Solution Oriented Hypnotic Analgesia in Naltrexone Treatment for Heroin Addiction*

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Abstract

I have been using Solution Oriented Hypnosis and Solution Oriented Counselling for a number of years. During that time, I have counselled several hundred Heroin addicts who were undergoing Rapid Opiate Detoxification (ROD) with the drug Naltrexone. Heroin addicts suffer from acute and chronic pain. Naltrexone only stops the acute physical pain. After ROD, the chronic psychological pain is intensified by the fact that they can no longer mask it with Heroin analgesia. Their initial reaction is "I need a fix." Another reason they want to use is due to an automatic thought process and behaviour that they've learned as Heroin addicts. Although I have had good results from Solution Oriented Hypnosis and Solution Oriented Counselling, some patients continued to have setbacks, stopped using Naltrexone, continued to use Heroin and discontinued their counselling. Why would they go back to using Heroin? Then a simple idea occurred to me. These people are in pain – the pain includes chronic psychological and emotional pain. I decided that the pain should be treated similar to any other pain. They needed an analgesic that would interrupt that pain. They needed something to replace Heroin analgesia. That's when I started to research the idea of using *hypnotic analgesia*. The hypothesis of this paper is that while the patient is under hypnosis, I can somehow use direct and indirect suggestions so that as soon as the unconscious senses a pain trigger beginning to travel towards the conscious, the unconscious then releases a hypnotic analgesia which disrupts those pain messages from reaching the conscious. The rest of the paper first presents a cyclic model of Heroin addiction and next considers the potential application of current research on hypnotic analgesia. The paper then presents two example case studies of patients recovering from ROD who I have treated using a new hypnotic analgesia technique. I discuss these case studies and show that they provide some evidence that is consistent with the presence of a hypnotic analgesia effect. The paper concludes by discussing the possibility that, for patients undergoing ROD, the new hypnotic analgesia treatment can replace Heroin analgesia and thus break the tragic cycle of Heroin addiction.

1. Introduction

I have been using Solution Oriented Counselling and Solution Oriented Hypnosis for a number of years. During that time, I have had the opportunity of counselling several hundred Heroin addicts who were undergoing Rapid Opiate Detoxification (ROD). Rapid Opiate Detoxification treatment involves going to hospital for one day and detoxing from Heroin while taking medication which results in conscious sedation. Post-detoxification treatment involves taking the drug Naltrexone along with sedatives and antidepressants.

Naltrexone has two principal effects: Firstly, Naltrexone is an antagonist that occupies the opiate receptors in the brain and blocks the action of Heroin. The drug sits in the opiate receptors of the brain and, while it sits there, opiates cannot occupy the receptors. It's like a key sitting in a lock blocking another key from being used. Naltrexone stops the physiological

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need for Heroin. Some post-ROD patients have tried using Heroin while taking Naltrexone and they report that they feel nothing – and that it has no effect. Secondly, Naltrexone alters neural chemistry, which affects the rest of the body. This causes favourable changes in measured sex and thyroid hormone levels, which move toward their norms.

Naltrexone only stops the physical pain of withdrawal (acute pain) but it does not stop the psychological pain (chronic pain). Chronic pain consists of psychological and emotional pain, which is the underlying pain, that Heroin analgesia has been masking for the term of the Heroin addiction. Chronic pain usually stems from the following causes: Dysfunctional childhood and adult family life and relationships; and/or sexual, psychological and emotional abuse. After ROD, patients feel very sensitive to emotional, psychological and physical pain. Physical pain is the pain that is endured for a period of one to three weeks as a result of the ROD. Some of the physical symptoms include physical weakness, nausea, vomiting, diarrhoea, cramps, insomnia, can't eat, and heavy perspiration. So after a ROD, not only does a patient have to deal with physical symptoms but on top of this a patient is faced with the awareness of having lived their life as a Heroin addict which usually involves some criminal activities, including prostitution, lying, cheating, hurting their loved ones and other socially dysfunctional behaviours.

For patients, all of the pain is intensified by the fact that they no longer can mask it with Heroin. Their initial reaction is to want to use: "I need a fix." Another reason that they want to use is due to a learned thought process and behaviour as Heroin addicts. Typically, they get up in the morning and the first thing they think of is getting a fix. This ranges from one fix per day up to as many times as they can afford to per day. Their whole day revolves around using Heroin. This becomes an automatic learned thought process and habitual behaviour, which is similar to other automatic learned behaviours such as walking or riding a bike. Although they don't need to use because of the Naltrexone, they think they still want to and need to due to the learned behaviour. This behaviour needs to be unlearnt. They also know that the next shot of Heroin could be fatal but they remember only the good feelings associated with the analgesic effect of Heroin. This is due to memories of analgesic pain relief as they escape the realities of life.

To learn to deal with the realities of life, these patients need to continue taking Naltrexone for 12 months or longer depending on the individual; they need to take antidepressants; they need to attend regular ongoing counselling sessions to deal with the realities of the underlying chronic pain and they need to unlearn the automatic learned thought process and behaviour. The counsellor needs to create an awareness of all of these aspects so those patients can adjust realistically.

2. In Search of a Solution

Although I have had good results from using Solution Oriented Hypnosis and Solution Oriented Counselling, patients had setbacks. Some stopped using Naltrexone and continued to use Heroin; some failed to continue with their counselling; some still maintained a very negative outlook about the future. I felt that there was something missing. What could I do to get through to that trigger that caused them to feel helpless and to stop taking Naltrexone; to stop counselling sessions and go back to using Heroin – even though they knew that that was a life that they didn't want to go back to – a life that they hated and detested? When that trigger of using took off, they could only remember the analgesic effect of Heroin. I became obsessed with the idea that there was an inner core of the patient which wasn't being reached by normal counselling and hypnosis.

Then a simple idea occurred to me: that these people are *in pain.* This pain is chronic ongoing psychological and emotional pain, post-ROD physical pain, and the pain of adjusting to the realities of life without Heroin analgesia. I decided that the pain of Heroin addiction is like any other pain and it should be treated like any other pain. They needed an analgesic that

would interrupt that pain. They needed something to replace Heroin analgesia. That's when I started to research the idea of using *hypnotic analgesia.*

3. Theory and Hypothesis

My theory is that the unconscious detects a pain trigger, which travels from the unconscious to the conscious. For example, when a person burns their finger it takes some time for the pain to travel from the finger to conscious awareness by the brain.

My hypothesis is that while the patient is under hypnosis, I can somehow use direct and indirect suggestions so that as soon as the unconscious senses that pain trigger and it starts to travel towards the conscious, the unconscious then releases a hypnotic analgesia which disrupts those messages from reaching the conscious.

4. Treatment Implications

The implications for a hypnotic analgesia treatment would be as follows:

1. Perform a hypnotic analgesia induction for the acute and chronic pain arising from withdrawal.
2. During the induction, trigger a dissociation / disruption along the following lines: Pain causes the urge for Heroin - this is the trigger. We want this unconscious pain trigger to cause the dissociation or disruption of the pain messages reaching the conscious.

The Case Studies section of this paper provides examples of the new hypnotic analgesia treatment.

5. The Heroin Addiction Experience

The Heroin addiction experience means that patients will present with many of the following problems:

1. Physical pain of withdrawal
2. Total chemical addiction on Heroin - Heroin is a dictator - it dictates their life
3. Low self-esteem
4. Social withdrawal
5. Depression
6. Inability to have relationships
7. Social contacts are other Heroin addicts
8. Heroin addiction becomes their lifestyle
9. Prostitution
10. Crime
11. Jail
12. Suicidal tendencies
13. Diseases of neglect
14. Loss of control over their own life
15. Chronic Pain
16. Acute Pain

6. A Cyclic Model of Heroin Addiction

In my experience, Heroin addicts seem to conform to the following proposed cyclic model of Heroin addiction:

1. Psychological Pain (usually caused by dysfunctional background or ideas). Person takes (analgesic) Heroin - result: no pain.
2. Addiction to Heroin develops; physiological pain due to withdrawal pain. Person takes (analgesic) Heroin - result: no pain.
3. Operant conditioning: increases in pain are reinforced by ingestion of Heroin (analgesic) which lowers pain (Heroin is a positive reinforcer because it lowers pain).

When chemical dependence develops, the need for the Heroin (analgesic) is signalled by an increase in withdrawal pain.

7. After Rapid Opiate Detoxification (ROD)

Heroin addicts suffer from chronic and acute pain. After ROD, patients go back to experiencing psychological and emotional pain, which is chronic. They can't cope easily with everyday life. Although, Naltrexone blocks the opiate receptors in the brain, patients still have a tendency to want to use. This is due to learned thought processes and behaviour as addicts - there seems to be an automatic response similar to other learned behaviours such as walking or riding. They remember the good feelings associated with the analgesic effect of Heroin. This need is due to memories of analgesic pain relief, which is the Heroin as they escape the realities of life. The learned thought process and behaviour remembers only the analgesic effect of Heroin dependence.

8. Understanding Heroin Analgesia

The following account of Heroin Analgesia is based on Leonard (1992): Opiates[1] exert their effects by binding to specific receptors located in the brain and on peripheral organs. There is a high density of opiate receptors in the spinal cord and this explains the spinal analgesia, which many opiates produce. There are different kinds of opiate receptors. One kind is high affinity and mediates supraspinal analgesia while a related kind is involved in respiratory depression and in the gastrointestinal effects. The common side effect of most opiates is euphoria and this helps to hook users into becoming dependent.

In the nontolerant adult, an acute dose of 100-200 mg of morphine can lead to respiratory depression, coma and death. Single doses of more than ten times this amount can have little visible effect in the tolerant individual. Dependent users require high doses of opiate to prevent the occurrence of withdrawal effects.

Reducing plasma opiate levels or the administration of an opiate antagonist, such as Naloxone, leads to withdrawal symptoms. Symptoms include restlessness, craving, lacrimation, perspirations, fever, chills, vomiting, joint pain, and piloerection. The effects peak around 2-3 days after the abrupt withdrawal of Heroin, Morphine, or related opiates.

Stress including the stress of everyday life can elevate the pain threshold. Studies have shown that physical stress leads to an activation of *endogenous opiate systems* that raise the pain threshold. The euphoria which arises from physical exercise (jogging etc.) is probably due to endogenous opiate effects. On the other hand, in chronic pain syndromes, the concentration of the opiates in the cerebrospinalfluid decreases.

9. Hypnotic Analgesia Mechanisms

Erickson (1998) states that in a hypnotic trance, patients alter their relationship to externalities; within a trance, the patient can learn to alter habit patterns while not attending to the things that govern everyday contacts. Erickson has characterised pain as a neuropsychophysiological complex characterised by various understandings of tremendous significance to the sufferer. He believes that it is an experience which is particularly amenable to hypnotic treatment

The following account of hypnotic analgesia is based on the work of Joseph Barber and Donald Price together with their colleagues, (Barber, 1996)[2].

Barber has described the pain experience has having both *sensory* and *affective* aspects. Price has reported that affective responses are more influenced by the patient's situational perceptions than are sensory responses. He reported that factors related to the patient's psychological context could powerfully reduce affective responses to pain.

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1 In this section, we simply use the term "opiates" to mean "opiates and/or opioids", but see also (Leonard, 1992).

2 In this section, all references after this point are cited in Barber (1996).

According to the *neodissociation* theory of Hilgard and Hilgard (1994), there is a reduced awareness of pain during hypnotic analgesia. According to this theory, pain is registered by the body and by the unconscious during hypnotic analgesia, but it is hidden by an amnesia-like barrier between dissociated streams of consciousness. This view of hypnotic analgesia suggests an explanation for the paradox that sometimes physiological stress is *still present* during hypnotic analgesia, even though the patient consciously feels little or no pain.

Price has suggested that hypnotic suggestions could reduce pain, by activating an *endogenous pain inhibitory system* that descends to the spinal cord. This system would actually disrupt the transmission of pain-related information to the brain. Several researchers have shown that *hypnotic analgesia* includes suppression of activity in *spinal* sensory neurons. Further studies have shown that this spinal hypnotic analgesia must be triggered by a mechanism which is *separate* from one involving spinal opiate receptor sites. This is because investigators have found that Naloxone Hydrochloride, an opiate antagonist, *does not* reverse analgesia produced by hypnotic suggestions. While this excludes the possibility of an opiate descending control mechanism, *nonopiate* brain-to-spinal-cord descending control mechanisms are known to exist (Price, 1988).

Kiernan et al (1995) have carried out extensive research on the existence of a descending inhibitory mechanism of hypnotic analgesia. In their study, they measured physical changes in the R-III, a pain-sensitive spinal reflex, during hypnotic reduction of sensory pain and unpleasantness (affective pain). The results of this study suggest that three mechanisms may by involved in hypnotic analgesia. Evidence for the first mechanism is suggested by measured physical reductions in the R-III and is related to spinal cord pain-blocking mechanisms. Evidence for the second mechanism is suggested by patient-reported reductions in sensory pain over and beyond measured reductions in physical R-III. This result may be related to mechanisms which hide awareness of pain, even though pain messages had reached higher brain centres as predicted by Hilgard's neodissociation theory (Hilgard and Hilgard, 1994). This second finding is consistent with Hilgards' finding that some autonomic responses to pain remain, even under the conditions of profound hypnotic analgesia. Evidence for the third mechanism is suggested by reductions in unpleasantness above and beyond reductions in sensory pain, and maybe related to selective reduction in the affective dimension, possibly as a consequence of reinterpretation of meanings associated with the painful sensation, as previously suggested by Price and Barber (1987). The results of this study provide crucial confirmation that hypnotic analgesia is a *measurable* psychophysiological phenomenon, and that it has measurable effects on *spinal* reflexes.

A more detailed analysis of these three mechanisms of hypnotic analgesic effects will have important therapeutic implications:

The third mechanism allows selective reduction of affective pain (i.e., unpleasantness) through changes in the meaning of sensations and of the contexts in which they occur. Price suggests that little or no hypnotic state is required for this type of influence, even though it may be an integral part of hypnotic intervention. This could explain why even just Solution Oriented Counselling on its own can cause pain reduction.

The second mechanism allows perceived reductions in sensory pain by diverting pain messages from conscious awareness, even though these pain messages have reached higher centres. Depending on how much pain is masked within a patient, the normal somatomotor reflexes and autonomic, neuroendocrine, and neuroimmunolgical consequences of pain are *not* diminished. This means that stress-related responses associated with pain still occur, and are potentially a physiological detriment to the patient if the source of the pain is not ultimately treated.

The first mechanism allows blocking of pain messages at the spinal level of processing. In contrast, to the second mechanism, negative physiological consequences of pain *would be*

diminished by this mechanism, since the blocking of pain messages would disrupt the supraspinal activation of brain structures involved in autonomic and neuroendocrine responses to pain.

Kiernan and Price have suggested that different patients may use different proportions of these mechanisms when undergoing hypnotic analgesia.

10. Case Studies

The following are examples of case studies conducted in the environment of a medical clinic. So far I have applied the new hypnotic analgesia treatment to 29 cases. The results of these cases are as follows: There are some patients who did not return for their post-ROD counselling session and did not return for any further counselling (13 patients). This is not unusual, as there are always a number of patients who do not seek further counselling. Some of those who did not return live interstate – outcomes for the rest are unknown. Of those patients who took Naltrexone and continued with ongoing counselling (16 patients), all have stopped using Heroin and feel in control and are positive about their future. Some of these patients have gone back to work, are now actively seeking employment, or are very positive about their future. The following are summaries of two example case studies:

10.1. Amber[3]

The following is a summary of six hypnosis sessions with Amber that occurred over a period of three months:

First Session - Pre-ROD: Amber, aged 38, has been a Heroin addict for 13 years and she has Hepatitis-C. Her Heroin addiction is costing her $50-$200 per week depending on how much money she can afford. She lives with her two young children. Amber is a professional artist, and before Heroin she was very successful. She wants to do a ROD to stop her Heroin addiction. Her Heroin addiction is stopping her from being a good parent and it's affecting her work, her health, and artistic abilities. This is making her depressed, guilty and socially withdrawn. Amber's parents were both alcoholics. She told me that this affected her a lot. She felt isolated from her parents – she withdrew and played by herself. Her drug addiction began at age 14 with alcohol. At age 17, she used Speed and alcohol. At age 25, she began using Heroin and still continued with Speed and alcohol. She wants to give up Heroin because she's sick of the Heroin lifestyle and she's sick of the helplessness she feels of not achieving her goals. Her future orientation is to see her children settled; have a nice car; feeling physically well; having a good job; and living like normal people; and not pretending that her house is tidy. Hypnotic induction used: her focus for the induction in this session was no more Heroin. After induction: She said that she felt great: "I went to a place that I used to go to when I was a child on the beach. And I used to throw rocks in the water."

Second Session – Post ROD: Amber had thoughts about using [Heroin] but has not used. Amber reported the usual post-ROD physical symptoms that most patients suffer from: sore back, sore legs, mouth thrush, physical weakness, insomnia – broken sleep pattern. She decided that she was going to deal with each day at a time – in small steps. In this case, her steps were moving from her house and keeping away from people who use. Hypnotic induction used: Her focus was no Heroin; feeling well; to continue to not want to use; to sleep well and to have no pain. After induction: She said that she felt great.

Third session: She reported that things were going well: "I had reality in the face. The responsibility of the kids, but no thoughts of using. I was shocked at the state of my house – I can see things more clearly." Hypnotic induction used: her focus was moving house; fixing up her finances and getting into a routine with the kids and to work on her art. During the induction, I suggested she might like to imagine herself at a place where there was a pond

3 All names and identifying details in the Case Studies section have been altered to ensure patient confidentiality.

with flowers of many colours surrounding it. After induction: She said: “It’s the best – the flowers.”

Fourth session: She reported that she still didn’t want to use and that things were going well; but she’s been having dreams about using Heroin and Speed; she’s been having dreams about her ex partner. Hypnotic induction used: was not to feel stressed; dealing with her dreams; and continuing to not use drugs. After induction: She said, “I’m feeling good – I went deeper than I ever have before.” She said: “I felt a tingling in my shoulders and the back of my hands.”

Fifth session: She reported that she was feeling good – still not wanting to use Heroin; she’s found a new house and is moving in four weeks. She informed me that she has seven works in progress. She told me that she thought about using [Heroin] but didn’t. When I asked her what stopped her, she replied, “I thought about the negatives and physical risk; my children; I’ve worked so hard – I like my new life; I’ve basically been happy. She now has a boyfriend. Hypnotic induction used: her focus is to keep going when she’s stressed and to get over the next few weeks. After induction: She said, “I’m feeling relaxed.” She informed me that when she’s working on her art at home, she thinks about our sessions and it [the ideas] just all comes.

Sixth session: She reported that she was not using and had no thoughts about using. She’s moving to her new house in that week. She informed me that it’s been difficult but she’s coping. When I asked her how has it been difficult, she said it was due to physical hard work [moving house] and confronting the issues surrounding the move – normal concerns. She informed me that she’s happy and going from strength to strength. Hypnotic induction used: her focus is being able to cope with her finances; and she’s concerned about coping with her child starting at a new school. After induction: She said, “That was great. I didn’t cough once – I have a cold you know. I got an idea for an art work.”

10.2. John

The following is a sample of several hypnosis sessions with John that occurred over a period of two months:

First Session – Pre-ROD: John, aged 41, has been a Heroin addict for 20 years and he has Hepatitis-C. He is married and has one child. He is a blue-collar worker. He has been on a Methadone program for the past seven years. He informed me that being on a Methadone program has made him hungrier for opiates. He said that “Doctor’s have always put me on a high dose of Methadone.” He informed that, prior to taking up Heroin, he had a very successful job as a retail store manager.” He informed me that he wants to do a ROD because he is “sick of being under the control of Heroin.” John informed me that he had a good childhood – to the extent of being spoiled because he was the youngest child. He had a good relationship with his parents. His drug addiction began at age 17 with cigarettes and alcohol. At age 19, he took Serapax and LSD. At age 21, he started using Heroin because of peer group pressure. His future orientation is no Heroin; to go back to work; to treat his wife like a human being, to understand her better; and to feel everything for her; to have self-esteem and no guilt; to have a better job; to join a gym and get fit; and to pay his debts and work hard. Hypnotic induction used: his focus for the induction in this session was not to use Heroin. After induction: He said, “I feel like I’ve found a bunch of keys on the floor. I enjoyed it. I felt peaceful. It was funny about the keys. I felt a Chinese man handed them to me – they were my house keys. I’m feeling good – I feel like I’ve had a good night’s sleep. I’m going home to sleep – I don’t feel like having Heroin.”

Second Session – Post ROD: Physical symptoms: cramps in the stomach, nausea, headache, inability to sleep, inability to eat. John informed me that he eventually got some sleep and that he felt good when he woke up. He said that he is feeling good mentally and is feeling refreshed. Hypnotic induction used: His focus was on going back to work and not using

Heroin; to look towards a positive future; to go on a holiday overseas. After induction: He said, “I’m feeling good. You took me back to places – remembering my childhood. I experienced the Sun, being at the pond, clear water and flowers – these all reminded me of where I was born. I could see the bottom of the pond. I’m feeling good – my stomach cramps are gone even.”

Third Session: He reported that he had no thoughts about using Heroin. He said, “I have days when I feel good and other days when I’m physically weak – my stomach is not sore any more. I went for a drive with my wife and baby the other night – that night I slept well.” Hypnotic induction used: his focus was to be able to sleep well; to not feel nervous; to not use Heroin and to feel healthy. After induction: He informed me that he felt relaxed: “I could feel a tingling in my legs and hands. My legs felt more relaxed – my mind felt more relaxed. I was thinking of sleeping.” He also informed me that soon after the previous session, he was reading a book at home in the evening at which point he felt a tingling in his back, after which he felt really good.

Fourth Session: He reported that he had no urge to use Heroin; that he was sleeping, eating, and had no urge to smoke cigarettes; and that he had no nervousness in the legs. He said, “The nervousness in the legs stopped on the day that I last saw you. I feel better now than ever [before].” He informed me that he’s now joining more in family activities e.g., dressing the baby. He also said he would like to do a university course. He said he’d had no contact with Heroin users. He said to me, “I’ve cleansed my soul of the bad things I did; I’ve forgiven myself.” Hypnotic induction used: his focus was to do a university course; stay off Heroin; looking towards a good future; to keep feeling positive; for the relationship with his wife to keep improving. After induction: He said, “I’m feeling very relaxed. I could go home and have a nap; I’m feeling great.”

Fifth Session to Sixth Session: [Omitted].

Seventh Session: John informed me, “I get feelings during the day where I get a ‘high’ . They occur spontaneously.” [rest of session omitted].

Eighth Session: He said that he was feeling well and was staying off Heroin. He informed me that he was starting a new job the next day. He said that he was sleeping OK. He said he wakes up but then is able to go back to sleep. He said his depression was gone. Hypnotic induction used: His focus was to stay off Heroin and continue to move forward. After induction: He said, “I’m feeling good; my headache is gone; it was like a tension headache but now it’s gone.”

11. Hypnotic Analgesia Techniques

Each patient session starts with a prehypnotic discussion, which includes some informal hypnotic suggestions, followed by a formal hypnotic analgesia induction. The prehypnotic discussion covers mainly affective pain (unpleasantness and mood). The prehypnotic discussion also appears to reduce some of the sensory pain, probably due to a change in affect, and also due to some informal hypnotic suggestions, which includes using metaphors. The formal hypnotic analgesia induction covers affective pain, sensory pain, and spinal-inhibitory pain.

11.1. Prehypnotic Discussion

To help patients, I use several techniques in the prehypnotic discussion: I tell them about solution oriented counselling and hypnosis. That it’s solution-focused. ; that you help them to focus on a solution. Because Heroin is such a dictator – it takes control of their life; my counselling and hypnosis is to try and help them. I help them to gain control over their life; to draw on their inner strengths and resources.

I never tell them what to do. The suggestions that I make are just suggestions - I'm not telling them what to do at all. When I suggest something I say, "That suggestion is for you to use in a way that is comfortable for you. I would never tell you what to do or how to do it. I think differently to you. For example, the way that we're both sitting is different. If I told you what to do it would be like me telling you to wear your left shoe on your right foot. Even if you wanted to do what I say you couldn't because you're different to what I am – your you." At this point, I sometimes tell a patient the metaphor about Erickson letting the stray horse guide itself back home.

I openly listen to what they have to say and observe their mood and their behaviour. I join them by listening which is empathic. It also means that what they have to say is important and it gives me an idea in what direction I guide them. I also observe them very closely. It tells me about any peculiarities and my observation also informs me about whether what I'm saying is having a negative or a positive impact on them. Every person is different – this is not a fixed format. I view every person as an individual. I cater to the individual's needs by observing, listening, and being empathic to the patient. I ask them on a 1-10 scale about how much they want to give up Heroin. If it's a low score then I ask them what will it take to get it to a higher score.

I explain to them about Naltrexone. I explain to them that Heroin has a learned thought process and behaviour which they need to unlearn. ROD is not a miracle cure and they need to adjust to a new behaviour. If they are serious about giving up Heroin, which I know they are, they need to commit to taking Naltrexone and attending counselling for a period of time. Depending on how long it takes. I emphasise that after the ROD, they will probably experience a need to use and a wanting to use. I emphasise to them that what they're experiencing is a chronic learned thought process and behaviour. I say to them that as long as the Naltrexone is sitting in the opiate receptors of the brain they don't need to use and they don't want to use because the Naltrexone takes away the physiological need. They really need to be aware of this distinction so that when the thoughts of using enter their mind they can recognise them as a thought process and behaviour from the past; and that the present is simply just that they don't need to and don't want to use.

I try to create an environment where the patient can draw on inner resources and abilities: When a patient first seeks my help, it's because that patient is dissatisfied with the present and wants to change their future. Associated with this is a sense of helplessness and hopelessness. They feel stuck – there's an inability to move forward. Most of these patients have tried giving up Heroin and tried conventional detoxing several times and failed. They come into the session with deep fears about wanting to use or needing to use. I accept the person as they are without passing judgement.

Another prehypnotic technique is normalisation: I view the person as a normal person. I try to normalise the patient's fears and experiences. I view them as normal people with Heroin addiction. I help the person by normalising their behaviour which helps take away believed labels about themselves, which come about through their own negative experiences, or which have been placed on them by others. My attitude towards them already starts to change their view about themselves. They begin to view themselves as normal. Once this normalisation process starts, the patients no longer view Heroin addiction as somehow organic or congenital. They weren't born with Heroin addiction – it's not organic – it's just habitual. It's just a learnt behaviour. Anything that can be learnt can be unlearnt.

Once the opiates are out of their system they are no longer Heroin addicts. They need to adjust to a new way of life without Heroin. They've had a relationship with Heroin. And like any other good or bad relationship that ends, they have to adjust to living without that relationship. They do this by taking Naltrexone which takes care of their physiological need and counselling / hypnosis which takes away their emotional and psychological pain.

They are now able to view Heroin as a separate entity from themselves; as something external that they can control rather than Heroin controlling them. They are now able to view Heroin as just an addiction. This enables them to gain control. They start to believe that they can control it.

I help them to gain control by understanding the nature of their Heroin addiction. During this process I'm empathising with them by helping them to externalise their actions due to Heroin addiction. I say things like, "Heroin is a dictator. It takes control of your life. It tells you what to do and when to do it." It tells them what to do. It makes them act against their own will. There is a total loss of control over their life. It's as though they're outsiders looking in; watching themselves spiral into degradation. Into a life of stealing, lying, depression, inability to work, bad relationships, sometimes prostitution, and suicidal tendencies. Heroin becomes a learned thought process and behaviour. Heroin becomes their life. It's almost as if they have a split personality where they don't want to take Heroin because they know what it does but they do it anyway. They do it because it takes away psychological and physiological pain.

To help them understand the external force of Heroin, I tell them metaphorical stories. For example, one of the stories that I tell is about a Heroin addict who was so desperate that she contemplated chopping her fingers off so that she could be taken to hospital and be given Morphine and Pethidine. Luckily, while she was in this frenzy she happened to come across something she could steal and sell for a fix.

This helps them to understand the externalised control of Heroin. It also helps them to know that I empathise with them. It helps them to come to terms with whatever dysfunctional actions they committed while under the influence of Heroin. I help empower them by getting them to view Heroin as an external dictating force. I help them to recognise their monster. I do this by telling a metaphor about a person who had recurring nightmares for most of his life. This person came from a dysfunctional background. This person would wake up every morning in a cold sweat. Then one night during his nightmare he decided to stop running and face his monster. With his fist clenched he turned to the monster and as he did that the monster vanished. This helps them to understand their monster (their problem) so it can be destroyed (problem solved).

Viewing Heroin as an external force helps patients to separate themselves from it.
By dissociating themselves from the guilt of their actions, they are able to start building their self-esteem. This process involves them starting to forgive themselves for the deeds they did while on Heroin and they need to start loving themselves again.

They can then begin to forgive themselves and start loving themselves. There's a shift to them starting to forgive themselves and love themselves and moving forward. How would you like your life to be? Why ROD? What are you expecting to happen after ROD? Why did you start taking Heroin? What are you expecting to change? I start to ask them about their future orientation. What would you like your life to be like?

Then I get them to explain their pain and their concerns; to get the to talk to me about their pain. I ask them about their childhood and the drug abuse and their actions as a Heroin addict – how Heroin has affected their life – what it has cost them financially – how Heroin has disrupted their social life, their work and relationships.

"You have survived a horrific ordeal and this has made you as stronger person." I try and take all that negative stuff that they tell me and I say the good thing is that the future hasn't happened yet and all this negative experience that you've had with Heroin can be a learning experience where in the future you won't be making the same mistakes. I tell a metaphor about a person who gets tomorrow's paper today. He then goes into the future to manipulate it. So the outcome is a positive one. So the patient learns that their future hasn't happened yet

–and isn't it great – then the patient can manipulate their own future so that there's a positive outcome.

I do this by orienting the client's expectation towards being successful by using future orientation. Their future hasn't happened yet. I use the metaphor of the magic wand to get them to imagine that we're in the future. They tell me what's happening in the future. These are their goals. What their life is like. They usually tell me, "No Heroin, I'm feeling fantastic. I've joined a gym. I have a wife and two children. I have a nice house, a car, a dog etc. I'm feeling great." I'm always moving them forward – I'm opening up possibilities – all the time. These discussions about future orientation take the patient away from their immediate pain and orient them towards a positive future. Hence these are a form of indirect informal hypnotic suggestion. This also causes some dissociation where they can experience a positive future. Dissociating themselves from a negative present and going into the future where they are actually experiencing an analgesic high on being and feeling successful. This causes a neuropsychophysiological change which is demonstrated by an observed change in affect; their posture changes, their voice – the tone of their voice changes to a more positive one – their skin colour changes.

11.2. Formal Analgesia Induction

I now ask the patient if they are ready to go into hypnosis. I ask them what do you know about hypnosis: the usual answer is stage hypnosis, or nothing. I explain that the hypnosis I'm about to do is not like stage hypnosis, where I'm somehow going to take over their mind and their body and they'll do exactly what I tell them to do – it's exactly the opposite. I make suggestions that will help them to gain control over their own lives by drawing on their own inner resources.

I explain to them that they don't have to feel in any particular way. That every individual experiences hypnosis in their own way. They don't have to feel that they're under hypnosis. And that they can move, talks, or do whatever they need to do – and that they can stop whenever they want to. It is their session and they are in control. That they can hear my voice but they don't have to listen to what I say. That they can have their own experiences.

I then ask them what their focus is for the induction – what they'd like to focus on. For example in John's first session, his focus was not to use Heroin.

My technique for the hypnotic analgesia induction has a structure based on Barber (1996) but the form varies depending on the individual needs of the patient:

It's important to elicit the patient's attention and cooperation. I do this by suggesting that they might like to close their eyes and that they might like to rest back in the chair and to allow their body to be as comfortable as they know how. I then reduce the patient's range of attention by suggesting that with their eyes closed, they might like to take a deep relaxing breath and hold it and then to let their breath all the way out as they feel their body sinking back deeper into the chair. The next thing I do is to narrow the patient's focus of attention and direct them to look inward; I say to them, "As you breathe in and out comfortably, you might begin to notice a pleasant heaviness that can become more and more a part of your awareness." As they notice that heaviness, they can also notice how easy it is to listen to the sound of my voice, and that they can understand what I say without any particular effort. All the sounds that they hear can become part of their comfort and well being with nothing to disturb them.

The next thing is to suggest dissociation. As they continue to be more absorbed in the comfort of their own breathing. I suggest that as they breathe in and out, their awareness of their breathing is all that matters; it's as if though nothing else really matters –just their breathing and their comfort. I then suggest that they might have begun to notice a tingling sensation in their fingers –a pleasant glowing sensation. This tingling sensation reminds them of how

deeply absorbed and comfortable they can be. I then suggest that they might notice a similar tingling sensation in their lower back and in the soles of their feet. They might feel as if they are glowing with energy while allowing the sound of my voice to continue to be part of their comfort.

After dissociation, I offer therapeutic suggestions by using metaphors. While making these suggestions, I incorporate their future orientation and their hypnotic focus. The reason I bring these in is because it's a continuation of the goals they want to achieve which were covered in the prehypnotic discussion. For example, I suggest that they might like to go to a place where the sun is shining through the tree tops and that they can feel the warmth of the sun on their chest, shoulders, and face, and their lower back; warm, glowing, energising, healing, comfort; and that in this place there's a pond with crystal clear water and the water is so very very clear that they *can* see to the very bottom of the pond. They pick up a tiny pebble and throw it into that pond and watch the ripples slowly, slowly, rippling away. I suggest that in this place they *can* have the life that they want; that they don't need to use Heroin; and they *can* stop using Heroin. They can achieve their goals and have the life that they want without using Heroin or other drugs.

The therapeutic suggestions now begin to focus more heavily on hypnotic analgesia. I suggest that as they continue to feel absorbed by the sensation of their breathing. I will be talking to that part of them that controls the sensations in their nerves. I suggest that they can listen to me or just float comfortably, knowing that their system is hearing everything that I'm saying to them. I suggest to them that whenever their unconscious detects that *trigger* of pain, whether it's psychological, physiological, or emotional pain, that their unconscious will release a hypnotic analgesia, which will *disrupt* those messages from reaching their consciousness. And whenever they take a deep breath, they might like to notice how comfortable they feel with nothing to bother them and nothing to disturb them. I suggest to them that they have the capacity to *increase* or *decrease* the sensation throughout their body. I suggest that they might feel interested in the way that they decrease the sensations in whatever part of the body they need to. "And you won't know how you do it – you can be curious and you can be surprised that whenever those painful electrical feelings begin to shoot towards your consciousness, for some reason they will just stop; like a sneeze that never quite happened. You won't know how at first but the sensation just seems to stop almost before it can quite get started. Almost as if your nervous system is beginning to retrain those nerves to no longer send those painful messages across to your consciousness." Then I suggest that sometime later that day, they will suddenly notice how well they are feeling; and they wont know how and they wont know why but they'll just feel better.

After this, I start providing suggestions to end the experience. I suggest that they might like to notice how easily they find themselves breathing; and with each breath they will find themselves more refreshed and more energised. I suggest to them that as they take really deep breaths, and as their eyes open, they might like to notice how refreshed they feel; as if they've just had a restful nap.

12. Discussion

In the case of Amber, when Amber first came, she felt an inability to give up Heroin. In the past thirteen years, she had tried many times but had not succeeded. She looked unkept and her face had no colour with a greyish defeated look. She felt stuck and out of control. Her hypnotic analgesic induction involved metaphors about her future orientation and about her hypnotic induction focus; also I made suggestions that she had the ability to control the sensations of her nerves, and that her unconscious would release a hypnotic analgesia to disrupt painful electrical feelings from reaching her consciousness.

After her induction in the first session, she reported that she had had a good experience and that she felt positive about her ability to give up Heroin and to have the life and future that she wanted. That it was within her reach. After each session, she reported and I observed

progressive changes in her whole physical and emotional affect. From her case study, after the fourth session induction, she reported she was feeling good, and that during the induction she had felt a tingling sensation in her shoulders and the back of her hands. Her physical look is now radiant – her skin glows with health. These changes are consistent with an analgesia effect. She is motivated, energetic, has good self-esteem, feels empowered and has started her art work again. She informed me that the hypnotic sessions inspire her with her art work ideas. Amber informed me that she is happy with her life and that she never wants to use Heroin again.

In the case of John, when he first came in, he informed me that he'd been a Heroin addict for twenty years. He looked tired, defeated, depressed and anxious. His physical appearance was untidy – his face looked drawn and grey. He informed me that he had tried many times to give up Heroin but he had failed. During his hypnotic analgesic induction, I suggested that he might like to go to a place where he felt comfortable, warm, glowing with energy and a sense of well being. I suggested he also had the ability to control the sensations in his nerves. He didn't know how or why but that he would just feel better. Whenever his unconscious detected that trigger of pain, whether psychological, physical, or emotional then his unconscious would release a hypnotic analgesia, which would disrupt those messages from reaching his consciousness. That at some stage, possibly today, or at some other time, he would notice a sense of well being.

After the first and each subsequent session, John reported a sense of well being. He reported that he had no need to use Heroin. He informed me that he felt in control about his future. He reported that he felt very positive about the relationship with his wife and child. He informed me that his depression was gone. I observed progressive changes in his physical and emotional affect. He began to take pride in how he presented himself. His skin colour had a healthy glow and looked more alert and he spoke more confidently about his future. From his case study, after the second session induction, he reported that he felt good and that his stomach cramps were gone. After the third session induction, he reported that he was reading a book at home in the evening at which point he felt a tingling in his back, after which he felt really good. After the seventh session induction, he told me, "I get feelings during the day where I get a 'high.' They occur spontaneously." Again, these changes are consistent with an analgesia effect. John informed me that he is feeling positive about his future and that he wont use Heroin ever again. He has forgiven himself and wants to keep working. He would like to eventually do a university course.

From the two case studies, there is some evidence that the new hypnotic analgesia treatment will make it easier for Heroin addicts to stop their addiction after ROD with Naltrexone.

My results in these case studies appear to support the work of Price and Barber (1996). From the case studies, the prehypnotic discussion does have a positive analgesic effect on the affective and the sensory pain. The formal hypnotic induction, as shown with these cases, shows a positive effect on sensory pain and a positive effect on spinal-mediated sensory pain. The dramatic changes observed in the healthy glow of their skin colour and the patients' reports of absence of pain lend support to the presence of a hypnotic analgesia which works via the spinal inhibitory system, which causes the total disruption of pain messages from reaching consciousness.

We can view the hypnotic analgesia as being stronger than Heroin analgesia: This is because, apart from disrupting sensory pain, it also disrupts emotional and psychological pain from reaching consciousness. Heroin only numbs the sensory pain for a short period and masks, but does not stop, the chronic emotional and psychological pain. When the Heroin analgesia wears off the pain returns so they need to use again.

This is a preliminary study. The case studies I have worked with so far provide positive evidence that supports my hypothesis of finding a hypnotic analgesia that would replace

Heroin analgesia. For patients undergoing ROD, the new hypnotic analgesia treatment can replace Heroin analgesia and thus break the tragic cycle of Heroin addiction.

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Long-term treatment of heroin addiction. If patients are simply discharged from the hospital after relief of the withdrawal syndrome, then the probability of renewal of compulsive use of opioids is high. Dependence is a chronic disease requiring long-term treatment.Â Although naltrexone was originally intended for the treatment of opioid dependence, it is now more widely used worldwide for the treatment of alcoholism. New methods of treating heroin dependence. Currently, new drugs that are potentially effective in various forms of dependence are of great interest. injection for treatment of heroin addiction. why is buprenorphine hard to reverse. strong affinity of opioid receptors (may take 4 ampules of naloxone to reverse). buprenorphine and naloxone are used for this treatment. treatment of narcotic addiction. why does buprenorphine and naloxone work? because if patient takes buprenorphine PO nothing happens, and if they inject it naloxone will take effect thus patient will have to take it appropriately. what are the uses of methadone. treatment of narcotic addiction (used as a baseline drug to keep patient stable, prevent death from OD, must pass nar...Â Sedative-Hypnotics & Anxiolytics. 93 terms. ryan_lovelessPLUS. Naltrexone is prescribed in treating opioid addictions. It blocks the harmful effects of opioids which reduces future drug cravings and urges.Â How Does Naltrexone Help Addiction Treatment? Oftentimes, opioids will give you a â€œhighâ€ or â€œrushâ€ feeling â€“ a feeling of contentment and pain relief. When taking naltrexone, these feelings will be blocked. Over time, you will regain a drug-free state of mind, allowing you to focus on developing a healthier lifestyle. Although naltrexone is commonly used to treat an opioid addiction, it may not stop drug cravings.Â Falling back on heroin or any other opioids could cause serious complications, including an overdose. Questions about treatment? Get confidential help 24/7.