Hypnosis as an effective adjunct treatment of female obesity

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ABSTRACT

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HYPNOSIS AS AN EFFECTIVE
ADJUNCT TREATMENT OF FEMALE OBESITY

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Dissertation dated May 2004

This study examines the problem of female obesity in the United States. A woman who has a Body Mass Index of 30 or above is considered to be obese and this applies to over 50 percent of American women. Both physical and psychological consequences of obesity were considered.

The study also examines current treatments available for the treatment of obesity and looks at the possibility that hypnosis may be an effective adjunct treatment.

The study was based on the premise that hypnosis is an altered state of consciousness in which certain normal human capabilities are heightened while others fall into the background. It is a state of relaxation during which subjects are able to experience an elevated ability to focus and concentrate. Cognitive and behavioral weight
loss ideas may be suggested to the subject while in a state of hypnosis and this may facilitate the ability to follow the suggestions.

Subjects were divided into two groups. One group heard only weight loss suggestions, the other group heard the suggestions while hypnotized. The amount or weight lost by each group was computed and the mean number of pounds lost was derived. A t test was used to analyze the data.

The researcher found that the hypnotized group lost significantly more weight than the control group. The conclusion drawn from the findings suggest that hypnosis may be an effective adjunct in the treatment of female obesity.
HYPNOSIS AS AN EFFECTIVE
ADJUNCT TREATMENT OF FEMALE OBESITY

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

BY
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ATLANTA, GEORGIA
MAY 2004
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CHAPTER I
INTRODUCTION

Health Risk Associated with Obesity

There can be no doubt that obesity is a serious health concern to a considerable number of people. Perry, Nezu, and Viegner (1992) point out that obesity contributes to coronary heart disease primarily through its strong association with risk factors, such as hypertension, hyperlipidemia, and impaired glucose tolerance, and they explain cross-sectional studies which document the association between obesity and these risk factors. According to Perry et al. (1992) obese persons in the 22-44 year-old range are five times more likely to have hypertension than their nonoverweight counterparts. Similarly, these young obese persons were more than twice as likely as their nonoverweight peers to have high blood cholesterol.

Noninsulin dependent diabetes mellitus (NIDDM) is the third most frequent cause of death in the United States and obesity is a major risk factor for this disease (American Diabetes Association, Sulans, Knittle, & Hirsch, 1983). In 1986, the National Committee for Health and Science (1986) indicated that there are almost six million Americans with known diagnoses of diabetes, and the American Diabetes Association (Sulan et al., 1992) estimates that there are as many as five million individuals with undiagnosed diabetes.
In a study conducted by the American Cancer Society (Lew & Garfinkel, 1979) the risk of cancer was shown to increase proportionately with increases in patient’s weight. The mortality rate from cancer was significantly higher for those individuals who were obese, compared to a reference group of average weight individuals. Cancers of the colon, rectum, gallbladder, breast, cervix, endometrium, uterus, and ovary contributed most to increased mortality (Lew & Garfinkel, 1979).

According to Bennion, Bierman, and Ferguson (1985), one of the problems most commonly connected with obesity is the chest discomfort that results from stomach acid getting up into the esophagus causing heartburn. Additionally, in obesity, the weight of the abdominal fat pushes on the stomach. The stomach itself can be pushed up partially through the diaphragm causing hiatal hernia (Bennion, Bierman, & Ferguson, 1985).

Bennion (1985) has shown that obesity causes the liver to secrete excessive amounts of cholesterol into the liver bile. When the bile contains more cholesterol than can be dissolved, the cholesterol crystallizes and may form gallstones. They can also cause cancer of the gallbladder (Bennion, Bierman, & Ferguson, 1985).

Arthritis means inflammation of, or damage to, the joints. There are several different types of arthritis. Two of them, gout and osteo-arthritis, are more common in obese persons (Bennion, Bierman, & Ferguson, 1985). No matter what the cause of arthritis, obesity worsens the damage to weight-bearing joints such as ankles, knees, and hips by overloading them (1985).

Humans have long and poorly designed spines and are, consequently, susceptible to low back problems. Obesity adds strain to the lower spine and renders individuals even more prone to low-back pain (Lew & Garfinkel, 1979; Manson, 1995).
Exertion brings on shortness of breath very quickly in the obese both because oxygen requirements are high and breathing requires extra work (Bennion, Bierman, & Ferguson, 1991). Even when asleep, obese people may have trouble breathing. Severe obesity is often accompanied by a condition known as sleep apnea in which sleep is interrupted by failure to breathe for several seconds at a time (1991).

Varicose veins are another affliction which is more common among the obese (National Research Council, 1989). In obesity, the veins which carry blood toward the heart are surrounded by fat preventing the blood from flowing efficiently. Veins become distended with blood. When blood clots form, there is a risk of the clots dislodging and being carried by the bloodstream to the lungs. There it can cause shortness of breath, chest pains, and even death (National Research Council, 1989).

Obesity increases the danger of major surgery by producing specific problems (Andres, 1990). For example, there is increased incidence of pneumonia in obese post-operative patients. Impaired healing of incisions is another problem experienced more often by the obese individual (Andres, 1990).

Obese pregnant women face additional risks and problems (Roberts, Savage, Coward, Chew, & Lucas, 1988). For example, they face a doubling of the risk of phlebitis, a fivefold increase in the risk of bladder and kidney infections and a ten to twenty fold increased risk of developing diabetes during pregnancy (Roberts et al., 1989).

Social Discrimination and Psychological Distress

In addition to physical health concerns, Wadden and Stunkard (1985) found that obese people experience social discrimination and psychological distress as a direct consequence of their weight. Problems range from lack of self-confidence to severe body
image disparagement accompanied by feelings of self-contempt and personal inadequacy. G.T. Wilson (1993) conducted a study of the relationship between being overweight and subsequent educational attainment, marital status, household income, and self-esteem. Characteristics of the overweight subjects were compared with those for other young people with chronic health problems. Seven years later Wilson (2000) found that women who had been overweight had completed fewer years of school, were less likely to have married, had lower household incomes, and had higher rates of poverty than their non-overweight counterparts (2000). Overweight men were less likely to have married. In contrast, people with other chronic health conditions did not differ in these ways from the non-overweight (Grimacer, 1994).

In a 1965 study, Goldblatt, Moore, and Stunkard reported on the social and psychological consequences of obesity. They determined that there is a strong prejudice against the obese in this country, regardless of age, sex, race or socioeconomic status. Children as young as six years old describe silhouettes of the obese child as “lazy”, “dirty”, “stupid”, “ugly”, “cheats”, and “lies”. When shown line drawings of a child of normal weight, an obese child, and children with various handicaps, children and adults rate the obese child as least likable. Overweight is regarded, not only as a sin, at odds with the Protestant ethic of self-denial and impulse control, but also as a crime for which a person is held responsible. And, beyond these moral and legal transgressions, obesity is an aesthetic crime (Goldblatt et al., 1965).

Hypnosis as an Adjunct to Weight Loss

According to Brown and Fromm (1986), hypnosis is a special state of consciousness in which certain normal human capabilities are heightened while others
fade more or less into the background. Of each 100 people in the United States, 90 of these have the ability to go into a hypnotic state, some more deeply than others. Hypnosis is now generally accepted as an altered state of consciousness (1986).

Ludwig (1966), coined the term “altered states of consciousness” (ASC), defining an altered state according to subjective experience and altered physiological functioning. In an ASC, one’s perception of and interaction with the external environment are different than in the waking state, and one is more deeply absorbed in the internal experience.

The degree to which people are able to become hypnotized is referred to as hypnotic depth. Viewed objectively, hypnotic depth is a measurement of the behavioral response to hypnotic induction and suggestion. While measuring a subject’s susceptibility has is merits in experimental work, probably the most important factor in the success of hypnotherapy is the subject’s unconscious motivation to succeed (Ludwig, 1966). Several tests of hypnotic susceptibility have been developed for experimental work. These tests are useful in screening individuals to locate the most promising hypnotic candidates. A posthypnotic suggestion is a type of higher-order conditioning, functioning as a positive or negative reinforcement to increase or decrease the probability of desired behaviors.

Regardless of the depth of hypnotic trance, many clinicians believe that hypnosis both enhances the effectiveness of behavior-oriented therapies and reduces the duration of treatment (Brown & Fromm, 1986). It is believed that the repetition characteristics of the hypnotic induction improves learning in hypnosis and heightens suggestibility (Weitzenhoffer, 1957).
In discussing hypnosis as an adjunct to psychotherapy, Spiegel and Debetz (1978), explored the restructuring of eating behavior with self-hypnosis. Spiegel and Debetz (1978), describe hypnosis as an altered state of intense readiness between hypnotist and subject, characterized by the subject’s submission and relative abandonment of executive control to a more or less regressed, dissociated state. They emphasized that, in clinical protocol, the hypnotist structures this regressed state to facilitate achievement of desired goals.

Hypnosis itself is not a therapy, but Spiegel and Debetz (1978), have shown that the hypnotic state can enhance the efficacy of therapy. Hypnosis can serve as an adjunct to many therapeutic approaches, including behavioral therapy. It seems obvious that hypnosis, at the very least, can serve to reinforce positive life style changes and that posthypnotic suggestions can directly influence the patient’s behavior outside of the therapy hour (Brown & Fromm, 1986).

Statement of the Problem

Medically, obesity is defined by an excessive accumulation of body fat. Body fat is considered to be excessive when it appears to impair health. Because of the difficulties in measuring body fat, Body Mass Index (BMI) has become the most popular and convenient indicator of obesity. It is the ratio of a person’s weight in kilograms to the square of that person’s height in meters: BMI = weight in pounds X 700 divided by height in inches X height in inches. Using this formulation, a woman who is of ideal weight would have a BMI of 19-25. An overweight woman would have a BMI of 26-29 and an obese woman would have a BMI of 30 and up. For example, a woman who is 5 ft. 9 in. tall would be overweight at 203 pounds and obese at 206 pounds. The majority of
experts acknowledge that obesity, however it is defined, is prevalent enough to be considered a serious public health concern of people in North America. A study conducted by Gortmaer, Dietz, Sobol, & Wehler, (1987) showed that the prevalence of obesity in the United States is high and steadily rising despite recent emphasis on exercise and healthy eating. In 1981 the National Center for Health Statistics conducted a study to determine the prevalence of obesity in the United States. In its survey, the NCHS (1981) defined obesity as a BMI equal to or greater than 30. The NCHS’s (1981) data showed that 34 million American adults were considered to be overweight. A comparison with surveys completed prior to 1981 (NCHS, 1966) shows an ominous trend. The incidence of obesity in America is increasing, and particularly large increases in obesity are occurring among children and adolescents (Gortmaker, Dietz, Sobol, & Wehler, 1987). A six-year federal study, completed in 1977, shows that Americans of all ages and races are fatter than they have ever been, and the trend shows no signs of being reversed. Children and adolescents are 5 pounds heavier than the last time a national measurement was taken and adults are an average of 15 pounds heavier.

In addition, the NCHS (1981) data showed that gender, age, race, and socio-economic status influence the prevalence of obesity. Fewer men than women are obese and, among men, obesity increases up to 55 years of age and then declines. For women, the prevalence of obesity is much higher among black women, in fact, between the ages of 45 and 54, the prevalence of obesity among black women exceeds 2 million (1981). Also, the survey data show that the relationship between obesity and poverty status differs for men and women. The prevalence of obesity is higher for men above the
poverty line than for those below it. Women below the poverty line show a dramatically higher prevalence of obesity than those above it (Jan Itallie, 1985).

Studies conducted as recently as 1999 continue to show dramatic increases in the percentage of Americans who are obese (The Atlanta-Journal Constitution, Tuesday, November 2, 1999). According to the Atlanta-Journal Constitution, more than 130 million Americans are fat with a BMI of 25 to 29.9 and 96.2 million are obese with a BMI over 30. The state of Georgia shows the largest increase in the number of obese people between 1991 and 1999 (Atlanta Journal-Constitution, Tuesday, November 2, 1999).

Over the past decade, it has been increasingly clear that obesity has a substantial adverse impact on health and well-being (Perry, Nezu, & Viegner, 1992). They (1992) have given an excellent overview of the subject and concluded that “obesity is associated with a number of serious illnesses and with risk factors for diseases that shorten life and decrease quality of life” (p. 9).

Many researchers have used post hypnotic suggestion to encourage patients to lose weight. A review of the literature shows that, while there have been numerous studies, they generally focus on only one aspect of cognitive and behavioral therapy. The hypnotic treatment protocol used in these studies were often ill-conceived and simplistic (Miller, 1974). Further controlled outcome studies are needed on the efficacy of treatment protocols which combine a broad range behavioral modification plan with hypnosis. This is the purpose of the study.
Need for the Study

Hypnotherapy can often enhance a cognitive/behavioral approach to weight loss, an observation that is one of the most clinically confirmed in all of the literature on hypnosis (Cohen, 1979; Crasilneck & Hall, 1976; Goldstein, 1981; Kroger, 1977; Mann, 1981; Nuland, 1974; Speigel & Speigel, 1978; & Stanton, 1975). Obviously, therapists who use hypnosis to help their patients lose weight report that it works. Others criticize the anecdotal nature of their reports and cite the lack, in many cases of scientific protocol (Mott & Roberts, 1979). Further controlled studies are needed to determine the effectiveness of treatments which combine cognitive and behavioral therapy with hypnosis.

Research Questions to be Addressed

Obesity is so prevalent in the United States however, there are relatively few strategies that address psychological contributors that are necessary in changing lifestyle issues. From the previous discussion, it is obvious that there are presently many obese Americans and that number is steadily growing. Obesity presents a real threat to physical and emotional health. Achieving and maintaining ideal relative weight can reverse the harmful effects of obesity, yet many people continue to have difficulties making the lifestyle changes which will facilitate weight loss. Use of hypnosis has been shown to be effective in communicating with the subconscious mind and in helping to reinforce behavioral and cognitive changes. Hypnosis may be an effective tool in the treatment of obesity when used in conjunction with cognitive and behavioral therapy. More testing is needed to confirm or dispel this possibility. These facts provide the rationale for this study. This researcher was interested in answering the question, “Does the addition of a
hypnotic therapeutic module to a cognitive and behavioral weight loss program increase
the effectiveness of that program?"

Significance of the Study

In a survey of adult concerns, American women placed weight concerns in first
place above worry about rising prices and worry about health (Kanra, 1981). A survey
conducted by MacMillan (1994) indicated that, in any one-year period as many as 45 out
of 100 American women are on a diet and that 75 out of 100 women think they should
lose weight. American women are spending an incredible amount of time, money and
effort in their pursuit of thinness. This study is important because it suggests American
women may soon be able to take advantage of an inexpensive, readily available weight
loss plan. This method of weight loss combines tried and true principles of
cognitive/behavioral therapy with the benefits of hypnosis. It’s also important because it
adds to the concept of weight gain as a lifestyle issue with underlying psychological
factors that can only be addressed through some type of counseling.

Organization of the Study

Chapter 1 is the Introduction. It includes a short summary of the literature, a
statement of the problem, the purpose for the study, the need for the study, research
question to be answered, significance of the study and definitions. Chapter 2 is a Review
of the Literature and includes a history of obesity in the United States, effects of obesity
on physical and mental health, benefits of weight loss, weight loss strategies and
treatment options. Chapter 3 outlines the Methodology used and includes the hypothesis,
research design, instrumentation, procedures and data analysis. Chapter 4 is an analysis
of the data. Chapter 5 is a Discussion of hypothesis, limitations, implications for treatment and conclusion.

Definition of Terms

Body Mass Index (BMI) is a popular and convenient indicator of obesity. BMI is the ratio of a person's weight in pounds, multiplied by 700 and divided by the square of the person's height in inches.

Behavioral Therapy is associated with conditioning and learning. When using behavioral therapy, the therapist utilizes positive reinforcement of desired behaviors or negative consequences for problem behaviors.

Cognitive Therapy helps the patient recognize and utilize thought patterns which will be beneficial to the patient.

For the purpose of this study, the word adjunct means an addition to an already existing plan to lose weight.

Hypnosis refers to a state of relaxation during which subjects are able to experience an elevated ability to focus and concentrate. It is an altered state of consciousness in which certain normal human capabilities are heightened while others fade more or less into the background. A certified hypnotherapist is able to observe this state in his/her subjects.

A certified hypnotherapist is a licensed therapist who has received advanced training in hypnosis and has demonstrated this ability to a nationally approved evaluator.

Hypnobehavioral treatment involves suggesting positive behavioral changes while a patient is under hypnosis. Hypnocognitive treatment involves suggesting positive cognitive changes while a patient is hypnotized.
CHAPTER II
SURVEY OF RELATED LITERATURE

History of Obesity

In the early 19th century, it was popular among middle-class families to have large families. Many families lived in rural farming areas and needed the help their children could provide. In this environment, middle-class children were economically priceless (Kett, 1990). Work was physically demanding and obesity was seldom a problem. Additionally, many of our ancestors appreciated the human body in a fuller form than is fashionable today.

By the late 19th century, families were moving from the farm to cities in great numbers. Middle-class families were distinguished by their declining size and the way in which they nurtured their children. Increasingly, middle-class daughters lived with their parents until they married. This period of dependency distinguished the middle class from the working class poor, who, of necessity, lived and labored outside the home, sometimes even in childhood (Kett, 1990).

As a result of the intensification of family life, middle-class girls received more parental attention. In this environment, middle-class girls became emotionally priceless and economically useless (Kett, 1990). In the 19th century middle-class society, parents gave gifts of material nature to their children as expressions of their love and concomitant to their social status (Kett, 1990). In this very fundamental way, love and one of the most basic gifts, food was intimately connected.
In an era when food consumption was increasing and culinary standards were escalating, family meals assumed enormous importance in the bourgeois milieu. The ambiance of the meal symbolized the spirit and values of the family. Among the middle class, it seemed that eating correctly was emerging as a new morality, one that set its members apart from the working class. Because the meal symbolized the emerging class of the family, what and how women ate took on added significance. Women learned to eat to avoid creating a certain image which was deemed inappropriate. At the same time that eating well and properly was becoming the norm for middle-class families, young women were encouraged to present certain images in order to marry well (Blumberg, 1988). Because the match reflected on the family, girls were under considerable scrutiny and many experienced intense pressures associated with becoming a proper kind of woman and making an advantageous marriage. Victorian mothers assumed the responsibility for helping their daughters develop a suitable social identity and moral character. This maternal involvement was reflected in the popularity of late-nineteenth century advice books. Much of the advice to mothers centered on how girls should eat, exercise, bathe, and fix their hair and what they should be told about adult sexuality (Kett, 1990).

The pendulum of fashion among the middle class began to swing to a look of daintiness. Young women were encouraged to look frail, dainty and naïve in order to attract a desirable mate. Appetite was regarded as a barometer of sexuality and both mothers and daughters became concerned about its expression and control. So, young women were being taught to ignore bodily sensations of hunger, and to eat to satisfy the needs of others (Kett, 1990).
No food, other than alcohol, caused Victorian girls more moral anxiety than meat. The flesh of animals was considered a heat-producing food that stimulated production of the blood and fat as well as passion (Blumberg, 1988). Doctors and patients shared a common misconception of meat as a food that stimulated sexual development and activity. Young girls were beginning to learn that some foods are strongly connected to emotions, and that one could control one's emotions by eating a certain way (Blumberg, 1988). For example, a woman might avoid eating meat in order to control sexual feelings.

At the same time that food was being used to express love and to control emotions in the bourgeois household, corporal punishment declined as a technique in the control of adolescents. New forms of emotional or moral discipline took the place of the rod. Denial of food was an easy, accessible parental weapon. Parents prided themselves on providing ample food for their children, yet, when a child's behavior was unsuitable, they chose to let the child go unfed (Blumberg, 1988). This disciplinary strategy was in keeping with a conception of the appetite as a representative of will. An almost universally accepted tenet was that Victorian children should never be allowed to express a food preference, but should eat what was set before them. At the same time that parents were depriving children of food as a form of discipline, they also used certain foods as a reward. Special food treats would be given to children who exhibited the desired behaviors.

In Victorian society, food and femininity were now linked in such a way as to promote restrictive eating among adolescent women. When food was plentiful and domesticity venerated, eating became a highly charged emotional undertaking. Displays of appetite were difficult for young women who understood appetite to be a sign of sexuality and an indication of lack of restraint (Blumberg, 1988).
Food and eating were connected to other unpleasantries that reflected the self-identity of middle-class women. Food preparation was a time-consuming job in the middle-class household when meals were served as individual dishes in a sequence of courses. Women of means were able to remove themselves from food preparation by hiring maids and cooks. Alienation from food became a symbol of prestige and status. Also, food was to be avoided because it was connected to gluttony and to physical ugliness. Sarah Josepha Hall (1857), the influential editor of Godey's Lady's Book and an arbiter of domestic manners, warned women that it was always vulgar to load the plate. Careful, abstemious eating was presented as insurance against ugliness and loss of love (Hall, 1857).

By the last decades of the 19th century, a slim body symbolized more than just a sublimity of mind and purity of soul. Slimness in a woman was a sign of social status. The idea that girth in a woman signaled prosperity in a man was no longer accepted. Rather, the reverse was true: a thin, frail woman was a symbol of status because she was unfit for productive work. Body image, rather than body function became of paramount concern (Blumberg, 1988).

By the turn of the century, elite society preferred its women thin and frail as a symbol of their social distance from working classes. Through restrictive eating and restrictive clothing, women changed their bodies in the name of gentility. In bourgeois society it became incumbent upon women to control their appetite in order to encode their bodies with the correct social messages. Appetite became less of a biological drive and more of a social instrument (Blumberg, 1988).
In the 20th century the body, not the face, became the special focus of female beauty (Blumberg, 1988). Dieting moved from the periphery to the center of women's lives. Dieting was already a fact of life for many American women by the 1920's when the institutions of beauty culture, the fashion and cosmetic industries, beauty contests, the modeling profession, and the movies were formalized (1988). As the rules of physical beauty were established in American popular culture, more and more women from a variety of backgrounds strove to meet the increasingly slender ideal.

Because the pursuit of thinness seemed to be accelerating in the 1920's, physicians took potshots at dieting programs that promised weight reduction. There were diet regimens based on everything from patent medicines to Kellogg's Obesity Food. Over the years, as the impetus of female slimness intensified, women were sold many products, including cigarettes, to help them become or remain slim. Between 1900 and 1920 both the medical establishment and the insurance industry began to promote an ideal body type that was decidedly thinner than fifty years before. During this period, the first medico-actuarial standards of weight and health emerged, and doctors suggested that overweight was a serious health liability (Blumberg, 1988).

**Overweight in Women**

While Progressive Era ideology fostered an expectation of personal responsibility for the body in both sexes, women began to internalize the responsibility for weight maintenance in ways that men did not. By the twentieth century, being an overweight woman was not only a medical liability, it was a character flaw as well (Blumberg, 1988).

By the 1930's ready-to-wear clothing was becoming increasingly available and popular. In order to market this type of clothing, the industry turned to standard sizing, an
innovation that put increased emphasis on personal body size. For women, shopping for ready-to-wear clothes in the department stores of the twentieth century fostered heightened concern about body size (Blumberg, 1988). By the end of World War II, heterosexual relationships were in transition. Marital dissolutions were on the rise. Personal happiness and satisfaction had replaced duty and sacrifice as the glue that made marriage work. Women were told by filmmakers, advice columnists, and often by other women, that their failure to retain their physical charm led to divorce court (Blumberg, 1988).

At the same time that larger bodies were becoming less socially acceptable and food was becoming more of an emotional experience, life styles for American women had been dramatically changing. In the early 1960s, only 2 million women worked outside the home. Today 75 million women have jobs outside the home and 62 million of them are women with school aged children. Women continue to perform more than their fair share of childcare and household duties. The constant stress of balancing job and family leads to emotional eating. Busy mothers may resort to the convenience of fast food to feed their families. These foods, while convenient are often highly processed and fat laden (Minirth & Meier, 1990).

There are more single mothers in our society today than ever before (Kett, 1988). In a survey of 6,000 single mothers, 3,276 reported that they often felt exhausted and overwhelmed (Kett, 1998). They spent spare time watching television and ate over half of their meals in restaurant. Many of these mothers reported spending increased time in front of the computer and stated that they allowed their children to spend their spare time watching television, videos, and playing computer games. Studies (Minirth and Meiers,
2000) show that Americans, in general, were more sedentary in 1999 than in 1989, spending an average of 35 hours per week per person in front of a computer screen or television (Minirith and Meiers, 2000).

From this discussion, it is evident that the consumption of food has evolved from a basic, uncomplicated necessity to a stress producing, symbolically complicated, and emotionally charged process. It is equally obvious that women are leading more sedentary lives. American women are no longer generally accepted in their fuller form and many are in a constant battle to stay slim (Minirith and Meiers, 2000).

Effects of Obesity on Physical Health

The Framington Study is a research project, begun in the 1960s, which compares all of the adult inhabitants of the town of Framington, Massachusetts. A great deal of information has been gleaned from this study. It is considered to be a major study on which many subsequent studies have been based (Anchors, 1997).

Experts disagree on the level at which obesity becomes a medical problem, but common sense dictates that it is a problem when life expectancy is reduced. The threshold level, deduced from the Framington data (Anchors, 1997), is around 20 percent above ideal body weight. The life expectancy curve slopes more steeply downward after 30 percent above ideal body weight: that level is defined as the threshold of obesity.

There are several different methods of calculating recommended weight range. For example, one formula is as follows: 100 pounds for the first 5 feet of height, plus 5 pounds for each additional inch, plus 10 pounds if you are a male. Another method is to use a recommended Weight Range Table as established by the Health, Education and Welfare Conference on Obesity (1973), or the weight table published by the Metropolitan
Life Insurance Company. The wide range in recommended weights in these tables is not sufficiently precise for a scientific study. Body Mass Index (BMI) is considered the most reliable standard of measure by many authors who are knowledgeable in this field including Michael Anchors (1997), A.W. Logue (1986), L.J. Bennion, M.D., E.L. Bierman, M.D., and J.M. Ferguson, M.D. (1991).

There can be no doubt that obesity is a serious health concern to a considerable number of people. Between 1981 and 1991, average BMI in the United States increased from 25.3 to 26.3 (Kuczmarski, R. et al, 1994). The increase was greatest for women, Hispanics, and African Americans who have a national average BMI of 28.3. In 1994, 34.9 percent of adults in the United States were morbidly obese according to their BMI's and suffer a higher rate of poverty than their thin counterparts. This may be due to the fact that obese women tend to drop out of school at an earlier age and suffer from job discrimination.

Researchers appear to be in agreement on the conclusion that obesity is associated with illnesses and risk factors for disease that shorten life and decrease quality of life. Bennion, Bierman, and Ferguson (1991), point out that obesity raises the blood levels of cholesterol and triglycerides. Too much cholesterol in the blood stream leads to clogging of the arteries that supply the heart with blood and oxygen. High cholesterol levels have been shown to contribute to heart disease, including heart attacks. Author, Michael Anchors, M.D. (1997), concurs with Bennion et al. (1991), and adds that obesity also increases the chance of a stroke. A stroke is a sudden loss of brain function due to loss of blood supply. Because strokes are usually caused by arteriosclerosis, the same fatty
clogging of the arteries that causes heart attacks, it is not surprising that obese people are subject to strokes as well as to heart attacks, conclude Bennion et al. (1991).

In one study, women who are obese had four times the risk of death from coronary artery disease as normal weight women (Manson, 1995). Manson (1995) has also concluded that obesity appears to be an important cause of high blood pressure. High blood pressure or hypertension means that the water pressure of the blood within a person’s arteries is higher than normal. This condition causes strokes, heart attacks, heart failure and kidney disease. How and why obesity causes hypertension are still matters of conjecture, but researchers including Abraham, Carroll, Najjar, and Fulwood (1983), concur with Manson’s (1995) finding.

Sulans, Knittle, and Hirsch (1983), point out that the prevalence of diabetes mellitus is three times higher in obese than in non-obese women. Diabetes is a chronic condition in which the blood levels of glucose, fats, and other nutrients are above normal. Over a period of many years, diabetes causes damage to the kidneys, nerves, eyes, and blood vessels, including heart attacks and strokes. According to Sulans et al., it is a major cause of disabilities and death, and contributes significantly to the elevated death rates seen in obese people. The well-respected American Diabetes Association (1979) concurs that obesity is the single most associated with the development of diabetes. The chance of developing diabetes increases five thousand per cent in morbidly obese people (Manson, 1995).

In a 1979 study, authorized by the American Cancer Society, Lew and Garfinkel found that the risk of cancer increases proportionately with increases in a patient’s weight. Bennion, Bierman, and Ferguson (1991) have found that several different types
of cancer are more common in obese than in non-obese individuals. They cite cancer of the endometrium, gallbladder, breast, colon, rectum, and prostate as being associated with obesity. They agree that a causative link is not clear-cut in all but endometrial cancer.

Michael Anchors, M.D. (1997) has found that obese individuals have an increased risk of cancer, particularly of the colon and breast. He states that women who are morbidly obese have twice the risk of death from cancer compared to normal weight women.

Manson et al. (1995) has focused their attention on gastrointestinal problems aggravated by obesity. They have found that, in obesity, the weight of abdominal fat presses on the stomach forcing stomach contents into the esophagus. Unlike the stomach, the esophagus is not coated with acid-reducing mucus. Acid in the esophagus causes pain, erosion, and scarring. This discomfort is often referred to as heartburn. Additionally, the pressure of abdominal fat can push the stomach partially up through the diaphragm, a painful condition referred to as hiatal hernia. Hiatal hernia may require surgery, which places the obese person at additional risk. Surgeons are in agreement that obesity increases the dangers of major surgery and produces frequent problems including difficulty taking deep enough breath to avoid pneumonia, increased risk of blood clots and impaired healing of incisions (Andres, 1990).

Bennion et al. (1991), Manson (1995) and Lew et al. (1979) have confirmed the connection between obesity and increased risk of gallstones. Although gallstones, which are rocks that form in the gallbladder, may cause no symptoms at all, they can potentially cause the gallbladder to become acutely inflamed requiring emergency treatment, according to Bennion et al. (1991).
In their 1979 study, Lew and Garfinkel have established the positive correlation between obesity, arthritis, and orthopedic problems. They point out that there are several different types of arthritis and two of them are more common in obese than in non-obese persons. One type of arthritis found more frequently in the obese is gout. Gout results from needle-like crystals of uric acid which form inside the joints. These crystals may also form inside the kidneys causing kidney stones and kidney damage. Obesity increases levels of uric acid in the blood and increases risk of crystal formation. The other type of arthritis associated with obesity is osteoarthritis. Lew and Garfinkel (1979) point out that, although the cause of this degenerative joint disease is not fully understood, excess weight complicates matters by putting pressure on weight-bearing joints. More recent studies by Manson (1995) have confirmed the findings of Lew and Garfinkel (1979).

Bennion, Bierman, and Ferguson (1991), in their book, Straight Talk about Weight Control, have mentioned several health problems which are more prevalent among obese people. For example, their research shows that obesity adds mechanical strain to lower the lower spine and renders persons more prone to lower-back pain. They also point out the fact that obesity causes a very specific skin condition known as acanthosis nigricans which causes a thickening and darkening of the skin. Acanthosis nigricans also is associated with insulin resistance and a tendency to develop diabetes.

At the 1989 meeting of the National Research Council, the Committee on Diet and Health, Food and Nutrition Board Commission on Life Sciences reported on the connection between obesity and problems with breathing. They found that large quantities of fat distend the abdomen, weigh down the chest wall and make breathing difficult. Even when asleep, obese people have difficulty breathing and may develop
sleep apnea, in which breathing during sleep is interrupted by periodic failure to breathe for several seconds at a time. Patients complain of feeling tired all the time and may become depressed. More dangerous and severe, however, is a condition known as Pickwickian Syndrome, in which periodic failure to breathe occurs even when the patient is awake. Obese people with this rare condition are unable to obtain an adequate supply of oxygen and energy. This can be a life-threatening situation and weight reduction is mandatory. Death may occur if the patient does not lose weight.

The 1989 National Research Council reported on other weight-related health problems, including varicose veins. They found that excess fat in the body prevents proper compression of veins and the blood cannot move efficiently. The veins become distended with blood resulting in wormlike bulges beneath the skin. Local stagnation of blood flow can result in swelling of the ankles and/or phlebitis which is a clotting of blood within the veins. Blood clots occasionally dislodge and can travel to the lungs, causing sudden shortness of breath, wheezing, chest pain, and even death.

Doctors who specialize in obstetrics and gynecology also report problems related to pregnancy, labor, and delivery caused by obesity (Roberts, Savage, Coward, Chew, and Lucas, 1988). According to P.E. Frisch (1990) extreme obesity can even prevent pregnancy because excess estrogen, produced by fat tissue, acts like a birth control pill and interrupts a woman’s monthly ovulation. Bennion et al. (1991) has discovered that, once pregnant, an obese woman faces risks and problems beyond those encountered by women of normal weight. These problems include a doubling of the risk of phlebitis, a four to fivefold increase in the risk of infections of the bladder, a several fold increase in
the incidence of developing high blood pressure, and a ten to twenty fold increase in the likelihood of developing diabetes.

From this discussion it is obvious that obesity is a serious health risk to a considerable number of people. Researchers appear to be in agreement on the conclusion that obesity is associated with illnesses and risk factors for disease that shorten life and decrease quality of life.

Effects of Obesity on Mental Health

In addition to physical health concerns, Wadden and Stunkard (1985) found that obese people experience social discrimination and psychological distress as a direct consequence of their weight. Problems range from lack of self-confidence to severe body image disparagement accompanied by feelings of self-contempt and personal inadequacy. Wadden, Stunkard, Rich, Rubin, Sweidel, and McKinney (1990), observed that psychological consequences of obesity vary according to social context, socioeconomic status, and race. For example, among lower socio-economic status (SES) groups, in which obesity is prevalent, being overweight represents less of a social stigma than for higher SES groups. As a consequence, obese individuals, in this social context, do not seem to experience as much weight related distress. Also, according to Wadden et al. (1990), there appear to be racial differences in preferred body types.

G.T. Wilson (1993) conducted a study of the relationship between being overweight and subsequent educational attainment, marital status, household income, and self-esteem. Subjects provided detailed personal information and data were updated annually over a seven-year period. Characteristics of the overweight subjects were compared with those for other young people with chronic health problems. Seven years
later Wilson (1993) found that women who had been overweight had completed fewer years of school, were less likely to have married, had lower household incomes, and had higher rates of poverty than their non-overweight counterparts (1993). Overweight men were less likely to have married. In contrast, people with other chronic medical conditions did not differ in these ways from the non-overweight (Grimacer, 1994).

In a 1965 study, Goldblatt, Moore, and Stunkard reported on the social and psychological consequences of obesity. They determined that there is a strong prejudice against the obese in this country, regardless of age, sex, race or socioeconomic status. Children as young as six years old describe silhouettes of the obese child as “lazy”, “dirty”, “stupid”, “ugly”, “cheats”, and “lies”. When shown line drawings of a child of normal weight, an obese child, and children with various handicaps, children and adults rate the obese child as least likable. Overweight is regarded, not only as a sin, at odds with the Protestant ethic of self-denial and impulse control, but also as a crime for which a person is held responsible. And, beyond these moral and legal transgressions, obesity is an aesthetic crime (Goldblatt et al., 1965).

Obesity and Self-Esteem

Many obese women experience psychological suffering which may be the most painful aspect of this condition (Bennion, Bierman, & Ferguson, 1991). The psychological consequences of obesity range from a sense of mild inferiority to severe incapacitation. For many obese women, contempt for their own bodies, and feelings of guilt, embarrassment, helplessness, and failure, brought on by their obesity, are enormously painful (Bennion et al., 1991). Human beings are unique in their ability to be aware of self. They form an identity and attach value to it. Attaching a high value to
one’s self image is said to be positive self-esteem, while attaching a low value to one’s image is labeled as low self-esteem. In a society where appearing to look thin is highly valued, it is difficult for an obese woman to think highly of herself (Bennion, Bierman, and Ferguson, 1991). Those who study self-esteem issues are quick to point out that self-esteem is essential for psychological survival. Without a positive sense of self, life can be enormously painful, with many basic emotional needs going unmet.

One problem with self-esteem is the human capacity for judgment. When a part of oneself is rejected, such as the physical body, damage is done to the psychological structures that keep one alive (Bennion et al., 1991). Negative self-judgments cause great pain and result in the avoidance of anything that might aggravate the pain of rejection. Individuals tend to take fewer social, academic, or career risks. The ability to connect with others is impaired which means that emotional needs normally met through relationships with others go unmet (Bennion et al., 1991).

Good mental health is partly dependent upon one’s ability to find strategies for meeting one’s own emotional needs. Human emotional needs vary from individual to individual but, in general, include the need to feel attractive, to be liked, to feel important, to be appreciated, to be approved of, to be safe, and to feel a sense of accomplishment. In our society, where thin body types are admired, women who are obese are often thought of as weak, unattractive, undisciplined, and undesirable. In an atmosphere where judgments are made daily in magazines, newspapers, television, and disapproving looks from others, it is difficult for obese women to maintain a positive self image and to avoid harsh self-judgments (Macmillan, 1994).
Psychological differences between obese individuals and normal weight individuals include perception about body image and attitudes toward weight and eating. According to Macmillan, (1994) body image has been defined as the “perception of one’s body size and appearance and the emotional response to those perceptions” (p.76). In body image evaluations patients are usually asked to identify drawings or pictures that correlate with their perceptions of their own bodies. Typically, obese individuals are less accurate than normal weight persons in estimating their size and appearance. On average, obese persons over estimate their size by six to twelve percent (Macmillan, 1994).

In a survey of adult concerns, American women placed weight concerns in first place above worry about rising prices and worry about health (Kanra, 1981). A survey conducted by MacMillan (1994) indicated that, in any one year period as many as 45 out of 100 American women are on a diet and that 75 out of 100 women think they should lose weight. Diet books continue to be best sellers and even children in elementary school are weight conscious. Teasing overweight children is commonplace, and psychological testing demonstrates widespread prejudice against obesity (MacMillan, 1994). By the sixth grade, as many as 40 out of 100 girls have already been on a diet.

Benefits of Maintaining a Healthy Weight Loss

Longitudinal studies (MacMahon, Wilcken, & MacDonald, 1986) have shown that weight loss can reverse many of the problems caused by obesity. Just as weight gain leads to changes in levels of blood pressure, cholesterol, glucose tolerance, and uric acid which increases the risk of cardiac disease, studies show that weight loss produces a corresponding decrease of risk (Bennion, Bennion, & Ferguson, 1991). In a study conducted by the Framington Group (1993), a cohort of 5,209 adults has been followed
since 1948. This study has provided valuable information about the long term-relationship between weight change and changes in the major risk factors for cardiovascular disease. The data show that, for a male between the ages of 45-54, a reduction of 20 pounds for a 200 pound man corresponds to a significant reduction in the risk of coronary heart disease. For a younger man, there is an even greater reduction of risk. For women, the reduction in risk is less dramatic, but important.

The associations between weight change and risk for coronary disease have significant implications in the treatment of obesity. It is clear that weight reduction leads to beneficial changes in atherogenic risk factors and reduces the risk of disease (MacMahon, Wilcken, & MacDonald, 1986). For many health care professionals, these data emphasize the importance of treating and preventing obesity.

Insurance company data also indicate that weight loss has a beneficial impact on health. In the 1959 Build and Blood Pressure Study, obese persons who lost weight had mortality rates comparable to persons who were never overweight (Society of Actuaries, 1980). These longitudinal findings clearly define the beneficial impact of weight loss on longevity.

Many intervention studies have documented the benefits of weight loss. In a 1986 controlled trial, MacMahon, Wilcken, and MacDonald evaluated the effects of weight loss versus appetite suppressant drugs versus a placebo in patients with hypertension. At the end of the three week study, patients in the weight-reduction group showed significantly greater decreases in diastolic blood pressure than subjects in either the group who took appetite suppressant drugs or the group who took a placebo. Wing, Koeske, Epstein, Nowalk, Gooding, and Becker (1987), have studied the effects of weight loss on
diabetic patients. One hundred and fourteen adults with diabetes underwent treatment for obesity and were followed for one year. Patients were divided into groups based on the amount of weight each person lost. After one year, six patients had weight loss that exceeded thirty pounds. These individuals showed dramatic improvements on measures of blood glucose and blood lipid levels. Even patients who lost between five and fifteen pounds showed significant improvement even though they did not achieve ideal weight (1987). These studies show that steady maintenance of normal weight for height is an important part of health care.

Impact of Weight Loss on Psychological Functioning

For years, the impact of weight loss on psychological functioning has been debated. Studies from the 1950s and 1960s routinely showed that weight loss was accompanied by depression, nervousness, weakness, and irritability (Stunkard, 1957). Some researchers have speculated that such negative emotional states are attributable to reductions in body weight below a biological set-point. Stunkard and Rush, in their 1974 study, speculated that negative emotional complications may not arise until weight loss exceeds a particular threshold and that, when the threshold is exceeded, adverse emotional consequences may be precipitated by metabolic processes operating in defense of a biological set-point for weight. A more recent study by Wadden and Stunkard (1986), tested the effects of three conditions: (a) a very low calorie diet (400-500 calories per day), (b) Behavioral therapy, and (b) the combination of a very low calorie diet and behavioral therapy. The researchers studied the impact of weight loss on mood. All three groups of subjects lost substantial amounts of weight. At post treatment, the mean weight losses were substantial and large enough to exceed the presumed threshold for emotional
complications. There were no increases in depression and patients whose treatment included behavioral therapy showed decreases in depression. The results of this study (1986) are important because they dispel the myth that weight loss is accompanied by depression. The findings, from a variety of studies, show that behavioral treatment of obesity is associated with improvement in mood (Wing, Teal, 1984).

Hamm, Shekelle, and Stamler (1989) have studied the impact of a cyclical pattern of weight loss and weight gain. Their results demonstrated that a history of large fluctuations in body weight increased the risk of death due to coronary disease.

Weight Loss Strategies

In light of the steadily growing obesity statistics, weight loss treatment plans abound. Treatments for obesity range from drug therapies to cognitive and behavioral models. In extreme measures, surgery, commonly known as gastric bypass, has been used to staple the stomach or tie off sections of the intestine so that less food absorption can occur (MacMahon, Wilcken, & MacDonald, 1989). To date, drug therapies have been problematic to say the least. Patients tend to quickly adapt to medications which suppress the appetite so that the medication is only effective for 2 to 3 weeks (MacMahon et al., 1989). Other drugs, which inhibit fat absorption in the intestine, have unpleasant side effects. Additionally, because no real change has taken place cognitively or behaviorally, patients tend to regain the pounds they lost while taking the medication (1986). In some patients, appetite suppressant drugs cause substantial increases in blood pressure. As a result, these patients must be monitored by a physician while taking the drug (MacMahon et al., 1986). The drug Redux is a cautionary tale on the dangers of seeking weight loss help in the form of a pill. The drug was banished from the market in 1998 after
researchers linked it to heart valve damages in obese patients (Wurtman, Kuczmarski, & Anchors, 1999).

At present, plans, which include cognitive and behavioral life style changes, seem to offer the safest, effective, and long lasting treatment (Wurtman et al., 1999). These plans encourage participants to attend weekly meetings or counseling sessions where they document weight and receive information pamphlets describing cognitive and behavioral changes. Participants are encouraged to record their food intake and attend short motivational and instructive meetings.

**Cognitive and Behavioral Therapy**

Studies (MacMahon, Wilcken, & MacDonald, 1986), show that new and enduring patterns of thinking, eating behavior, and physical activity are the keys to permanent weight reduction. To achieve a lasting solution to obesity, cognitive and behavioral modification teaches people to eat in a controlled way, stay physically active, assert themselves in eating situations, change thoughts and attitudes about food and free themselves from eating for emotional reasons. There are advantages and no disadvantages to the use of cognitive and behavioral modification therapy in the treatment of obesity. It is a therapy that anyone can use. It is inexpensive and safe. Furthermore, cognitive and behavioral changes can result in overall improvement in mental and physical health. Cognitive and behavioral therapy, like other forms of obesity treatment, is still evolving. New strategies to improve eating and exercise behavior and thinking are constantly being tested. For example, some weight loss treatment programs encourage their patients to listen to tapes which reinforce behavioral changes. Others provide participants with pamphlets which promote different life style changes each
week. Still others encourage participants to attend a weekly lecture which stresses certain aspects of cognitive or behavioral therapy such as following a certain food program or becoming more active. Although some of the techniques are successful for some overweight people, more research is needed to improve the effectiveness of this treatment for more individuals.

Behavioral medicine is a relatively new field in which clinical methods and theories derived from the behavioral sciences are applied to the treatment of medical illness. In the early 1970s, behavioral medicine was developed as a scientific and clinical discipline in its own right. During the 1970s behavioral medicine underwent a significant revision. Behaviorism had traditionally been associated with conditioning and learning. The early clinical procedures, based on a conditioning model, were largely aversive. As outcome studies began to accumulate, it became clear that positive reinforcement of desirable behavior was more effective than negative reinforcement of problem behaviors (Schachter, Gross, & Stuart, 1980). Behavioral therapists began to think more about the generation of new adaptive repertoires. Additionally, behavioral scientists began to focus on the patient’s internal resources as well as her outward behavior. As cognitive psychology began to emerge as a legitimate field of inquiry within psychology, behaviorists began to soften their historic rejection of the importance of thought processes in behavioral change (Schachter et al., 1980). The current practice of behavioral medicine is an integration of behavioral therapy, an understanding of physiological processes, cognitive therapy, self-control strategies, and an understanding of altered states of consciousness and biofeedback.
Standard tools of the behavioral therapist include self-monitoring, stimulus control, self-control of internal states, and behavioral self-regulation. Self-monitoring is the process of becoming consciously aware of behaviors. Stimulus control involves becoming aware of triggers for certain behaviors and controlling those stimuli. Self-control of internal states involves becoming aware of and controlling emotions which may lead to certain behaviors. And, behavioral self-regulation is the means by which the patient increases the probability of promoting health behaviors through self-monitoring, establishing self-imposed performance criteria and setting up means of self-reinforcement. Of particular interest to those therapists who work with obese patients is behavioral self-regulation and self-monitoring (Brown & Fromm, 1987).

Since hypnotherapy is an effective tool in communicating with the subconscious mind and in altering old beliefs and habits, it appears that the addition of hypnosis to a cognitive and behavioral plan may be effective.

Hypnosis

Brown and Fromm (1987) have defined hypnosis as a special state of consciousness in which certain normal human capabilities are heightened while others fade into the background. They point out that hypnosis is now generally accepted as an altered state of consciousness (ASC). Ludwig (1966) coined the term, ASC, defining it an altered state according to subjective experience and altered psychological functioning. According to Ludwig (1966), in an altered state, one's perception of an interaction with the external environment are different than in the waking state, and one is more deeply absorbed in internal experience. Tart (1975) argued with Ludwig and expanded on Ludwig's (1966) work by noting that each altered state of consciousness is a stable
pattern and that it takes a certain energy and attention to disrupt this pattern and to produce the new quasi-stable state.

Hypnosis meets the criteria for an ASC as set forth by Ludwig (1966) and Tart (1975). This altered state of hypnosis has been described by many authors including As, Arrid, and Ostrold (1968), Field and Palmer (1969), Fromm (1977), Fromm et al., (1981), Gill and Brenman (1959), and E.R. Hilgard (1977) along the dimension of absorption in an unusual experience, the fading of awareness of one’s surroundings, and alterations in perception and in cognition.

The degree to which subjects become hypnotized is commonly referred to as hypnotic depth. According to Brown and Fromm (1987), hypnotic depth may be viewed objectively as the behavioral response to hypnotic induction and suggestion. It may also be viewed subjectively as the sense of how deep into the experience of hypnosis the subject feels she goes. Hilgard’s (1965) assessment of depth involves both behavioral and experiential viewpoints. Hilgard (1965) defines hypnotic ability as “the ability to become hypnotized, to have the experiences characteristic of the hypnotized person, and to exhibit the kinds of behavior associated with it”.

Innumerable research studies, especially those with the Stanford Hypnotic Susceptibility Scales (Weitzenhoffer & Hilgard, 1962) have made it clear that there are vast individual differences in response to hypnosis. According to Weitzenhoffer and Hilgard (1962), hypnotizability is a relatively enduring characteristic that presumably exists independently of whether one has been hypnotized before. Responsiveness to hypnosis is much less due to the skills of the hypnotist than to the ability or lack of ability of the person being hypnotized. Hilgard (1965) has found that only moderate
susceptibility is needed for most clinical situations and that about sixty percent of all people are initially responsive enough to warrant considering hypnotherapy.

According to Crasilneck and Hall (1985), one of the most important factors in the success of hypnotherapy is the patient’s unconscious motivation to succeed. Von Dedenroth (1962) concurs and adds that unconscious motivation may be more important to success than “depth” of trance. Patients themselves cannot assess this, nor can therapists, but when patient’s conscious and unconscious motivation is both high, success in hypnotherapy is most likely. Von Dedenroth (1962) has found that motivation does not necessarily correlate with severity of the problem; it may be related more to the emotional meaning of the problem. According to Crasilneck and Hall (1985), the patient must believe in the suggestion being given and must accept the well meaning of the hypnotherapist in order for motivation to work maximally. Braun and Fromm (1987) have shown that hypnosis enhances the effectiveness of behaviorally oriented therapies and reduces the duration of treatment. Weitzenhoffer (1957) has found that the repetition characteristic of the hypnotic induction improves learning in hypnosis and heightens susceptibility. Additionally, Weitzenhoffer (1957) has extensively studied the use of posthypnotic suggestions and found that they can directly influence the patient’s behavior outside the therapy hour. Posthypnotic suggestions can serve as a means of reinforcement as an adjunct to behavioral self-regulation.

Crasilneck and Hall (1985) report consistent positive results using hypnosis with behavioral suggestion to reduce total daily calorie intake. They have also used hypnosis to modify certain cognitive processes, such as the desire to eat certain foods. Hypnotherapy can often enhance a cognitive/behavioral approach to weight loss, an
observation that is one of the most clinically confirmed in all the literature on hypnosis (Cohen, 1979; Crasilneck & Hall, 1976; Goldstein, 1981; Kroger, 1977; Mann, 1981; Nuland, 1974; Speigel & Speigel, 1978; & Stanton, 1975).

Ringrose (1979) found that more than eighty-five percent of 159 obese patients lost notable amounts of weight using hypnosis in combination with cognitive and behavioral suggestions for change. According to Halpern (1983), it is important to help patients develop a positive body image as well as to facilitate weight loss. Obviously, therapists who use hypnosis to help their patients lose weight report that it works. Others criticize the anecdotal nature of their reports and cite the lack, in many cases of long-term follow-up results (Mott & Roberts, 1979).

Hirsch and Knittle (1970) have done studies which involve the taking of a weight history, including the age at which the weight first became a problem. They found that obesity which begins in childhood differs from adult obesity. In the former there are usually a greater number of fat cells. Patients with childhood-onset obesity may have a more difficult time losing weight than patients with adult-onset obesity. Hirsch and Knittle (1970) attempted to ascertain significant variations in weight over the course of the life cycle and looked for changes in life events associated with weight changes. They then used post-hypnotic suggestion to teach patients to respond to life events in a way that did not lead to weight gain. While many of these patients did lose weight, there were no long-term follow-up studies done to indicate whether or not the results were permanent.

Christensen, Jeffrey, and Pappas (1997), Ferster, Numberger, and Levitt (1962), and Wallersheim (1977) studied the patient’s motivation to lose weight. They found that
some patients needed intervention designed to clarify or increase motivation. Specific reasons for losing weight were incorporated into post-hypnotic suggestions to strengthen the patient’s desire for weight loss (Crasilneck & Hall, 1975; Winkelstein, 1959). Because there was no control group, there is no way to tell if the weight loss was or was not facilitated by hypnosis.

Many researchers have used post hypnotic suggestion to encourage patients to resist certain fattening and unnecessary foods (Sclafani, 1980; Hershman, 1955; Kroger, 1970; Winkelstein, 1959; & Aja, 1977). In hypnosis, patients may be given suggestions to eat healthful foods previously thought to be distasteful, to reduce the amount of food eaten, to reduce appetite, or to fast occasionally (Brodie, 1964; Glover, 1961; Crasilneck & Hall, 1975). Here again, there were no control groups which leaves the conclusion of the studies in doubt. Several researchers have reported that their patients lost weight when they received post hypnotic suggestions about the act of eating. They were encouraged to eat more slowly and to make eating a vivid gustatory experience (Erickson, 1960; Brodie, 1964; & Aja, 1977). These studies were conducted with a very limited number of subjects; there were no control groups and no follow-up studies.

Taylor, Buskirk, and Remington (1973); Brownell and Stunkard (1980); Miller and Sims (1981); and others have used hypnosis to encourage compliance with exercise programs. They concluded that post-hypnotic suggestion did increase the likelihood of patient’s compliance and that the patients who received this treatment did lose weight. They also found that these patients maintained their weight losses over the next five years. There were no control groups used in these studies.
Wadden and Anderton (1982) claimed a hypnotic induction did not add anything to the treatment effect and that treatment outcome did not correlate with hypnotizability (Cohen & Alpert, 1978; Deyoub, 1979; Deyoub & Wilkie, 1980). They concluded that “hypnosis does not appear to be of unique value for weight reduction” (p. 224) and that positive treatment gains were due to expectation effects, not to the hypnotic condition. However, the studies that failed to show a difference between hypnotic and non-hypnotic treatment utilized simple, direct suggestions for weight loss (Wadden & Flaxman, 1981) or simple suggestions for changing eating patterns and self-image (Miller, 1974). In other words, these researchers felt that the hypnotic treatment protocol used in all these studies were ill-conceived and simplistic.

This review of literature shows that there have been numerous studies which focus on only one aspect of cognitive and behavioral modification. Further controlled outcome studies are needed on the efficacy of treatment protocols which combine a broad range behavioral modification plan with hypnosis.
CHAPTER III  
METHODODOLOGY  

Hypothesis  

The null hypothesis in this study may be stated as follows: There is no significant difference between the mean weight loss of the treatment group and the mean weight loss of the control group.

Subjects  

The subject pool is composed of women between the ages of 40 and 50 who have some level of motivation to lose weight. The women responded to fliers posted in public areas surrounding three universities: Clark Atlanta University, Georgia State University, and Kennesaw University. An office phone number was provided for those who were interested.

Criteria for participation in the study included a BMI of 30 or over, which was calculated by the researcher and score in the high hypnotizability range on the Induction Profile. The sample was composed of 40 women who were participants in the subject pool and who were willing to participate in an 8-week program directed at weight loss. Participants were required to weigh in each week and signed statements of confidentiality (Appendix A). Twenty women were randomly assigned to a control group who listened to weight loss suggestions each week and the treatment group, which consisted of the regular treatment as well as hypnotherapy.
Instrumentation

Patients were weighed in each week on a standard physician's scale. The weigh in was always at the same time of day and subjects weighed with their shoes on.

Research Design

This study involved a comparison of the mean weight loss of two samples, the treatment group who used post hypnotic suggestions to reinforce weight loss suggestions and the control group who only listened to the same suggestions. The researcher arranged with Emory Parkway Medical Center the use of a classroom in the Parkway Professional Building. The use of the same classroom for all sessions provided uniform experiences for both groups. Each group of 20 women met once a week for approximately a half hour. The two groups met on different nights of the week. Participants weighed in at the beginning of each meeting and their weights were recorded. After the weigh in, each group was read a lesson which emphasized weight loss suggestions (see Appendix B for Lesson Plans). One group was hypnotized (Appendix C) before hearing the lesson. The other group was not. At the end of the 8 weeks, the amount of weight lost by each group was computed and the mean of each group determined. The t test was used to determine statistical significance between the mean weight losses of the two groups. The recording of participant's weight at the beginning and end of the study served as pre-test and post-test.

There are assumptions that must be made about the population and the sample in order to use the small sample test of a hypothesis (McClave & Dietrich, 1993). They are as follows: (a) The population variances are equal (b) the samples are randomly and
independently selected from the population. The researcher has made the above assumptions in the use of the t test in this study.

Pilot Study

During the pre-test phase of the study, the researcher, who also served as the facilitator of the groups, conducted a pilot study. The researcher read books about diet and nutrition. She also attended weight loss meetings to determine the types of cognitive and behavioral weight loss suggestions most commonly given. Some of the groups visited were Weight Watchers, Jenny Craig, Overeaters Anonymous, and Doctor’s Quick Weight Loss Plan. The researcher compiled a list of weight loss suggestions and determined that there was a consensus among these weight loss experts. The various programs used many of the same ideas and suggestions (see Appendix B).

Procedure

Pre-Research: Procedure one. The researcher read various books on hypnosis to determine the best wording for post hypnotic suggestions. She reviewed several types of hypnotic trance inductions as well. She chose wording which, according to experts in Behavioral Hypnotherapy, was likely to facilitate compliance with post hypnotic suggestions. She chose a hypnotic induction which was suited for subjects in a small group who may be somewhat difficult to hypnotize. The researcher also examined several ways to test subjects for hypnotizability and attended a seminar in Florida to be trained to administer the test.

Pre-Research period: Procedure two. The researcher wrote a series of eight lesson plans which incorporated the most commonly used weight loss ideas with post hypnotic suggestion.
Pre-Research period: Procedure three. The researcher arranged with Columbia Parkway Medical Center the use of a classroom in the Parkway Professional Building. The use of the same classroom for all sessions provided uniform experiences for both groups.

Pre-Research period: Procedure four. The researcher printed fliers asking for volunteer subjects and posted them in public areas. She also spoke to classes of psychology students at three universities: Clark Atlanta University, Georgia State University and Kennesaw University and informed them of the study. An office phone number and address were provided for those who are interested.

Pre-Research period: Procedure five. When volunteers called to inquire about the study, a receptionist answered and told prospective subjects only the information provided on a script. Prospective subjects were asked to come to the office and fill out a preliminary intake sheet. These volunteers were asked to weigh and record their weights, to fill out a medical screening form, and to give an estimate of their levels of motivation. They were given a hypnotizability test without being told the purpose of the test. These volunteers also gave their names, phone numbers, ages and were asked if they could be available for a meeting each Tuesday or Wednesday night at 7:15 PM for a period of 8 weeks. Volunteers were thanked for their interest, told they will be called if they fit the parameters of the study, and told that they will be informed of the outcome of the study if they wish.

Pre-Research: Procedure six. The intake sheets of those subjects who met the requirements for the study were placed into a box, other applications were reserved so that we could later mail out the study outcome. Requirements were as follows: (a) be a
female between the ages of 40 and 50, (b) score in the high hypnotizability range on the Induction Profile, (c) have a BMI over 30, (d) have a motivation level of at least 5, (e) be available for all sessions. The applications of all those who met the requirements were randomly divided into two groups. These volunteers were called and asked to attend a meeting.

*Research Period: Procedure one.* Session one for the control group. As subjects arrived at the classroom, they were greeted by the researcher and asked to sign a consent form (see Appendix A), agreeing to participate in the study and explaining confidentiality. They were then asked to weigh in and record their weights. The researcher explained that each week the group will hear a lesson (see Appendix B), containing a weight loss suggestion. Subjects were asked to do their best to comply with the suggestion during the coming week and were told that they would be asked to report their compliance the following week. After the lesson was read, subjects were free to leave.

*Session one for the treatment group.* This group was also greeted by the researcher and asked to sign a consent form. Then the researcher explained that the purpose of the study was to evaluate the effectiveness of hypnosis in facilitating weight loss. Hypnosis was briefly explained and subjects were asked to sign a form agreeing to use hypnosis. They were then asked to weigh in and record weights. The group was told that each week they would first listen to a hypnotic induction (see Appendix C), and then they would hear a lesson containing suggestions for weight loss. Subjects were asked to do their best to comply with the suggestion during the coming week and told that they will be asked to report their compliance at the next meeting. After the lesson was read
and subjects were given the suggestion to be refreshed, alert and feeling fine, they were free to leave.

Research Period: Procedure two. Subsequent weeks of the study were like the first week with these exceptions: (a) subjects were asked to record compliance with the previous week's suggestion, (b) those subjects who had lost weight were recognized by the researcher, (c) a different lesson was read.

Data Analysis

The researcher kept records of the number of pounds subjects gained or lost each week. At the end of the 8 week period, the mean number of total pounds lost (or gained) was computed. The means of the two groups was used to obtain the small sample statistic. Once the rejection region was determined, the test statistic was compared to the Table of Percentage Points of the t Distribution to determine whether or not the null hypothesis has been proved. The total amount of weight lost, the median and mode were also reported.
CHAPTER IV

ANALYSIS OF DATA

Data from the 40 subjects, divided into 2 groups of 20, were analyzed to determine the amount of weight lost during an eight-week program. The treatment group consisted of 20 women between the ages of 40 and 50 whose Body Mass Index (BMI) was 30 or above at the beginning of the study. The control group also consisted of 20 women between the ages of 40 and 50 whose BMI was 30 or above at the beginning of the study.

The treatment group, which listened to the hypnotic induction (see Appendix C) and then the lessons, was made up of 6 African-American women, 12 Caucasian women, and 2 Hispanic women. They ranged in age from 43 to 49. The BMI range was from 31 to 48. Beginning weights ranged from 172 to 301.

They were read the following lessons: Lesson 1 which suggested a well-balanced, low calorie diet, Lesson 2 which emphasized getting up and getting going in the morning, Lesson 3 which suggested eating healthy snacks between meals, Lesson 4 which emphasized drinking plenty of water daily, Lesson 5 which suggested reversing your dinner habits, Lesson 6 which suggested increasing activity levels, Lesson 7 which outlined stress management techniques, and Lesson 8 which suggested getting a second wind (see Appendix B). Participants were encouraged to follow the lesson presented in each session.
The control group, which listened to only the lessons, was made up of 8 African-Americans, 4 Hispanic women, and 8 Caucasian women. They ranged in age from 44 to 50. The BMI range was from 32 to 48. Beginning weights ranged from 160 to 316.

Ending weights of the treatment group ranged from 164 to 307. The treatment group lost a total of 206 pounds during the 8 weeks with a mean weight loss of 10.3 pounds, a median of 10 and a mode of 10. The person who lost the most weight in the treatment group was a Caucasian, age 45 who lost 20 pounds. An African-American woman, age 46 lost the least amount of weight, 2 pounds. Ending weights for the control group ranged from 155 to 307. The control group lost a total of 103 pounds with a mean weight loss of 5.2 pounds, a median of 5 and a mode of 5. The person who lost the most weight in the control group was a Hispanic woman, age 44 who lost a total of 9 pounds. A Caucasian woman, age 47 lost the least weight. She gained 1 pound.

Treatment group members were told that the purpose of the study was to evaluate the effectiveness of hypnosis in the treatment of obesity. Hypnosis was explained as a state of relaxation during which subjects are able to experience an elevated ability to focus and concentrate. It is an altered state of consciousness in which certain normal human capabilities are heightened while others fade more or less into the background. Treatment group members listened to a hypnotic induction before the lessons were read and were in a light trance at the time the lessons were read. It is important to note than the treatment group sessions lasted approximately 5 minutes than the sessions of the control group. This was to allow time for the hypnotic induction. The extra time given to the treatment group could have skewed the results.
At the end of the eight-week period, the mean number of pounds lost was computed. The means of the two groups were used to obtain the sample statistic. The test statistic was compared to the Table of Percentage Points of the t Distribution. The probability of the results occurring by chance was less than .05, so the null hypothesis was rejected and the study hypothesis was accepted. The number of pounds lost by the study group was significantly higher than the number of pounds lost by the control group during the same period of time.
CHAPTER V
DISCUSSION

Hypothesis

The null hypothesis in this study may be stated as follows: There is no significant
difference between the means of the treatment group and the means of the control group.
This study involved a comparison of two samples, the treatment group who used post-
hypnotic suggestions to reinforce weight loss suggestions and the control group who
listened to the same suggestions but were not hypnotized. The mean weight loss of the
two groups were compared and a t test was used to analyze the data. Significant
difference was found between the two groups. This means that the null hypothesis must
be rejected and suggests that hypnosis may be a useful tool in facilitating weight loss.

Limitations

For the purpose of this study the researcher has focused on a population of female
subjects between the ages of 40 and 50 who have a BMI of 30 or more living in an urban
area in the Southeast. This was done to help establish that the population is homogeneous
on certain criteria. However, the researcher acknowledges that caution must be used in
generalizing the results of this study onto the entire population based on gender, age, and
ethnicity as well as the geographic region.
bias could have created an atmosphere in the treatment group that could have effected the 
motivation of the subjects positively skewing the results.

The researcher met with each group on a separate night and asked volunteers not to discuss the study until it was completed. This was done to control cross contamination between groups. However, it is not possible to monitor subject’s behavior outside of the group. It was assumed that participants would follow instructions.

The sessions for the study group were approximately 5 minutes longer than the sessions for the control group. Having a longer treatment may have impacted the results of the study. Additionally, this study did not examine the long-term weight loss of either group and therefore, we cannot draw any conclusions regarding maintaining weight loss in either group.

As in any study there were confounding variables in this study. For example, even though subjects for each group were randomly selected, selection bias may have taken place. It is possible that group selection bias led to placing all of the most motivated subjects in the treatment group. Additionally, there may be reactive effects of experimental arrangement. For example, if some subjects are aware that they are being observed by an experimenter, they may behave atypically. Outside influences may also be a source of variance.

Implications for Treatment of Obesity

Results of this study indicate that hypnosis along with cognitive and behavioral therapy appears to be a successful treatment for obesity. There are many ways in which hypnosis could be incorporated into a program which would facilitate weight loss and then weight maintenance. For example, a subject may easily be taught to induce her own
trance state, which is referred to as self-hypnosis. Subjects could devise their own personalized plans for healthy living, incorporating the subject's own lifestyle into the equation. The plan could include menu selections, snack selections, suggestions for eating out and buying groceries. Also included in the plan could be suggestions for a more active lifestyle such as taking up a new sport or simply enjoying walking instead of riding. Suggestions for taking time to de-stress and relax could be useful. Subjects might include suggestions for new ways of thinking such as thinking of food as a fuel for the body instead of food as entertainment. A subject could record her own suggestions and listen to them daily while in a state of self-hypnosis.

This technique could be incorporated into established programs such as Weight Watchers. These programs promote achieving optimum weight levels through wise food choices and increased activity. Participants could listen to the motivational suggestions of the instructor while in a trance state. Offering women this simple technique may help them feel more of a sense of control and mastery over their own weight and, ultimately, their physical and mental health.

Implications for Future Research

This research suggests the possibility for future studies. For example, a follow up study to determine long-term effects of the treatment could be implemented. A researcher might want to extend the study to more heterogeneous groups including men and other age groups. Or perhaps one might wish to study subjects in rural areas as well as those in urban areas and compare the results. Additional research could identify even more homogeneous groups for a study. For example, one could study how effective this treatment is for only African-American women or how effective it would be for only
Hispanic women. One could study how effective this treatment is for women who are 100 pounds or more overweight versus women who are only 30 pounds overweight. Children love hypnosis and are wonderful subjects. One might want to study the effectiveness of this treatment with children.

Conclusion

A review of the literature shows that many hypnotherapists believe that hypnotherapy is a useful tool in the treatment of obesity. They report using this technique to help clients remain focused on a variety of suggestions including the suggestion that the client would be able to maintain her diet, that limited food intake would satisfy hunger and that weight loss would be consistent. While the data from these studies has aroused interest in hypnosis, the contribution to educational knowledge appears somewhat limited. This is due to the anecdotal nature of many reports and the lack of scientific protocol used in the studies.

Despite the fact that thousands of patients have received hypnobehavioral treatment for obesity, it appears that data to evaluate this treatment is sparse. These limited studies failed to show any significant benefit derived from the use of hypnosis. Some researchers have concluded that positive treatment gains may be due to expectation effects and not to the hypnotic conditions. In this study, the researcher has attempted to use scientific protocol and control for expectation effects.

This study has shown that subjects who are hypnotized and then listen to lessons which promote cognitive and behavioral change, lost more weight during an 8-week study than subjects who only listened to the lessons but were not hypnotized. It may be concluded that post-hypnotic suggestions given to the treatment group influenced the
subject's behavior and served as a means of reinforcement and an adjunct to the treatment of female obesity.
APPENDIX A

Informed Consent

This is to request your participation in a study to find out whether using a certain specific treatment along with cognitive and behavioral suggestions is effective in the treatment of obesity. The study will last for 8 weeks and you will be expected to attend a class with 19 other women. The class will be in the evening and will not last longer than one-half hour. Each week you will be expected to weigh in and record your weight. You will be expected to do your best to follow instructions given and to refrain from discussing the study with others during the 8 week period.

A report of the findings will be shared with you when the study is completed. If you agree to participate, please sign below.

__________________________________________
APPENDIX B

Lesson 1

It is usually the simplest ideas that are considered the most revolutionary. A few years ago the idea that one diet could prevent, to a significant degree, all of the major diseases, was considered absurd. But, in fact the diet detailed in this study does exactly that. It is the most effective type of diet that can be devised, based upon present scientific and medical knowledge, for the prevention of arteriosclerosis and coronary heart disease, stroke, hypertension, diabetes, several forms of cancer and a number of other disorders. It is, in addition, ideally suited for gradual weight loss and is, according to Conner and Conner, 1986, the most promising diet available for long-term weight maintenance once target weight is achieved.

What sets this diet apart from others, in addition to its unified approach to preventing disease, is its genesis in controlled experimental scientific research. It is a diet which may not only help you live longer, but is also a diet that you can live happily with.

This fat and fiber based plan has only a few rules and lots of options. You decide what to eat based on two main factors: fat and fiber. Although you may have heard or read that limiting fat grams is the key to a healthy diet, doing that is only a part of the solution. That’s because, if you’re thinking only low fat, you may miss out on foods rich in health promoting nutrients. When you also focus on getting enough fiber, you’re much closer to a healthy eating plan.
Plan Rules:

Limit total fat grams to between 15 and 35 each day; men can go up to 45.

1. Eat at least 20 grams of fiber each day; men a minimum of 25 grams.

2. Men and women should eat a minimum of 2 servings of dairy foods daily. The portion for a serving of dairy food is based on the amount of calcium it provides. One serving is equal to 1 cup of milk, 1 cup of yogurt, or 2 slices of cheese. No matter what amount of fat is in the dairy products you choose, it is essential to count these fat grams towards your daily limit.

3. Eat at least 5 servings of fruit and vegetables daily. Serving sizes are 1 cup or 1 whole fruit or vegetable.

4. Go really easy on refined sugar and alcoholic beverages.

5. Gradually reduce the amount of salt you use by using less or by using a lite-salt product.

Calculate the fat and fiber grams daily in a personal journal.

You’ll find that this plan is simple and fun to do. All foods are allowed and you get to choose what you want to eat.

It’s easy to find out the number of fat and fiber grams which are in the foods you eat. Just look at the labels of the foods you choose, or if eating out, you can purchase a pocket sized reference book at most book stores. Most reference books even include fat and fiber gram listings for popular fast food and ethnic restaurants. To help you get started, I’ve included a listing of foods you may be selecting in the next few days along with a few sample menus.

But remember, it’s easy and fun to create your own healthy meal plan. Just write
down the fat and fiber grams in the foods you eat and keep the daily totals of fat grams between 15-35 for women, under 45 for men. Keep fiber grams around 20 for women and 25 for men.

You’ll feel happy and proud as you take care of your body and look forward to wearing that smaller sized suit or pair of pants lurking in the back of your closet.

Have a great week.

Lesson 2

If, like lots of other people, you consider your body’s fat cells “the enemy”, then you’re surrounded. You probably have about 30 billion of them and they are capable of storing many, many pounds of fat. For years now, many of us have been coming at the enemy with well-intended but ultimately ineffective tactics. Or, we attack it in a piecemeal fashion that, biologically speaking has doomed us to failure.

Research has shown us that doing more of the same, only harder, isn’t the way to succeed. It’s time to shift gears and break out of old routines. That’s exactly what this program is designed to do for you. Each week you’ll hear one new tip that, when used, will help your body produce less fat and burn up the fat already stored. Just imagine that, your body actually burning up stored fuel much like a fire burns up wood, and then, when no new wood is added to the pile, the wood pile gets smaller and smaller. In the same way that the wood pile gets more tidy and compact, your body will do the same. And because of the group support and common goals we all have, as well as the information we’ll be sharing, you’ll find it easy to follow the program throughout the week, looking forward to coming back each week and seeing the positive results. Now, for Tip #1:

By simply using this one tip you can increase your energy level and fat burning
patterns for the rest of the day. From the moment you get out of bed, your brain begins
cueing your body to match current and anticipated physical demands. If your morning
ritual takes place in low light and in slow motion your brain gets a low signal. If you
extend this sleepwalk activity level into the morning, you fail to crank up your fat
burning metabolism.

Turn up the lights! Studies show a direct correlation between light exposure and
the part of the brain that is thought to play a key role in attention focus and energy
production. When your alarm sounds tomorrow morning, flick on the light you usually
turn on and then turn on some extra light. Open the curtains and pull up the blinds. Go
outside and take a brief stroll around the yard. Already, the metabolism is cranking up
and beginning to burn that fuel giving you more energy and helping you feel great!

Get at least five minutes of easy physical activity. I know you’re busy and you
have a lot to do in the morning, but you’re worth it. Out of 1440 minutes there are in each
day, you can afford to take these five important minutes for yourself. If you’re just
starting to do morning activities, don’t worry about whether or not you’ll be able to
continue the routine. Perhaps you will. A recent study found out that 3 out of 4 people
who did some morning exercise continued the habit one year later. Evidence shows that
exercise in the morning may give you a head start in burning off excess body fat. After a
night’s sleep, you don’t have as much stored carbohydrate in your muscles, so when you
exercise before breakfast, you tend to pull fat from the cells for fuel.

Easy physical activity may include a relaxed pace on an exercise bike as you
watch the morning news or do some simple toning exercise. And remember, breakfast is
the meal that matters most. What you do or don’t eat in the morning can throw off the fat
burning process for the rest of the day. When you eat a moderate serving of a low fat breakfast, you switch on your energy and fat burning power. There you are, sitting at the breakfast table, eating a healthy, low fat breakfast, and your body getting ready for a great day! If you don’t like to eat in the morning and don’t feel hungry, it’s probably because you’ve learned to override your own body clock. Once you re-establish your normal, healthy metabolic rate, you’ll begin to feel hungry in the morning. In addition, you will be hungry at appropriate times during the day and will lose the urge to binge in the evening. This coming week you will notice a new level of energy and a sense of pride as you start your day with more light, five minutes of activity and a healthy breakfast.

Lesson 3

Tip #2:

Eat 3 low fat, high fiber meals a day plus four snacks. The 3 + 4 eating plan will satisfy your appetite while keeping your energy level high. Snacking on low fat foods throughout the day has several advantages. By eating low fat snacks in midmorning and mid afternoon, you’re less likely to stuff yourself at main meals or lapse into stress-related eating binges in the evening. Snacking and eating smaller meals will help you guard against eating large amounts of food at one time. This tactic reduces the hormonal signal that causes the fat cells to divide and multiply. (1)

Suggested times for snacking are midmorning, mid afternoon, as an appetizer before dinner, and after dinner. Snacks should be lower in fat than meals. Some suggested snacks include:

- One thick piece of whole grain bread topped with nonfat cream cheese and all-fruit.
- A whole rye bagel with nonfat cream cheese and a piece of fruit.
• A whole wheat English muffin with nonfat cream cheese and all-fruit preserves.

• A fat free whole grain muffin or snack bar.

• A low fat, whole oats granola bar.

• A whole grain bagel with Dijon mustard and 2 slices of turkey breast.

• Four ounces of nonfat frozen yogurt.

• Eight ounces of tapioca pudding made with non-fat milk.

• One cup of non-fat or low fat soup such as Progresso, Pritican or Healthy Choice.

• A variety of fresh cut raw vegetable and fruit pieces with three whole grain crackers and non-fat dip.

• One apple or other fresh fruit with three whole grain crackers.

• One slice of whole grain bread with one teaspoon of non-fat mayonnaise and two ounces of water packed tuna

You may notice that the snack suggestions rely more on natural foods than on using artificial sweeteners. It appears that artificial sweeteners may block the natural cues to the brain and body. Thus, after you’ve had an artificially sweetened food or beverage you may find yourself craving another food. Additionally, it’s thought that consuming large amounts of artificial sweeteners may decrease the level of serotonin which is one of the chemicals that signal the brain “I’m full.”

Remember that many snacks that are labeled “healthy” by food producers really are healthy, but only up to a point. The trouble is, even if they are completely fat free, some foods trigger an unusually strong insulin response and this, in turn, triggers fat-making in the body. Polishing off an entire bag of fat free chips or rice cakes may actually rev up the fat forming process.
To get in the snacking habit, it's important to keep low fat, high fiber snacks handy. Right now think about one place you can put an apple, a pear, a bag of carrots, celery or radishes where it will be ready for a snack break tomorrow. Having a fresh snack in your desk drawer or glove compartment actually changes your environment. When you make environmental changes, it's easy to succeed.

You'll feel in control this week as you follow the 3 meals plus four snack meal plan and make sure your healthy snacks are handy.

Lesson 4

*Drink Water and Other Fat Fighting Beverages*

For years' doctors have been advising us to drink plenty of fluids and often recommend 8 ounces of water every day. Every day our bodies lose at least 10 cups of water through exposure to forced air heating or low humidity air conditioning, breathing, perspiration and elimination. On the intake side, you have some easy sources of fluid even when you are not thinking about it. Many foods contain a large amount of water and the body itself does a modest amount of re-cycling.

Since you lose about 10 cups of water a day and get only four, it seems obvious that you need at least 6 cups of water just to stay even. Heat, humidity, exercise, and diet can make a difference in how much you actually need. While needs may change, depending on the individual, the point is that you almost always need extra fluids.

Getting your fill of liquids is important for several reasons. Water is a medium for every chemical reaction, including the burning of fat. When you do not drink enough water, your body will secrete the hormone aldosterone, which causes tissue to hold onto almost every molecule of liquid (Lindsey, 1992). Several researchers suggest that a
decrease in water may cause fat deposits to increase.

Additionally, even slight dehydration can cause fatigue, simple headaches, lack of concentration and dizziness (Applesate, 1991).

“Even a tiny shortage of water disrupts your biochemistry,” (Colgan, 1992). Dehydrate a muscle by only 3% and you lose 10% of contractile strength and 8% of speed. Water balance is the single most important variable in lifelong good health and top performance.”

There is another side effect of hidden thirst: You may think you are hungry when you are not. As a result, you may eat too many snacks or fill your plate too full when what you actually need is a glass of water.

The good news is that getting your fill of liquids does more than just preserve energy and help your body perform more efficiently, it also speeds up the fat-burning process and fights tension and tiredness. Some studies also indicate that increased water intake may actually help reduce fat deposits. When the body is fully hydrated, the bloodstream has all the fluids it needs to transport fatty acids from place to place. Drinking water also enhances the physiological processes that release fat cells and fatty acids into the bloodstream for delivery to the muscles for burning.

There is some evidence to suggest that the colder the beverage, the greater it’s fat burning power. You can maximize calorie burn by keeping the water ice-cold (Darden, 1992).

What about caffeinated beverages? Certainly an occasional cup of coffee or diet soda is fine. But, it’s important to know that caffeine-containing beverages act as diuretics, increasing your urine production and prompting loss of fluids.
Claims that caffeine stimulates weight loss by revving up the metabolism may be overstated. “Caffeine stimulates in a negative, because it provokes insulin release and may in fact enhance the storage of what is eaten as fat” (Rodin, 1992). "Countless women drink caffeinated diet sodas to help them through days of dieting. This practice may lead them to feeling even more hungry and it prepares their bodies for maximally storing whatever food they eat as body fat.”

You may be in the habit of reaching for a cough drop or some saline eye drops whenever you experience dry throat or itching eyes. Next time, before you try these methods, have a tall glass of water. Chances are the extra liquid in your body will soothe dry eyes, nose or mouth without any other remedy.

To put a little zing in your water, try adding a drop of natural flavoring in lemon, berry, or mint flavoring. Either real or artificial sweeteners may push your metabolism in the wrong direction, so be sure to read labels on drinks and stick to flavored plain or carbonated water and decaffeinated coffee or tea.

Hint: Purchase a 16 ounce container for water. One with a thermal cover and shoulder strap will keep your beverages cold and available. Fill the bottle and put 4 rubber bands on your container. Each time you refill the container, remove one rubber band. In this way you will be able to keep track of the refills.

So, remember that drinking water will help you feel more energetic while it flushes fat cells from your body and be sure to have your water handy.

This week you’ll find it easy to remember to drink your water every day.
Lesson 5

Reverse Your Dinner Habits

Let’s imagine something really ridiculous. What if you set a goal to get just as fat as you possibly could? Well, you’d need to eat the biggest, highest-fat meal of the day late in the evening, at 7 o’clock or later, and then sit around and snack on high-fat foods until bedtime. It does sound ridiculous, yet that’s what many Americans do every evening.

There is no doubt about it, this pattern helps our bodies store fat. The evening meal occurs just as your metabolism is slowing down. With the approach of night, your biology slows fat-burning and speeds up fat-storing processes. Fortunately, this natural slowdown is not inevitable and it can be delayed until nearer your bedtime.

For some time, researchers believed that the French have a much lower incidence of heart disease and other fat related diseases because they drink far more wine with their meals. But, as scientists looked more closely at the evidence, they realized that other factors are at work here. They found that the French eat their main meal earlier than we do, and they follow that main meal with more physical activity. The typical French person consumes 57 percent of total daily calories before 2 p.m. (Ellison, 1992).

In contrast, Americans take in a total of only 38 percent of daily calories before 2 p.m. Most of us eat our dinners in the evening, and, for most of us, it’s the largest and highest-fat meal of the day. The late, heavy meal not only leads to fat production and storage, it also inclines us toward skipping breakfast (Cloyatre, 1992).

In a study at the University of Minnesota in Minneapolis, researchers demonstrated that people on a 2,000 calorie diet put-on weight in very different ways,
depending on when they ate. Those who ate most of their calories earlier in the day lost weight. Those who ate the very same meals later in the day gained, and they gained a lot! The average difference between those who lost and those who gained was 2.3 pounds per week. (10)

The ideal time to eat the evening meal is between 5:30 and 6:00 p.m. Eating between 6:30 and 7:00 p.m. is fine on occasion, but, if you end up eating later than 7:00 p.m., you should make it a point to eat small servings and to eat more slowly.

Additionally, if you eat late, focus on vegetables and grains and eat fewer protein-rich foods.

What about weekends? Eat your main meal at mid-day if you can. If you're going out to a movie or a show, plan on eating beforehand, with a light snack afterwards.

Research suggests that you need to limit the evening meal to the range of 7-8 fat grams. But, most of us are amazingly unaware of how much we consume from 5:00 p.m. on into the evening. The first and perhaps most important change in lifestyle behavior is to keep records. On average, those who kept the most accurate records lost the most weight. So, this week focus your attention on keeping track of those fat and fiber grams.

Out of a possible 35 dairy fat grams, shoot for 8 at breakfast, 20 at midday and 7 in the evening. Fiber grams could be divided up in a similar manner, 5 at breakfast, 10 at midday and 4 in evening. This week, imagine that your body is like a coal burning furnace that keeps your house warm. At night you let the fire burn down because everyone sleeps under blankets and this saves fuel. By morning the house has gotten chilly, so someone needs to jump up and get the furnace going. As the day progresses it is important to keep adding coal to the fire to keep the house comfortable and warm. During
the day, people are coming and going so heat escapes whenever the door is open. At the end of the day, you add just enough coal to get you through to bedtime. It wouldn’t make much sense to pile on coal just when you’re ready for the house to cool down. So, this week you’ll find it easy and comfortable to keep records and to reverse your dinner habits.

Lesson 6

All of us are too busy. Many of us are out of shape. Our knees and our backs may hurt. And, as we get older, we all have a crowded lifestyle. It all adds up to little time for exercise. However, research has shown that, all forms of exercise help improve your health and burn calories. “Any activity that increases your metabolic rate and burns more calories provides benefits.”

To see just how those active minutes can have life-lengthening benefits, consider these statistics which are based on a large-scale study published in the *Journal of the American Medical Association*. In this study researchers divided individuals into three fitness groups. The “low” exercisers were almost sedentary; they did lots of sitting. The “moderate” group got about a half hour a day of light physical exercise. Those in the “high” group went regularly in aerobics classes or played a sport almost every day. The age adjusted death, rate per 10,000 women was 40 deaths in the low exercise group, 7 deaths in the moderate exercise group and 15 deaths in the high exercise group. So, the statistics show that there is a dramatic life-lengthening benefit for those who exercise only one-half hour per day. Just think how easy it would be to exercise one half hour per day. A fifteen minute walk on your lunch break and a fifteen minute walk in the evening would do the job.
Additionally, by combining do-it-anywhere active minutes on some days and low intensity aerobics on other days, studies show you may dramatically lower your chances of having osteoporosis, breast cancer and colon cancer. Even small amounts of exercise throughout the day may help alleviate depression, anxiety and stress.

Some studies show that regular exercise may be the single most important factor in maintaining weight loss success. Ninety percent of the individuals who reached and maintained goal weight reported exercising moderately.

Exercise may also help you reduce dietary fat intake by offsetting your natural cravings for high-fat food. Studies indicate that a key fat-storing enzyme is restricted by exercise and the reduction of this enzyme helps the body burn the fat rather than store it.

A key to starting and maintaining a habit of moderate activity is to break up your exercise into simple small units. For on-the-go people who are determined to fit active minutes into their daily lives, there are hundreds of ways to do it. For example, you can begin by taking several short walks every day. If it seems like there’s no good time to walk, consider some of these prime-time opportunities: walk to a near by restaurant for lunch, walk around the grounds of the building when you’re taking a break at a conference, go for a walk down the block or around the mall after work, or go for a short walk around the neighborhood after dinner. If you naturally sink into a chair when you talk on the phone, stroll around the next time, look out the window or do a few knee bends. Many people regret that they don’t have time to get to the health club, but you can lose a pound of fat a week by ratcheting up your household chore level a notch or two. Mowing the lawn, raking, brisk vacuuming, mopping or cleaning out the basement can help incinerate calories.
"It's not the intensity of physical activities that leads to better health, it's the total number of minutes you spend each week exercising." (Duncan, 1993).

Discovering time to exercise is usually easier said than done. The moments that you can grab for exercise come suddenly and pass swiftly, so it's important to watch for the opportunities. For example: take the stairs instead of the elevator, park at the far side of the parking lot at the mall, get out of your cab two blocks short of your destination and walk, tighten and relax muscles when standing in lines, jump rope during TV commercials, sweep the driveway or the patio, pedal a stationary bike while you watch TV, take the dog for a walk or walk up and down the stairs one time while you’re waiting for the washer or dryer to finish a cycle. Start today to establish the moderate activity habit. You’ll find it easy and fun to do and the rewards will start immediately.

Lesson 7

How often do you worry about things you can do nothing about (the drinking problem of a loved one, friends who are quarreling, traffic in Atlanta, etc.)? Do you often feel guilty about things you haven’t finished or about people you’ve forgotten? Do you lose your temper when the driver in front of you fails to signal properly?

Feelings of anxiety, anger, and guilt create stress in your body. Usually they vanish quickly. But, if the feelings hang on, the stress tenses your body and adds to the feeling of being under pressure. In the struggle to deal with these feelings, your body pays a considerable price.

Of course, people’s attitude about stress differ. While one person may enjoy the challenge of preparing a formal dinner for 40 people, another person would worry for days that something would go wrong and feel anxious for days.
Under conditions of stress, strong physiological reactions are triggered. Your heartbeat becomes more rapid, blood pressure rises and muscle tension increases. It’s not unusual for anxiety and fatigue to increase and for mental concentration to decrease. Reactions set off by stress-related hormones can translate directly into increased body fat. Studies report the distress related triggering of the “starvation response” which is the unconscious tendency to store food as if our bodies were preparing for a famine. (12) Distress sets fat-making processes into overdrive, so we end up storing more body fat. Fat-making is further increased by hormones which are released in stressful situations, including cortisol and epinephrine. These hormones may actually jolt your body into storing more fat. Additionally, when distress levels are high, blood sugar is routed away from chemical pathways that would burn it. Instead of serving your muscles, blood sugar is converted into fat and stored in fat cells.

Extended periods of distress may make it more difficult to listen to brain/body signals that tell you when you are hungry and what your body needs. When reacting to stress rather than meeting it and growing from it, many people overeat, consuming foods high in fat and refined sugar which compounds the problem.

Today you’ll learn a series of distress reducing techniques that diffuse anger and tension enabling your mind and body to sustain a high energy level. And, along with higher energy comes correspondingly higher-efficiency fat-burning.

1. Breathe away stress. Many of us hold our breath during stressful situations. This reduces oxygen to the brain and pushes you toward feelings of increased anxiety, anger, frustration, and panic. When you feel yourself getting hit with increased stress, one of the best ways to regain calm is to breathe deeply and slowly. At the
same time, say to yourself “Alert mind, calm body”. It is the inner breathing of the cells in your body that enables you to produce biological energy (Hendler, 1993). Let’s try that right now. We’ll all take a deep breath, hold to the count of four and slowly exhale. As you inhale repeat the words “alert mind”, as you exhale, repeat the words “calm body”.

2. For an instant leap from tension into a state of greater calm, behavioral scientists recommend a cue word. Cue words with specific meaning are usually more effective, like “beach” or “mountains”. You can personalize this association by adding the name of your favorite beach, mountain or vacation spot. When you practice using your cue word, try to develop every aspect of the mental image using all the senses. Let yourself imagine the way the seagulls sound as the waves lap the beach. Let yourself feel the warm sand on your feet and the sun on your shoulders. Imagine the unique seawater smell.

   Each time you use your cue word, the instant-recall power of the word becomes stronger and the word becomes an instant tranquilizer. Take a moment right now to think of a cue word for yourself and imagine the sounds and sensations related to that word.

3. Say a kind word to yourself. When it comes to coping with distress, your thought processes can have both direct and indirect effects on your energy and fat-burning power. Self-suggestion, or self-talk can magnify distress if we’re directing criticisms against ourselves. If you find that little nagging voice in the back of your mind is negative, judgmental, or discouraging, you can retrain the way you think. You need to teach your little voice to be more supportive, like a coach for a
It's hard to be overweight in our thinness driven culture without adding to
the problem by being hard on yourself. It's essential to distinguish between
having a body and being a body. Remind yourself that the best of who you are as
a human being is your head and your heart. The fact that you have a body to live
in is something to be thankful for. Tell yourself you're in the process of learning
to take care of your body and encourage yourself. So, when you notice self-talk
turning negative, make it a point to pause and say something more positive to
yourself. Follow that statement with some activity step to bring out inner strength
and self-pride. When that inner voice tries to tell you that this is hopeless and you
don't have any willpower, pause and give yourself a different message. Learning
to do something new is difficult because humans are creatures of habit. It was
difficult to learn to ride a bike, play an instrument or to learn the English
language. But, you stick with it. You just don't give up when you know
something is important. If you don't give up, you'll get the hang of taking care of
your body in a new way.

Lesson 8

Catch A Second Wind

It's late in the afternoon. You've been doing great. You started the day off right
with a low fat breakfast and some light activity. You ate low fat snacks and a healthy
lunch. You've been careful to short circuit tension with breathing exercises and positive
self-talk, but, as the afternoon wanes, you find that your energy is beginning to flag.

Perhaps you begin thinking of grabbing some fast food on the way home and
spending the evening in front of the TV. There’s a name for this mid to late afternoon period of tenseness and tiredness. Chronobiologists call it the breaking point. There are some easy ways to fight it and win, to turn it around and catch a late day second wind.

1. Shake a limb. Pause and ask yourself where you feel tightness and tension. Then loosen those areas by doing a few exercises slowly with relaxed motions.

- Neck rotations - Sitting in a relaxed position, gradually bring your chin toward your chest, then gradually rotate your head to the right, back and left in a smooth, continuous movement. Let’s try it together right now. (Pause to give students a chance to rotate the neck.).

- Shoulder shrugs - Lift both shoulders simultaneously, hold until you count to four, and then let them relax completely. You’ll automatically breathe in on the upward motion and release your breath as you relax. (Pause to let students practice shoulder shrugs).

- Torso turns - Stand, raise both your elbows as if you were resting them on a chest high wall, then turn your body slowly first to one side and then to the other. (Take a moment to let students practice torso turns).

2. As you leave your office, let your mind lead, followed by your body. Begin to imagine yourself at home. See the sights, hear the sounds, feel the hugs and the smiles that bring up fond memories of home. Leave your work worries behind. Use the transition period between work and home to unwind. We all leave behind a lot of loose ends at the end of the workday. Be confident you’ll have the morning energy to wrap things up. Right now, think ahead to home.

Somewhere between leaving work and arriving home, take a few minutes
to look at something beautiful, a flower, a plant, a row of trees, or the sky. This break can be an excellent way to reduce mental fatigue.

Today, more and more people rush home, hurry to fix dinner and plunge into another round of activities. What’s missing is a brief time to shake off stress and tension. If you have children and a partner, buddy up and give each other a break after you greet them. Take a break, take a quick shower, change into comfortable clothes or do a relaxing set of exercises. If you have young children, this is a great time of day to hire a high schooler to come over and baby-sit for an hour or so.

Get in a few laughs. Humor is one of the quickest ways for the human brain to switch gears. So, bring home at least one joke or off-beat story to share with your family.

It seems obvious that to increase fat-burning you need to move around. Another fat-burning tip is to eat an appetizer before you eat your evening meal. According to scientists, when you stay active in late afternoon and early evening and munch on a low fat appetizer, chances are your mood and energy will stay higher. In the end you’ll eat less dinner and store less food as fat.

Probably one of the best appetizers is a cup of tomato soup with several whole grain crackers. According to scientists (Stone, 1994), an appetizer of soup can reduce fat craving and total calorie intake. Their studies show that people who eat soup appetizers take in 25% less fat in the meal that follows than those who eat high fat appetizers (Stone, 1994).

So, this week, imagine yourself getting a second wind at the end of the
day. Relax your body, focus your mind on home and find something beautiful to focus on. When you arrive home, take a short break and then treat yourself to a low fat appetizer before dinner.
I'd like for you to begin to relax and make yourself as comfortable as you can. Let's begin by utilizing a simple technique for focusing attention. Perhaps you'd like to hold your arm in the air at about eye level. Now, clench your fist so that you can feel the muscles begin to tighten. Focus your eyes on your clenched fist and observe the knuckles, the fingers. Notice your wrist and feel the tension in all the parts of your fingers, hand, wrist, and arm. Focus your attention on your arm for as long as you like, until your arm feels tired. Whenever your arm tires, just let it slowly sink down until it rests comfortably in your lap. Take all the time you need, and, at your own pace, let the arm sink slowly. Do this whenever you are ready.

Once your arm is resting comfortably in your lap, you may begin to notice feelings of relaxation spreading from your hand and arm. The feelings of relaxation spread from your arm, across your chest, and into your other arm. The feelings of relaxation may also spread throughout your body, your chest, your abdomen, your legs, feet, and toes. As you begin to focus on the sound of my voice, you may notice that other sounds begin to fade, fade, fade into the background. The sounds of the ticking clock, doors slamming, people in the building talking, or phones ringing all fade into the background as you are able to focus your attention on the sound of my voice.
You may begin to become more aware of your breathing....feeling your lungs inflate as you inhale....taking nice deep breaths. Perhaps you could imagine that your lungs are like party balloons and that each time you inhale you fill them. Keep the breath inside your lungs for a few seconds and notice how pretty the balloons are. Then let the balloons completely deflate. As you are breathing in this way, you are becoming a little more relaxed.....more and more relaxed.

Your body is amazing...the way it is able to automatically know how to breathe. And your blood knows exactly how to pick up the oxygen and take it throughout your body. You don’t even have to think about it. Even when you are asleep or when you’re busy thinking of other things, your body just keeps on working. So, the knowledge to do certain things in a certain way can become such a part of you that you just do it automatically with no effort. That’s something we’ll be focusing on in this class....learning behaviors that will help you reach and maintain your goal. The power to do that is there, right now, inside of you.

You also have the power to scan your body if you like. Check various parts of your body for areas of stress. Notice your neck, your scalp and your jaw. If you become aware of tension in those areas, just simply say to yourself, “Please relax neck, please relax jaw, and please relax scalp. Imagine that the muscles are becoming limp and loose like a Raggedy Ann doll. You may also want to scan your arms, hands and fingers for signs of tension in the same way. Ask them to relax. You may begin to notice that your arms, hands and fingers are becoming heavy...as if the bones were made of heavy steel rods. It’s a nice, comfortable heavy feeling...as if the arms just want to rest for a short time. You may want to scan the muscles in your chest, abdomen, legs, feet and toes.
When you locate signs of tension, just ask those muscles to please relax...as you gradually become a little more relaxed. That’s excellent...very good. Deeper and deeper...more and more relaxed.

Just as you can begin to relax your body, you can also relax your mind. You can allow your mind to float and drift as if it were a fluffy, white cloud. You can let it float and drift off to anywhere you’d like to be. Maybe a special place that is peaceful and relaxing. Perhaps it is a place you’ve been to before, or maybe it is a place you’ve imagined. It may be a beautiful beach with soft, white sand. You can rest on a blanket and listen to the sounds of the ocean as the waves lap the shore. You can hear the sounds of the seagulls and of palm fronds as they rustle in the breeze. Or your special place may be in some lovely mountains where it is quiet and cool...a place where you can just relax with nothing to do for a time except rest and enjoy the beautiful scenery. Perhaps a peaceful wooded area with beautiful trees and perhaps a lovely waterfall...you can enjoy the peaceful sound of water cascading over the rocks as you relax. You find that you can go to your special place anytime you’d like....whenever you’d like to feel a little more relaxed.

As you are relaxing your body and you’re mind...see yourself at the top of a lovely flight of stairs. As you descend the stairs you find that you feel a little more relaxed with each step that you take. starting at 10...9...8...feeling more and more relaxed. That’s very good...fine. Deeper and deeper...7...6...5...feeling very comfortable and relaxed now...4...3...2...and 1. Very good...excellent. You are very relaxed now.
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 want 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 the parts of your body that you want the weight to be off. See this very, very vividly and summon this image into your mind several times a day; particularly just after waking in the morning and before going to sleep at night, also have it vividly in 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 be. 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 it to be. You will find it easy to follow a healthy eating plan and to follow the weekly tips. You will find that you are quite 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, 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 foods. Instead, day-by-day you will desire low calorie, healthy foods and these will replace the high calorie foods you have eaten in the past. As you lose weight and become closer and closer to the weight you want to be, you 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 each week. Here is the first (second, third, fourth, fifth, sixth, seventh, eighth) weeks’ suggestion.
After lesson is read...Now I want to suggest that you slowly ascend the lovely flight of stairs. With each step that you take up the stairs you will find that you are feeling more and more alert. You are feeling refreshed, as if you just took a nice relaxing break. Your body feels perfectly normal...as we begin to count up from 1....2....3....4....5....6....7....8....9.....and 10. And now you can begin to move your fingers and toes...get your circulation going...and open your eyes whenever you are ready.

This concludes this week’s lesson. I’ll look forward to seeing you next week.
REFERENCES


