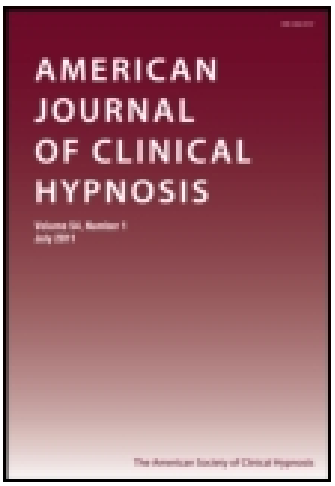

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Weight Loss Through Hypnosis

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A method of effecting weight loss through the use of hypnosis is described embracing: (a) direct suggestions relating to amount and type of food eaten, (b) ego-enhancing suggestions to help patients live their lives more pleasantly, (c) mental imagery to establish a desired goal, (d) auto-hypnosis to reinforce the therapists suggestions, and (e) use of audio-tape to provide additional support after the completion of formal treatment. Although the approach has proven successful with many patients, two year follow-up data was available for 10 only, and it is upon these that the article concentrates. Emphasis is placed upon the importance of the therapist-patient relationship and, in particular, the fostering of positive expectation that the treatment will be successful.

"Most obese persons will not stay in treatment for obesity. Of those who stay in treatment, most will not lose weight and of those who do lose weight, most will regain it [Stunkard, 1958, p. 79]."

These words were written some years ago, yet more recent reports would seem to indicate that the position has not changed greatly. When survey studies of patients in medical settings are considered (*e.g.*, Shipman & Plesset, 1963; Silverstone & Solomon, 1965), the record of success over the long term is very poor, confirming Stunkard's rather pessimistic conclusion. Perhaps, however, this is true only for medical situations, for Stunkard's own studies (1958, 1959) were concerned with outpatients and, in particular, with people attending the Nutritional Clinic of a large teaching hospital.

A consideration of reports furnished by behaviour therapists negates this possible interpretation (*e.g.*, Cautela, 1966; Ferster *et al.*, 1962; Goldiamond, 1968; Wolpe, 1958). Despite their very impressive performance in other areas, practitioners of this particular approach seem to find it difficult to cope successfully with the problem of obesity. This appears to be true whether patients are seen individually or in groups, so it would seem that Stunkard's conclusion is generalizable beyond the rather restricted outpatient sample he surveyed.

One of the dificulties in the area, referred to by Stunkard and by others, is that the relative ineffectiveness of obesity treatment has been obscured by the ambiguity of journal reports. Probably this criticism pertains to those of us who employ hypnosis as a method of treating weight problems just as strongly as it does to those treating hospital outpatients. Primarily, this seems to be because most of the studies reported in the area are case histories of techniques which have proven to be successful with one, or a very few patients (*e.g.*, Erickson, 1960; Hanley, 1967; Wollman, 1962). Such studies often lack follow-up data and it is difficult to ascertain whether the improvement recorded was only temporary in nature. Obviously, achieving the initial weight loss is only part of the problem; maintaining the lighter weight on a relatively permanent basis is perhaps the more difficult aspect.

I am very much aware that the present article shares one of the weaknesses already

mentioned; it is a case study report involving relatively few patients. It does, however, attempt to improve on earlier studies by providing some follow-up data. Because the very simple technique used achieved consistent success over a relatively long term, it does seem useful to present these data to offset that provided by Stunkard.

Patients were seen individually for four weekly sessions, each of one hour. During the first session, emphasis was placed on the establishment of rapport between patient and therapist, and, in particular, upon the creation of a positive expectancy that the use of hypnosis would be effective in achieving the desired goals. It is becoming increasingly apparent (Bedner, 1970; Friedman, 1963; Frank, 1968; Goldstein, 1962) that if a patient believes that a certain therapeutic technique will help him get better, the chances of ultimate success are greatly enhanced. Lazarus (1973), in fact, would argue that the particular technique used is virtually irrelevant. What is important is the belief of the therapist in what he is doing and the belief of the patient that *this* therapist using *this* technique will be able to help him. The interaction here resembles the self-fulfilling prophecy syndrome (Rosenthal & Jacobson, 1968) where a person who expects to achieve a certain outcome enhances his possibility of doing so simply through the positive power of his expectation. Again, Gindes (1951) has referred to the same phenomenon when he points out that a patient will get well when he is convinced that he can be well.

During this initial session, the patient's ideas about hypnosis were explored and his fears allayed. Hypnosis was then induced, usually by Hartland's distraction method (1971), and the trance deepened. The patient was then awakened, his feelings discussed, and the trance state re-induced. At this time, ego-enhancing instructions (Hartland, 1971) were given. In support of Hartland's claim for the therapeutic value of these suggestions, *all* of the patients treated reported one or more of the following benefits: (a) gains in their ability to relax, (b) increased confidence, independence and energy, and (c) enhanced powers of concentration and memory. These are anecdotal reports, of course, and as such might be considered an unreliable source of data. However, I find myself very much in agreement with Combs, Avila and Purkey (1972) when they affirm the value of such introspective data. Reality for each of us is located "behind our eyeballs" determined by our past experiences and by the interpretation we place on the current situation. It is not normally something that can be objectively evaluated by an observer who has no way of sharing the internal frame of reference of another person. Therefore, if one does want to find out how an individual is responding to changes in his environment, it would seem necessary to rely upon his own report, supported, if possible, by that of outside observers.

After the ego-enhancing instructions had been completed, I used the following suggestions specifically relating to the patient's weight problem.

> And now I want you to have a clear mental image, in your mind, of yourself standing on the scales and the scales registering the weight you wish to be. See this very, very, clearly for this is the weight you will be. See yourself looking the way you would like to look with the weight off those parts of the body you want the weight to be off. See this very, very vividly and summon this image into your mind many times during the day; particularly just after waking in the morning and before going to sleep at night, also have it vividly in your mind before eating meals. And this is the way you will look, and this is the weight you will be. As you believe this, so it will happen. When you have attained this weight, you will be able to maintain it, you will find yourself eating just enough to maintain your weight at the weight you would like to be. Until you *do* attain this weight you will find you have less, and less desire to eat between meals. In fact, very, very soon, you will have no desire at all, to eat between meals. You simply will not want to. Also you will find you will be content with smaller meals. There will be no sense of unhappiness

or dissatisfaction, smaller meals will be quite satisfactory to you, and you will have no desire to eat large meals. Also you will have less, and less desire for high calorie, rich, unhealthy foods. Day by day, your desire for such foods will become less and less, until very, very soon, you will have no desire at all for rich, high calorie, unhealthy foods. Instead, day by day, you will desire low calorie, healthy foods, and these will replace the high calorie foods, the rich foods, you have eaten in the past. As you lose weight and approach closer and closer to the weight you wish to be you will find yourself growing stronger and stronger, healthier and healthier. Your resistance to illness and disease will increase, day by day. With less weight you will feel better and better, and your health will become better and better. Remember too, that your own suggestions will now be just as effective as the suggestions I give you, either personally or by tape.

The patient was then awakened from his trance and his thoughts and feelings discussed. In succeeding sessions, hypnosis was induced far more rapidly, leaving time to repeat the weight reduction suggestions several times. In addition, the patient was taught self-hypnosis, and was asked to practice this skill for a quarter of an hour each day. During this time, he was to repeat to himself the same suggestions about his eating, and to visualize the same images about his weight as he had done when with me. The hypnotic induction and the suggestions of the final session were recorded and the patient took the tape with him. This could be used over succeeding weeks until the target weight was achieved.

Although many patients have been treated in the manner outlined, I have two-year follow-up data on only ten (See table 1).

Most of the patients wished to lose approximately 20 lbs. in weight, so they would not be classifiable as grossly overweight. Still, referring to Stunkard's (1959) review, it may be seen that only 25% of obese outpatients treated were able to lose 20 lbs., and of these, less than 10% were able to maintain their weight loss. The picture derived from the Nutritional Clinic outpatients was even more dismal with only 12% able to lose 20 lbs. Two years after the end of treatment, only 2% of these had maintained the lower weight. By comparison, the data quoted above indicate success in ten cases out of ten, both in terms of achievement of desired weight and in stabilization of weight at this level over a two year period.

The technique used is, of course, quite common, embracing as it does: (a) direct suggestions relating to reduction of the amount of food eaten and change in type of food eaten, (b) ego-enhancing suggestions to help patients live their lives more pleasantly, and (c) mental imagery to establish a desired goal. Maltz (1967) has pointed out just how effective such target imagery may be. When one imagines a desired end-product, whether it be a state, such as re-

TABLE 1
WEIGHT LOSS IN LBS. RECORDED BY TEN PATIENTS OVER A FOUR-WEEK TREATMENT PERIOD AND A TWO-YEAR FOLLOW-UP PERIOD

Patient					Treatment Phase. Weight at:			Follow-up Phase. Weight After Treatment:			
No.	Sex	Age	Initial Weight	Target Weight	2nd Session	3rd Session	4th Session	6 Mos.	12 Mos.	18 Mos.	24 Mos.
1	F	40	133	118	130	126	122	116	117	115	116
2	F	54	151	130	149	145	143	135	131	131	132
3	F	38	127	114	124	120	117	112	115	114	113
4	M	42	162	154	160	156	154	154	152	155	154
5	M	27	198	158	191	190	185	161	154	154	155
6	F	21	139	114	132	125	121	114	112	115	115
7	M	26	183	158	170	167	161	157	159	158	158
8	F	37	143	115	137	135	128	117	117	118	116
9	F	23	161	140	159	151	143	139	138	141	139
10	M	41	176	154	171	163	161	153	155	155	154

duced weight, or a different behaviour, such as confidence displayed in previously anxiety-provoking situations, the sub-conscious mind is provided with a target. According to Maltz's formulation, the sub-conscious mind will then direct the individual's behaviour so that the target will be achieved, often without any conscious effort on the part of the person concerned. That this may have happened with my own patients is suggested by their reports wherein they often stated their surprise that the whole process was so easy, seeming to occur almost automatically without any real effort on their own part. From experience with other weight reduction treatments, they thought they might well feel miserable and deprived as they ate less, avoiding the rich foods they had previously enjoyed. Yet, this did not occur. As they lost weight, they remained cheerful and good-tempered. Overall, the impression I gained from a reading of these reports was one of ease and pleasure.

Trying to isolate the specific effects of each aspect of the treatment described would be very difficult. Direct suggestive therapy, imagining of a desired goal, and positive thinking were inextricably interwoven. Further, the variable of the therapist-patient relationship would seem to embrace these specific techniques and provide something else in addition, the belief-expectancy factor alluded to earlier. To the experimentalist, the attempt to solve this problem must be made, for this is the task he sets himself. However, the clinician, though still concerned with the specific effect of certain factors, is more concerned with the help he can offer to his patients. The approach outlined in this article does appear to work very successfully, and, by so doing, make more enjoyable the lives of the people treated.

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