense of dissatisfaction on their obesity and therefore seemed highly motivated to alleviate the dissatisfaction. However during the treatment program many subjects discovered that their eating patterns were linked to other issues and the motivation of some began to waver. Those who were able to maintain their motivation after becoming aware of their related personal issues tended to make lifestyle choices which
included weight loss, but also included the related issues. One subject changed jobs, three went to university, one left her husband and others made less dramatic but important decisions. Many of the subjects who were unable to maintain the needed motivation to lose weight seemed to be using obesity as a defence mechanism that shielded them from issues they were not ready to confront. This lack of readiness seemed to undermine the initial motivation that was focused exclusively on obesity. There is no evidence that obese people have more psychological problems than the general population (Rand & Stunkard, 1977), which leads the researcher to tentatively conclude that motivation is a key issue in the success or failure of people who attempt to lose weight.

Assessing the families of origin does not, it would appear, provide a sufficient picture of how well the subjects have coped with personal problems that may have their roots in the family of origin. As the case studies illustrate, some subjects were able to experience successful weight loss even though their families of origin were lacking in many of the qualities usually found in harmonious families. Whereas many subjects who reported current unresolved issues also reported dissatisfaction with their families of origin, some subjects came from positive family situations and experienced relationship problems in later
life which seemed to correspond to obesity onset. The case studies seem to illustrate the need to assess the current status of the subjects' emotional life and lend support to Erickson's (1976) belief that hypnotherapy, like most forms of therapy, is most effective when applied within the context of each subject's unique life situation. As was mentioned earlier, this observation leads to the implication that a group approach can be effective for some subjects but others may need a more open-ended, intensive one-to-one approach.

Education level and family income were not significant variables in this study but the case studies illustrate that among the five very successful subjects described, the income level was high and the education level was high. These subjects had all experienced considerable successes in their lives. If education level and income reflect a form of personal motivation then, along with readiness to work on personal related issues and the personal desire to be slim, these two variables may provide useful predictive data in future studies.

**Future Research**

It seems that the most obvious limitation of this study is that it was conducted with female subjects only. This situation tends to reflect the trend in studies on hypnosis and obesity (Mott & Roberts, 1979). Possibly
men are less willing to participate in weight loss studies or maybe they are less concerned about their weight loss. However since all of the findings and implications of this study are based on a sample of women, a global recommendation for future research which includes men is in order.

As was previously mentioned, the importance of absorption in multi-modal imagery requires further study for verification of its influence among successful subjects and for a more detailed analysis of its application. The Ericksonian approach to hypnotherapy has become very popular in the clinical setting but controlled research studies designed to evaluate the potential impact of specific imagery activities and the manipulation of the subject's representational systems is just beginning.

Because indirect suggestion is becoming more prominent in hypnotherapy, there is a need to develop reliable measures of suggestibility that reflect the indirect approach.

It seems important to consider, in future studies, ways of maximizing the benefits of a group format. Criteria need to be developed to assist in the determination of the appropriateness of group therapy or individual therapy for a given subject. The findings of this study have provided some initial implications for such a differentiation but further research is needed to crystalize the issues.
Perhaps it is a mistake to continue using normative designs in research on hypnotherapy and obesity. A normative design implies the equality of subjects and of variables. Statistical significance was shown for the hypnotherapy treatment but there was practical significance for only a minority of the subjects. Since each subject is an active information processing organism it is difficult to be specific about what worked for whom. It is also difficult to assess with a broad measure such as age of onset or Family or Origin what specific issues are related to obesity for individual subjects. Future research in this field may best progress if the single case design is used. In this way the hypnotherapy can be tailored to the individual needs of each subject and knowledge can build case by case.

Mott and Roberts (1979) concluded that research on hypnotherapy and obesity is only in the preliminary stages. The present study has provided some directions for the expansion of knowledge in this field.
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APPENDIX A

The Barber Suggestibility Scale
The Barber Suggestibility Scale

The BSS can be administered under a variety of experimental conditions: with and without Hypnotic Induction, with and without Task Motivational Instructions, by means of a tape-recording or by oral presentation. Generally the scale has been administered to subjects with their eyes closed.

Eight Test Suggestions

1. Arm Lowering. "Hold your right arm straight out in front of you like this." (Guide the subject to extend the right arm directly in front of body at shoulder height and parallel to the floor.) "Concentrate on your arm and listen to me."

   (Begin timing) "Imagine that your right arm is feeling heavier and heavier, and that it's moving down and down. It's becoming heavier and heavier and moving down and down. It weighs a ton! It's getting heavier and heavier. It's moving down and down, more and more, coming down and down, more and more; it's heavier and heavier, coming down and down, more and more, more and more." (End 30 seconds)

   "You can relax your arm now." (If necessary, ask the subject to lower the right arm.)

   Objective score criterion: 1 point for response of 4 inches or more. (Response is measured by placing a ruler
near the subject's hand at the beginning of the suggestions and noting degree of displacement at the end of the 30-second suggestion period.)

2. Arm Leviation. "Keep your eyes closed and put your left arm straight out in front of you in the same way. Concentrate on your arm and listen to me."

(Begin timing) "Imagine that the arm is becoming lighter and lighter, that it's moving up and up. It feels as if it doesn't have any weight at all, and it's moving up and up, more and more. It's as light as a feather, it's weightless and rising in the air. It's lighter and lighter, rising and lifting more and more. It's lighter and lighter and moving up and up. It doesn't have any weight at all and it's moving up and up, more and more. It's lighter and lighter, moving up and up, more and more, higher and higher."

(end 30 seconds)

"You can relax your arm now." (If necessary, ask the subject to lower the arm.)

3. Hand Lock. "Keep your eyes closed. Clasp your hands together tightly, and interlace the fingers." (If necessary, the experimenter states, "Press your hands together, with palms touching," and assists the subject to interlock the fingers and to bring the palms together.) "Put them in your lap. Concentrate on your hands and hold them together as tightly as you can."

(Begin timing) "Imagine that your hands are two pieces of steel that are welded together so that it's
impossible to get them apart. They're stuck, they're welded, they're clamped. When I ask you to pull your hands apart, they'll be stuck and they won't come apart no matter how hard you try. They're stuck together; they're two pieces of steel welded together. You feel as if your fingers are clamped in a vise. Your hands are hard, solid, rigid! The harder you try to pull them apart the more they will stick together! It's impossible to pull your hands apart! The more you try the more difficult it will become. Try, you can't." (end 45 seconds)

(5 second pause) "Try harder, you can't." (10 second pause) "You can unclasp your hands now."

Objective score criteria: 1/2 point for incomplete separation of the hands after 5 second effort; 1 point for incomplete separation after 15 second effort.

4. Thirst Hallucination. "Keep your eyes closed." (Begin timing) "Imagine that you've just finished a long, long walk in the hot sun. You've been in the hot sun for hours, and for all that time you haven't had a drink of water. You've never been so thirsty in your life. You feel thirstier and thirstier. Your mouth is parched, your lips are dry, your throat is dry. You have to keep swallowing and swallowing. You need to moisten your lips. (3 second pause) You feel thirstier and thirstier, drier and drier. Thirstier and thirstier, dry and thirsty. You're very very thirsty! Dry and thirsty! Dry and thirsty!" (End 45
"Now, imagine drinking a cool, refreshing glass of water." (5 second pause)

Objective score criteria: 1/2 point if the subject shows swallowing, moistening of lips, or marked mouth movements; additional 1/2 point if the subject indicates during the "post-experimental" questioning that he or she became thirsty during this test (e.g., "I felt dry." "I was parched." "I felt somewhat thirsty."). (See "postexperimental" questions for final scoring criteria on this test.)

5. Verbal Inhibition. "Keep your eyes closed." (Begin timing) "Imagine that the muscles in your throat and jaw are solid and rigid, as if they're made of steel. They're so solid and so rigid, that you can't speak. Every muscle in your throat and mouth is so tight and so rigid that you can't say your name. The harder you try to say your name the harder it becomes. You can't talk! Your larynx has tightened up; your throat and jaw feel as if they are in a vise. Your throat is clamped so tightly that you can't talk; you can't say your name. The harder you try the harder it will be. "It's useless, the words won't come out; you can't speak your name; it's impossible to talk! The harder you try to say your name the harder it will become. Try, you can't!" (End 45 seconds)

(5 second pause) "Try harder; you can't." (10 second pause) "You can say your name now."

Objective score criteria: 1/2 point if the subject does not say name after 5 second effort; 1 point if subject
does not say name after 15 second effort.


(Begin timing) "Imagine that for years and years you've been sitting in that chair just as you are now. Imagine that you've been sitting in that chair so long that you're stuck to it! It's as if you're part of the chair. Your whole body is heavy, rigid, solid and you weigh a ton. You're so heavy that you can't budge yourself. It's impossible for you to stand up, you're stuck right there! Your body has become part of the chair. When I ask you to stand up you won't be able to do it! You're stuck tight. The harder you try the tighter you'll be stuck and you won't be able to get up. You're heavy in the chair! Stuck in the chair you can't stand up. You're so heavy and stuck so tight. You can't stand up and you're stuck. Try you can't." (End 45 seconds)

(5 second pause) "Try harder, you can't." (10 second pause) "You can relax (or sit down) now."

(The subject is considered not standing if he or she rises slightly from the chair without straightening into an erect posture. In this event, the experimenter says, "Try to stand fully erect. You can't", instead of "Try harder, you can't").

Objective score criteria: 1/2 point if the subject is not standing fully erect after 5 second effort. 1 point if not standing fully erect after 15 second effort.
7. "Posthypnotic-like Response" (The auditory stimulus consists of tapping once on the metal back of a stop watch with a fountain pen). (Begin timing) "When this experiment is over in a few minutes and your eyes are open, I'll click like this (experimenter presents auditory stimulus) and you'll cough automatically. At the moment I click (experimenter presents stimulus). You'll cough. It will happen automatically. When I click like this (stimulus is presented) you'll cough immediately. I'll click and you'll cough. When your eyes are open, I'll click (stimulus is presented) and you'll cough. When I click you'll cough."

(End 30 seconds)

Objective score criterion: 1 point if the subject coughs or clears throat "postexperimentally" when presented with the auditory stimulus.

8. Selective Amnesia. "Your eyes are still closed but I'm going to ask you to open them in a minute. When they're open I'm going to ask you to tell me about these tests." (Begin timing) "You'll remember all the tests and be able to tell me about them, all except for one. There's one that you'll completely forget about as if it never happened! That's the one where I said your arm was becoming lighter and moving up and up. You'll forget all about that and when you try to think about it, it will slip even further away from your mind. You will forget completely that I told you that your arm was becoming lighter. This is the one test that you cannot remember! You will remember
that I said your arm was heavy and all the other tests will be perfectly clear but the harder you try to remember that I told you your arm was rising the more difficult it will become. You will not remember until I give you permission by saying, now you can remember, and then, and only then, you will remember that I said your arm was rising!" (End 45 seconds)

Objective score criterion: 1 point if the subject does not refer to the Arm Levitation item (Test-suggestion 2) but recalls at least four other items and then recalls Test-suggestion 2 in response to the cue words.

"Postexperimental" Objective Scoring of Test-suggestions 4, 7, and 8

"Open your eyes, the experiment is over."

Scoring of Test-suggestion 7. The "Posthypnotic-like" Response item (item 7) is scored at this point. The experimenter presents the auditory stimulus after the subject has opened his or her eyes and before conversation commences.

Scoring of Test-suggestion 8. The experimenter next asks: "How many of the tests can you remember?"

The experimenter prompts the subject by asking, "Were there any others?" "Can you think of any more?" and "Is that all?," until the subject mentions at least four of the test-suggestions. If the subject verbalizes the Arm Levitation item during the recital, he or she receives a
score of zero on Test-suggestion 8 (Selective Amnesia). If the subject does not include the Arm Levitation item in the enumeration, the experimenter finally states, "Now you can remember," and, if the subject still does not verbalize the Arm Levitation item, "You can remember perfectly well now!"

The subject receives a score of 1 point on Test-suggestion 8 (Selective Amnesia) if he or she mentions at least four of the test-suggestions, but does not mention the Arm Levitation item before given the cue words, and verbalizes the Arm Levitation item when given the cue words. "Now you can remember," or "You can remember perfectly well now!"

Final scoring of Test-suggestion 4. The objective scoring of Test-suggestion 4 is completed when the subject refers to this item during the recital. At this point the experimenter asks: "Did you become thirsty during this test?" If the subject answers, "Yes" to this question he or she receives the additional 1/2 point on Item 4. If the subject answers, "Yes" but adds a qualifying statement, e.g., "I had been thirsty to begin with," he or she is asked: "Did the imaginary glass of water help quench your thirst?" If the subject now answers, "Yes" he or she receives the additional 1/2 point.

The maximum objective score obtainable on the BSS is 8 points.

"Revised" Subjective Scores

After objective scores have been assigned, the
subject is given a mimeographed questionnaire which assess subjective responses to the BSS and is worded thus:

Please answer the following questions truthfully. Place a check mark above the most accurate answer.

1. When it was suggested that your right arm was heavy and was moving down, the arm felt: not heavy; slightly heavy; heavy; very heavy.

2. When it was suggested that your left arm was light and was moving up, the arm felt: not light; slightly light; light; very light.

3. When it was suggested that your hands were stuck together and you wouldn't take them apart, the hands felt: not stuck; slightly stuck; stuck; very stuck.

4. When it was suggested that you felt thirsty, you felt: not thirsty; slightly thirsty; very thirsty.

5. When it was suggested that your throat was stuck and you couldn't speak, your throat felt: not stuck; slightly stuck; stuck; very stuck.

6. When it was suggested that you were stuck to the chair, you felt: not stuck; slightly stuck; stuck; very stuck.

7. When the experiment was over the experimenter clicked his fingers (presented the posthypnotic cue), you felt: not like coughing; slightly like coughing; like coughing; very much like coughing.

8. When the experiment was over and you were recalling the tests, you felt that you remembered the test
about the arm rising (the test S was told to forget): with no difficulty; with slight difficulty; with difficulty; with great difficulty (or did not remember at all).

Each of the above eight items receives a score of 0 to 3; 0 for the first answer ("not"), 1 for the second ("slightly"), and so on. The total Subjective scores on the eight items thus range from 0 to 24.
APPENDIX B

The Tennessee Self Concept Scale
Sample Questions
<table>
<thead>
<tr>
<th>Item No.</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have a healthy body.</td>
</tr>
<tr>
<td>3</td>
<td>I am an attractive person.</td>
</tr>
<tr>
<td>5</td>
<td>I consider myself a sloppy person.</td>
</tr>
<tr>
<td>19</td>
<td>I am a decent sort of person.</td>
</tr>
<tr>
<td>21</td>
<td>I am an honest person.</td>
</tr>
<tr>
<td>23</td>
<td>I am a bad person.</td>
</tr>
<tr>
<td>37</td>
<td>I am a cheerful person.</td>
</tr>
<tr>
<td>39</td>
<td>I am a calm and easy going person.</td>
</tr>
<tr>
<td>41</td>
<td>I am a nobody.</td>
</tr>
<tr>
<td>55</td>
<td>I have a family that would always help me in any kind of trouble.</td>
</tr>
<tr>
<td>57</td>
<td>I am a member of a happy family.</td>
</tr>
<tr>
<td>59</td>
<td>My friends have no confidence in me.</td>
</tr>
<tr>
<td>73</td>
<td>I am a friendly person.</td>
</tr>
<tr>
<td>75</td>
<td>I am popular with men.</td>
</tr>
<tr>
<td>77</td>
<td>I am not interested in what other people do.</td>
</tr>
<tr>
<td>91</td>
<td>I do not always tell the truth.</td>
</tr>
<tr>
<td>93</td>
<td>I get angry sometimes.</td>
</tr>
</tbody>
</table>

Responses: Completely False 1 Mostly False 2 Partly False & Partly True 3 Mostly True 4 Completely True 5
<table>
<thead>
<tr>
<th>Item No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>I like to look nice and neat all the time</td>
</tr>
<tr>
<td>4</td>
<td>I am full of aches and pains</td>
</tr>
<tr>
<td>6</td>
<td>I am a sick person</td>
</tr>
<tr>
<td>20</td>
<td>I am a religious person</td>
</tr>
<tr>
<td>22</td>
<td>I am a moral failure</td>
</tr>
<tr>
<td>24</td>
<td>I am a morally weak person</td>
</tr>
<tr>
<td>38</td>
<td>I have a lot of self-control</td>
</tr>
<tr>
<td>40</td>
<td>I am a hateful person</td>
</tr>
<tr>
<td>42</td>
<td>I am losing my mind</td>
</tr>
<tr>
<td>56</td>
<td>I am an important person to my friends and family</td>
</tr>
<tr>
<td>58</td>
<td>I am not loved by my family</td>
</tr>
<tr>
<td>60</td>
<td>I feel that my family doesn't trust me</td>
</tr>
<tr>
<td>74</td>
<td>I am popular with women</td>
</tr>
<tr>
<td>76</td>
<td>I am mad at the whole world</td>
</tr>
<tr>
<td>78</td>
<td>I am hard to be friendly with</td>
</tr>
<tr>
<td>92</td>
<td>Once in a while I think of things too bad to talk about</td>
</tr>
<tr>
<td>94</td>
<td>Sometimes, when I am not feeling well, I am cross</td>
</tr>
</tbody>
</table>

Responses:

<table>
<thead>
<tr>
<th>Completely False</th>
<th>Mostly False</th>
<th>Partly False &amp; True</th>
<th>Mostly True</th>
<th>Completely True</th>
</tr>
</thead>
</table>
APPENDIX C

Family History of Distress Scale
### NAME

Please circle the appropriate response for each of the following items:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I had a very happy home life.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>2.</td>
<td>My childhood was probably happier than most.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>3.</td>
<td>I had a very unhappy childhood.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>4.</td>
<td>My parents really never understood me.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>5.</td>
<td>I was very anxious, as a young person to get away from my family.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>6.</td>
<td>Before marrying, I was quite eager to leave home.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>7.</td>
<td>The members of my family were always very close to each other.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>8.</td>
<td>My parent's marriage would be a good example to follow for any married couple</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>9.</td>
<td>My parent's marriage was happier than most</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>10.</td>
<td>My parent's had very few quarrels.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>11.</td>
<td>My parent's didn't communicate with each other as well as they should have.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>12.</td>
<td>I often wondered whether my parent's marriage would end in divorce.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>13.</td>
<td>My parent's loved each other.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>14.</td>
<td>All the marriages on my side of the family appear to be quite meaningful.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>15.</td>
<td>I hope my marriage turns out (or has turned out) better than the marriages of some of my relatives.</td>
<td>T</td>
<td>F</td>
</tr>
</tbody>
</table>
APPENDIX D

Representational Systems Inventory
People experience altered states of consciousness through the five senses, or representational systems. These systems are: visual, auditory, kinesthetic (feeling), olfactory (smell), and gustatory (taste).

For each of the following statements please indicate, by circling the appropriate number, the response which best represents your experience in the following imagery exercises.
Coat Imagery:

1. I was able to experience visual images in this activity. 1 2 3 4
2. I was able to visualize a coat in this activity. 1 2 3 4
3. I was able to recognize colors in this activity. 1 2 3 4
4. I was able to visualize other people in this activity. 1 2 3 4
5. I was able to feel the texture of the coat in this activity. 1 2 3 4
6. I was aware of verbal responses of some of the other people in this activity. 1 2 3 4
7. I was aware of my emotional responses in this activity. 1 2 3 4
8. I was aware of my emotional response as I sought to remove the coat. 1 2 3 4
9. I was aware of the response of some members of the audience as I sought to remove my coat. 1 2 3 4
10. I found that I became quite absorbed in my experiences during the coat imagery exercise 1 2 3 4

Sub Total
Mirror Imagery:

1. I was able to experience visual images in this activity.  
   Responses: 1 2 3 4

2. I was able to visualize a full-length mirror in this activity  
   Responses: 1 2 3 4

3. I was able to visualize my body as slimmer in this activity.  
   Responses: 1 2 3 4

4. I was able to visualize other people in this activity.  
   Responses: 1 2 3 4

5. I was able to recognize colors in this activity  
   Responses: 1 2 3 4

6. I was aware of verbal responses of some of the other people in this activity.  
   Responses: 1 2 3 4

7. I was aware of my emotional responses in this activity.  
   Responses: 1 2 3 4

8. I was aware of my emotional responses as I stood before the full-length mirror in this activity.  
   Responses: 1 2 3 4

9. I was aware of the emotional responses to my slimness by some of the other people in this activity  
   Responses: 1 2 3 4

10. I found that I became quite absorbed in my experiences during the mirror imagery exercise.  
    Responses: 1 2 3 4

Sub Total
Responses: Not True Partly True Mostly True Completely True

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I was able to experience visual images in this activity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>I was able to visualize an idol (statue) in this activity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>I was able to recognize colors in this activity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>I was able to visualize the modelling clay in this activity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>I was able to feel the texture of the modelling clay in this activity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>I was aware of my emotional responses in this activity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>I was aware of my emotional responses as I sought to construct a new statue in this activity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>I was aware of my emotional responses as I sought to construct a favorable statue of me in this activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>I felt that I would be able to protect my newly created statue in this activity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>I found that I became quite absorbed in my experiences during the idol (statue) imagery exercise.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Sub Total

Total Score
APPENDIX E

Hypnosis Curriculum
CONCEPTUAL FRAMEWORK

Initial weight loss does not seem to be the major problem for most overweight people. The maintenance of weight loss is a much more serious problem. It seems that there is something which makes it more advantageous for some people to be overweight than to be slim. The choices that they have available for coping with life seem functional if they are overweight but not if they are slim. If one accepts the premises that everyone does the best he/she can with the choices that he/she currently has available then it follows that a successful weight-loss program should provide a means of identifying what being overweight does for a person, help that person generate other choices and assist that person to develop ways of implementing alternative choices. Since the motivational factors for being overweight are often unconscious a hypnotherapy program designed to uncover these unconscious factors, to facilitate the development of alternatives and to learn acceptable means of implementing these alternatives seems plausible.

The hypnotherapy program that follows is designed to meet the objectives outlined above. There are a total of ten three hour sessions with groups of six to eight women in each group. The total number of subjects is forty and there is a control group of twenty women. The subjects are randomly assigned to each of the two treatment groups and
the control group as they respond to the newspaper advertisements. To maintain workable groups the program is repeated with treatment groups of six to eight subjects until the total of twenty subjects for each group is completed. The control group constitutes a wait list and receives no treatment until the six month follow-up period is over.

**HYPNOTHERAPY PROGRAM FOR WEIGHT LOSS**

**Session One:**

In this introductory session the subjects receive name tags, calorie sheets that indicate the calories in the more common foods and some basic nutrition pamphlets that describe the basic aspects of a healthy nutritional lifestyle. The subjects then fill in the intake forms including initial height and weight data. The consent forms are explained and completed by the subjects and the medical certificates are collected. The subjects are then asked to complete the pre-tests with the Barber Suggestibility Scale being done individually while the other subjects are completing the written tests.

The remainder of this session is devoted to introductions among the group members and an introduction to the group leader. The group leader provides a basic description
of the program providing suggestions of probable positive outcomes when applicable.

Session Two:

This session is devoted to an introduction to hypnosis. The myths, misunderstandings and basic concepts of hypnosis are discussed and each subject receives a one hour tape recording that describes the basic principles of hypnosis with an emphasis on the skills involved in learning self-hypnosis.

1. Without informing the group that a hypnosis induction is beginning, the subjects are introduced to a "yes set". They are asked to become comfortable, to place both feet on the floor, to rest a hand on each leg and to imagine how pleasant and comfortable it is to listen to a story that most of them may have heard many years ago. They are casually reminded that sometimes it is really comfortable to listen to stories with the eyes closed. They are told the story of the sun and the wind who had a contest to see which of them could get a traveller on the road below to remove her coat. The basic message of this story, told slowly and with indirect suggestions for becoming more and more comfortable, is that a warm and positive approach to a problem is more effective than a forceful method. When the traveller has removed her coat she can pause under a tree by the side of the road and enjoy the visual aspects of the
sky, countryside, and general surroundings. This traveller can then learn to enjoy her auditory senses as she listens to the sounds of the breeze in the trees and grass and the distant sounds of the country-side. The olfactory senses can be activated as it is suggested that she can become aware of the smells of the grass and flowers. Finally the kinesthetic aspect of the experience can be suggested as she becomes aware of her feelings of comfort and contentment.

This initial introduction to an altered state of awareness tends to minimize resistance since there is no direct statement that hypnosis is beginning. It also serves as a method of activating the major communication modes that people have available to them and it gives the group the suggestion that the therapist will be using the sun approach rather than that of the wind. The suggestion is then given that the group can return to the present in comfort and in their own time.

2. When everyone has reoriented, the group is given the opportunity to discuss their experiences and comment on what they assume took place. Many questions will arise from those who were pleased with their surprising experience and from those who found it difficult to participate in this activity.

One of the primary goals of this second session is to facilitate an altered state of the consciousness for each group member so that she will know that hypnosis is a learned
skill and resides in the subject rather than the therapist. Demonstrations with individual group members are provided to illustrate various induction methods so that those who are having difficulty or who doubt their experiences can gain some assurance that they, like everyone, are able to experience an altered state of consciousness. A traditional induction is demonstrated using the steps of focusing on a spot, eye closure, systematic relaxation and count out. A confusion induction is demonstrated as are the principles of indirect suggestion.

3. When it becomes apparent that all group members have been able to experience some degree of an altered state, a group induction is utilized to introduce the possibility of unconscious issues related to weight problems. This activity is a form of projective test since the suggestions are permissive and it also heightens the skills of imagery development. The group is asked to relax and if necessary, only pretend to be in hypnosis. Pretending reduces resistance and provides the opportunity for induction. The group is then asked to imagine standing in front of a house ... any house ... (they usually choose a house of significance to them). They are asked to notice if there is a sidewalk leading up to the house ... are there any trees around the house ... is there a lawn ... notice the roof of the house ... is it painted ... is there one chimney or more than one ... is the house made of brick ... wood or some
other material. This activity is continued so that the subjects will become familiar with noticing details. They are then taken into the house and through the same permissive method, they are guided through the various rooms. It is suggested that sometimes they may find that they are in more than one house (this accommodates any variability in the experience they have - e.g., possibly the house chosen by a subject has no basement). They are asked to notice if anyone is present in the house and if anything ever occurred there that might in any way be associated with their weight. They are asked to find an old trunk containing objects long forgotten and finally a letter addressed to them. They are asked to read the letter and return when ready. Indirect suggestions about trusting the unconscious and learning are incorporated into this activity as it progresses.

4. When everyone has returned to a conscious state a discussion develops around their experiences. Sometimes some subjects experience emotion laden issues and the therapist allows individuals to spend as long as necessary to discuss what they wish of these experiences. The term "injunction" is introduced and explained during the discussion period and the idea that, in some cases, there may be unconscious reasons for weight problems is discussed.

5. When everyone has had an opportunity to express themselves about the previous experience the concept of ideomotor response is introduced. Ideomotor response is an
unconscious nonverbal signal that is utilized to communicate with a subject in an altered state of consciousness. Dr. David Cheek used finger signals: a specific finger for "yes", another for "no", another for "I don't know", and another for "I don't want to answer". Milton Erickson and Bandler and Grinder use whatever signal the subject presents to represent yes or no. It is best to use the signal presented by the subject. A volunteer from the group who has consistently responded well to suggestions is used to demonstrate this skill to the other group members. If time permits each subject will be given the opportunity to develop ideomotor responses in this session and if there is not enough time it will be continued in session three.

Session Three:

This session begins with each member stepping on the scale to note weight loss. This is not recorded by the therapist but is used as a motivational factor for each subject. The group is then given an opportunity to discuss their progress since the previous week and to discuss any issues that may have arisen. If there are some subjects who have not yet had an opportunity to develop ideomotor responses that exercise is completed at this time and the ideomotor responses will be used with the subjects throughout the sessions.
1. A group induction is done to get everyone into an altered state in preparation for the activities of this session. An Ericksonian model is used to illustrate that each person is unique and will respond to suggestions in her own way. The model of a multiple grade classroom is used with examples of how the children in one grade often learned material designed for another grade. An illustration is then presented of what could be learned inadvertently when the story of the ugly duckling is told to one grade and overheard by some members of another grade. Again using Ericksonian methods, the following type of indirect suggestions is used to conclude this activity.

I don't know ... in which way ... you will respond to suggestions for weight loss ... and I don't know ... which suggestions ... you will accept ... and comfortably ... and consistently ... enjoy becoming slimmer ... but you can be curious ... and wonder about ... how ... your unconscious will help you reach your goal.

Without comment the therapist now briefly discusses the benefits of moderate exercise as a valuable tool in weight loss and maintenance. Turning attention to another issue tends to prevent the conscious analysis of indirect suggestion thereby increasing the probability of at least partial amnesia for those suggestions. Prior to bringing the subjects back from an altered state of consciousness they are asked to be curious about false pregnancy. Following
the count out they tend to discuss how the unconscious can produce the symptoms of pregnancy which implies that the unconscious can do many things including bringing about some physiological changes.

2. At this point the group has been prepared, through the learning as others learn analogy, to begin work with ideomotor responses. The therapist seeks a volunteer so that those who may not yet be ready for this activity have the option of holding back. The volunteer is inducted and her ideomotor responses are clarified. It is then possible to determine, through the unconscious yes or no responses, if there is an underlying issue or issues associated with this person's obesity. If the responses indicate that underlying issues do exist then the subject is asked, in trance, if it is acceptable to go to the most important of those issues now. If a no response is given it is suggested that when the subject is ready, next session or next week, the important issues can be identified. If a yes response is given, as it usually is, the person can be guided to the issue by asking ... is it before you are 30 ... is it before you are 25 ... until the time period is identified. The subject is then asked to do an unconscious search in that year and when the issue is identified to indicate with the yes finger. Often some verbal or nonverbal response takes place as the yes finger responds. This is often an emotion laden experience for the subject and if it
seems too powerful the subject can be gently pulled back by suggestion and then asked, in trance, if it is acceptable to watch what occurs in this situation as if it was on a movie or T.V. screen. The emotional response is called an abre- action and the method of placing the whole activity on a screen or stage is called dissociation. The therapist must accommodate the needs of the subject and therefore time must be provided for the client to discuss, out of trance whatever she chooses about this experience. While in trance the subject is also asked, at the appropriate time, if it is acceptable to let go of the issue that has been related to her weight. If it is, fine, if not further work will be necessary.

The time that each individual requires for this activity will determine how many subjects can be accommodated in this session. All subjects will experience this activity at least once during the program.

3. The group is now asked to participate in a group induction. Preinduction comments are made concerning the burden aspect of excess weight and how very pleasant it feels in the Spring to remove ones coat and move more freely.

In this activity when everyone is inducted the subjects are asked to imagine a coat that they are wearing. The same type of permissive suggestions are provided as were used in the house imagery. You can notice the color of the
coat, the material ... the collar, is it a high collar ... is it tight or loose at the neck. I don't know if it has buttons, a zipper, or some other means of closing and opening. The therapist provides considerable permissive detail about the weight, length, feelings inside the coat and finally asks the subjects to imagine removing the coat in front of the important people in their lives. Included among these people may be father, mother, spouse, children, friends and lovers. The subjects are asked to be aware of the feelings they experience in their efforts to remove the coat and to allow into awareness any particular factors that may make removal difficult or impossible. Who most supports your efforts, is another good question to ask. The group is then counted back and a discussion of experiences is held. Ideomotor response can be used for any individual who may be unsure of the relationship of the coat and her weight. Experience indicates that those who are unable to remove the coat need some specific work with their issues.

4. The subjects are now paired off and asked to follow a simple set of instructions for inductions with each other. This is the first phase of teaching self-hypnosis and is designed to increase the confidence of the subjects that they will be able to do self-hypnosis if they can induct another person. Since all hypnosis is self-hypnosis, their lack of skill is no problem when they follow the simple instructions. This activity is not used with the
treatment group that receives weight-loss audio tapes. The therapist monitors the progress of the dyads and a discussion is held upon completion of the activity about what was successful and what wasn't. The subjects are asked to practice simple inductions at home with suggestions of comfort, confidence, and relaxation prior to the next session.

Session Four:

1. Following the usual opening discussion about the weight related experiences of the subjects since the last session the group is inducted and asked to experience the following imagery. Again the imagery is permissive. The group members are asked to imagine sometime in the future when they have reached their ideal weight. They are asked to imagine a full-length mirror in their home, or wherever they choose. They can stand before this mirror without clothing and then with clothing. They are asked to pay close attention to the details of body image and to take note of their feelings. Do they feel proud ... confident ... or do they have some other feeling. They are asked, after reasonable time for the development of details of body imagery, to notice the scale beside the mirror, to stand on it and to read the number representing their weight. While standing on the scale they are asked to notice the calendar on the wall and to note the month and year. They are then asked to move to the living room wearing whatever flattering
clothing they wish and to act as hostess to the important people in their lives. They are asked to note carefully the response of their guests to the new body image and the more confident outgoing personality that they have acquired. They are also asked to attend to their own feelings and responses as they become aware of the reactions of individuals who, past and present, play an important role in their lives.

This activity, like the coat activity, is a form of evaluation of how well each subject can perceive herself as slimmer and it includes some indirect suggestions for slimness, confidence and pride. Each subject is asked to count herself out of trance when she has completed this activity. This provides individual completion time and some practice with an element of self-hypnosis.

2. The group is now given the opportunity to discuss their experiences through and with the therapist which leads to the resumption of work with ideomotor responses with subjects who experienced some difficulty with the slimness imagery. Appropriate time must be allowed for the exploratory work with ideomotor response.

3. The group is now given an opportunity to practice self-hypnosis. Various induction methods are discussed and the subjects are encouraged to experiment and discover which method is best for each of them. It is suggested that they practice becoming aware of visual,
olfactory, auditory and kinesthetic sensations as part of the induction process. Each subject is asked to choose a personally pleasant place and time and to experience an enjoyable activity to perform, at the weight and body image that they have set as their goal. They are then asked to count themselves back feeling alert, wide-awake and refreshed. A discussion of experiences follows with the therapist providing encouragement and positive expectations of future enhancement of this skill.

4. The final induction of this session is designed to incorporate weight loss suggestions, ego enhancement and to promote future unconscious learning. Following the induction, references are made to the manner in which the unconscious can allow information and learning into awareness through daydreams and dreams at night. The subjects are asked to be curious about the manner in which their unconscious will provide the confidence and motivation for continued weight loss. The subjects are asked to focus on a fishing boat that has lines running from the front, the sides and the back of the boat. Some of these lines are at minimal depth, some are deeper and some are very deep. They can be curious about what interesting things can be brought to the surface and digested. This analogy is designed to promote continued work on the weight issue between sessions.
Session Five:

This session begins with each subject stepping on the scale to measure their own progress. The progress or difficulties of the past two weeks are discussed.

1. The focus of this session is upon the polar aspect of gaining and losing weight. Since most of the subjects have lost and gained weight in the past the subjects will be asked to consider the factors involved at both poles.

An Ericksonian induction is used to introduce the first activity of this session.

"I am going to ask you to do only the things that are actually possible for you to do. You know how to move and you know how not to move. You can lower your blood pressure but you don't know how you do that ... and you can alter your breathing but you don't really know how you do that; but all of the things that I ask you to do, every one of them, will be within the range of your experience and I will ask you to do only the things I know you can do. First of all I want you to enjoy being very comfortable. You can enjoy yourself so much that you can let your unconscious mind listen to me while your conscious mind can busy itself with thoughts far removed from this room.

Now I would like to explain something to you. When you first went to school you learned to recognize numbers and letters; you didn't know at the time that you were learning those numbers and letters for all the rest of your life.
You learned what a three looked like and what a nine looked like. You formed a mental picture of those numbers. You learned to form a visual mental picture of each letter of the alphabet without thinking about the fact that you would keep that visual image all the rest of your life.

You can do many things as you have both your conscious and unconscious resources to draw upon. You can be curious now as you notice that door off to your right and wonder what kind of room it opens into. You can notice the door knob and I don't know if it is brass or glass or some other material but when you open that door and step into that room you can be surprised. You can open it now and step in noticing that the walls, the floor and the ceiling are covered with mirrors. You can see yourself from the top, from each side and from the bottom. One particular mirror reflects you as you were before you started to lose weight. Notice how you looked ... moved ... felt ... at that weight. Another mirror reflects you as you are. Notice your progress. Is it acceptable to take credit for the progress you have made? You can be proud of your efforts. Another mirror reflects you as you will be when you reach your goal. Notice your pride in your body. Notice your confidence of movement. Allow that image and those feelings to develop clearly in your mind so that visual image will be part of you all the rest of your life. Step into that ideal body image for a few moments now. Appreciate the difference from the first image. You can
imprint this body image and its accompanying sense of well being into your unconscious like a guiding beacon and I don't know if this beacon will lead you to diet, nutrition, exercise or all three. I wonder if this beacon will guide you to your goal within three months or maybe it will take nine months. The group is then asked to be curious about time, and to wonder how long they have been comfortable. They are gently counted out of trance and talk about the varied estimations of how much time has passed in this activity. Distracting attention from the trance activity is an Ericksonian indirect method of producing some amnesia for the trance activity.

2. A discussion is now lead by the therapist on unconscious learning. It is pointed out that a person can learn many things unconsciously that often do not make sense consciously. A phobia is mentioned as an example of how the unconscious, in an effort to protect a person, responds to a situation such as an elevator, with a feeling of intense anxiety that seems disproportionate to the situation. The unconscious seems to respond with what Orne called "trance logic" in that rational analysis of the fear may do little to alleviate the fear if the unconscious feels that the fear is needed for protection.

The two-chair method is used with individual subjects to demonstrate this phenomenon. The chairs are placed at the front of the room. One chair represents the
overweight aspect of the subject and the other chair represents the subject when she is slim. The subject is inducted and through ideomotor response her feelings and reasons for being overweight are sought. In the other chair, again through ideomotor response, the subject is asked to explore the consequences and feelings associated with being slim. The concept of integration is eventually explored in trance to see if the unconscious will agree to an alternative means of meeting the subject's needs.

This activity will vary in the time required from subject to subject and is used with each subject when the subjects express readiness.

3. The group is now given the opportunity to discuss self-hypnosis and how one gives suggestions in self-hypnosis. The therapist points out that the least effective means is by direct suggestion. The subjects are instructed in a relatively simple form of indirect suggestion whereby they experience whatever activity they wish in hypnosis but do it at their desired weight and body image. In this way they can enjoy a form of role rehearsal and at the same time evaluate various lifestyle alternatives. Practice time is provided and additional encouragement to use self-hypnosis on a regular basis is given.
Session Six:

1. Following the discussion of progress and experience since the last session the group is inducted and offered another permissive imagery activity that focuses on efforts for personal kindness and attention. As part of the induction the term self-sacrifice is introduced. The subjects are asked to consider the various meanings of self-sacrifice: kindness to others, never saying no, being constantly busy. Sacrifice of self is interchanged with self-sacrifice to make the point that one can even sacrifice one's health, appearance and esteem. Reference is made to sacrifices to gods and goddesses and how the fatted calf was often sacrificed to please some god or goddess.

The induction proceeds with the subjects being guided down a hillside to the bottom where they can see, on the top of an adjacent hill, idols or statues to whom they may have been sacrificing themselves. Sacrificing for others is often desirable and noble but when it means one has no time or energy to look after one's own needs then it can be a problem. The subjects are asked to climb the hill to get a closer look at the statues. They are asked to consider the sizes of the statues, how solidly built are they, how do you feel in their presence? Is it really necessary to sacrifice so much? Can you learn to sacrifice a little less and be so bold as to give some time and effort to you? After giving time for each subject to experience
this situation they are then asked to notice, off to the right, a large pile of modelling clay which they can enjoy squeezing and moulding into the replacement statue they would like. I don't know ... if ... you will make a statue of you ... or of somebody else ... but you can enjoy this constructive experience in the manner most appropriate to you. They are given some time for this activity and are then asked to notice if anyone or anything may be coming up that hill to destroy or damage what they have constructed.

The subjects are asked to consider alternatives for protecting and maintaining the image that they have created. Suggestions for confidence, optimism and motivation are provided and the subjects are asked to consider setting aside some time each day for themselves to use self-hypnosis as a means of reaching their goals.

2. When the subjects are brought out of the altered state time is provided for a discussion of their experiences and the conclusions they reach.

Some time is now provided for individual ideomotor response work with individuals who have not yet had the opportunity to explore via their nonverbal responses. For those who have made comments such as "part of me wants to lose weight and part of me seems to want to keep it on," the two chair element is used with ideomotor responses.

3. The group is again inducted and this time direct suggestions are used along with some indirect suggestions.
Suggestions are given for pairing relaxation with eating so that one can enjoy, from a gourmet perspective, the quality of nutritious food rather than quantity. Feelings of fullness and satisfaction are suggested so that one can enjoy overeating just enough nutritious food to lose one to three pounds per week. The subjects are reminded, in trance, that they can enjoy learning to use all of their resources to achieve their goal. They can use both their conscious and unconscious resources as they become aware of altered priorities and new choices for winning by losing. Suggestions are given for highly efficient digestion so that the entire fueling process from consumption to elimination is efficient and a quality activity.

As a result of the artistry of the nutrition process it is suggested that the subjects can become aware of more satisfying and rewardingly comfortable body movement and soon they will notice a change in lifestyle and growing sense of well-being. They can be pleased with that growing sense of optimism and confidence as more and more they realize that they are in charge of their bodies. They can really enjoy that sense of pride that develops as they take personal credit for continuing success.

The group is brought out of trance with another reminder to show themselves some kindness by setting aside time each day for self-hypnosis.
Session Seven:

This session begins with each subject stepping on the scale to measure their progress and then time is provided for discussion of any issues from the previous week.

1. The group is inducted via imagery designed to specifically bring into play the four modes of communication: visual, auditory, kinesthetic and olfactory. The subjects are asked, as they begin to relax, to prepare for an enjoyable, pleasant, relaxing learning experience on a Southern summer night. They are asked to imagine a Southern mansion with a large open veranda on the back which opens onto a grove of orange and lemon trees. A gravel path meanders through the grove and manicured lawns are all about. The moon is out and full, the air is warm with just a gentle breeze. Back somewhat from the mansion is a wall of rose bushes that surround a swimming pool that is only three to four feet deep, for those who may not be swimmers. The group is guided slowly through this setting experiencing sights, sounds, feelings, tastes and smells. They are then taken to the pool where they can enjoy, with or without bathing suits, floating safely and comfortably on their backs, with air mattresses if desired, and looking up into the night sky. At this point suggestions are given about wonder, learning, confidence, body image and life-style. They can wonder and learn about the past, the present and the future, and in what way they will achieve their goals.
The group is guided out of the pool, back into their clothes, back along the path to the mansion and out of trance.

2. A discussion is held about their experiences with the therapist listening for references to the acceptance of sensory suggestions. Subjects will tend to describe their experiences of tasting the fruit, smelling the flowers and feeling the water.

3. A self-hypnosis activity is now outlined whereby each subject, following self-induction, is asked to visualize herself at home before a full length mirror. The subjects are asked to look carefully and with pride at that body image and then to imagine stepping onto a scale and reading the number representing their weight. They are then asked to enjoy a shopping trip where they purchase new clothing for the new body image and new life style. It is suggested that they can consider all types of clothing from underwear to formal dress wear - all of which will reinforce the ideal body image. They are asked to be aware of any feelings of pride, excitement, pleasure or optimism as they consider clothing sizes long since considered too small for them.

4. A discussion of color choice, sizes, style and other issues is conducted. Before leaving, the group is asked to begin now to specifically set aside at least one fifteen minute period each day for self-hypnosis.
Session Eight:

The subjects are given time to bring up any problem issues or factors relating to their progress that they wish to discuss.

1. The group is inducted and it is suggested that each subject allow the images to develop of her favorite physical activity. Maybe she has not participated in this activity for years but she can be pleasantly surprised to find that she can recall the many pleasures of that activity. When each subject has her activity in mind she can indicate with her yes finger. It may be swimming, bowling, skating, walking, dancing, or some other activity. When all of the subjects have indicated a chosen activity they are guided, via the sensory modes, in experiencing the feelings of pleasure involved in their personal activity. They are asked to compare the activity as they perform it at their peak weight and at the weight they have chosen as their goal. They are asked to step into that ideal body image and now to really become aware of the ease of movement, the increased energy, the confidence and the pride they experience. Suggestions are given for an increasing interest in physical activity and it is then suggested that they might like to take some time and consider other activities they could enjoy at their goal weight. Often people tend to accept a current level of awareness as the only awareness. Providing this activity in a state of altered consciousness
can be a powerful motivator. The subjects are brought out of hypnosis with the suggestion that they may wish to use one of their desired activities as a motivational goal as they continue to grow slimmer and more healthy.

2. The group is given an opportunity to discuss their experiences and then ideomotor responses are used with those subjects who indicated adult onset of obesity on the intake forms. They are guided, through age regression to a time before the onset of obesity and then work up to the time and situation when they began to put on weight. This activity can often identify the perceived initial reason for weight gain and provide directions for making the necessary changes. Relationship issues, separation issues and punishment issues are among the experiences that may arise with this activity.

3. The group is now inducted using the imagery of a high building. The subjects are asked to leave the excitement, variety and interest of street level and to enter an elevator that will take them up. It is suggested that possibly this elevator is in some way comparable to a lifestyle that will promote weight gain. They are asked to watch the numbers pass as the elevator goes up and up. This building may be over two hundred stories high. When they reach the top they can step out of the elevator noticing how far removed they have become from the interesting activities of other people at street level. It is suggested that the
elevator only goes up and the stairs are the only way down. They are guided to the stairs and before beginning the descent they are asked to consider a few things. Once one chooses to go down there may be a temptation to bound down the stairs as quickly as possible. However, experience has taught them that such an approach to going down often results in fatigue and maybe a dangerous slip. It is suggested that they can enjoy going down one or even two stairs at a time pausing to rest on a landing when necessary. It is suggested that one way to make the descent more enjoyable is to make plans for their activities among the people at street level. They can formulate these plans and images in their minds as they continue going down with comfort and consistency. They can become so involved in these optimistic plans that going down will seem automatic just as they have often thought in the past of what they will do as they descend the stairs at home or in some other building. The unconscious maintains and directs the descent activity while the conscious is busy planning for the future.

This activity is a form of indirect suggestion and is based on an experience that all subjects can relate to because they have all gone down stairs while thinking of something else. It is suggested that the subject take as long as necessary to complete their learning in this activity and then count themselves back.
4. Prior to the end of this session a little time is taken to encourage and congratulate the subjects on their efforts to date. Since there are only two sessions left some group members may begin to feel a little anxiety about being able to continue losing weight following the last session.

Session Nine:

Time is provided to weigh in and to discuss any concerns or issues before starting the formal aspect of the session.

1. A group induction is introduced with some comments about learning and behaving. Obese subjects often comment on what they call the lack of will power and what seems to be automatic eating behavior. The group is asked to become comfortable, to remember that pleasant, deep, relaxing state which they have now entered numerous times and they are asked, when everyone is clearly induced, to listen to the therapist's voice. With the appropriate voice tone and pace, the subjects are reminded that in the past they have attempted to starve themselves into reducing body weight resulting in tension, anxiety, frustration and the eventual cessation of their efforts. This process often leads to a rapid regaining of weight and consequent depression. Now you are familiar with that pattern and you can notice that it is very similar to going down stairs.
If a part of you wants to go down those stairs and another part of you believes it is necessary to remain at the top, the part of you that wants you to stay at the top can affect your decision about going down. You may find that you decided in the past to rush down by starving yourself and you know what happened then. That same part of your mind that only allowed you to lose and then gain weight in the past can be utilized now to make choices that will result in a gradual, consistent and comfortable loss of weight. Just as you learned, in the past, to eat in an automatic manner, now you can enjoy discovering, how eating and relaxation can be paired. Each time you prepare to eat you can become aware of that body image that is your goal; you can pause, take a few deep breathes and really become comfortable. You can notice that you will enjoy, in this comfortable state, deciding to overeat just enough to continue losing one to three pounds per week. When you relax your body and your mind you can enjoy the quality of nutritious food and you can enjoy that sense of pride and satisfaction that comes with choosing those foods that are good for you and passing by those foods that give you problems. You can learn to experience the pleasure of smaller amounts of quality food as you develop the art of eating slowly, comfortably doubling your enjoyment as you eat longer and eat less. As you establish these new and enjoyable patterns of eating you can become aware of a release from anxiety and frustration as
your confidence, optimism and satisfaction continue to grow. Your unconscious has a vast capacity for learning and you can be proud as you learn a lifestyle that will lead you to your weight loss goal and you can maintain that goal for as long as you wish.

2. Upon returning from trance the group is given some time to discuss the progress or problems they are encountering as they use self-hypnosis. The therapist responds to the concerns of the group reinforcing the desirability of daily self-hypnosis.

3. Ideomotor response is used with group members as a final check to evaluate probable outcome. In trance each subject is asked the following questions: "Is it acceptable to your unconscious for you to reach the weight you have chosen?" "Is it acceptable to your unconscious to maintain that desired weight?" If there are no responses or uncertain responses the subjects are asked, in trance: "Does anyone benefit from you being overweight?" "If yes, what name(s) come to mind?" The activity now becomes a negotiation to see if alternatives can be developed to meet the needs of the subject in a more productive way. Questions can be asked about punishment, guilt, protection. Age regression can be used as can age progression until affirmative responses are provided to weight loss and maintenance questions.
4. The group is inducted and each subject is asked to imagine a favorite activity. Maybe one they have not enjoyed doing for years. They are asked to stand before a full-length mirror before beginning this activity and experiencing the visual and kinesthetic aspects of their desired body image. Then with the desired body image the subjects are asked to experience that favorite activity while the therapist gives periodic suggestions for enjoyment, pride, confidence and optimism. Reminders are provided for maintaining the body image through nutritious artful eating.

The subjects are asked to return when their activity is complete and a brief discussion is held about their activities.

Session Ten:

The final treatment weigh-in takes place and the weight of each subject is recorded.

1. The final session begins with a discussion of achievements and concerns for the future. Some group members have some fears that on their own they will be unable to continue their progress. They are reminded about the function of the unconscious and the value of self-hypnosis whereby they keep the desired body image in mind on a daily basis. They are given general encouragement to trust their unconscious.
2. The group is inducted using a standard relaxation process followed by deepening activities. The subjects are then asked to project a few months into the future and consider how their lives will be different as their weight continues to decline. They are asked to focus on family relationships, social situations, career situations, recreational activities and any unique situations that they expect to encounter. They are asked to consider how they responded to these situations in the past and how they will respond to them as they continue to lose weight. It is suggested that they can consider new and satisfying ways of responding to situations that seemed threatening in the past. They are asked to move ahead a few more months in time and to reflect upon these same situations as they have become even more slim and finally to the point when they have achieved their desired weight loss. Suggestions are given for pride, confidence and optimism and they are reminded that the end result will be worth the efforts and the risks. Suggestions for self-worth are given to encourage a belief that as individuals, they are worth being the very best they can be.

3. Discussion takes place on the experiences in this exercise and time is provided for any individual concerns. Arrangements are made for the six-month follow-up and the group is given the opportunity to ask any last minute questions about self-hypnosis.
4. The final induction is a form of wrap-up incorporating references to earlier inductions so that nutrition, exercise, moderation, eating artistry and self-hypnosis are included. Final suggestions for confidence, optimism and trust in the unconscious are provided and the group is returned from trance.
APPENDIX F

Intake Form
HYPNOSIS RESEARCH PROJECT INTAKE FORM

1. NAME______________________________________________________

2. ADDRESS____________________________________________________

3. TELEPHONE NUMBER______________________________

4. SEX: MALE__________ FEMALE__________

5. ONSET OF OBESITY: 0-18 YEARS______ ADULT______

6. INITIAL WEIGHT __________  HEIGHT__________
   POST TREATMENT WEIGHT __________  IDEAL WEIGHT__________
   6 MONTH FOLLOW-UP WEIGHT__________

7. MARITAL STATUS: SINGLE__________
   MARRIED__________
   SEPARATED__________
   DIVORCED__________

8. BARBER SUGGESTIBILITY SCORE______

9. MEDICAL DONE__________________________________________

10. EDUCATION______________________________________________
APPENDIX G

Height-Weight Chart
# HEIGHT-WEIGHT FRAME

**DESIRABLE WEIGHTS FOR MEN AND WOMEN AGED 25 AND OVER**

Weight in Pounds According to Frame (In Indoor Clothing)

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<th>Small Frame</th>
<th>Medium Frame</th>
<th>Large Frame</th>
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*Metropolitan Life Insurance Company.

†For girls between 18 and 25, subtract 1 pound for each year under 25.
APPENDIX H

Consent Form
CONSENT FORM

DATE __________________________

I, __________________________ agree to participate in the research project conducted by Gordon Cochrane, a doctoral candidate in Counselling Psychology at the University of British Columbia. I understand that this research project involves regular hypnotherapy treatments for eight sessions over a period of one month. I also agree to participate in the follow-up to take place following treatment and again at six months.

I understand that hypnotherapy is a means by which I can learn to use a cognitive skill which enables me to better utilize my unconscious mental functioning and unconscious resources which, in this case, may facilitate a desired weight reduction. I understand that this hypnotherapy program involves the three basic components of indirect suggestion utilizing analogies, uncovering unconscious motivations and direct and indirect suggestion for healthy weight loss. The three basic components of this program have been fully explained by the researcher. I agree that prior to participation in this project, I will obtain from my physician, a signed statement indicating that I am without medical problems contraindicating weight loss.
The follow-up information, like all information given, will be confidential. If I wish to withdraw from this project at any time I am free to do so without prejudice.

Signature

________________________

Researcher's Signature
APPENDIX I

Transcript of Audio-Tapes
Induction:

The induction is unique to each subject utilizing the imagery that has been most effective with each subject during the treatment sessions. Some subjects are able to respond to depth suggestions while others prefer light floating suggestions. Some subjects can enjoy imagery of pleasant outdoor scenes, possibly near water, and others prefer indoor scenes, possibly from childhood.

Suggestions:

From the given setting, the subject is asked to enjoy the comfort, the pleasant relaxed feelings that move slowly and pleasantly throughout her head and body. In this relaxed state she is asked to visually imagine her body as it will be when she has reached her weight loss goal. She is asked to slowly, carefully see her body from head to toe. A double bind statement is provided. "I don't know if you will see your body as it is with all of your excess weight gone or if you will see your body getting progressively slimmer with each passing week." The subject is asked to note the feelings of confidence and satisfaction that accompany her weight loss and it is suggested that she can be proud of her achievements. "It is interesting when one achieves a sense of confidence, satisfaction and pride
in one area that those feelings often extend into other areas of one's life."

Suggestions are given emphasizing quality over quantity. "You can enjoy learning about quality and quantity. You can be curious about your qualities, those things for which you can feel proud and you can enjoy learning how ... you will choose foods of quality in the quantity that will help you to reach your weight loss goal. With quality choices you can notice your growing sense of confidence, your growing sense of pride and your growing sense of optimism.

The tape concludes with a post-hypnotic suggestion from Milton Erickson. "And my voice will always go with you and become the voice of your parents, your teachers, your friends, and become the voice of the wind and the rain."

The subject is then counted out with the suggestions to feel alert, wide awake and refreshed.
APPENDIX J

Record of Audio-tape Use
UTILIZATION OF AUDIO-TAPES

Please indicate, by placing a check mark in the appropriate blanks, how often you used the personalized audio-tapes provided for you.

MONTH ONE:  

____ not used

____ 1-2 times per week

____ 3-4 times per week

____ 5-6 times per week

____ daily

____ more than once per day (times per day ___)

MONTH TWO:  

____ not used

____ 1-2 times per week

____ 3-4 times per week

____ 5-6 times per week

____ daily

____ more than once per day (times per day ___)

MONTH THREE:  

____ not used

____ 1-2 times per week

____ 3-4 times per week

____ 5-6 times per week

____ daily

____ more than once per day (times per day ___)
MONTH FOUR:  

____ not used

____ 1-2 times per week

____ 3-4 times per week

____ 5-6 times per week

____ daily

____ more than once per day (times per day ____)

MONTH FIVE:  

____ not used

____ 1-2 times per week

____ 3-4 times per week

____ 5-6 times per week

____ daily

____ more than once per day (times per day ____)

MONTH SIX:  

____ not used

____ 1-2 times per week

____ 3-4 times per week

____ 5-6 times per week

____ daily

____ more than once per day (times per day ____)

168
The following data is for computer use only.

Your household income per year is:

- _____ under 10,000 per year
- _____ 10,000-20,000 per year
- _____ 20,000-30,000 per year
- _____ 30,000-40,000 per year
- _____ 40,000-50,000 per year
- _____ above 50,000 per year

NOTE: Household income means your income if you are the sole source of income in your family. If a spouse or partner also contributes to your household income, check the appropriate category for the combined income.

DO NOT WRITE BELOW THIS LINE

Mean use in months 1-3 _______ (daily)
Mean use in months 4-6 _______ (daily)
Mean daily use, total _______ (daily)
APPENDIX K

Original Data Prior to Statistical Analysis
### ORIGINAL DATA PRIOR TO STATISTICAL ANALYSIS

#### GROUP ONE

**HYPNOSIS AND AUDIO-TAPES**

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One Month Weight Loss \( x = 6.53 \) pounds

Six Month Weight Loss \( x = 17.82 \) pounds

**GROUP TWO**

**HYPNOSIS**

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Six Month Weight Loss \( x = 17.12 \) pounds

\( s = 13.966 \)
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One Month —
Weight Loss $x = +1.95$ pounds

Six Month —
Weight Loss $x = +1.73$ pounds
APPENDIX L

Analysis of Variance and Multiple Contrasts
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On One Month and Six Months Weight Loss

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<td>Six Months Weight Loss</td>
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df = 44

### Contrasts of Expau with Expnau
On One Month and Six Months Weight Loss

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<tr>
<td>One Month Weight Loss</td>
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df = 44
APPENDIX M

Selected Case Studies

175
Selected Cases

Five subjects have been selected for discussion to provide additional understanding of the dynamics involved in their successful efforts to achieve considerable weight loss. An additional five subjects have also been selected for discussion to provide further understanding of the difficulties they experienced in achieving only limited and, in some cases, temporary success. To preserve the anonymity of these selected subjects, details have been altered without unnecessarily distorting the facts.

Some Who Succeeded

Subject A

Subject A entered the hypnotherapy program at 195 pounds, weighed 142 pounds at the six-month follow-up and at an interview eleven months following treatment weighed 131 pounds. Her chosen goal is maintenance at 125 pounds. She is a registered nurse and is very dedicated to her profession. Her reported family income is in the $50,000 a year category and she developed a weight problem during childhood. Her Barber Suggestibility Score was in the medium range and her Family of Origin Score was above the mean indicating some disharmony in her family of origin. Her Representational Systems Inventory score was in the highest category and her Tennessee Self Concept Score was in the highest category. This subject was not in the group that was given audio-tapes but she made her own tape and reported that she used it often but kept no record of actual use.
On a marital satisfaction inventory initially considered for use in the study, Subject A scored at or above the 85th percentile on all of the sub-scales providing an index of satisfaction in the areas of social, emotional, sexual, intellectual and recreational activities with a cumulative index of high compatibility.

At the follow-up interview, Subject A reported that she responded well to the positive rather than negative type of suggestions that were given. "I was pleased with the de-emphasis on food - the more I concentrate on not doing something the more likely I am to do it." This observation supports the findings of Erickson (1976) who reported that the use of negatives in hypnosis usually results in the subject ignoring the negatives and responding to the rest of the message. A common example of this phenomena occurs when a dentist tells the patient "this won't hurt much."

Following the suggestions provided in the form of imagery, metaphors and stories (Appendix E) during the treatment period, this subject was always willing to explore her feelings and responses to the various indirect suggestions. Most of her emotional responses resulted from indirect suggestions of regression and often involved parental injunctions. She called these injunctions "bricks" and described them as if they were the individual components of a wall between her and her desired goal. Even at the interview conducted eleven months after the treatment period she made reference to her continuing exploration of her
personal "bricks". It would seem that this subject actively sought increased self-awareness and was motivated to continue this pursuit following the treatment period. It is interesting to consider the historical aspect of the "bricks" that this subject explored. She reported no current unresolved issues with the exception of a weight problem.

Subject B

Subject B entered the hypnotherapy program at 162 pounds and lost 36 pounds during the six month follow-up period. This loss resulted in a follow-up weight of 126 pounds which was her expressed goal at the beginning of the program. Like Subject A, Subject B made her own tape and used it often. She reported no current unresolved problems. She lost no weight in the treatment program until she was age-regressed twenty years and recalled a marital infidelity. Following this regression and the resulting expressions of guilt, she began losing weight and continued to do so until she reached her goal. This subject also had scores on the pre-tests that were very similar to Subject A and listed adult onset as the beginning of her weight problem. She seemed to be able to express her feelings of guilt and then let go of those feelings as if a load had dropped from her shoulders.

Rand and Stunkard (1977) reported that obese subjects in psychotherapy lost more weight and maintained these losses better than subjects in other weight loss programs. The assumption in psychotherapy is that obesity
is the symptom and with the resolution of underlying issues weight loss is easier and more lasting. Subjects A and B provide some support for this position as both subjects seemed able to resolve their issues and lose a dramatic amount of weight. Hypnosis was the means of accessing the issues that seemed to be weight related and was also the vehicle for weight-loss suggestions. Both subjects reported that their family members provided support and encouragement during their weight loss efforts. Both seemed to be free of any current family, marital or career concerns that might undermine their efforts.

It is interesting that both of these subjects reported an initial resistance to entering an altered state of consciousness and both reported that ultimately their desire to lose weight seemed to override their resistances. This situation may reflect a readiness to change. It has been long recognized (Haley, 1968) that some subjects have an unconscious resistance to entering an altered state. Even if this initial resistance is bypassed by the therapist, the subject may still reject suggestions of change or suggestions of regression to the foundation issues from which stem the obesity symptoms. Cheek (1968) pointed out that repression is a form of self protection and if, at an unconscious level, the subject is not yet ready to confront specific problematic situations resistance will occur. Erickson (1976) often indicated that each subject is unique and whereas the therapist possesses a variety of facilitative
therapeutic techniques, some subjects will resist therapeutic suggestions until a level of readiness is achieved. It is conceivable then that some subjects are highly motivated to lose weight at a conscious level, but unconsciously resist or quickly replace lost weight following an initial success. It may be that subjects like those in these case-studies can lose weight and keep it off because they are ready to accept suggestions for what must be done to lose weight and they have no other current unresolved issues that they are unwilling to confront.

**Subject C**

Subject C entered the hypnotherapy program at 200 pounds, weighed 150 pounds at the six-month follow-up and at an interview one year following treatment weighed 142 pounds. She is a physiotherapist currently working with the elderly. Her reported family income is in the 20-30 thousand range and she developed a weight problem during childhood. It did not become serious until three years ago. Her Barber Suggestibility Score was the second highest recorded in this study and her Family of Origin Score was below the mean indicating a harmonious family of origin. Her Representational Systems Inventory score was the highest score in the study and her Tennessee Self Concept score was at the upper level of the medium category. This subject was in the group that was provided with audio-tapes and she reported using her tape on 76 occasions during the six-month follow-up period. This is the second highest reported tape usage in the study.
Subject C graduated from university as a physiotherapist in the 1940's and promptly joined the International Red Cross. She was stationed in Europe during the war working with the war injured. She returned to Canada following the war but soon volunteered to go to Africa with the Red Cross and became the director of a rehabilitation clinic. Upon returning to Canada she worked in a hospital setting in Western Canada with many and varied experiences. During this period of her life she reported that she weighed close to 135 pounds and credited this consistency to her very active and satisfying life-style. She was very active in the outdoors as a hiker and a mountain climber. Along the way she learned French and is comfortably bilingual. She also took post-graduate courses in the United States. She never married but has always had a close network of friends and a very close family network. In 1978 she moved to Regina. Most of her family lives in the Regina area and she reports considerable satisfaction with their frequent company. Her weight began to increase dramatically following her move to Regina and reached 200 pounds prior to the treatment program. She attributed this sudden gain to a decrease in physical activity but also indicated that she has been unable, until recently, to return to her former home because of the anticipated emotional impact of returning to the scene of fond memories. Possibly she would have been less successful if she had entered a weight loss program a year or two earlier when she may have been less ready.
This subject was very responsive during the treatment program and during an imagery activity (Appendix E) which required the subjects to construct their desired body image from clay, she reported that she changed the image from clay to granite to ensure its permanence. With the exception of the emotional pain of moving to the prairies, which seems to have been at least partially resolved by the time she entered treatment, this subject appeared free of unresolved issues that could hinder her weight loss efforts. She has a background of experiences that suggest high motivation and an openness to new and varied experiences. Again, readiness and a freedom from issues that she was unwilling to confront seemed, as in the case of Subjects A and B, to result in a situation where this subject was eventually able to focus her mind exclusively on the task of weight loss.

The three subjects discussed in these case studies all used tapes. One subject used a tape prepared by the therapist and the other two subjects made their own tapes. However two other subjects reached their expressed weight-loss goals within the six-month follow-up period and did not use tapes. Subject D was from the group provided with a tape, but she reported non use, and the other, Subject E, was from the group that did not receive tapes.

Subject D

Subject D, who weighed 146 pounds, expressed a strong desire to weigh 125-130 pounds on her wedding day.
which was four months in the future. She lost no weight for the first few weeks of the treatment program until it was discovered, through age regression, that she had been raped as a teenager. Following this disclosure and the resulting suggestions for letting go of the feelings of self blame she began losing weight and weighed 127 pounds when she got married. At an interview seven months following her marriage this subject reported that she is happily married and her weight seems less important to her. She gained five pounds during this seven months, possibly because her initial motivational focus was on her wedding date.

**Subject E**

Subject E, who reached her goal without using a tape is a high school teacher who, during the treatment program, worked on her feelings of guilt surrounding the death of her father and the resulting decision concerning the living accommodations for her invalid mother. At the follow-up interview she weighed 127 pounds and expressed appreciation for having the opportunity to "let go of my guilt and renew my confidence in myself."

Like the first three subjects, these two subjects were able to satisfactorily work through their unresolved issues within the time limited treatment period. Three of the subjects uncovered historical issues and two of them focused on issues that apparently they had been actively attempting to resolve before they entered the hypnotherapy
program. All five of these subjects seemed highly motivated to achieve their goals and all five had experienced considerable successes in other areas of their lives.

Some Who Struggled

Subject 1

Subject 1 entered the treatment program weighing 210 pounds, was 191 pounds after six months but at an interview nine months following treatment, reported that she had begun to gain weight again. Her Barber Suggestibility score was among the highest in the study and her Family of Origin score was low, indicating a harmonious family of origin. She reported that obesity became a problem during her adult years and her family income was in the 30-40 thousand per year range. She is a French teacher taking master's degree classes in Canada and Paris, France. Her Representational Systems Inventory score was in the highest category as was her score on the Tennessee Self Concept Scale. She was in the group that was provided with a tape and her reported tape usage was above the mean although it declined near the end of the six month follow-up period.

During the treatment period this subject was cooperative, responsive and seemed well motivated. She openly discussed her separation and pending divorce which had been, in her view, a factor in her eating habits. As her marriage had begun to deteriorate her weight rose dramatically. She indicated however, that she had begun to rebuild her life
prior to entering the treatment program and she was progressing well.

She has a lot in common with the subjects in the selected group of successful weight losers, including a record of achievement in other areas of her life. However shortly after the six-month follow-up period was over her former husband and his girlfriend moved into a townhouse next door to her in the same townhouse village where they had lived for the previous few years. The residents of this village shared considerable social contact and the husband's new partner had been the wife of one of the men residing in this complex. This subject reported renewed anxiety and frustration with this unexpected development and she began gaining weight.

On a form provided for follow-up comments she said, "I must state that losing weight became secondary to other personal problems during the latter months but self-hypnosis helped me weather these problems."

From a clinical perspective it would be appropriate to engage this subject in therapy again to assist in the resolution of what seemed to be her primary problem and then help her return her focus to the obesity symptom.

Subject 2

This subject has been divorced for seven years, has a Master's degree in recreational planning and reported that her obesity problem began during her adult years. Her Barber Suggestibility score was in the medium range but she
was exceptionally responsive to indirect suggestion. Her Family of Origin score was slightly above the mean, indicating some disharmony in her family of origin. She was born in England and was a young child during the bombing of London. During regression she reported that food was difficult to obtain and her father seemed to be pleased that she appreciated his efforts to find food for her. Her family income was in the 30-40 thousand per year range and her Tennessee Self Concept score was at the upper level of the medium category. Only two subjects in the sample scored higher on the Representational Systems Inventory than she did. Her group did not receive audio-tapes.

During the treatment period she made many references to her former husband and it seemed that she had not yet disengaged from her marriage even though it had formally ended seven years earlier. She works in the same office as her former husband, in the same department. This subject responded very well to induction suggestions and to suggestions of regression but her loss of only one pound during the treatment period indicated a resistance to suggestions of weight loss. In one of the imagery activities she created a massive statue of her husband and experienced considerable trauma as she imagined this statue falling on her and "crushing the life out of her." The therapist used a technique developed by LeCron (Cheek and LeCron, 1968) which is a suggestion that the subject look into the future to a time when she has lost weight. She was able to do this
and then she was asked what had occurred that facilitated the weight loss. She said "love, understanding, caring and honesty." When asked from whom, she stated the name of her former husband.

The time constraints of the treatment program did not permit extensive attention to the resolution of her feelings for her former husband and she resisted suggestions for letting go of those feelings. As indicated earlier, Erickson (1976) stated that each subject is unique and is able to resist suggestions to change until a level of readiness is reached that will allow change to occur. A time limited group setting may not provide the opportunity for the attention to individual differences that seems necessary for this type of subject. The supportiveness and reinforcement that can occur in a group may be ideal for subjects like those in the first set of case studies described here, but it is possible that individual open-ended therapy may be more appropriate in cases such as this one. Hypnosis can still be utilized as the means of uncovering and treating the primary issue and can then be utilized for weight-loss. Sometimes, as in the next case study, the group seems to hinder the therapeutic process.

Subject 3

This subject entered the treatment program weighing 224 pounds and weighed 213 pounds at the six month follow-up. She placed in the lowest category on the Barber Suggestibility Scale, had a Family of Origin score well
above the mean and her Representational Systems Inventory was in the lowest category. Her Tennessee Self Concept score was in the lowest category and her reported tape usage was very low. She has a high school education, reported that obesity became a problem in childhood and has a personal income well above 50 thousand dollars per year.

Subject 3 always chose a chair that was somewhat removed from the rest of the group and was reluctant to offer much personal information. During induction and imagery activities she was very resistant and yet seemed to be pleading for help. She did however lose a reasonable six pounds during the four weeks of treatment. At the six month follow-up interview she revealed that she had been very afraid of responding to the various induction suggestions in case she would talk about her primary concern in the presence of the other group members. She described a very stressful family issue that she had known about for a number of years but seemed powerless to do anything about. She said that over the years she would wake up every night at 2:00 a.m. to check on her family and if all was well she would go into the kitchen and eat. She reported that she had no clear awareness of how much she would eat until the next morning when she would discover the reminders of the previous night on the cupboard and in the kitchen sink. One of the family members is now an aware adolescent and to punish her mother for not acting on the issue, extorted considerable money from her mother on the threat of informing an older happily
married family member who is not aware of this issue.

It is not possible to conclude that this subject would have been more successful at losing weight if she had been able to resolve the problems in her family. Her scores on the pre-tests are very much different from the scores of those subject who did lose a lot of weight and she may not have responded to the hypnotic suggestions for weight loss even if her family problem did not exist. However, Hanley (1967) indicated that some subjects use obesity as "the ticket of admission" to therapy when the primary issue seems too intense to initially acknowledge. Possibly this subject would have responded differently in individual therapy and possibly family therapy would have been the appropriate treatment for what appears to be the primary concern of this subject.

Subject 4

Subject 4 entered the treatment program at 215 pounds and weighed 201 pounds at the six month follow-up. She scored below the mean on the Family of Origin inventory, reported adult onset of obesity, reported a family income of 30-40 thousand dollars per year, scored low on the Representational Systems Inventory and scored in the lowest category on the Tennessee Self Concept Scale. Subject 4 placed near the top of the middle category on the Barber Suggestibility Scale. She was in the group that did not receive tapes and has five years of training beyond high school.
Again the pre-test profiles differ from the subjects who lost considerable weight and this subject reported issues that she was unable to resolve during the treatment period. Subject 4 reported a dramatic weight gain after moving to Canada from England in 1967. She enjoyed regressions that took her "home" and frequently cried when discussing her feelings about her family and friends in England. She and her husband have no relatives in Canada and in times of stress, often marital related, she reported a feeling of distance from her husband as well as the geographical distance from her family of origin. She reported that her education seemed out of date and she lacked a sense of purpose. She listed her sense of isolation and loneliness as the two issues that most frequently precipitated sessions of overeating.

Subject 5

Subject 5 weighed 234 pounds at the beginning of the hypnotherapy program and weighed 216 pounds after six months. Like Subject 4, she scored below the mean on the Family of Origin inventory, reported adult onset of obesity, reported a family income of 30-40 thousand dollars per year, scored low on the Representational Systems Inventory and scored in the lowest category on the Tennessee Self Concept Scale. She placed in the high category on the Barber Suggestibility Scale, had completed grade eleven and was in the group that did not receive tapes.
Subject 5 has been married to an alcoholic for over 20 years and her responses to the imagery in the treatment program (Appendix E) revolved around the past and present difficulties of her marriage. At the first session she brought a place-mat with a photograph of a large pig on it. Her husband had given it to her as she was leaving for the first session. She worked very hard during the program, exploring her feelings and responding to the uncovering activities. At the follow-up interview she reported that she had enrolled in university on a full-time basis and was doing very well but her husband was making repeated efforts to discourage her weight loss and her education. She had contacted a lawyer to explore the possibility of divorce but was obviously finding it difficult to maintain a steady loss of weight while living in a disruptive environment. Reflecting the disharmony of her home, her oldest son was struggling with a drug addiction and a younger son had left home before finishing high school. At times weight loss seemed to fade into the background as she was forced to struggle with the emotion laden issues in her family.

The selected cases presented here give some support to the contention (Feinstein, 1960; Hanley, 1967; Olefsky, 1980; Wolman, 1982) that obesity is often symptomatic of underlying problems and as Erickson (1976), Kline (1982) and Rand and Stunkard (1977) point out, treatment success often seems to at least partly depend upon client motivation and readiness to contend with the underlying issues.
APPENDIX N

Advertisement
Hypnotherapy for Weight Loss

A doctoral candidate in Counselling Psychology at UBC is conducting a doctoral research project on the effectiveness of hypnotherapy for weight loss. Two treatment groups and one control group will be established. The two treatment groups will meet for eight three-hour sessions over a period of six weeks and will meet again in six months. The members of the control group will receive treatment, if desired, following the completion of the experiment.

Participants must be at least 20% overweight and be 20 to 65 years of age. Participants are requested to have a medical statement from a physician indicating that they have no medical problems that contraindicate weight loss.

For further information call: Phone Number.