A Study on Effectiveness of Hypnotherapy Techniques on Withdrawal Symptoms

—Dr.Pranay KumarTripathy* and Shweta Srivastava **

Addiction treatment stresses heavily on the management of the withdrawal symptoms. Once the withdrawal symptoms are managed, the next step is to inculcate the life-skills that the addict needs to cope with a life without the reward-giving substance. Relapse, furthermore complicates the treatment. An average addict proclaims to be using the substance to evade frustration and seek temporary comfort while facing life situations. It is accompanied by a need to use the substance and inability to stop using it. Soon, the inability transforms into low self-esteem, dependency and loneliness. Another common reason addict gives for sustaining the substance-abuse is the need to get a kick or "lift". This sheds light on the pervasive sense of feeling low or self-pity that brings out the need to rise above.

Hartland categorized addicts according to the justification addicts give and he marked the frustration-avoiding addicts or neurotic addicts in one category and the euphoria- chasing addicts in another.

While Ausubel categorized addicts in three distinct categories: the primary addiction where in, the substance compensates for a personality defect; in symptomatic addiction, the addict is merely acting out of behaviour disorder; and the reactive addict is influenced by a peer group to cross over developmental milestones according to the peer group norm.

This is why psycho-analysis plays a significant role in the addiction treatment when it comes to treating the root cause of the addiction. The personality assessment provides the key to categorise the addict in either of the three criteria. Once the personality variables are ascertained, the neuropsychological aspect of addiction can be targeted. The cravings are sustained by various neurotransmitters and not feeding the substance leads to violent withdrawal symptoms. The Pavlovian mode of treatment in withdrawal hence becomes effective in managing the neuropsychological factors of the addiction.

Addiction treatment, hence operates on two levels: Addressing the personality of the addict and the psychological need for sustaining the addiction; and managing the neuro-psychological side effects or withdrawal symptoms. It is vital to also include various factors like drug availability, cultural norms and attitude towards the drug and other psycho-social factors while deducing the individual case.

Withdrawal symptoms can have 2 categorizations. The acute withdrawal symptoms and protractive withdrawal symptoms. Acute withdrawal is defined as "the onset of a predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in, dosage of a psychoactive substance" by the

American Society of Addiction, which start within hours or days of abstinence and can span for a time dependent on the substance that was abused. These symptoms are curiously opposite of the intoxication effects.

Substance abuse treatment advisory of Samhsa(Substance Abuse and Mental Health Treatment Administration), an U. S Department of Health and Human Service have delineated the time span of acute withdrawal symptoms according to the substance that was abuse: for alcohol it is 5-7 days; for Benzodiazepines it may range from 1-4 weeks and if the dosage is reduced then it can span to 3-5 weeks; 3 for Cannabis it is 5days; for Nicotine it is 2–4 weeks; for Opioids it is 4–10 days (methadone withdrawal may last 14–21 days);and for Stimulants (e.g., amphetamines, methamphetamine, cocaine) it can span for 1–2 weeks.

The protracted withdrawal symptoms can be defined as signs and symptoms of common acute withdrawal that are specific to the substance to be persisting beyond the time frames expected by the acute withdrawal of that substance. It can also include non-substance specific signs and symptoms that are present or evolving during the treatment. Protracted withdrawal symptoms are also known as post-acute withdrawal syndrome, protracted abstinence, sub-acute withdrawal, persistent post use symptoms, chronic withdrawal and sobriety-based symptoms. Due to lack of substantial research on these symptoms Diagnostic and Statistical Manual of Mental Disorders have not addressed protracted withdrawal symptoms for any psychoactive substance. But the common substance specific symptoms for opioids are anxiety, sleep disturbances, fatigue, dysphoria, irritability and may be depression. Methamphetamines have found to have impacted the executive control functions that may persist even after recovery.Impulse control and emotional regulation issues have found to be side effect of cocaine abuse. Marijuana is found to have contributed to sleep disturbances and strange dreams. Benzodiazepine's abuse has significantly caused psychological symptoms of agitated depression, generalized anxiety, obsessive-compulsive disorders, panic and schizophrenia.

While time frames of withdrawal symptoms can only be definitively noted when only one or two substances have been abused. Moreover, the complexity increases when it comes to benzodiazepines as demarcating the symptom re-emergence and symptom rebound time can become almost impossible. Symptom re-emergence is the return of symptoms with equal intensity before the substance abuse started. It indicates an underlying pathology that requires therapeutic attention. While symptom rebound of benzodiazepines is the return or prolonging of acute withdrawal symptoms stronger than its previous intensity.

Bryan has found results in barbiturates and dexedrine by using hypnotherapy. He delineated the markers of a good prognosis.1- The patient's willingness to recover; 2- Constant supervision of the patient is necessary; 3- The drug use is to be

permanently eliminated; 4-uncovering all the significant neuroses and psychological variables that lead to drug use and finding alternatives to the drug using direct hypnotic suggestions; 5- regular check-up for minimum one to two hours everyday along with a hypnotic suggestion that relapse is unlikely. One patient was given hypnotic suggestion to imagine injecting herself and evoke the pleasurable effects of opiate but if administered physically it will not help. For 6 weeks, the patient fared well but upon injecting herself one day, she reported to have violent retching. Hypnotic suggestions of creating association of injecting herself with a negative experience has helped the patient from abstaining from drug -abuse.

Bauman guided the adolescent drug abusers into trance state and revivified the euphoric trip and strengthened the euphoria so that it surpasses the previous drug induced euphoria. Self-induced hallucinated experiences have an advantage as they are not illegal, can be exercised without any cost and most importantly it is always under the thumb of the subject. To be able to regulate the flow of the trance bestows a different level of independence in the patient. It brings a sense of agency that the adolescent was deprived of, making it more an internalised experience rather than seeking external validations from drugs, by effortlessly eliminating the side effects of the drug.

Hypnosis induced trance states can curb the cravings and drug dependency for its ability to think the unthinkable and do the undialed. The creative adventure it provides helps the subject to manage the ebb and flow of the bodily sensations which is significantly missing when withdrawal strikes. Reforming addicts find it hard to control their mind and body. They claim that their body and mind are out of their reach. Self-hypnosis contributes generously in bestowing a sense of renewed connection with the bodily sensations, the thought process by repeating suggestive statements like “I am relaxing” multiple times and allowing the body to relax. Moreover, the changes seem impossible almost magical and this sense of wonder reinforces the sense of agency, as confirmed by Ludwig, Lyle, and Miller, who worked with drug addicts in a group setting in U.S. Public Health Hospital, Lexington, Kentucky. It is their belief that the seemingly magical yet authoritative approach to dealing with current problems of the 22 male addicts brought significant control on their cravings.

The self-hypnotic suggestions towards pain management can work to mitigate the withdrawal symptoms like muscle spasms, anxiety and muscle tension and help get better sleep.

The ability of the hypnotic suggestion to distort time becomes helpful in managing pain and diverting to pleasurable experience and maintain it longer. This can curb the withdrawal symptoms like irritability, nausea, restlessness, shakiness and sleep difficulties. The pain management technique in hypnotherapy doesn’t eliminate

pain, rather it helps to modulate the pain. The imaginative powers of the mind and its strong connection with the body makes it possible for the subject to step up or step down the pain. The Pain management technique of hypnotherapy starts by progressively relaxing the body and then using anchors like a remote control or a finger to regulate the pain. It allows the body to increase the pain and give it a subjective unit of distress, so that the body knows the pain intensity through a number and then one unit at a time step it down till three units. Then in second cycle it steps up by three units and steps further down and continues this process till it reaches manageable range or comes down to 0 (non-existence). Once the pain is managed, mind can be diverted to a pleasurable experience, especially when the pain is dominating the imaginative experience. Dr. Lisa Lombard, a licensed Clinical Psychologist said that pain is not to be eliminated, rather accepted but not be bothered by it.

Alvin Ackerman and B. J. Hartman used a hypnotherapy technique wherein they employed the time distortion element of hypnotherapy to evoke and sustain the pleasurable experience for 10 minutes which the subjects experienced it as a ten-hour experience. The need of the body and mind to relive stress can be a precursor to choosing substance or drug-abuse in a stressful life of today.

Hypnodelic treatment used by Ludwig and Levine on 70 patients have found that patient recovered much better in one session using LSD with hypnosis and psychotherapy than only using psychotherapy, only LSD, LSD with hypnosis or only hypnosis, in a controlled study which was evaluated for 2 weeks and 2 months interval.

The ego-strengthening hypnotic suggestions have lasting impact on the patients recovering from addictions. Optimal ego-strength is the primary element in allowing for any therapeutic technique to work for the client. Addicts grapple with self-pity and thus they are unable to be flexible, adaptable to the changes and demands of their life. The ego-strength is not optimal and in-such cases, ego-strengthening suggestion work well. The ego-strengthening suggestions for anxiety can be “I am becoming more and more relaxed, with passing time I am becoming more and more peaceful, less agitated and less depressed”. For diverting attention from self-pity- “As I am relaxing more and more, I am becoming less and less pre-occupied with my own emotions”. “I am becoming more and more contended each passing moment and each passing day, more and more powerful and much happier and more optimistic towards life”.

Ego-strengthening suggestions for resources or life skills that are being subjugated by the drugs can be given as “I am becoming more and more in control of my body. I am able to regulate my cravings and becoming more and more powerful, so much that I am relying less on drugs, people and things”.

Such suggestions can be given as post-hypnotic suggestion to sustain the changes and also to state that the relapse is unlikely.

Hypnotherapy can be effective in intervening the myths pertaining to withdrawal of the recovering addict: cessation needs willpower, I choose to use drug or smoke, belief that there will be terrible withdrawal symptoms, or the belief that it is difficult to quit.

In conclusion, hypnotherapy techniques of self-hypnosis and hypnotic suggestions provide with a promise of managing the withdrawal symptoms. Hypnotherapy can be used in adjunct with conventional and ashypnodelic technique to revivify the euphoria or the good trip. It has been found that the success rate is significant up to 2% in long term deaddiction programs that did not use hypnosis, while it fared well from 60%-70% when in use. While hypnodelic technique ensures supervised substance use for therapeutic recovery, its success is ensured by meticulous case taking and case formation using hypno-analysis.

References :

1. Hartland, J. Medical and Dental Hypnosis. Baltimore: Williams and Wilkins Co., 1966.
2. Kroger, W. S. Clinical and Experimental Hypnosis. Philadelphia: J. B. Lippincott Co., 1963.
3. Ausubel, D. P. Drug Addiction: Physiological, Psychological, and Sociological Aspects. New York: Random House, 1964.
4. Bryan, W. J., JR. Hypnosis and Drug Addiction. J. Amer. Inst. Hypnosis, 8: 46-47, 1967.
5. Baumann, F. Hypnosis and the Adolescent Drug Abuser. Clin. Hypnosis, 13: 17-21, 1970.
6. Ackerman, A. L. The T-Group Approach: Applications to a Narcotic Addict Population. Paper presented at the California State Psychological Association Convention, Coronado, California, January, 1971.
7. Ludwig, A. M. and W. H. Lyle, and J. S. Miller, Group Hypnotherapy Techniques with Drug Addicts. Internat. J. Clin. Exper. Hypnosis, 12; 53- 66, 1964.
8. Ludwig, A. M., and J. A. Levine, A Controlled Comparison of Five Brief Treatment Techniques Employing LSD, Hypnosis, and Psychotherapy. Amer. J. Psychotherapy, 19: 417-435, 1965.
9. Edwards, G. (1966). Hypnosis in treatment of alcohol addiction: Controlled trial, with analysis of factors affecting outcome. *Quarterly Journal of Studies on Alcohol, 27*(2), 221–241.
10. Ries, R. K., Miller, S. C., Fiellin, D. A., &Saitz, R. (Eds.). (2009). Appendix 1: ASAM addiction terminology. In Principles of addiction medicine (4th ed.). Chevy Chase, MD: American Society of Addiction Medicine.
11. Wright, T. M., Culver, J. S., & Myrick, H. (2009). Management of intoxication and withdrawal: General principles. In R. K. Ries, S. C. Miller, D. A. Fiellin, & R. Saitz (Eds.), Principles of addiction medicine (4th ed., pp. 552–558). Chevy Chase, MD: American Society of Addiction Medicine.
12. American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Washington, DC: Author.
13. Center for Substance Abuse Treatment. (2006). Detoxification and substance abuse treatment. Treatment Improvement Protocol 45. HHS Publication No. (SMA) 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration.

14. Dickinson, W. E., Mayo-Smith, M. F., &Eickelberg, S. J. (2003). Management of sedative-hypnotic intoxication and withdrawal. In A. W. Graham, T. K. Schultz, M. F. Mayo-Smith, R. K. Ries, & B. B. Wilford (Eds.), Principles of addiction medicine (3rd ed., pp. 633–639). Chevy Chase, MD: American Society of Addiction Medicine.
15. Juergens, S. T., & Cowley, D. S. (2003). The pharmacology of benzodiazepines and other sedative-hypnotics. In A. W. Graham, T. K. Schultz, M. F. Mayo-Smith, R. K. Ries, & B. B. Wilford (Eds.), Principles of addiction medicine (3rd ed., pp. 119–138). Chevy Chase, MD: American Society of Addiction Medicine.
16. Welch, S. P., & Martin, B. R. (2003). The pharmacology of marijuana. In A. W. Graham, T. K. Schultz, M. F. Mayo-Smith, R. K. Ries, & B. B. Wilford (Eds.), Principles of addiction medicine (3rd ed., pp. 249–270). Chevy Chase, MD: American Society of Addiction Medicine.
17. Hughes, J. R. (2007). Effects of abstinence from tobacco: Valid symptoms and time course. Nicotine & Tobacco Research, 9(1), 315–327.
18. Collins, E. D., & Kleber, H. D. (2004). Opioids: Detoxification. In M. Galanter & H. D. Kleber (Eds.), Textbook of substance abuse treatment (3rd ed., 265–289). Washington, DC: American Psychiatric Publishing.
19. Wilkins, J. N., Danovitch, I., & Gorelick, D. A. (2009). Management of stimulant, hallucinogen, marijuana, phencyclidine, and club drug intoxication and withdrawal. In R. K. Ries, S. C. Miller, D. A. Fiellin, & R. Saitz (Eds.), Principles of addiction medicine (4th ed., 607–628). Chevy Chase, MD: American Society of Addiction Medicine.
20. Brower, K. J. (2001). Alcohol's effects on sleep in alcoholics. Alcohol Research & Health, 25(2), 110–125.
21. Satel, S. L., Kosten, T. R., Schuckit, M. A., &Fischman, M. W. (1993). Should protracted withdrawal from drugs be included in DSM-IV? American Journal of Psychiatry, 150(5), 695–704.
22. Prosser, J., London, E. D., &Galynkera, I. I. (2009). Sustained attention in patients receiving and abstinent following methadone maintenance treatment for opiate dependence: Performance and neuroimaging results. Drug and Alcohol Dependence, 104, 228–240.
23. Li-ping, F., Guo-hua, B., Zhi-tong, Z., Yan, W., En-mao, Y., Lin, M., et al. (2008). Impaired response inhibition function in abstinent heroin dependents: An fMRI study. Neuroscience Letters, 438, 322–326.
24. Baicy, K., & London, E. D. (2007). Corticolimbic dysregulation and chronic methamphetamine abuse. Addiction, 102(Suppl 1), 5–15.
25. Fox, H. C., Axelrod, S. R., Paliwal, P. J., Sleeper, J., & Sinha, R. (2007). Difficulties in emotion regulation and impulse control during cocaine abstinence. Drug and Alcohol Dependence, 89, 298–301.
26. Budney, A. J., Hughes, J. R., Moore, B. A., &Vandrey, R. G. (2004). Review of the validity and significance of cannabis withdrawal syndrome. American Journal of Psychiatry, 161(11), 1967–1977.
27. Smith, D. E., & Wesson, D. R. (2004). Benzodiazepines and other sedative-hypnotics. In M. Galanter & H. D. Kleber (Eds.), Textbook of substance abuse treatment (3rd ed., pp. 239–242). Washington, DC: American Psychiatric Publishing.
28. Salzman, C. (1991). The APA task force report on benzodiazepine dependence, toxicity, and abuse. American Journal of Psychiatry, 148(2), 152–153.

29. Wesson, D. R., Smith, D. E., & Ling, W. (2003). Pharmacologic interventions for benzodiazepine and other sedative-hypnotic addiction. In A. W. Graham, T. K. Schultz, M. F. Mayo-Smith, R. K. Ries, & B. B. Wilford (Eds.), Principles of addiction medicine (3rd ed., pp. 721–733). Chevy Chase, MD: American Society of Addiction Medicine
30. Beaven-Marks K., Ego-strength and hypnotherapy, The Hypnotherapy Training Company retrieved from https://hypnotc.com/ego-strength-hypnotherapy/
31. Alladin A. (2008) Cognitive Hypnotherapy: An Integrated Approach to the Treatment of Emotional Disorders, John Wiley & Sons, Ltd. ISBN: 978-0-470-03251-0 retrieved from https://onlinelibrary.wiley.com/doi/pdf/10.1002/9780470773239.app5
32. Center for Substance Abuse Treatment. (2010). Protracted Withdrawal. Substance Abuse Treatment Advisory, Volume 9, Issue 1 retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma10-4554.pdf
33. Terry T., Hypnosis Could Be Key Treatment For Opioid Addiction, WSFA12 News Aug 31, 2018 retrived from https://www.wsfa.com/story/38996388/hypnosis-could-be-key-treatment-for-opioid-addiction/ (Tonya Terry)