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Clinical Hypnotherapy for Stopping Drug and Alcohol Addiction: Building Resilience in Clients to Reduce Relapses and Remain Clean and Sober

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Abstract

Clinical hypnotherapy is a powerful promoter of mental and behavioural change that can help clients experiencing out-of-control alcohol and drug use or addiction to move towards sobriety and recovery – fast – by assisting deep, unconscious change.

In clinical practice success rates clearly increase specifically according to the hypnotherapist's level of training, experience and reflective supervision. Hypnotherapists can learn to recognise addiction, devise staged treatment plans, and execute fast therapeutic change during substance withdrawal from the overuse of prescription drugs through to amphetamine and opioids withdrawal and helping clients build resilience to remain clean and sober on a long-term basis.

Introduction

Substance Use Disorders (American Psychiatric Association, 2013) (World Health Organization, 2016), which are part of a class of substance-related disorders including misuse, dependency and abuse, involves a set of complex behaviours. Hypnotherapists working in this area must undergo extensive professional training and on-going supervision specifically in addiction.

The majority of treatments for addictions fail, including long-term residential care. McLellan, Lewis, O'Brien, and Kleber (2000) reported a 40% to 60% relapse rate. Since it is impossible to follow up relapsed long-term addicts and alcoholics as they are generally cognitively incapable of taking part in long-term studies, the rate is likely to be far higher.

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Failure of treatment is generally through poor therapeutic techniques, inadequate staff training, inauthentic delivery of treatment by low-skilled professionals, low-skilled volunteers, fraudulent delivery of treatment, lack of commitment from the client and failure of the client to change their personality. Vogel (2018) discusses how acute care is also constantly let down by a lack of recovery capital which is the lack of social support, housing, employment opportunities and alternatives to being involved in crime or being criminalised.

Glasner-Edwards and Rawson (2010) clearly reviewed the move towards evidence-based treatment within the healthcare fields but unfortunately many hypnotherapy schools do not teach or understand evidence-based practice. Cowen (2015) found a lack of agreed training standards and the operation of evidence-based practice in hypnotherapy in Australia. Alcohol and drug addiction recovery therapy requires therapists to undergo training and supervision by therapists experienced in addiction, not simply hypnotherapy. Since addiction presents a life or death situation for clients/patients, therapists working in the field need to understand psychodynamics and the cognitive and behavioural psychological drivers of addiction in order to work with patients effectively.

Booth, Walton, Barry, Cunningham, Chermack, and Blow (2011) found extremely high levels of co-morbidity, including depression, and lowered cognitive functioning, in 15% of people experiencing alcohol and drug abuse/dependency, in 5,641 patients presenting to an inner-city hospital emergency department. As addiction is associated with a high level of mental distress and illness, hypnotherapists working in the field need to be trained as mental health professionals.

Addicts have always been historically amongst us and have included Caravaggio, Alexandra Feodorovna Zarina of Russia, Sigmund Freud, Winston Churchill, Princess Margaret, Betty Ford, David Bowie, Kurt Cobain, Ozzie Osborne, and millions of ordinary people throughout history. Today they include millions of people across the planet.

The level of training denotes the role of the hypnotherapist in addiction recovery

Professionals using the title ‘hypnotherapist’ come from different sectors of the workforce who are trained in hypnosis, including psychiatrists, doctors, nurses, psychologists, psychotherapists, counsellors, social workers, naturopaths, and clinical hypnotherapists (Kirsch and Heap, 2006). The profession does not denote the level of training in hypnotherapy although the job title and recognition do indicate the primary profession. Hypnotherapy can be used as a primary or adjunct treatment in addiction cessation. There is also a need to distinguish between those practising hypnosis as dentists, in education or the corporate sector from those practising hypnotherapy as primary or adjunct professional skill.

Recognising addiction is dependent on the clinician’s primary discipline, socio-political perspectives, observational skills and ability the therapist

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has to confront their clients about addictions. Outward physical signs include skin colour changes, perspiration, muscle tension or laxity, alertness, breathing irregularities, eye dilation or constriction, speech incompetency, mispronunciation, parapraxis, short and long-term memory lapse, signs of brain damage and presence of psychosis. Is the client's history showing substance-induced psychosis, incongruency, evasiveness, obvious confabulation, memory loss, avoiding discussing substance abuse, displaying lack of cognitive ability and deviation from the client's known history? What does the blood essay, urine test, hair drug testing and obvious organ dysfunction suggest about the client's substance misuse (O'Keefe, 2018)?

Levels of training in hypnotherapy can range from a two-day course of 16 hours to several years and doctorate level specifically in hypnosis and related therapies. Competency in hypnotherapy also does not derive from which profession the professional practices but the level of training, practice and extended clinical supervision in hypnotherapy. No basic training in hypnotherapy covers the ability to help people with drug and alcohol addictions. In Australia anyone can advertise and practise hypnosis but some associations produce required minimum standards (Australian Society of Clinical Hypnosis, (n.d.) (Australian Hypnotherapists Association, (n.d.).

In many countries, including Australia, there are no laws against practising and advertising services for hypnosis, so there is a further class of people advertising as hypnotherapists who have a very low level of training, some with no professional insurance, low skills, no professional peer association, who do not engage in clinical supervision and may even be involved in hypnosis for entertainment (O'Keefe, 1998). These people cannot be considered as health professionals.

In varying countries and states there is a great variation on who can help people with addictions and what they may call themselves. For instance, in some places in the USA, there is licensing of addiction counsellors and psychologists (Rieckmann, Farentinos, Tillotson, Kocarnik, and McCarty, 2011). In Australia there is no such licensing system but an individual offering therapeutic health services must comply to the guidelines set out by either the federal registration body or the state guidelines set out for registered (Australian Health Practitioner Health Regulation Agency, (n.d.) or non-registered healthcare practitioners such as in NSW (HCCC, (n.d.) including appropriate advertising, training and insurance.

Research on the efficacy of hypnotherapy in substance misuse recovery

The use of altered states of awareness and hypnotic methods in the relief of substance abuse dates back to Egyptian, Greek and Roman times (Gauld, 1995). The popularist revival of hypnosis was initiated by Mesmer in the late 1700s, Braid in the1800s, Charcot in the1800s, and Hall and Erickson in the 20th century, which all led to it being used regularly as an adjunct and core treatment for substance abuse problems.

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Hartman (1972) reviewed the reported successful use of hypnosis by several hypnotic practitioners in drug withdrawal in the Journal of the National Medicine Association sometimes in association with clinical drugs. Potter (2004) published utilising hypnosis over serval years with clients recovering for substance abuse with 77% success rate at one-year follow-up. Kaminsky, Rosca, Budowski and Yakhinich (2008) described using group hypnosis with street drug addicts obtaining a 90% success rate after six months, reducing to 70% after two years.

Crocker (2004) experimented with a small group of problem alcohol drinkers divided up into those who received hypnosis and a control group, resulting in a stronger reduction in alcohol after a 30-day review in those who underwent hypnosis. Pekala, Maurer, Kumar, Elliott, Masten, Moon and Salinger (2004) found hypnosis to be a useful adjunct treatment for improving self-esteem, serenity, and anger/impulsivity in chronic substance abuse individuals using self-hypnosis.

However, recent studies such as that conducted by Shestopal and Bramness (2019), which compared the effectiveness of hypnotherapy against motivational interviewing, fail outright to understand the nature, mechanics, qualitative nature and complexities of hypnotherapy administration.

Research in hypnosis has generally fitted into two hypnotic paradigms: intrinsic and instrumental hypnosis.

Intrinsic research into the effects of hypnosis are bound with examination of the hypnotic state, its effects on the body, mind and hypnotisability (Jamieson and Burgess, 2014).

Instrumental hypnosis research examines suggestibility and a person's responsiveness to suggestion (Oakley and Halligan, 2013). Such studies may quantitatively commodify intrinsic and instrumental factors but frequently ignore the variables of administration of hypnosis and hypnotherapy as the major variable in effectiveness of treatment. A further line of research points to the value of hypnotic suggestion in modulating cognitive control processes (Raz et al. 2006), which supports the instrumental use of hypnosis for studying psychopathology in a controlled environment (Woody and Szechtman, 2011).

Since many researchers into hypnosis limit their controls to a small number of variables in order to prove or disprove their hypothesis, the characteristics of the hypnotist's hypnotic education, substance abuse recovery education, practice, experience, delivery and personality, the client's psychodynamics and personal history are never factored into the delivery of the treatment effectiveness – all of which have direct causal links on the efficacy or not of the treatment.

As Jensen et. al (2017) suggest, we need to change the way we do research into hypnosis and its therapeutic applications. We need to validate qualitative clinical research, which takes place within real work situations, on an equal footing with

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experimental and quantitative research and clearly consider administration factors.

Many experimenters, researchers and clinicians such as Erickson (1980a), Crasilneck and Hall (1973), Hilgard and Hilgard (1994) and Miltner and Weiss (2007) showed that intrinsically the hypnotic state, in of itself can reduce the activity of pain receptors. This supports the use of hypnosis in drug withdrawal which can give rise to pain, anxiety and the perceived fear that life without the substance will be painful. Indeed, this is observed in the thousands of substance misuse withdrawal patients I have worked with in my own clinic. A parallel to this can be seen in Tibetan Buddhist meditation and the use of the Tummo meditation state where monks endure long periods of extreme physical exposure to cold without experiencing a variation in their core body temperature (Benson, Lehmann, Malhotra, Goldman, and Hopkins, 1982)

Instrumentally we can also see from Erickson's (1980b) experiments and clinical work, and that of others, with pain control that hypnotically induced saddle-block and cataleptic hand anesthesia can be used and even transferred to other parts of the body to reduce physical discomfort without the use of pharmaceuticals (Elkins, Jensen and Patterson, 2009).

My own clinical experience with patients is that using such hypnotic intra and post-hypnotic suggestions can profoundly change cognitive processing in cases of substance misuse withdrawal, and thereby physiological function and experience. This has now involved patients with a 90% success rate due to hypnotherapy, immediately producing a life without the substance misuse that does not include withdrawal pain, anxiety or panic.

Cognitive behavioural therapy (CBT) approaches

Tolin (2010) suggested that cognitive behavioural therapy (CBT) is more effective in treating psychiatric disorders and should be offered and be considered as a first-line psycho-social treatment. From a research perspective, however, it is actually the way in which therapies are measured that determines research outcomes. Nevertheless, CBT is recognised as having high levels of success in behavioural modification with many patients.

When emotional drivers are introduced, turning it into emotive cognitive behavioural therapy, it becomes more effective when amplified by the application of hypnotic interactions and suggestions to initiate cognitive, behavioural and emotional reprogramming in substance misuse withdrawal (O'Keefe, 2018). Emotion is a powerful neurological impulse when a person is in a non-resourceful state and always wins over logic.

Discussion

Addiction is a complex of interrelated self-destructive thoughts and behaviours that make up the addict's dependent personality. Being clean and sober requires the addict to displace those self-destructive thoughts and behaviours permanently

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and replace them with a new psychological structure that automatically operates a sober way of living. It must be a permanent change of sub-personalities and the whole maturing of the central personality.

The mistaken idea that clinical hypnosis or hypnotherapy are non-interactional commodities to be applied by reading a script from a book, or applied dogmatically without consideration of what the therapist brings to the session, leads to poor addiction recovery outcomes. No two clients, hypnotists, hypnotherapists or hypnotic experiences are the same so a hypnotherapist must always be leading their client, guided by their own training, study, practice, experience, and therapeutic reflection (supervision) towards a recovery via authentic hypno-psychotherapeutic intervention.

Since clinical hypnosis and hypnotherapy can never be nominalised into an inanimate or standardised application, it is intrinsically and instrumentally dependent on many interactive factors and variables between the participants, just as sailing is dependent on ever-changing winds and the skill of the sailor and crew. Intrinsically and instrumentally these variables promote or restrict the levels and effectiveness of the hypnosis experience and effectiveness of hypnotherapy in substance withdrawal.

In other words, the evolution of the hypnotherapist's automatically operating hypnotic personality and skills is one of the major variables in whether therapy will succeed or fail, not only with addiction recovery, but all therapy as it builds or destroys rapport. As any experienced hypnotherapist knows, it is rapport that magnifies or diminishes the hypnotic state and power of suggestion.

For a therapist to initiate an authentic clinical application of treatment for drug and alcohol addiction recovery, the therapist needs to be highly knowledgeable and experienced in the field of addiction separately from hypnosis. It is a vast field with many substances being misused and therefore many approaches need to be applied for recovery.

Building resilience and sobriety in a client is, in my view, built on the foundation of the therapist being resilient and sober. Clinical hypnotherapy is an interactive process, not simply active for the hypnotist and passive for the client as a receptacle for suggestion. Just as a well-trained hypnotist is always monitoring the client's responses, so is the client's unconscious monitoring the hypnotist's actions and responses in all sensory systems. When a client's unconscious notes even a small incongruency in the hypnotist, it lessens the effectiveness of suggestions and psychodynamic change.

We can see from studying highly successful therapists such as Freud, Jung, Perls, Rogers, and Satir, and successful hypnotists such as Mesmer, Braid, Esdaile, Charcot, Janet, Coué, Elman, Weitzenhoffer, Erickson, Weiss, Crasilneck, and Hammond that they all brought three elements to their practice: enormous study and training, considerable practice, and intellectual association. Although Janet, Coué and Erickson at times would claim not to be command hypnotists leading

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their patients, all were and needed to be in order to guide their client.

In substance misuse recovery we can also see that the most effective movement worldwide over the past one hundred years has been Alcoholics Anonymous started by Bill Wilson and Bob Smith, both of whom remained clean and sober for life after recovery from alcohol and drugs. The movement was so successful because it was led by clean and sober people, so their help and messages were authentic and congruent, leading people's unconscious to follow them.

Therapists are teachers but it is not the teachings that teach alone but the teacher teaching the teachings that teaches the addict to be clean and sober. Would you learn to drive from someone who cannot drive? Or learn to play tennis from someone who has never picked up a racket?

The majority of treatments for treating addictions fail, including long-term residential care, through poor therapeutic techniques, inadequate staff training, inauthentic delivery of treatment by low-skilled professionals and volunteers, fraudulent delivery of treatment, lack of commitment from the client and therapist which leads to failure of the client to change their personality. There is clearly a long-term lack of professional accountability in the substance misuse recovery industry including hypnotherapy.

The level of commitment needed by therapists to work with drug and alcohol addictions needs to be at 100%, just as the therapist needs to require the client to be 100% committed. That means the therapist does not offer sympathy or capitulates to the addiction but that the therapist lays down clear boundaries around what treatment entails and what is expected from the client and therapist.

Therapists need to coach addicts and require clients to display that 100% commitment in getting clean and sober at all times. When the client is not 100% committed, they are in denial about their addiction which a therapist can never ignore and they need to bring the client back to that commitment to therapy to be effective. This will only be possible when the therapist is also displaying 100% commitment to the outcome.

Cognitive behavioural intervention and delivery for stopping the addiction must happen early in treatment as drug and alcohol addiction is a medical emergency. Practised delivery of this change can be amplified with the effective instrumental use of hypnotic suggestion giving operational advantages over other forms of addiction cessation by delivering suggestions that appeal to the emotional drivers in the unconscious.

To work with people addicted to drugs or alcohol takes a lot of training that never ceases, as a therapist should always be adding to their armory of techniques and knowledge. We can never as therapists rest upon what worked with the previous client as therapy works best when it is interactive and developmental.

Treatment is fraudulent when the therapist is out of their depth, not constantly

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developing their skills and knowledge around addiction recovery. The therapist's ego also gets in the way of their observations when they are using techniques in which they have no training, practice or supervision.

Authentic delivery of treatment for stopping drug and alcohol addiction requires the therapist to do what they teach, be someone who is fully committed to resolving their own life issues and a champion of the clean and sober direction and way of living so they are leading their client towards sobriety. Only then can the dynamics of the client's integrated major personalities develop into a central independent personality that is no longer dependent on substances.

In working with addicts, therapists need structure in their work or they become engulfed in the shared pathology of the addiction. Structure in a therapist's work gives them objectivity, processes, procedures and protocols to follows as they consistently help the client move through the different stages of recovery, changing and maturing their personality and creating resilience as a clean and sober individual.

Guidelines for hypnotherapists working with drug and alcohol addiction

1. Having a documented training in hypnosis and drug and alcohol recovery, and making the client aware of that fact, adds to the placebo effect of treatment. That also needs to include mental health training.
2. Therapists needs to understand all of the substances being misused and the issues they produce, including physical, mental, emotional, legal and social, far more than the client does, otherwise the client will not have confidence in the therapist or the treatment.
3. Therapists need to be able to recognise addiction and address those issues, even when the client remains in denial.
4. Being trained, qualified and recognised in addiction recovery covers the therapist and client legally for insurance purposes in the event of malpractice or death. Therapists in this area also need to have fieldwork experience in the voluntary or government sector.
5. Treatment needs to be methodical, organised, staged with recognisable benchmarks driven by cognitive, behavioural and emotional change assisted by hypnotic interactions intrinsically and instrumentally.
6. Continual professional development and supervision specifically in addiction recovery and hypnosis increases results. Simply completing a training and relying on those skills and knowledge does not display professional enthusiasm about the treatment to the client.
7. Not only does the therapist need to hold the client accountable but they also need to hold themselves accountable for the continuing development of their skills and results produced.
8. Addicts are lost in their addiction; they do not know the way out and the therapist is the leader to guide them towards a clean and sober lifestyle. This is always most effective when the therapist is leading that life themselves because it increases rapport and congruency and the hypnotherapist becomes a mentor.

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9. Resilience is built in a personality by raising the tolerance to stress levels for pain and discomfort, creating psychological stability and a sense of endurance. Hypnotherapists working in drug and alcohol misuse recovery need to be able to help their clients create all these abilities fast in order to cease addiction, and to do that they need to create it in themselves first and on a continuing basis.
10. Therapists need to understand the physical and lifestyle, exercise, diet, time management and relationship dynamics changes that the client needs to make in order to create a life that supports and promotes being clean, sober, heathy, happy and resilient.

Conclusion

Clinical hypnotherapy for drug and alcohol misuse recovery can be highly effective when used by therapists with extensive training in both hypnotherapy and addiction recovery. Evidence to substantiate this can only be gathered qualitatively because quantitative research restricts the observation of the extensive number of variables involved in successful administration.

However, the extent of qualitative published cases by highly experienced hypnotherapists who are also trained in substance abuse withdrawal does lend considerable validity to hypnotherapy being used in accelerated recovery that is faster than other therapies, at times stopping the addiction in a single session. This can lead to a high level of resilience against relapse in substance misuse recovery due to deep unconscious change and training the client to tolerate higher real-life stress levels without resulting to a substance dependency relapse.

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