A Response to an Open Letter to the Editor of the American Journal of Clinical Hypnosis

Howard Sutcher, DDS, MS
Chicago, IL

Dr. Yager has raised a number of interesting points in his open letter to the Editor (Yager, 2010) of the Journal regarding the efficacy of smoking cessation treatments which utilize hypnosis. While I share many of his concerns, I would like to make three points which I feel he has not addressed in his “open” letter.

First, smoking is a more complicated problem than generally considered. Smoking is both an addiction as well as a bad habit. It can also be a response to anxiety as well as a response to benign social cues and pressures. People start smoking and continue smoking for different reasons. There are biological, psychological, and sociological variables associated with the initiation and continuance of smoking. All of these variables should be evaluated in developing an individual treatment strategy to help a smoker stop smoking with or without hypnosis.

Second, as I emphasized in earlier papers (Sutcher, 2008a; 2008b), with the exception of treatments for pain, hypnotizability is probably not a major determinant of successful outcome in any other treatment strategy that employs hypnosis. While hypnotizability significantly correlates with pain relief for both hypnotic and non-hypnotic pain interventions (Appel & Bleiberg, 2005; Frischholz, 2005; Frischholz, Spiegel, & Spiegel, 1981; Hilgard & Hilgard, 1975; Katz, Kao, Spiegel, & Katz, 1974), at best, it accounts for only 20-30% of the outcome variance in such studies. This leaves the remaining 70-80% of the variance in treatment outcome unexplained by hypnotizability.

In empirical studies of smoking interventions which utilized hypnosis, two studies did not find a significant correlation between scores on the Stanford hypnosis scales (Hilgard, 1965) and treatment outcome (Perry & Mullen, 1975; Perry, Gelfand, & Marcovitch, 1979). In contrast, one study did find a significant correlation between scores on the Hypnotic Induction Profile (Spiegel & Spiegel, 1978), a self rating of hypnotizability and complete abstinence one week after treatment and again two years after treatment. Nevertheless, the magnitude of this relationship accounted for only 10-20% of the outcome variance leaving the remaining 80-90% unexplained by hypnotizability measures.

I believe the single most important determinant of treatment outcome in all smoking interventions is not hypnotizability, but the patient’s motivation and determination to quit. While I do not have empirical data to support my belief, two
Response to an Open Letter

previously reported case studies are consistent with this hypothesis. For example, in Case 3 (The Case of Lilith discussed in Sutcher, 2008a; p. 63), it was not even clear that the patient was determined to quit smoking. Lilith’s appointment with me for hypnosis appeared to be a request for a verbal “magic” potion that would cause her to stop smoking. It turned out that I could not hypnotize her. Every method I tried was unsuccessful and we both acknowledged this fact. In fact, after my failed attempt to hypnotize her, Lilith got out of the chair and immediately lit a cigarette. Although I did not usually allow smoking in my office, I decided not to make it an issue at this time. Interestingly, Lilith smoked the cigarette half-way and then put it out. I asked her if that was the way she usually smoked. Lilith replied, “No, I usually smoke cigarettes down to the nub. Strange, I wonder why I did that (Sutcher, 2008a; p. 63).” Obviously, something had changed. But neither Lilith nor I had any idea what caused that change.

Lilith called me two days later to tell me that she did not know what I had done. She added, “and I’m pretty sure that you don’t either (Sutcher, 2008a; p. 63). I agreed. I didn’t know if it was anything I did. I still do not know what initiated her self-admitted change in smoking behavior or subsequent non-smoking. However, I was asked by Dr. Frischholz to hypothesize what I thought had happened.

I believe this was a case where, whether or not hypnosis was used, any smoking cessation strategy that focused on this patient’s motivation to quit would have been successful. She was ready to stop and she stopped. After 3 months, she still had stopped smoking and in her own words “what is more amazing, I have not wanted to (Sutcher, 2008a; p. 63).” Her son reported that she was still not smoking two years after our session. I theorize that she was ready to quit and she quit.

In contrast, in Case 4 (the Case of Aphrodite discussed in Sutcher, 2008a; p. 64), the patient said she wanted to quit but (I believe) was really not motivated to do so (as she later admitted). She was extremely hypnotizable (as indexed by her high scores on the Hypnotic Induction Profile: Profile Grade 3-4 Intact; Induction score: 9/10). I used a technique where I suggested that she would find the taste of cigarettes to be “nasty” (her own metaphor).

After treatment she continued to smoke but reported that now cigarettes had no taste. This was an indication that the suggestion was not literally successful as it did not prevent her from smoking, however, it still had some effect post-treatment [i.e., she experienced “no taste” (Sutcher, 2008a; p. 64)]. Prior to treatment she reported enjoying the taste of cigarettes. After a few days of smoking this “no taste” experience went away and she began to enjoy the taste of cigarettes again.

Interestingly, about 6 months following my smoking intervention with Aphrodite, she phoned me to say that she was in pain because of two broken fingernails. Over the phone, I instructed her “go back to that place where you were when we were trying to get you to stop smoking. Let the pain drain out of your fingers and fall onto the floor” (Sutcher, 2008a; p. 64). Aphrodite informed me that her pain reduced greatly immediately. Again, I think that this data indicates that without true motivation to quit smoking cessation technique (whether with or without hypnosis) will be effective. High hypnotizability does not seem to overcome the problem of lack of motivation to quit in smoking interventions which utilized formal hypnosis. Nevertheless, high hypnotizability still seemed to have some relationship with this patient’s ability to successfully respond to suggestions for pain control even when given over the telephone without any formal induction of hypnosis.

Third, you can never be certain of the efficacy of any smoking treatment method without empirical validation. In this regard, I recently became aware of a clinical research program on a single session treatment for smoking using adjunctive self-hypnosis conducted
in Herb Spiegel’s laboratory over the last 40 years. In the preliminary studies (Spiegel, 1970a; Spiegel, 1970b), a consecutive series of patients were followed up by mail six months after treatment. Although the response rate to this method of follow up was only 44%, twenty percent of the original samples reported they were not smoking after the single session treatment.

A later study (Spiegel, Frischholz, Fleiss, & Spiegel, 1993), which used the same treatment method, followed up on the treatment outcome of a consecutive series of 226 patients at one week, three months, six months, nine months, one year and two years post-treatment. This time patients were followed up by phone individually at each follow up period and self-reports were verified by someone else living with the patient. A week after treatment, 52% of patients were completely abstinent. Three months post-treatment, the abstinence rate had dropped to 38% and at 6 months to 30%. The rate of relapse began to stabilize at 9 months (27% abstinent), 1 year (25% abstinent) and at two years post-treatment 23% were still abstinent.

I do acknowledge that there have been many other studies of smoking interventions which also utilized hypnosis. However, these three studies tested the same intervention in different samples and replicated the long term efficacy of this treatment method (20-25% long term abstinence). In addition, the results of the Spiegel et al. (1993) study indicated that there seem to be two distinct phases of quitting: initiation of abstinence and maintenance. Finally, the Spiegel et al. (1993) study also demonstrated that, other than scores on the Hypnotic Induction Profile, different variables predicted the initiation of abstinence from the maintenance of abstinence. The findings underscore the necessity of both replicating the efficacy of any smoking treatment method as well as understanding who responds best to this type of treatment.

I further believe that if the Spiegels had attempted to measure their patient’s motivation to quit, the outcome would also have been a significant predictor of both initiation and maintenance of smoking abstinence. Also, it might show an even stronger treatment outcome predictor than hypnotizability or the other predictor variables.

I also find it interesting that both Dr. Yager (2010) and the Spiegel’s (1993) utilized only a single treatment method in their study. I believe this is what accounted for the 20-30% long term abstinence rates. Perhaps, if the treatment were tailored to different aspects of the patient’s smoking habit rather than the same treatment for every subject, these authors would have produced higher abstinence rates. Nevertheless, I recognize that this hypothesis is also in need of empirical verification. I applaud these authors’ attempts to verify the efficacy of their methods and I support their contention that this must be done before any licensed health care professional can claim to have an effective treatment for smoking cessation.

References


Response to an Open Letter