HYPNOBEHAVIORAL AND HYPNOENERGETIC THERAPY IN THE TREATMENT OF OBESE WOMEN: A Pragmatic Randomized Clinical Trial

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Abstract: This study compared the effectiveness of hypnobehavioral therapy (HypBe) and HypBe enhanced by elements of energetic psychotherapy (hypnoenergetic therapy, HypEn) for obese women. Sixty clients were randomized to either HypBe or HypEn. Body weight, BMI, eating behavior, and body concept were assessed at baseline, posttreatment, and at a follow-up. Mixed ANOVA models and effect sizes were used for statistics. Both treatments improved weight, BMI, eating behavior, and some aspects of body concept. Improvements in eating behavior and body concept were higher for those who also
lost weight (responders). Weight and BMI reductions were not signifi-
cantly different for the HypEn versus HypBe groups at follow-up.

Due to the rising obesity rates in industrialized countries, therapy
for obesity and excess weight has become increasingly important.
However, the various therapies for obesity have shown little success
and high rates of relapse. Due to their treatment resistance, their pas-
sive and excessive therapy expectations, and their strong tendency to
delegate responsibility, obese patients are not very popular among ther-
apists. These characteristics may lead to low success rates and high rates
of relapse.

Several therapeutic approaches, including psychodynamic, behav-
ioral, cognitive-behavioral, and hypnotic therapy, have shown promise
in the treatment of obesity (Benecke, 2003; Sapp, Obiakor, Scholze,
& Gregas, 2007; Shaw, O’Rourke, Del Mar, & Kenardy, 2005; Weiss,
2006). Moreover, several authors have called for a combination of
treatment methods (Hohage & Haisch, 1991; Johnson & Karkut, 1996;
Vanderlinden & Vandereycken, 1994; Weiss, 2006).

The present study aims to investigate and compare, within a
naturalistic setting, the effectiveness of two treatments for obesity:
hypnobehavioral therapy, which is a combination of hypnotic and
behavioral elements (Mewes, Stich, Habermüller, & Revenstorf,
2003; Revenstorf & Schmid, 2006), and hypnoenergetic therapy (Neumann,
2009; Zips, 2009), which is a combination of hypnobehavioral therapy
and techniques from energetic psychotherapy (Gallo, 2002).

**Obesity**

The indication for treatment of obesity is when (a) Body Mass Index
(BMI) is ≥30; (b) BMI is between 25 and 29.9 and weight-related health
disorders and/or a significant abdominal pattern of fat distribution
and/or disease exists that can be worsened by the excessive weight; or
(c) BMI is 25 to 29.9 and significant psychosocial distress exists (World
Health Organization, 1995). According to success criteria published by
the Institute of Medicine (IOM) in 1995, treatment of obesity is rated as
successful when a weight loss of 5 kg or a reduction of 1 in the BMI is
maintained for more than a year (Stern & Hirsch, 1995).

Life circumstances, especially binge-eating disorder (BED), have a
substantial influence on the development and maintenance of obe-
sity and are often an indication of particularly strong and unfavor-
able forms of the disease development (Leibbrand, 2002). BED is
often coupled with other mental disorders, especially depression and
decreased self-esteem. Approximately 30% of American participants
in weight-loss programs meet the diagnostic criteria for BED (Pudel, 2003b). Overall, 10% of obese patients classify for a diagnosis of BED (Bruce & Agras, 1992).

Psychological factors (see Friedman & Brownell, 1995) emphasize the impact of disadvantageous learning experiences—using food as reward or comfort or its withdrawal as a punishment, sweets as a substitute for emotional support, rigid table manners, etc. (Benecke, 2003). Personality variables, such as depression, psychopathology, social adaptation, masculine versus feminine personality traits, locus of control, assertiveness, and self-awareness do not significantly differentiate between obese and normal-weight persons (Shaw et al., 2005). However, the treatment of obesity should not focus exclusively on weight reduction but also, among other things, on eating behavior and body concept to validate measurable results (Striegel-Moore, 2001). Thus, due to the many facets of the problems underlying obesity, combined therapeutic interventions appear to be more successful than individual treatments, even when surgical procedures are included (Kielmann & Herpertz, 2002).

Eating Behavior and Body Concept in Obesity

Eating Behavior

Herman and Polivy published their concept of “restrained eating” in 1975. According to them, obese persons are chronically hungry and respond strongly to food stimuli because of their self-controlling diet behavior (Pudel, 2003a). When exceeding the self-imposed cognitive “diet boundary,” a “counter-regulation” sets in (Herman & Polivy, 1984) in terms of an “all-or-nothing” principle (Westenhöfer, 1992; Westenhöfer, Stunkard, & Pudel, 1999). Furthermore, some industrial foods (sugar, white flour, fat, etc.) have a strong reward effect and trigger the release of beta-endorphins as endogenous opiates (Hoebel, Rada, Gregory, & Pothos, 1999; Pert, 2001). The calming effect of sugar and carbohydrates may be aimed at increasing the body’s serotonin synthesis (Rozin, 1998; Wurtmann, Growdon, & Henry, 1981), triggering addiction-like behavior (Jochims & Gerl, 2004).

Body Concept

Body concept (Nutzinger & Slunecko, 1991) can be understood as the mental representation of the body being part of the self-esteem and affecting the long-term disposition of a person (Mayer & Eisenberg, 1988); it is particularly important in childhood and adolescence (O’Dea & Abraham, 2000). No reliable link between BMI and dissatisfaction with body concept has been definitively identified in obese women; however, survey results indicate that patients who have undergone obesity surgery would rather endure a disability or blindness than
be “monstrously fat” again (Rand & Macgregor, 1990). Body concept appears to be one of the main motivational drives to start weight-reducing measures. However, the question remains of whether an improvement in body concept is dependent on weight loss (Rosen, 1996; Sarwer, Thompson, & Cash, 2005).

**Behavioral, Cognitive-Behavioral, and Hypnotherapeutic Treatments for Obesity**

Most previous studies of weight reduction using psychotherapy of different orientations have focused on the weight loss assessed in terms of kg or BMI (see Benecke, 2003; Logue, 1998). Other factors, such as eating behavior or body concept, have been recorded infrequently (Beutel, Dippel, Szczepanski, Thiede, & Wiltink, 2006).

Behavioral and Cognitive-Behavioral Therapy

These therapies for obesity, which focus on behavioral and cognitive-control mechanisms of eating behavior and promote an adaptive affective management without “emotional eating” (see Majewski, 2003), are among the elective methods (see Shaw et al., 2005; Wilhelm, Strütt-Neeb, Opielka, & Cuntz, 2002). Some studies have investigated improvements in body concept among obese patients, usually with explicitly behavioral treatment programs showing positive results (e.g., Beutel et al., 2006). Unfortunately, there are no meta-analyses investigating the effectiveness of the numerous behavioral programs with regard to body concept specifically. Another study, which compared psychodynamic and cognitive-behavioral treatments, focused on weight loss, eating behavior, and body image (Beutel et al., 2006). The results showed no difference among the two treatment forms. However, 60% of the treated patients did not reduce their weight or increase their well-being, leading to demands for improved and expanded treatment models. Although behavioral programs for weight reduction have increased in effectiveness over the past 30 years, most participants still regain their weight within 3 years. Moreover, there are no reliable evaluations available with reference to similar treatment forms such as relaxation training (Becker, Rapps, & Zipfel, 2007). Another remaining question is whether, within a behavioral or cognitive-behavioral approach, a group setting is more effective than an individual setting.

Hypnotherapy

This mainly focuses on the detection and integration of neglected resources through relaxation, hypnotic suggestions, and visual imagery.
by processing the eating-related problems and has been shown to be
effective for the treatment of obesity (Sapp et al., 2007). A study of
posthypnotic suggestions has provided evidence of the specific ben-
efits of hypnosis in improving the body concept of obesity patients
(Van Denburg & Kurtz, 1989). Some findings support the effectiveness
of the pure hypnotic treatment of weight reduction compared to control
groups (Cochrane & Friesen, 1986) or to behavioral-therapy groups
(Goldstein, 1981). The majority of authors, however, have indicated that
not just hypnosis alone but rather a combination of treatment methods
is desirable (Johnson & Karkut, 1996; Vanderlinden & Vandereycken,
1994). Other studies have emphasized the high catamnestic value of
integrative treatment programs involving hypnosis in comparison to
pure behavioral treatments or dietary counseling (Bolocofsky, Spinler,
A meta-analysis reported by Kirsch (1996) and Kirsch, Montgomery,
and Sapirstein (1995) showed that the effect size significantly increases
when hypnosis is applied in combination with cognitive-behavioral
therapy, particularly in weight reduction, during long periods of
catamnestic investigations. Similar results were provided by Mewes
and colleagues (2003), who recommended the combination of hyp-
nosis and behavioral therapy within a hypnobehavioral treatment
model.

Therefore, although the psychological treatment of obesity has been
a privileged domain of behavioral therapy, there is evidence that
a combination of the change processes involved in hypnotherapy
and behavioral treatments is highly promising. The effectiveness of
hypnobehavioral therapy, which has been extensively proven for the
treatment of bulimia nervosa (e.g., Griffiths, 1989; Griffiths, Hadzi-
Pavlovic, & Channon-Little, 1994), has also been supported for the
treatment of obesity (e.g., Becker et al., 2007; Mewes et al., 2003).
Moreover, it has been suggested that hypnobehavioral therapy for
obese clients should also focus on body concept, which has often been
neglected in previous studies, to promote permanent weight loss with-
out a yo-yo effect (Sarwer et al., 2005). Finally, it has also been suggested
that the integration of hypnotic and behavioral therapies should be
realized within group settings to maximize the effects (Mewes et al.,
2003).

**Purpose of the Study**

The purpose of the present investigation springs from the above
considerations, according to which the combination of hypnotic and
behavioral therapy within a group setting may represent an elective
model in the treatment of obesity. More specifically, in the present
study, we ask if the clinical effectiveness of hypnobehavioral therapy
for obese clients can be increased through the techniques of energetic
psychotherapy. Energetic psychotherapy (Bohne, 2010; Feinstein, 2008; Gallo, 2000, 2002, 2004a, 2004b) consists of “a set of physical and cognitive procedures designed to bring about therapeutic shifts in targeted emotions, cognitions, and behaviors (Gallo, 2004b)” (Feinstein, 2008, p. 199). Energetic psychotherapy is, in its essence, an exposure-based treatment directed to specific feelings, cognitions, and behaviors that represent a target for change. As in other exposure-based treatments, exposure is achieved by eliciting hyperarousal associated with threatening situations and/or traumatic memories through in vivo, imagery, and/or narrative experience (as in the case of relaxation, mindfulness, flooding, repeated exposure, or desensitization; Feinstein, 2008). In energetic psychotherapy, these techniques are used in association with acupressure, that is, the manual stimulation of acupuncture and related points (see Bohne, 2010). This specific technique, which is derived from non-Western health care practices, is used to reduce the previously elicited hyperarousal, leading, according to practitioners, to a more rapid and powerful treatment outcome than using traditional exposure-based treatments. Energetic psychotherapy has been shown to be promisingly effective, especially for specific phobias (Wells, Polglase, Andrews, Carrington, & Baker, 2003) and for maintenance of weight loss (Elder et al., 2007; for a review, see Feinstein, 2008; see Feinstein, 2009; McCaslin, 2009; Pignotti & Thyer, 2009, for a discussion).

The effectiveness of a combination of hypnobehavioral therapy (HypBe) with elements of energetic therapy in hypnoenergetic therapy (HypEn; see the “Method” section) has been demonstrated in the context of individual observations as part of outpatient psychotherapeutic practice, but no empirical investigation has been conducted on this subject. The present study attempts to investigate, within a naturalistic setting, the effectiveness of HypBe and HypEn for weight reduction and improvement of eating behavior and body concept in obese clients. More specifically, the following hypotheses are formulated (see the “Method” section for details):

1. Weight reduction: Both treatments (HypBe and HypEn) are likely to promote significant weight reduction in the participants during the study period or at least a stabilization of the starting weight without subsequent weight gain. However, it is hypothesized that the HypEn group will achieve greater improvements.

2. Improvement of eating behavior: The eating behavior of clients of both HypBe and HypEn will significantly improve during the study period, possibly depending on the weight reduction of the clients. The HypEn treatment is expected to achieve greater improvement.

For other body-oriented forms of therapy, see, for example, Lejonclou and Trondalen (2009).
3. Improvement of body concept: The body concept of clients of both HypBe and HypEn will be significantly enhanced during the study period, possibly depending on the weight reduction of the clients. The HypEn treatment is expected to achieve greater improvement.

**METHOD**

**Research Design**

This was a parallel, pragmatic, randomized clinical trial comparing the effectiveness of hypnobehavioral and hypnoenergetic therapy for obesity (see “Treatments” section). Assessment of outcome variables was conducted at the beginning and end of treatment, as well as at a 6-month follow-up (see “Outcome Measures” section). The study was conducted at the private practice of the second and fourth authors of this article in Vienna, Austria.

**Sample**

Participants were recruited using newspaper advertisements (“Kurier,” 1.12.2006). Eighty subjects responded to the advertisement and were screened by two expert clinicians (the first and last authors) over an approximately 6-month period. The aims of the screening process were (a) to check whether patients were suitable for therapy (due to more or less realistic expectations and the willingness to cooperate in conducting trance and behavioral exercises — see “Treatments” section), (b) to check for inclusion criteria (see below), and (c) to eventually obtain informed consent. The inclusion criteria were as follows: (a) BMI ≥25, (b) age between 25 and 70, and (c) improvement of eating behavior, which means that the patients were able to say whether the food was “too much,” “unhealthy,” or “too high in calories.” The exclusion criteria were as follows: (a) BMI <25; (b) at least one of the following clinical diagnoses according to the International Classification of Disease, 10th revision (World Health Organisation, 1992): depression (F32, F34), severe anxiety disorders (F40, F41), personality disorders (F60, F62), or suicide attempts or psychotic episodes in the last 10 years (F20, F23, F25, F30); (c) age <25 and >70; (d) unrealistic treatment expectations such as losing weight without changing eating and exercise behavior or without any specific change in food selection; and (e) an extremely low basal metabolic rate (<~1000 kcal) as a result of frequent dieting or statements such as “I hardly eat anything.”

Twenty (25%) subjects assessed for eligibility were excluded because they did not meet the inclusion criteria (see Figure 1). Thus, 60 eligible female participants (75%) were included in the study, received detailed information about the study and provided a written informed consent. No eligible patients refused to participate in the study. The participants’
assessed for eligibility ($n = 80$)

- Excluded ($n = 20$)
  - Not meeting inclusion criteria ($n = 20$)
  - Declined to participate ($n = 0$)

Randomized ($n = 60$)

- Allocated to Hypnoenergetic Therapy ($n = 30$)
  - Received allocated intervention ($n = 30$)

  - Lost to follow-up (give reasons) ($n = 0$)

  - Analyzed ($n = 30$)

- Allocated to Hypnobehavioral Therapy ($n = 30$)
  - Received allocated intervention ($n = 30$)

  - Lost to follow-up (give reasons) ($n = 0$)

  - Analyzed ($n = 30$)

**Figure 1.** Flow chart of study participants.

Ages ranged from 27 to 67 ($M = 50.7$, $SD = 10.4$), body weight ranged from 69 to 128 kg ($M = 93.9$, $SD = 33.5$), and BMI ranged from 26 to 44.6 ($M = 34.1$, $SD = 5.5$). According to the subjective clinical ratings of the therapists, the participants showed a medium-to-high responsiveness to hypnosis. All of the patients had attempted to lose weight in the past and had experienced weight fluctuations $>10$ kg. The participants were randomized to the treatment groups (see Figure 1).

**Randomization**

The 60 participants were randomized, using simple randomization with a ratio of 1:1, to the two treatment groups. Thus, each participant received either hypnobehavioral therapy ($n = 30$) or hypnoenergetic therapy ($n = 30$) (see “Treatments” section). Randomization was realized by the drawings of lots by a collaborator who had no direct contact with the participants. All participants receiving the intended treatment were analyzed for outcome.

The two treatment groups did not differ with respect to sociodemographic and other variables measured (weight-related variables, eating behavior, and body concept—see “Outcome Measures” section below) at baseline (see Table 1). The participants in the study could be considered well educated because more than two thirds went to college. More than half of the participants lived in a partnership.
Table 1
Sociodemographic and Weight-Related Variables Assessed at Baseline in the Two Treatment Groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Hypnobehavioral (n = 30)</th>
<th>Hypnoenergetic (n = 30)</th>
<th>p value&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age&lt;sup&gt;b&lt;/sup&gt;</td>
<td>50.5 (10.4)</td>
<td>50.8 (10.3)</td>
<td>.959</td>
</tr>
<tr>
<td>Highest level of education&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>.513</td>
</tr>
<tr>
<td>Primary school</td>
<td>2 (6.7%)</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>Apprenticeship</td>
<td>3 (10.0%)</td>
<td>7 (23.3%)</td>
<td></td>
</tr>
<tr>
<td>Additional education</td>
<td>6 (20.0%)</td>
<td>6 (20.0%)</td>
<td></td>
</tr>
<tr>
<td>Matura (High school degree)</td>
<td>13 (43.3%)</td>
<td>13 (43.3%)</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>6 (20.0%)</td>
<td>4 (13.3%)</td>
<td></td>
</tr>
<tr>
<td>Lifestyle&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>.644</td>
</tr>
<tr>
<td>With children</td>
<td>4 (13.3%)</td>
<td>4 (13.3%)</td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>5 (16.7%)</td>
<td>9 (30.0%)</td>
<td></td>
</tr>
<tr>
<td>With partner</td>
<td>9 (30.0%)</td>
<td>10 (33.3%)</td>
<td></td>
</tr>
<tr>
<td>With partner and children</td>
<td>8 (26.7%)</td>
<td>11 (36.7%)</td>
<td></td>
</tr>
<tr>
<td>Height&lt;sup&gt;d&lt;/sup&gt;</td>
<td>1.67 (0.1)</td>
<td>1.67 (0.1)</td>
<td>.976</td>
</tr>
<tr>
<td>BMI at admission&lt;sup&gt;b&lt;/sup&gt;</td>
<td>33.8 (5.7)</td>
<td>34.6 (5.4)</td>
<td>.666</td>
</tr>
<tr>
<td>Begin of obesity&lt;sup&gt;e&lt;/sup&gt;</td>
<td>28.3 (16.2)</td>
<td>29.8 (15.1)</td>
<td>.657</td>
</tr>
<tr>
<td>Lowest weight as adult&lt;sup&gt;f&lt;/sup&gt;</td>
<td>62.6 (9.5)</td>
<td>62.3 (9.8)</td>
<td>.882</td>
</tr>
<tr>
<td>Highest weight as adult&lt;sup&gt;f&lt;/sup&gt;</td>
<td>104.2 (23.3)</td>
<td>100.0 (22.5)</td>
<td>.329</td>
</tr>
<tr>
<td>Outcome measures&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restrainted eating&lt;sup&gt;g&lt;/sup&gt;</td>
<td>9.1 (4.4)</td>
<td>8.7 (4.7)</td>
<td>.711</td>
</tr>
<tr>
<td>Disturbance of eating behavior&lt;sup&gt;g&lt;/sup&gt;</td>
<td>11.7 (2.3)</td>
<td>11.3 (3.4)</td>
<td>.630</td>
</tr>
<tr>
<td>Experienced hunger&lt;sup&gt;g&lt;/sup&gt;</td>
<td>8.8 (3.1)</td>
<td>8.0 (3.6)</td>
<td>.343</td>
</tr>
<tr>
<td>Health and physical condition&lt;sup&gt;h&lt;/sup&gt;</td>
<td>22.1 (5.4)</td>
<td>21.8 (6.2)</td>
<td>.843</td>
</tr>
<tr>
<td>Body care&lt;sup&gt;h&lt;/sup&gt;</td>
<td>35.5 (5.7)</td>
<td>35.8 (6.2)</td>
<td>.846</td>
</tr>
<tr>
<td>Physical efficiency&lt;sup&gt;h&lt;/sup&gt;</td>
<td>34.7 (9.0)</td>
<td>35.6 (8.2)</td>
<td>.687</td>
</tr>
<tr>
<td>Physical contact&lt;sup&gt;h&lt;/sup&gt;</td>
<td>25.1 (6.5)</td>
<td>25.4 (5.9)</td>
<td>.852</td>
</tr>
<tr>
<td>Sexuality&lt;sup&gt;h&lt;/sup&gt;</td>
<td>23.6 (5.2)</td>
<td>23.0 (5.5)</td>
<td>.684</td>
</tr>
<tr>
<td>Self-acceptance of the body&lt;sup&gt;h&lt;/sup&gt;</td>
<td>18.7 (5.8)</td>
<td>17.6 (4.6)</td>
<td>.419</td>
</tr>
<tr>
<td>Acceptance of the body by others&lt;sup&gt;h&lt;/sup&gt;</td>
<td>13.2 (3.8)</td>
<td>13.2 (2.9)</td>
<td>.969</td>
</tr>
<tr>
<td>Aspects of physical appearance&lt;sup&gt;h&lt;/sup&gt;</td>
<td>60.7 (6.0)</td>
<td>59.3 (6.3)</td>
<td>.369</td>
</tr>
<tr>
<td>Dissimilatory body processes&lt;sup&gt;h&lt;/sup&gt;</td>
<td>17.0 (2.5)</td>
<td>17.0 (2.6)</td>
<td>.920</td>
</tr>
</tbody>
</table>

Note. HypBe = Hypnobehavioral therapy; HypEn = Hypnoenergetic therapy.
<sup>a</sup>Two-sided. <sup>b</sup>M (SD). <sup>c</sup>Absolute frequency (percentage). <sup>d</sup>M (SD) expressed in m. <sup>e</sup>M (SD) of age. <sup>f</sup>M (SD) expressed in kg. <sup>g</sup>Questionnaire on eating behavior. <sup>h</sup>Frankfurt Body Concept Scales.

Treatments

Hypnobehavioral and hypnoenergetic therapy treatments (described below) were performed in a group setting. Participants from each treatment group were randomly assigned to three smaller groups (n =
and treated by one of two female therapists (the second and fourth authors) with many years of experience in these two treatment forms. Both therapeutic programs consisted of 12 sessions (called modules) lasting 120 minutes over a period of 8.5 months. The core treatment comprised the first 10 modules, which were provided weekly for 2.5 months. Two stabilizing sessions were conducted 3 and 6 months after the end of the treatment. Because of the structure and content of these two last sessions (see below), this period after the end of the treatment (6 months) could be considered to be a follow-up.

Each induction procedure was designed in the same way for both groups, according to the common treatment goals: Prosody was modulated in order to underline the crucial suggestions, while no sensory stimulations were administered. Subjects were encouraged to find the most comfortable position and close their eyes if desired. Ideomotoric signaling was not explicitly encouraged: Nonetheless, participants were seated in a circle so that the hypnotist could monitor the nonverbal, minimal cues shown by everyone and attune to them. The structure of inductions was as follows: (a) focalization of the attention toward inner experience, progressive detachment from everyday life, and empowerment of self-absorption by means of relaxing, natural images (“The calm sound of waves on a beach”); (b) deepening of the trance by means of metaphors (“A more and more fine-tuned perception of single thoughts and emotions”) and administration of the key-suggestions (see Table 2); (c) reorientation to the usual state of consciousness, with consolidation of the results (“New awareness gained, new resources raised”).

Direct suggestions aimed at the core themes of the mottos (see subsections below and Table 2) were given in a neutral, generic way, so that every subject could receive it and shape it easily on a personal basis.

**Hypnobehavioral therapy.** The hypnobehavioral treatment (HypBe) employed in this study is based on a slightly modified version of the approach proposed by Revenstorf and Schmid (2006), which specifically combines elements of hypnotherapy (i.e., hypnotic trances) and behavioral therapy (i.e., behavioral exercises, role-playing, and homework) within a short-time, theme-centered, problem-specific, and solution-oriented treatment model for the treatment of obesity (see Zips, 2009, for details). Similarly to Revenstorf and Schmid, HypBe was organized around specific mottos that characterized each single session of the treatment. A motto stands for the main thematic topic that organized the content and the related aims of a specific session. Trances were induced according to the specific thematic topic of each session; analogously, behavioral exercises and role-playing were conducted to fit the particular session’s theme. Moreover, trances and behavioral exercises related to the theme of each session were assigned as homework.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Working model, goal imagination</td>
<td>Working model, hypnotic future progression with goal imagination</td>
<td>You can see your body getting more and more slim, and your target weight gets nearer every single breath you take.</td>
</tr>
<tr>
<td>2</td>
<td>Feelings</td>
<td>Conscious vs. emotional eating: learning the difference</td>
<td>And you will be able to feel the difference and your eating getting more and more conscious and mindful.</td>
</tr>
<tr>
<td>3</td>
<td>Feelings</td>
<td>Childhood and eating: understanding correlations</td>
<td>As your inner child grows up, his/her old way of eating fades away . . . and as you are eating in your mindful way, he/she can use his mouth to speak about what’s going wrong.</td>
</tr>
<tr>
<td>4</td>
<td>Feelings</td>
<td>Improving body movement and perception</td>
<td>And your body will discover the number of ways he can feel pleasant sensations, outside as inside, and move to go out and get them every day of your life.</td>
</tr>
<tr>
<td>5</td>
<td>Edge, limit</td>
<td>Recognizing and allowing rage</td>
<td>And feel that every emotion has a good reason to stand by you, and that there are no negative feelings inside you to throw out, just small voices encouraging you to do something better for yourself.</td>
</tr>
<tr>
<td>6</td>
<td>Self-acceptance</td>
<td>Improving beliefs</td>
<td>Because all this, it’s ok, and you are ok, and your body can just do nothing but reflect the good flow inside and outside yourself.</td>
</tr>
<tr>
<td>7</td>
<td>Self-acceptance</td>
<td>Setting limits</td>
<td>And your inner voices will help you to recognize that your personal, private space is the very realm you live in and you can defend. And your bascule bridge will allow visits and speech just to the very few who respect the rules of your castle.</td>
</tr>
<tr>
<td></td>
<td>Relationship</td>
<td>Raising self-acceptance: Mindfulness in relational context</td>
<td>And you will see clearly the flow of people getting in touch with each other, and you being a part of the whole picture, taking care of yourself when giving attention to others.</td>
</tr>
<tr>
<td>---</td>
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<td>------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9</td>
<td>Body</td>
<td>Raising body-acceptance: positive perception of one’s body</td>
<td>And everyone out there will see just what you want them to see, your body and your feelings in the way you decide, and everything will go well.</td>
</tr>
<tr>
<td>10</td>
<td>Integration</td>
<td>Integrating goals, successful integration of the acquired knowledge</td>
<td>And you will discover day-by-day that any part of your new life touches, affects, reflects, influences each other, and what you are understanding in any single moment makes you stronger and calm.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obtained changes, future effectiveness of achievements</td>
<td>Are you curious about the so many ways you can experience your new achievements in practice? In how many ways you will experience how easy and how strong your efforts make you feel now?</td>
</tr>
</tbody>
</table>

*Stabilization sessions (follow-up).*
Compared to the original program developed by Revenstorf and Schmid, some mottos were slightly modified, and two stabilization sessions (see Table 2 and below) were added.

Each session of the treatment was organized by a specific internal structure (see also Revenstorf & Schmid, 2006):

1. The trance of alertness ("Who am I today?" "In what mood am I today?") was induced at the beginning of each session with the aim of stimulating the personal attention of the clients to inner processes related to the theme of the session.

2. Reflection on homework given during the previous session: Participants were asked, with reference to their experiences, feelings, and ideas during the past week, questions such as "What did you realize about yourself during the past week concerning the issue discussed in the last session?" and "How do you think this could help you to change in the future?" The goal was to stimulate the ability to focus and verbalize perceptions, thoughts, and behaviors that occurred during the past week and to stimulate their framing within possible future adaptive scenarios. This step did not occur in the first and eleventh (first stabilizing module) sessions. In the twelfth session (second stabilizing module), the reflections regarded the participants’ "personal romance" (see Number 5 below).

3. Induction of trances and conduction of behavioral exercises and role-playing consistent with the motto of the session: The goal was the uncovering of the "psychical background" underlying the problematic eating behaviors and the strengthening of resources for more adaptive cognition and action. In the eleventh and twelfth sessions (first and second stabilizing modules), the trances and behavioral exercises dealt specifically with the topics of "What has changed during the treatment" and "Saying good-bye," respectively.

4. Final Round ("flash"): The clients were asked to report on the most relevant experiences from the current session ("What was the most important thing for you that happened during this session?"). The goal was to stimulate the collection of and reflection on what had been experienced during the session that was ending, as well as preparation for the coming session. In the last two stabilizing sessions, the "flash" focused on the experiences of the clients during the 3 months preceding each stabilizing session.

5. Assigning and describing homework: The homework (auto-hypnotic trances, exercises of thematic behavioral observation and modification) that had to be completed by the client before the next session was briefly described and discussed and then assigned. The aim was to consolidate the processes initiated during the session and to promote their readjustment and their integration into personal everyday-life situations. In the first stabilizing session, the homework consisted of the writing of a "personal romance," in which the clients were invited to describe their life up to that point and to imagine a "happy ending" (not necessarily related to the weight reduction). In the last stabilizing session, no homework was assigned.
Two CDs were made containing hypnotic and behavioral exercises compiled from various sources (Martin, 2005; Orbach, 2003; Revenstorf & Schmid, 2006) to support and orient the homework of the clients during the treatment (see Zips, 2009, for details).

**Hypnoenergetic therapy.** Hypnoenergetic therapy (HypEn) was developed by two Austrian practitioners (Zips & Neumann, 2006; see also Neumenn, 2009; Zips, 2009) as an eclectic approach to the treatment of obesity. More specifically, this technique comprises the HypBe treatment described above, enhanced with a specific element of energetic psychotherapy: acupressure, that is, the manual stimulation of acupuncture and related points (Feinstein, 2008; Gallo 2000, 2002, 2004a, 2004b, 2007; see the introduction of this article). This technique was used to reduce the hyperarousal previously elicited through the hypnotic trances and behavioral exercises performed as homework by the clients between the sessions.

As with the HypBe treatment, each session was characterized by a specific motto that organized the content and the aims of the session. Additionally, the internal structure of each session was organized exactly in the same way as for HypBe (see above), with the following exception: At the end of Session 3, the prescription of the homework included acupressure. The therapists explained how to apply this technique with reference to the specific motto of Session 3, demonstrated a concrete example and prescribed this additional homework. The additional prescription of acupressure homework took place at the end of each session up to module 10, always with reference to the specific motto of each session. Moreover, the following reflections on homework (Sessions 4–11) included a reflection on the acupressure exercises conducted at home. As in HypBe, two CDs were given to the clients to support and orient them during their homework between the sessions. In addition to the hypnotic and behavioral exercises, one of these CDs contained acupressure exercises (see Zips, 2009, for details).

**Outcome Measures**

Participants were assessed at the beginning and end of the treatment, as well as at 6-month follow-up, using the following measures/instruments: (a) a medical scale and computation of body mass index (BMI), (b) a questionnaire on eating behavior (Pudel & Westenhöfer, 1989), and (c) the Frankfurt Body Concept Scales (Deusinger, 1998).

**Questionnaire on eating behavior.** The questionnaire on eating behavior (Fragebogen zum Essverhalten [FEV]; Pudel & Westenhöfer, 1989) is the German version of the Three-Factor Eating Questionnaire (TFEQ; Stunkard & Messick, 1985). This questionnaire is a self-report instrument consisting of 51 items with a dichotomous answer format (0 =
absence of the described behavior; 1 = presence of the described behavior) that assesses three basic problematic dimensions of eating behavior:

1. Restrained eating (21 items): This construct refers to the cognitive control of hunger, appetite and fullness, such as counting calories, skipping meals or high-calorie foods, and restriction to small portions.
2. Disturbance of eating behavior (16 items): This scale measures the extent to which the ingestion of food may easily be triggered by certain constellations of situational stimuli (e.g., smell and sight of food, social eating, etc.).
3. Experienced hunger (14 items). This scale measures the control of food intake by emotional states (e.g., fear, grief, loneliness, boredom, etc.).

For each scale, a total sum score is calculated; there is no overall score. The internal consistency of the three scales has been shown to range from .75 to .87, indicating sufficient reliability (Pudel & Westenhöfer, 1989).

**Frankfurt Body Concept Scales.** The Frankfurt Body Concept Scales (Frankfurter Körperkonzeptsalen [FKKS]; Deusinger, 1998) is a self-report instrument consisting of nine one-dimensional scales (64 items) for the assessment of one’s body concept. The nine scales are as follows:

1. Health and physical condition (SGKB [Selbstkonzept der Gesundheit, des körperlichen Befindens], six items): This scale describes the degree of physical well-being and the self-appraisal of physical strength.
2. Body care (SPKF [Selbstkonzept der Pflege des Äußeren und der körperlichen Funktionsfähigkeit], eight items): This scale describes the attention given to the care and appreciation of one’s appearance and health.
3. Physical efficiency (SKEF [Selbstkonzept der körperlichen Effizienz], 10 items): This scale captures the self-perception of strength and toughness of the body, as well as skill and mobility.
4. Physical contact (SKKO [Selbstkonzept des Körperkontakts], six items): This concept measures emotions and cognitions in relation to closeness and contact with other people.
5. Sexuality (SSEX [Selbstkonzept der Sexualität], six items): This scale summarizes emotions, cognitions, and actions with regard to personal sexuality.
6. Self-acceptance of the body (SSAK [Selbstkonzept der Selbstakzeptanz des Körpers], six items): This scale describes the emotions and cognitions related to how much one accepts his/her own body.
7. Acceptance of the body by others (SAKA [Selbstkonzept der Akzeptanz des Körpers durch Andere], four items): This scale measures the effects that one assumes physical appearance has on others.
8. Aspects of physical appearance (SASE [Selbstkonzept zu Aspekten der körperlichen Erscheinung], 14 items): This scale measures the degree
of positivity of self-perception, which refers to the personal physical appearance, especially in terms of aesthetics.

9. Dissimilatory body processes (SDIS [Selbstkonzept zu dissimilatorischen Körperprozessen], four items): This scale is a summary of attitudes (perceptions, judgments, actions) about personal body odors.

Each item describes the attitude toward a specific problematic aspect of personal body concept; a 6-point Likert-type scale assesses the agreement of the subject (1 = not at all; 6 = completely). For each scale, a total sum score is calculated; an overall score can also be calculated. The following scales showed very high-reliability coefficients: (1) SGKB (.90), (3) SKEF (.89), and (4) SKKO (.86). The lowest reliability coefficients were seen in the scales that consisted of only four items: (7) SAKA (.63) and (9) SDIS (.65).

**Statistical Analysis**

The sociodemographic variables between both groups were compared using either paired t tests or Mann-Whitney U tests, depending on the normality assumption, and Pearson chi-squared tests in the case of categorical data. Changes over time depending on treatment and “response group” (responder: clients who were able to lose at least 1 kg; nonresponders: clients who lost less than 1 kg or even put on some weight) as the covariate were tested via mixed analysis of variance (ANOVA) models with the type of treatment and the treatment response as between-subjects factors. Effect sizes (Cohen’s d and Eta²) were reported. All analyses were performed using SPSS 19.0, with p values ≤ .05 considered significant and p values ≤ .10 considered statistical tendencies.

**Results**

**Weight Reduction (Hypothesis 1)**

In agreement with our Hypothesis 1, significant reductions in body weight (p < .001) and BMI (p < .001) were observed over time across both treatment groups, indicating that, regardless of the treatment received, weight was reduced from beginning to follow-up (kg: p < .001; BMI: p < .001). However, only a tangential interaction effect between treatment and time for both variables was observed (kg: p < .077; BMI: p < .086) (see Table 3). More specifically, the HypBe group revealed a significant weight reduction from baseline to posttreatment (kg: Cohen’s d = .12, p < .001; BMI: Cohen’s d = .12, p < .001); however, there was no significant change in weight reduction from posttreatment to follow-up (kg: Cohen’s d = .01, p = .752; BMI: Cohen’s d = .01, p = .734). The results in the HypEn group showed a highly significant weight reduction from baseline both to posttreatment (kg: Cohen’s d =
Table 3
Change in Weight and BMI Scores at Each Time Point

<table>
<thead>
<tr>
<th></th>
<th>HypBe (n = 30)</th>
<th>HypEn (n = 30)</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>M (SD)</td>
<td>Factor</td>
</tr>
<tr>
<td>Weight$^a$</td>
<td></td>
<td></td>
<td>Time</td>
</tr>
<tr>
<td>Beginning</td>
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<td>96.7 (21.3)</td>
<td></td>
</tr>
<tr>
<td>End</td>
<td>96.0 (19.7)</td>
<td>93.6 (20.3)</td>
<td>Treatment</td>
</tr>
<tr>
<td>Follow-up</td>
<td>95.8 (20.8)</td>
<td>91.4 (20.0)</td>
<td>Time $\times$</td>
</tr>
<tr>
<td>BMI$^b$</td>
<td></td>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td>Beginning</td>
<td>35.2 (6.7)</td>
<td>34.5 (7.1)</td>
<td>Time</td>
</tr>
<tr>
<td>End</td>
<td>34.4 (6.6)</td>
<td>33.4 (6.8)</td>
<td>Treatment</td>
</tr>
<tr>
<td>Follow-up</td>
<td>34.3 (6.9)</td>
<td>32.6 (6.7)</td>
<td>Time $\times$</td>
</tr>
</tbody>
</table>

Note: HypBe = hypnobehavioral therapy; HypEn = hypnoenergetic therapy; BMI = body mass index.
$^a$kg. $^b$kg/m².

Figure 2. Weight over time in the two treatment conditions. HypBe = Hypnobehavioral therapy; HypEn = Hypnoenergetic therapy.

.15, p < .001; BMI: Cohen’s d = .16, p < .001) and to follow-up (kg: Cohen’s d = .11, p < .001; BMI: Cohen’s d = .11, p < .001), signifying prolonged effectiveness of HypEn after the end of the therapy (sleeper effect; see Figure 2).

For the following analyses (Hypotheses 2 and 3), participants (HypBe: n = 30; HypEn: n = 30) were divided into two groups based on weight loss between the beginning and stabilization sessions. These groups were labeled “responders” (R: n = 43; weight loss of at least one
kilogram) and “nonresponders” (NR: *n* = 17; weight loss of less than one kilogram or weight gain).

*Improvement of Eating Behavior (Hypothesis 2)*

An improvement in eating behavior was observed in the domains of disturbance of eating behavior and experienced hunger, regardless of treatment group and weight loss (responders vs. nonresponders). Restrained eating improved significantly in both treatments and, as expected, more in the group of responders than in the nonresponders (see Table 4).

*Improvement of Body Concept (Hypothesis 3)*

An improvement in body concept was observed in the domains of health and physical condition and sexuality (this last at a significance level of 10%), regardless of treatment and weight loss. A further differentiation was observed with regard to physical efficiency, self-acceptance of the body, and aspects of physical appearance, which showed a higher significant improvement in the responder group compared to the nonresponders (see Table 5) but were improved regardless of the treatment group.

Contrary to our hypothesis of a greater effectiveness of HypEn, dissimilatory body processes showed a significant improvement in the HypBe group; moreover, this variable worsened in the HypEn nonresponders (see Table 5 and Figure 3).

**Discussion**

*Weight Reduction (Hypothesis 1)*

The hypothesis of the effectiveness of both treatments for weight reduction, assessed as a reduction in kg and BMI, was supported. Moreover, the hypothesis of a greater effectiveness of HypEn for weight reduction between the end of the treatment and the follow-up was supported at a significance level of 10%. Thus, the participants in the HypEn group, in contrast to the participants in the HypBe group, benefited from further significant weight reduction during the follow-up period, as if the process of losing weight had not yet finished (*sleeper effect*). This finding, which should be replicated in further investigations with similar and longer catamnestic periods, suggests that HypEn may achieve more sustainable effects in weight loss compared to HypBe.

One reason for this result could be that the specific techniques of energetic therapy implemented in HypEn (i.e., the assignment of acupressure homework) may have been more effective in working through the unconscious ambivalence and conflicts regarding losing weight or wanting to be slim (e.g., “I should be slim” vs. “I should be...
Table 4
Changes in Eating Behavior (FEV) Over Time

<table>
<thead>
<tr>
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<th>HypBe ($n = 30$)</th>
<th>HypEn ($n = 30$)</th>
<th>ANOVA</th>
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</thead>
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<td>Responder ($n = 20$)</td>
<td>Nonresponder ($n = 7$)</td>
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<td><strong>Restraint eating</strong></td>
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<td></td>
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</tr>
<tr>
<td>Follow-up</td>
<td>8.8 (4.4)</td>
<td>11.6 (4.2)</td>
<td>13.8 (5.4)</td>
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<td><strong>Disturbance of eating behavior</strong></td>
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<td>10.7 (4.0)</td>
</tr>
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<td>End</td>
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<td>9.4 (3.4)</td>
<td>8.4 (3.9)</td>
</tr>
<tr>
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<td>9.7 (4.0)</td>
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<tr>
<td><strong>Experience of hunger</strong></td>
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Note. FEV = questionnaire on eating behavior; HypBe = hypnobehavioral therapy; HypEn = hypnoenergetic therapy.
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(Continued)
Table 5  
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Downloaded by [Joannes Mertens] at 02:29 07 August 2015
### Acceptance of the body by others

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<th>End</th>
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<th>Treatment</th>
<th>Response</th>
<th>Time × Treatment</th>
<th>Time × Response</th>
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### Aspects of physical appearance

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<th>Treatment</th>
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<td>Follow-up</td>
<td>60.9 (4.6)</td>
<td>64.8 (6.8)</td>
<td>57.6 (6.6)</td>
<td>61.9 (7.0)</td>
<td>Treatment .02</td>
<td>Response .02</td>
<td>Treatment .02</td>
<td>Response .02</td>
</tr>
</tbody>
</table>

### Dissimilatory body processes

<table>
<thead>
<tr>
<th></th>
<th>Beginning</th>
<th>End</th>
<th>Follow-up</th>
<th>Time</th>
<th>Treatment</th>
<th>Response</th>
<th>Time × Treatment</th>
<th>Time × Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissimilatory body processes</td>
<td>16.5 (2.2)</td>
<td>17.2 (2.7)</td>
<td>17.3 (1.8)</td>
<td>17.0 (2.8)</td>
<td>Time .01</td>
<td>Treatment .01</td>
<td>Response .01</td>
<td>Treatment .01</td>
</tr>
<tr>
<td>End</td>
<td>17.6 (3.0)</td>
<td>17.9 (2.8)</td>
<td>16.4 (2.0)</td>
<td>17.5 (2.8)</td>
<td>Treatment .01</td>
<td>Response .01</td>
<td>Treatment .01</td>
<td>Response .01</td>
</tr>
<tr>
<td>Follow-up</td>
<td>17.9 (2.9)</td>
<td>18.1 (2.1)</td>
<td>15.0 (3.2)</td>
<td>17.4 (2.6)</td>
<td>Treatment .01</td>
<td>Response .01</td>
<td>Treatment .01</td>
<td>Response .01</td>
</tr>
</tbody>
</table>

**Note.** FKKS = Frankfurt Body Concept Scales; HypBe = hypnobehavioral therapy; HypEn = hypnoenergetic therapy.
Figure 3. Dissimilatory body processes over time of responders vs. nonresponders in the two treatment conditions. SDIS = Dissimilatory body processes; HypBe = hypnobehavioral therapy; HypEn = hypnoenergetic therapy.

fat”). According to the literature (e.g., Orbach, 2003, 2005), these conflicts are responsible for the difficulty in losing weight in obese clients and take considerable time to overcome. The specific techniques of HypEn address these conflicts in a clinically meaningful way. Another reason for the observed sleeper effect could be that clients who received HypEn may have learned to make use, on their own initiative, of the acupressure exercises in critical (eating) situations. Future studies should check for this possibility by surveying the behavior of the clients between the end of the treatment and the follow-up assessment.

Improvement of Eating Behavior (Hypothesis 2)

The improvement of eating behavior is an essential criterion in goal-oriented behavior management in obesity (Skender & Goodrick, 1996). The current study showed that, as expected, both HypBe and HypEn produce significant improvements in the investigated problematic domains of clients’ eating behavior (i.e., restrained eating, disturbance of eating behavior, and experienced hunger), with these positive effects occurring between the beginning and the end of treatment. Contrary to our expectations, there were no significantly greater improvements in the eating behavior of the HypEn group compared to the HypBe group, although the HypEn clients lost almost twice as much weight as the participants in the HypBe treatment group. This result indicates that the acupressure homework, which was specific to the HypEn treatment, did not significantly affect the resolution of problems related to emotional eating in obese clients.
The hypothesis of a relationship between weight reduction and the improvement of eating behavior could be supported for restrained eating but not for disturbance of eating behavior or experienced hunger. A greater significant improvement in restrained eating (i.e., the extent to which clients cognitively control the ingested food) was observed in the group of responders compared to the nonresponders. There is evidence of a mediating role of weight loss for the improvement of restrained eating, according to which the reduction of weight would facilitate the task of reducing the cognitive control associated with restrained eating. The opposite could also be true: Clients able to improve their restrained eating behavior would more easily lose weight. Future studies should more specifically address the directional nature of this relationship.

On the contrary, disturbance of eating behavior (i.e., the extent to which the ingestion of food may be triggered by situational stimuli) and experienced hunger (i.e., the extent to which several inner states may trigger the experience of hunger) significantly improved in both treatment groups regardless of weight loss. There was no relationship between success in weight reduction and the improvements shown in these two problematic domains of eating behavior.

In summary, these results would suggest that whereas the cognitive control of eating behavior (restrained eating) has a significant relationship with weight loss, the same cannot be said for the emotional-related problems in eating behavior (disturbance of eating behavior and experienced hunger). This difference could be due to the clients consciously adopting the former strategies, while remaining unaware of the latter.

Improvement of Body Concept (Hypothesis 3)

In the present study, there was support for the hypothesis of the effectiveness of both HypBe and HypEn for the improvement in most of the scales addressing clients’ body concept: health and physical condition, physical efficiency, self-acceptance of the body, aspects of physical appearance, and sexuality (this latter at a significance level of 10%). Contrary to our expectations, body care, physical contact, and acceptance of the body by others did not show any significant change across time. This result supports the idea that the modification of body concept represents a difficult therapeutic aim with obese clients, especially because of the negative feedback from the social environment that contributes to the formation of stable beliefs about the inadequacy of one’s own body (Adami et al., 1998; Stunkard, 1986; Stunkard & Burt, 1967; see also Wardle, Waller, & Fox, 2002). According to our results, this difficulty in significantly modifying aspects of body concept involves body care, physical contact, and acceptance of the body by others. Within the specific context of the present study, this result may be due to the relatively high initial scores of the clients on these three scales at the beginning of the treatment. This issue should be further considered in future studies.
Moreover, as expected, responders showed a significantly higher improvement in body concept compared to nonresponders, although only for physical efficiency, self-acceptance of the body, and aspects of physical appearance. These results suggest that there is a relationship between weight loss and improvement of those aspects of body concept connected with the idea that “my body can do it” (physical efficiency), “my body is good” (self-acceptance of the body), and “my body looks good” (aspects of physical appearance). The same cannot be said for the other dimensions of body concept. Overall, these findings support the complexity of body concept, the improvement of which may only be related to weight loss in obese clients to a minimal degree.

Finally, contrary to our expectations, greater effectiveness of HypEn compared to HypBe in any of the investigated dimensions of body concept was not observed. In the case dissimilatory body processes, HypEn was even less effective for those clients who did not lose weight during the treatment. More specifically, whereas both the responders and nonresponders treated with HypBe and the responders treated with HypEn showed a significant improvement in dissimilatory body processes, nonresponders treated with HypEn showed deterioration in dissimilatory body processes.

Although these results indicate that the technique specific to HypEn (acupressure homework) does not add any significant effectiveness to HypBe in the improvement of most dimensions of body concept, they also suggest that this specific technique may be deleterious concerning dissimilatory body processes with clients who do not lose weight during the treatment.

To explain this unexpected finding, we considered the following: (a) Acupressure homework is of an exposure-based nature, involving the elicitation of hyperarousal to a targeted stimulus, which is then reduced by the manual stimulation of specific acupuncture points; (b) nonresponders, due to a type of “disappointment effect” concerning the maintenance of their weight, present a lack of motivational resources necessary for reducing the elicited arousal through the acupressure, with the consequence of a prolonged hyperarousal; (c) the “olfactory” body concept (i.e., the attitude about personal body odors) assessed by the dissimilatory body processes scale reflects processes of self-acceptance situated at a deep, unconscious emotional level, which usually have strong psychophysiological components (see Bensafi et al., 2002). Moreover, autonomic hyperarousal tends to be correlated with negative emotions (Kreibig, 2010; Van der Kolk, 2004; Wiedemann & Mühlberger, 2002), and olfactory information stored in long-term memory has strong connections to emotional experience and memory (Herz & Engen, 1996). Thus, nonresponders applying energetic techniques may not be able, because of a motivational deficiency, to reduce the elicited hyperarousal by acupressure, which would consequently negatively influence their attitude toward their own body odors. Future
studies should focus on this hypothesis by investigating the relationship between attitude about personal body odor, autonomic arousal, emotional regulation, weight loss-related motivational factors, and treatment effectiveness in the therapy of obese clients.

Limitations and Suggestions for Future Studies

The main limitation of this study is the relatively small sample size; this aspect reduces the external validity of the results and may prevent the detection of subtle but significant effects of the treatments (Gold, in press). Another main limitation is represented by possible therapist allegiance effects (see Wampold, 2001). Although randomization was blind to the researchers, the therapists administering the treatments were aware of the aims of the research. Moreover, these therapists were the developers of one of the treatment modalities (HypEn) being investigated. Multicentric studies aimed at replicating the present research could overcome these two main limitations.

Some other suggestions for future studies may be drawn considering the following observations. First, the current study showed that there is a variation in effectiveness for participants in the group treatment programs. The same treatment program enabled some participants to lose 20 kg or more, whereas others gained up to 9 kg. With regard to this issue of individual differences in effectiveness, future studies should more specifically focus on the differences in effectiveness of these treatments on “responders” versus “nonresponders.” These two groups of obese clients should be identified as soon as possible with the aim of differentially improving their eating behavior and body concept by means of a combination of programs. Participants who have not succeeded in improving their eating behavior could change to an individual setting. Demonstrating the benefits of a split-program treatment remains a task for future investigations.

Second, even though the treatment programs in the present study were not effective in improving the body concept of obese women, this latter domain remains a useful target for further research. A better body image and a higher self-esteem could affect weight reduction and lead to a positive cycle. Improvements in these domains could also influence other body concepts, thus contributing in a similar way (as weight reduction) to improving the quality of life. Third, this study provided some evidence that HypEn treatment alone stimulates weight reduction even after the end of treatment. Future studies should specifically focus on the mechanisms that might be responsible for this effect.

Finally, weight reduction is a multifactorial process that incorporates the spirit, soul, and body. A psychotherapeutic program can only be a contributing segment of treatment. Follow-up studies should deal primarily with the combination of various measures in the treatment of obesity. Psychotherapists could consider suggesting obesity
surgery given that there are no other effective interventions available. However, such interventions should be combined systematically with psychotherapy follow-up programs. Metabolic balance (see Funfack, 2007) poses another possible combination (especially in moderate obesity) in metabolically oriented nutrition programs. Metabolic regeneration aims to initiate secondary, health-related body reactions, and, above all, results in substantial weight reduction. However, this treatment program requires discipline and persons who are able to cope with the mental rigors of renunciation of food as a calming, relaxing, or activating agent; psychotherapeutic support is often necessary. Future research should concentrate on the interdisciplinary treatment of obesity with the incorporation of psychotherapy.

REFERENCES


Hypnobehaviorale und Hypnoenergetische Therapie in der Behandlung von übergewichtigen Frauen: Ein pragmatischer, randomisierter klinischer Versuch

Omar Carlo Gioacchino Gelo, Astrid Zips, Elisabeth Ponocny-Seliger, Karin Neumann, Renzo Balugani und Christian Gold

Le rôle de la thérapie hypno-comportementale et hypno-énergétique dans le traitement des femmes obèses: Un essai clinique pragmatique randomisé

Omar Carlo Gioacchino Gelo, Astrid Zips, Elisabeth Ponocny-Seliger, Karin Neumann, Renzo Balugani et Christian Gold


Johanne Reynault
C. Tr. (STIBC)

Terapia hipnoconductual e hipnoenergética en el tratamiento de mujeres obesas: Un ensayo clínico pragmático aleatorizado

Omar Carlo Gioacchino Gelo, Astrid Zips, Elisabeth Ponocny-Seliger, Karin Neumann, Renzo Balugani, y Christian Gold

Resumen: Este estudio comparó la eficacia de la terapia hipnoconductual (HypBe) y la HypBe complementada con elementos de psicoterapia energética (terapia hipnoenergética, HypEn) en mujeres obesas. 60 clientes fueron aleatoriamente seleccionadas para HypBe y HypEn. Se evaluó peso corporal, IMC, conducta alimentaria, y concepto corporal durante la línea basal, postratamiento, y seguimiento. Los estadísticos utilizados fueron los modelos de ANOVA mixtos y el tamaño de efecto. Ambos tratamientos mejoraron peso, IMC, conductas alimentarias, y algunos aspectos del concepto corporal. Las mejoras en las conductas alimenticias y el autoconcepto corporal fueron mayores para aquellos participantes que también perdieron peso. Las reducciones de peso e IMC no fueron significativamente diferentes entre HypEn e HypBe en el seguimiento.

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