Hypnotically Enhanced Treatment for Addictions

Alcohol Abuse, Drug Abuse, Gambling, Weight Control, and Smoking Cessation





Joseph Tramontana, PhD

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For clients who are motivated to change, however, change can occur. In working with gambling addiction, the techniques described in Chapters 2 and 3 for alcoholics and drug addicts are utilized. In Session 1, the first three steps of the 12-Step program are hypnotically suggested and reinforced. The difference, of course, is substituting gambling for alcohol or drugs. For example: *I came to admit that I am powerless over gambling, that gambling has made my life unmanageable.*

Session 2 with gambling addicts involves a similar approach to Session 2 with alcoholics and drug addicts, and subsequent sessions also follow the same course.

One hypnotic approach used with gamblers is a script described by Allen (2004) which he calls "Generic Habit Control" (pp. 49–52). This approach involves a number of colored doors, beginning with more pleasant colors and finally getting to a black door that opens to the part of you that encourages you to indulge in the problem behavior (gambling in this case) that you really want to break away from. It involves taking a position of strength, confronting that part that is the habit and threatening to banish the part unless it agrees now to cease the destructive behavior once and for all.

Cognitive-behavioral approaches, hypnotic regression regarding uncovering self-destructive patterns, the ideas regarding "addiction to unhappiness," and "self-sabotage" described in Chapter 3 are explored, both in and out of hypnosis. As the reader might expect, self-sabotage is a very important factor with pathological gamblers, who seem to continue their problematic behaviors regardless of the consequences (losing their homes, possessions, relationships, livelihood, and so forth).

As in the prior chapters, metaphors (story telling) occur both in and out of the hypnotic state. One story I often tell is:

> A former client who was seeing me for other issues, just happened to work as a Casino Host at a local casino. In one of our sessions, he was proudly relating to me how good he was at his job. He told me about the good care he took of his "good players." He mentioned, for example, that he had called an elderly couple who were good players, two weeks before

> Thanksgiving. He told them: "Don't cook for Thanksgiving. If you already have a turkey, give it away or freeze it. I am going to send a limousine to your house on Thanksgiving morning with a complete Thanksgiving dinner, with all of the trimmings." He went on, "Everything from appetizers to dessert, including their favorite wine." When I finally interrupted him with the question: "What do you call good players," he responded, with a grin on his face, "People who lose a lot of money."

While casinos are famous for giving free drinks to players to "loosen" them up while at the casino, they also do many other things to entice people to come to the casino. They offer everything from special promotions that include "free" match-play chips or tokens, discounted rooms, automobile raffles in which you must play to be entered, to free rooms, food, and beverage (RFB) and even free airfares to high rollers. Many of the casino-type gambling addicts with whom I have worked are frequently "seduced" by what they see as "free" chances to win money. One female client, who was seeing me regarding "family problems," was in great denial about her gambling problem. Family members, however, were quite aware of it. She told me on one occasion about how she and her mom just went and played their "match play" chips. I responded that a gambling addict going to play just their match play chips would be akin to giving alcoholics free drinks during happy hour!

Cognitive-behavioral techniques, with somewhat of an educational bent, often are helpful in this area.

In May, 2008, I had the good fortune of attending a workshop presented by Dr. Dabney Ewin sponsored by the New Orleans Society for Clinical Hypnosis entitled "Ideomotor signals for rapid hypnoanalysis." At the time that I signed up for this continuing education experience (Ewin, 2008), I assumed that learning more about his approach would be of benefit to me in working with psychosomatic illness, especially since I work at a pain management clinic one day each week. I came to realize, however, that I could adapt his techniques to my work with addictions, as well. To provide a brief summary, Ewin teaches his patients ideomotor signals: that is, raising the index finger signals "yes," the long (middle) finger signals "no," and the thumb signals "I'm not ready to deal with that" or "I don't want to answer, yet." In the workshop

and book of similar title, he described "seven common causes" of psychosomatic disorders. These include conflict, organ language, motivation, past experience, identification, self-punishment, and suggestion. To simplify, the theory is that since the left brain controls verbal behavior, logical and analytical thinking, and so forth, when questioned while in a hypnotic state, the client may still try to analyze what might be the most logical answer. The right brain, on the other hand, controls nonverbal behavior, creativity, reflexive or instinctive responding, and, in general, emotions or feelings. So his questioning always involves the phrases "do you feel" or "do you sense" that you are being affected by ____? (for example, conflict). Kroger and Fezler (1976, p. 46) postulated that one cannot talk to the unconscious. Rather, they believe Cheek's ideomotor signaling technique acts like a projective technique and, as such, can elicit valuable information.

I had learned about ideomotor signaling many years ago, and used it at times, but not in hypnotic uncovering of the origins of psychogenic disorders. One difference from his approach is that I always give an "I don't know" signal (the "pinky" finger). I ask that the client only use this as a last resort, since this response may make it too easy for the client to avoid a "yes" or "no" signal. One observation that has always amused me is that when instructed to answer with their fingers, some clients would give a yes signal while nodding from side to side (a "no" response) or a "no" signal while nodding up and down.

A case in which ideomotor questioning proved beneficial is as follows: A 40-year-old African-American hairdresser who owned a salon presented to my office. She had two children, ages 15 and 17. The "reason for contacting this office" on her personal data sheet was "relief of gambling." She reported that she has a very nice income, but has been averaging a $6000/month loss on slot machines. She said that she sometimes wins, but will often lose from $3000 to $4000 per week. She noted that she hadn't hocked her jewelry or lost her possessions. Based on my calculations, I believed her average loss to more than $6000 per month.

When I did the muscle testing (described in Chapter 1) with her, she began to cry when I asked her to think about the most positive

thing in her life. When questioned about what made her cry, she responded that she thought of her children, but immediately began to think that she is cheating them. She noted that they have an average lifestyle, but if not for the gambling she could do so much more for them.

The first hypnotic induction was done in my initial session with her, in order to help her relax and leave that first meeting with a sense of optimism that help was forthcoming. She came back one week later and reported that she had practiced the self-hypnotic techniques that I had taught her the previous week for the first three days, but then "got too busy at work." She reported that she had only gone to the casino one time during the past week, as compared to her usual pattern of three to four times per week. She proudly announced that she took only $300 with her, no check books or ATM cards, and when she lost the $300, she went home.

After teaching her the ideomotor signaling technique (Ewin & Eimer, 2006; Ewin, 2008), I asked:

> One of the things that causes symptoms is what we call conflict. A conflict occurs when a person wants to do one thing and feels he or she should do the opposite. It is as if you feel you are being pulled in two directions. Answer with your fingers. Do you feel or sense that your gambling problem is caused by conflict? ***She lifted the yes finger. I then asked:*** Would it be alright for you to tell me about it? ***She responded: "The relationship I'm in. I am really indecisive about the relationship." When asked how gambling fits into this indecision, she indicated that going to the casino took her mind off of her questioning herself about whether to discontinue the relationship.***
>
> ***I continued:*** Organ language is another thing that can cause symptoms. Organ language refers to phrases in our everyday conversation that include negative mention of a body organ like "I feel like I have been stabbed in the back." ***She responded with the "no" signal. I said:*** Another thing that causes symptoms is motivation. A person can be motivated to have a symptom because it seems to solve some other problem; for example, a student who gets sick at exam time. Do you feel that you are motivated to have this problem? ***She responded affirmatively. When queried, she gave a very similar answer to the one she gave for conflict, that is, the relationship questions.***

Next:

> Another possible cause of symptoms is past experience. An emotionally charged event may cause immediate onset of symptoms or sensitize you so that some other analogous event will activate the symptom. Do you sense or feel that your gambling problem started with a significant experience in your past? ***She responded affirmatively. I then asked:*** Would it be alright to go back and make a subconscious review of everything that was significant to you in this episode? ***After she raised her index finger, I asked:*** Did it happen before age 20? ***Since she indicated that it had not happened before age 20, I moved forward in 5-year increments (If she had indicated that it was before age 20, I would have gone backwards in 5-year increments). She gave the "yes" response to before age 35.***

Then I asked:

> Is it alright to orient your mind to what happened between ages 30-35 that relates to the present problem with gambling? ***Her response followed:*** I felt that I needed some alone time. I didn't enjoy going to movies alone, but the casino was a place I could go alone but be in a large group of people at the same time. I was alone but not lonely. Then when the relationship started, I needed even more time alone.

I determined at this time that she might need relationship counseling more than anything else at present, but she may not be ready to make a change in this aspect of her life.

> Another possible cause of symptoms is what we call identification. Do you feel that you are identifying with someone who had the same or a similar symptom? ***She gave an affirmative signal. When questioned further, she indicated that her biological father suffered from drug addiction. She stated:*** I remember my mother helping my father. They were apart but were still friends. She helped him to find help. He was really strung out.

She gave the "no" signal to questioning regarding whether her gambling could be some kind of self-punishment or a response to a suggestion or imprint. She indicated that her gambling started when she was in her early twenties, and it was not until her thirties that it became a problem. In summary, ideomotor signaling helped me gain some insights about the psychodynamic causes of this client's pathological gambling. Her treatment remains in

the early stages, with some progress and some retrogression, but this technique helped in developing insights and in formulating a treatment plan.

One approach that has *not* proven effective in my practice is to create a managed approach to gambling (as in the Moderation Management approach to drinking), although it was attempted with at least a couple of patients. The clients were instructed to read books about money management methods for gamblers. Such approaches to casino gambling theoretically would result in always leaving with a significant portion of winnings still intact, assuming they did get ahead. One patient reported that this approach was working for him. He was now a "controlled gambler." Then he came in for a session and reported that after having been up several hundred dollars, he quit while ahead, took the cash out to his truck and hid it under his seat. He then went back into the casino, had a few drinks at the bar, got bored, went back out to his truck, and the rest is history. He lost his winnings plus another thousand.

This example also brings up the issue of cross-addictions. As noted above, casinos are famous for giving their players "free" drinks. It is for this reason that traditional AA/NA-based rehab programs tell their patients they "can't go" to casinos and stay clean and sober.

One particularly difficult case I encountered was that of a very successful professional. He combined primarily smoking and gambling. The husband of another successful professional and father of two young athletes, he was a "closet smoker." His "closet," however, was apparently the truck-stop gambling parlors (video poker) in the next county. He would go and play video poker, smoke cigarettes, and drink one or two drinks (although alcohol did not seem to be a major factor in the behavior, because he might just as well do that at dinner with friends or even at home, and never to excess). So the gambling was a getaway, in the evening (several evenings per week), where he had the "freedom" to do things he didn't do at home.

After a significant number of sessions, with no apparent improvement, I was somewhat frustrated about which direction to take. The client was intelligent and seemed motivated, but nothing changed. Then the idea came to look at other psychological issues. Psychological testing ensued. It turned out that he scored quite high on depression, anxiety, and obsessive-compulsive tendencies. It became apparent that the psychological issues were primary, and the smoking and gambling appeared secondary. In retrospect, it became clear that his patterns were quite consistent with obsessive-compulsive behavior. At the time of this writing, he had been referred to a Medical Psychologist (Louisiana has a law whereby psychologists can obtain prescription privileges if they have a master's degree in clinical psychopharmacology and pass the necessary exams). Some of the newer medications seem to be quite helpful with OCD as well as symptoms of depression and anxiety. However, shortly thereafter he terminated therapy with me, although he continues to see the Medical Psychologist for medication management. I suspect that he continues to go to the video poker establishments.

Another technique frequently used with pathological gamblers is the Space Travel Meditation described in Chapter 3 with drug abusers.

In addition to the covert sensitization mentioned earlier in this chapter with the patient who frequented the dog track, an approach referred to as collapsing anchors, presented by Zimberoff (1999), is sometimes utilized. The client is given the following suggestions:

> Now begin to get in touch with the behavior that you would like to reduce or eliminate in your life … gambling … Now, I want you to open up the hand that is **not** your dominant hand … face the palm up toward the ceiling … and begin to bring up the urge to gamble in this hand … whether it involves poker chips, cards, sitting at a slot machine or video poker machine … now I'm going to count from one up to five … and that urge to gamble will become stronger … 1 … you feel the urge to gamble coming up now … 2 … it is getting stronger and stronger and stronger … the desire to gamble … 3 … feel that urge, that craving coming up even stronger … 4 … it's really coming up … and 5. How strong is that urge now from 0–10? Zero means no desire, 10 is the strongest. Talk to me

and tell me how strong it is now. … ***(wait for response) …*** Now bring your attention to your most dominant hand, the one you associate with your addictive behavior … Turn that palm up and put into this hand, the most repulsive, gross thing you can imagine. Get in touch with whatever it is that really grosses you out. Perhaps you can see it … notice the color and texture … maybe it really looks gross to you … Let's begin to bring up that most repulsive feeling … 1 … really increase that awful experience in your dominant hand … 2 … perhaps you can really smell it … that odor is so strong! That gross disgusting smell is nearly making you sick, it is so disgusting … 3 … feel that slimy feeling … using all your senses … 4 … the way it looks, smells, tastes, feels … that feeling of revulsion is getting stronger and stronger … 5 … What number is it now from 0–10? Zero means no feelings of disgust, 10 means the most. Tell me how strong that feeling is … ***(wait for response) …*** Now, in a moment, I will count to three and on the count of three, you will clap your hands together and hold them there. This will totally collapse the original urge to gamble … Okay … 1 … 2 … 3 … Clap! Hold your hands together now … just begin to feel or see this association in your mind … the minute your hands touch, the association may begin to develop deep within your subconscious mind … the association with that craving becomes mixed with this most repulsive image in your mind … You can't even stand to think about gambling anymore. You immediately begin to feel sick, nauseous, uncomfortable when gambling is even talked about and you have to leave the area … you find yourself repulsed at the thought of it. Notice how that gross experience has collapsed the urge for that original behavior.

All of the techniques utilized with alcoholism and drug addiction can be modified to work with pathological gambling.

In summary, gambling addiction is quite complex and all issues related to the behavior need to be considered. In this chapter, use of techniques/scripts described in Chapters 2 and 3 with alcoholics and drug abusers are described with respect to how they can be adapted to use with pathological gamblers. There are also a number of stories (metaphors) that I use with gamblers, which are presented. The importance of investigating or uncovering the psychological motives involved in self-sabotage is also discussed.

Chapter Five

Focus on Smoking Cessation

This chapter focuses on the three-session smoking cessation program I employ, as well as various marketing techniques regarding selling the program as a "package."

As most readers are aware, cigarette smoking is said to be even more addictive than heroin, yet it is legal! As with alcohol and drugs, the first session for clients who wish to give up tobacco includes interviewing them about health concerns. If they have not had a recent physical examination, they are instructed to do so.

A hypnosis marketing seminar some 10 years ago (Yarnell, 1998) yielded a number of marketing/packaging techniques for use with this population of clients. The presenter was a hypnotist, quite a salesperson, and not certified in any mental health or medical area. He was one of the originators of the "Traveling Seminar" approaches to smoking and weight loss programs (i.e., group sessions in which the hypnotist reserves a meeting room at a local hotel and carries out his program). One of his books provided additional ideas (Yarnell, 1996). Although much of what I learned at that seminar was not usable for ethical reasons – for example, many of the marketing/advertising techniques involved an overglamorization of the programs and were inconsistent with the ethical guidelines of psychologists regarding advertising – what did, in fact, prove to be of great utility was his approach of packaging sessions. Before this seminar, my approach was to see clients on a session-by-session basis, just as in other psychotherapy cases. After the seminar, however, smoking cessation programs were sold in a three-session package. Further, the smoking cessation client was told the usual hourly fee and that they would be expected to pay all three sessions in advance, in return for which there would be a 20% cash discount. This approach ensures the

client's commitment to the three-session program, is more cost-effective for the client and helps the therapist's cash flow.

If the client balks at the idea of paying that much money "up front," they are given information regarding the average annual cost to someone who smokes one pack per day. I have been using the figure $2000, although this amount may need adjustment as the cost of cigarettes continues to increase and according to the region in which people live.

In the past, during slow times, I ran newspaper ads offering a free 20-minute consultation. During this preview session, I went over the smoking questionnaire provided, presented an overview of hypnosis, and then made the case for the scheduling (and paying for) their three sessions.

Some authors/treatment providers recommend a two-session approach. Hammond (1990) notes that research shows that there is approximately a 25% success rate with one session and 65% for four to five sessions. I have not kept data regarding success rates with the three-session approach, but based on feedback from clients, it is estimated that the success rate is quite high for those who are motivated to change and stick with the three sessions. If clients are engaged in treatment because someone else wants them to change, such as doctors or family, the success rate is low. I share this information with clients in the first session. They are also told that this approach involves much work on their part; that is, success will be hard to attain if they come in expecting me to fix them.

The typical three-session format is presented next.

Session 1

I first have my assistant give the client a smoking questionnaire (see Appendix A) to fill out in the waiting room. This questionnaire asks typical questions concerning how much the client smokes per day, at what age did they begin, previous attempts

at quitting, whether or not parents smoked, do significant others smoke (especially in the same house), and so forth.

After a hypnotic state is elicited, followed by breathing exercises, then deepening techniques, the client is told about the practice effect (See Chapter 1, p. 12), the generalization effect (See Chapter 1, pp. 12–13), and trance ratification ensues (See Chapter 1, pp. 13–14).

1. Regression to first cigarette

> The next thing I want you to do … in that safe, comfortable room that you entered after your elevator descent … I want you to imagine that on one wall in that room is a giant movie screen … it covers almost the whole wall and there is a projector and a reel of film. This reel of film is all about your life … it's like a documentary of your life … and in just a moment I'm going to count backwards from 5 to 1 … and as I count, I want you to imagine the film rewinding … and as the film rewinds, we're going to go back into your past … and what we're looking for today is that very first experience with smoking … I believe you said it was at age ___ … and I'll ask you to imagine a picture coming onto the screen … coming into focus on the screen. Then I'll ask you to talk to me all about it … tell me where you are … how old you are, but especially everything about your body's reaction to that very first cigarette. Let's rewind the film now going back in time … 5 … rewinding … 4 … going back in time … 3 … seeking, searching … 2 … and 1 … all the way back to 1 … imagine a picture coming into focus. I want you to tell me what you see, hear, feel, sense, or know about that very first cigarette. You have that image? Okay … and how old are you … Tell me all about it. I am especially interested in knowing how your body reacted to that first cigarette.

After they have told me about the first cigarette:

> Okay … alright I want you to relax and concentrate on what I'm saying … for most human beings … that very first experience with cigarettes, or maybe even the first few … is very negative … you see, the natural human instinct is to reject foreign substances … cigarettes, tobacco, nicotine … these are all foreign to the human body. Think about it … if you get a speck of dirt in your eyes, your eyes are probably going to tear up, automatically … you don't have to think about it … to rid your eye of the foreign particle … or even a puff of wind in your eye and you probably

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