

## **AN ERICKSONIAN APPROACH TO CRACK COCAINE ADDICTION: A SINGLE-SESSION INTERVENTION**

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### **Abstract**

Cocaine addiction is a significant problem in the United States and treatment is hampered by high relapse rates. This is particularly the case with crack cocaine because it is smoked and consequently has a rapid but relatively short-lived effect on the brain. This readily creates a cycle of craving and dependence. Moreover, the multiple environmental cues associated with the craving set up powerful conditions for relapse. This paper describes an Ericksonian approach alongside more traditional hypnotic techniques. In particular, the methods of utilization and orientation to the future are described and a one-year follow-up is discussed.

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**Key words:** hypnosis, Ericksonian approach, addiction, crack cocaine, single session, utilization

### **Introduction**

Cocaine addiction is a problem of considerable magnitude in the United States. A major difficulty in treating the disorder is the propensity for relapse. This is particularly true with crack cocaine. Crack cocaine impacts on the pleasure centre of the brain, and the intensity of its effects has been compared with sexual orgasm.

Because crack is smoked, its effects are almost immediate. In a gaseous state this form of the drug goes into the bloodstream and to the brain in an undiluted form, in contrast to when the drug is taken intranasally or intravenously. The effects of the smokable cocaine are also quickly depleted. This creates a rapid cycle of craving and dependence. It also sets up an environment where every stimulus can be presented as a cue for craving and subsequent relapse. This cycle of craving and relapse is characterized by feeling of hopelessness and anhedonia.

A single-session intervention for crack cocaine addiction will be offered as an example incorporating an Ericksonian (Otani, 1989; O'Hanlon and Martin, 1992) approach with traditional methods of hypnosis. The cornerstone of this approach is 'utilization' (Zeig, 1988) – the use of the symptoms that the client presents with (DeSchazer, 1979). Orienting the client to the future (Erickson, 1954; Erickson and Rossi, 1989; Torem, 1992) and developing an orientation towards success is critical to this approach. A one-year follow-up will also be discussed.

### **Cocaine withdrawal**

The essential features of withdrawal from cocaine, as described in the Diagnostic and Statistical Manual of Mental Disorders (4th Edition), are dysphoric mood and any

combination of fatigue, insomnia and psychomotor agitation occurring on the cessation or reduction of cocaine use (DSM IV). In a study of cocaine-dependent males in a 28-day inpatient treatment setting Nademanee and his colleagues (Nademanee et al., 1989) reported a 'strikingly high incidence of silent spontaneous myocardial ischaemic episodes in cocaine addicts during the early stages of cocaine withdrawal'. This underscores the fact that withdrawal from cocaine is not only a psychological problem but has medical implications as well.

Until recently, withdrawal from cocaine dependence was seen as being dissimilar from withdrawal symptoms in alcohol- and opiate-dependent individuals. A triphasic cocaine abstinence pattern has been postulated that dispels recent perceptions that cocaine use produces no withdrawal symptoms (Gawin and Kleber, 1986). This triphasic phenomenon can be described as:

*Phase I – 'Crash'*: A crash of mood and energy immediately follows cessation of a cocaine binge, or prolonged cocaine use. Cocaine craving, depression, anxiety and agitation rapidly intensify, followed by increasing exhaustion and craving for sleep. Hypersomnolence can last several days.

*Phase II – 'Withdrawal'*: A protracted dysphoric syndrome including anhedonia, boredom and lethargy emerges shortly ( $1/2$  to 4 days) after the crash. These symptoms are often subtle and may masquerade as feelings of wanting to discontinue treatment, depression or negativism with treatment professionals or treatment programmes. These symptoms are less dramatic than those of the crash and are frequently not constant enough or sufficiently severe to meet criteria for major mood disorders.

*Phase III – 'Extinction'*: Following the resolution of withdrawal anhedonia, intermittent, conditioned stimulant craving can still emerge. Abstinence through this stage depends on experiencing these intermittent cravings without relapse.

Cocaine increases neurotransmission and produces reuptake inhibition of norepinephrine, dopamine and serotonin. Gawin and Ellinwood state:

The nervous system's usual response to persistent, drug-induced neurochemical perturbation is compensatory adaptation in the perturbed systems. Dysregulation occurs when the drug is not present. Despite this, it had recently been assumed that neuroadaptation does not occur in cocaine abuse. This perception that cocaine was only 'psychologically' addicting contributed to the rapid spread of dependence. (Gawin and Ellinwood, 1989, p.)

They further suggest that chronic high-dose cocaine use generates sustained neurophysiological changes in brain systems that regulate the processes that produce hedonic response. 'Changes in these neurophysiological systems produce a true physiological addiction and withdrawal, but one whose clinical expression appears psychological' (Gawin and Ellinwood, 1989).

### **Managing withdrawal**

At this time 'there is no particular drug that is implicated in the management of cocaine detoxification' (Nuckols and Greeson, 1989). A plethora of medical model-type interventions have been described in the literature, most notably those that seek to reduce the craving (Dackis et al., 1987; Pike, 1989) and those that attempt to reinstate a neurochemical balance and alleviate the depressive symptomatology

(Kosten et al., 1987; O'Brian et al., 1988; Gawin et al., 1989). These pharmacological interventions have been primarily of the tricyclic antidepressant type.

There has also been the more traditional model of treatment for the management of withdrawal symptomatology and accompanying depression (Nuckols, 1987; Washton and Gold, 1987; Washton, 1989). These models all incorporate several similar aspects of treatment. They all rely heavily on the bio-psycho-social model with the addition of a strong 12-step component. In addition, all reportedly successful models of treatment seek to incorporate as a primary component a strong relapse prevention aspect in the beginning phase of treatment. The addition of a relapse prevention tract early in the course of treatment is one of two major divergences from traditional models of treatment for alcohol- and opiate-dependent individuals. The other major change in focus for the cocaine-dependent individual is the recognition of the peculiarity of the drug and the individuals that tend to find themselves dependent on cocaine. Nuckols has stated on more than one occasion that:

In order to treat a cocaine addict effectively, you need to enter his map of the world. You have to make him feel like he is the most unique client that you have ever had, or for that matter that you are ever likely to have. Only then will he begin to accept you as an expert in the field for recognizing his specialness (Nuckols, 1989, personal communication).

This is not a new development in treatment. It is cited by Haley as the basis of much of Erickson's therapy (Haley, 1973) and is called the utilization approach (Erickson and Rossi, 1979).

### **An Ericksonian approach**

Milton H. Erickson, MD, is typically thought of as the pioneer of indirect methods of clinical hypnosis (Haley, 1967; Erickson et al., 1976; Erickson, 1977; Gilligan, 1987). Erickson is also considered one of the theoretical founders of 'brief' or 'solution-focused' therapy (De Shazer, 1979; Yapko, 1989; Otani, 1990; Dolan, 1991; O'Hanlon and Martin, 1992). Some of the techniques and stratagems used in this approach are: implied directives, truisms, binds and double binds, seeding and therapeutic assignments. These are not to be exclusively substituted for traditional counselling methods, skills and practices. The use of empathy, congruence and unconditional positive regard (Rogers, 1942) must remain an integral part of the therapeutic interaction.

The basis of this approach is to reach the patient where they are in their phenomenological world and to incorporate both that and experiential knowledge of hypnotic phenomena (Erickson, 1966) into the use of the symptom as an integral part of therapy (Erickson, 1965).

This forms the basis for the 'fixation of attention' in the five-step paradigm for trance induction and therapeutic suggestion, as postulated in *Hypnotic Realities* (Erickson et al., 1976). The effect is such that the patient cannot deny the reality of the therapeutic intervention, hence quickly and effectively establishing rapport, which in turn facilitates the indirect induction of a trance state. The uniqueness of the utilization approach is that it focuses rather than defocuses the patient on the altered state of reality that the drug creates, while binding this feeling of concentration and introspection to the induction of a therapeutic trance state. As a rule this is what differentiates this approach from the more traditional methods of treatment of withdrawal. Rather than focusing the patient's attention on some alternative reality, their attention and concentration are focused on the phenomenological reality of both the

withdrawal symptomology and the recalled euphoric effects of the drug.

Once the induction of an altered state has been achieved through whatever method is best suited to the individual (Erickson, 1961; Erickson and Rossi, 1976), the second step in the paradigm 'depotentiating of conscious sets' is set up by a variety of techniques. These may include such things as 'not doing, and not knowing', confusion, distraction and cognitive overload. Using the addict's reality several images may be brought up: 'Just sitting there like when you were high'.

An 'unconscious search' can be initiated through puns, metaphors, the implied directive, questions and tasks requiring unconscious searches. This turning inward provides the patient with the feeling of autonomy, power and control, while at the same time providing valuable information for the healing process.

Once the unconscious searches are completed, the hypnotic suggestion becomes a process of evoking and utilizing the patient's own mental processes in ways that are outside his or her usual range of ego control. This is the fourth stage of the paradigm. The fifth stage of the paradigm follows in that the successful utilization of unconscious process can lead to an autonomous response: patients are surprised to find themselves confronted with new data or behaviour. It seems to happen all by itself.

In streamlining this paradigm even further Rossi has pruned mind-body healing down to a three-step process. He postulates that the essence of the therapeutic approach lies in what may be called the basic accessing formula. This formula (Rossi, 1986) has three standard parts:

- (1) A time binding introduction that initiates an inner search of state-dependent memory, learning and behaviour systems;
- (2) Accessing and transduction of the state-bound problems and symptoms;
- (3) An observable behavioural response signalling when the process of accessing and therapeutic transduction is complete.

This basic formula can be put to work on the management of withdrawal symptoms for the cocaine-dependent individual.

### **Hypnotherapeutic management**

Staying within the framework of the mind-body healing paradigm previously mentioned, the first, and perhaps most readily accomplished task to achieve is the fixation of attention. This can be done by entering the addict's map of the world and allowing them to express in depth the inner turmoil that they are going through, paying close and painstaking attention to the minute detail – to those things that make them so unique. The second stage or depotentiating of the conscious set may be accomplished through a variety of techniques. With cocaine addicts it is possible to use their resistance in the form of their uniqueness, which causes disequilibrium, and frequently can result with the possibility of a double bind, or trance induction.

Only someone with unique talents, traits etc. would be able to accomplish the achievement of this relaxed (trance) state so quickly.

It is in the third stage that the true work of this type of therapy can be put into place. By initiating and facilitating an unconscious search of the problem and using those symptoms (depression, agitation, anhedonia) and their unique problem-solving abilities the patient can be given the autonomy and control that have been so lacking

during the spiral of their addiction. The crack addict will have a multitude of innovative problem-solving memories from which to draw. They have had to be extremely inventive in the ways that they maintained their addiction, and the ways they dealt with the world in general. Some frequently used metaphors for this stage of mind-body healing include the 'building of calluses on the nerve endings' to reduce agitation, the anaesthetic effect of cocaine producing the same decrease in agitation. The production of a 'pleasant state' to be anchored and reproduced via kinaesthetic anchors as an antidote for depression and anhedonia.

The following case example is offered as a descriptor of one of the many ways a clinician may deal with this unique population. Although this is only one individual, the basic approach remains much the same for all of these clients. Approach them and meet them in their own individual world, join with them, and let them define the method of trance induction and resolution of their complaint.

An African-American male presented at a community-based substance-abuse prevention programme. He was slightly dishevelled and tremulous in the extremities. Both sclera were reddened. He presented with symptoms of depression, hopelessness and helplessness. He denied suicidal ideation and intent. His major complaint was that he could not stop 'hitting the pipe'. He had had several unsuccessful treatment attempts, including a 28-day detoxification and inpatient drug treatment, long-term residential treatment and structured outpatient therapy. He described several unsuccessful attempts at joining and stabilizing in a 12-step environment and in his church.

The client was allowed to describe, in great detail, the routines and rituals surrounding his crack cocaine use. Although this set up a state-dependent memory – a learning and behaviour scenario – possibly increasing the craving at the time, it simultaneously served an all-important function. While describing in detail the rituals, the client's eyes became unfocused and the facial muscles of his cheeks and forehead relaxed and flattened out. This is the basis of the utilization approach (Zeig, 1988) – taking what the patient gives and turning it into a therapeutic opportunity. All of his physiological responses were acknowledged and ratified as an 'altered state'.

The patient had described in his own words, and as a phenomenological reality, the basis of trance – the fixation of attention and the focusing of attention inward – as he described the effects of the cocaine. He described a blending of several states of awareness including cognitive, kinaesthetic and sensory states. He had given the key to the resolution of the cravings. This was how he felt after he had achieved the high. All that was left was to 'reframe' and 'seed' the successful resolution.

The patient described in great detail the feeling of fullness and completeness when he had achieved the high. He framed this in terms of the sensations in his lungs and diaphragm, as well as an internal feeling of completeness and wholeness.

The patient was invited to simply close his eyes, and fully participate in the moment. His behavioural manifestations were fed back to him creating a cybernetic loop, with each piece of information providing another piece to put him deeper in the trance. His own words were fed back to him, to deepen the experience. A simple ideomotor signal was established to signify affirmative and negative.

His words and sensations were used in conjunction with a variant of Torem's age progression technique (Torem, 1992). The client was invited to see himself in the future handling his cravings. He was encouraged to experience himself enjoying the internal feeling of completeness and wholeness, and the sensations of fullness in his lungs. When he had signalled that he had truly made these experiences his own, he was invited via Rossi's general accessing formula to signal when he had brought

something back from the future that would aid him in developing and utilizing this trance state at a time when he might experience the cocaine cravings. This was accomplished and ratified both in the trance and in the wakened state. The patient left in good spirits and with high expectations of his success in the future.

Due to the nature of the agency, no further contact other than phone follow up was expected. Because of the nature of the agency funding, and the population that was dealt with (homeless, destitute and addicted), the keeping of follow-up statistics was not considered a priority. Three-month telephone follow up, if any at all, was the rule rather than the exception. However, about one year after this intervention, the patient presented again at the agency. He requested a 'tune-up with that breathing and finger thing', because he feared relapse to cocaine use. An extensive interview revealed that the client had used self-hypnosis including the projection into the future to access successful problem-solving skills.

## **Conclusion**

The use of clinical hypnosis and indirect suggestion can be beneficial for the management of withdrawal symptoms of those people addicted to cocaine. The use of therapeutic suggestion can accomplish a multitude of tasks. The scenario presented here was an 'end case' where the patient had tried all other alternative forms of available treatment and hypnosis was deemed to be a last resort. This does not have to be the case. Hypnosis can be offered as a standard adjunct to traditional chemical dependency withdrawal and treatment.

The art of using this modality with this particular population lies in the therapist's ability to 'see and hear' with the patient's eyes and ears. The therapist utilizes the world of the crack cocaine addict to the advantage of the therapeutic endeavour, rather than, as is often the case, to deny or vilify the reality of the withdrawal and use patterns.

The primary component of this is the overt management of the withdrawal symptoms in their gross state. Depression, agitation, and anhedonia have all been treated successfully using hypnosis (Yapko, 1989, 1994). As these are also the primary symptoms of withdrawal from cocaine, it would follow that successful drug treatment can be enhanced with the use of hypnosis.

Since hypnosis is a state of focused concentration and inner absorption, one of its most beneficial applications is future rehearsal where the person visualizes themselves performing a certain act or function. The use of future projection can have great value in these cases. The typical crack addict has many innovative problem-solving experiences to draw on. This 'back from the future' technique can be incorporated in many ways including a triphasic picture or movie screen. The screens can symbolize the past, the present and the future.

On another level, the use of hypnosis to manage these symptoms might also facilitate the readjustment of the neurochemical perturbation created by the continued use of cocaine. This is a hypothesis that has yet to be verified in a clinical, methodical fashion. This concept presents a host of research opportunities and research problems.

Some of the major research problems that plague the use of hypnosis with this population lie in the inherent nature of an Ericksonian approach. By its very nature it is individualized to the patient's unique needs. The nature and type of intervention will depend on how the patient presents his or her phenomenological representation of the addiction and possible recovery.

Other difficulties lie in the population itself. The relapse rate for crack cocaine is almost unquantifiable in its magnitude. The nature of the chemical disruption to the

brain is such that the patient frequently, if erroneously, sees no other way out of their dilemma.

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