

Smoking Cessation and Hypnosis

A comparative review of the effectiveness of hypnosis, an advanced method of hypnosis, and other interventions used for the cessation of smoking

Prepared for Stop Smoking in One Hour™
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1. Introduction

This paper presents the findings from a study looking at all methods of smoking cessation, including standard hypnotherapy techniques and compares those to a specially developed advanced method of hypnotherapy for smoking cessation; quit rates are compared; some tentative conclusions are suggested.

What's the problem?: Smoking—the biggest cause of preventable death in the developed world

It is estimated that there are 1.1 billion smokers worldwide and that smoking-related illness costs the NHS £400m and kills 111,000¹ people a year in the UK. In view of the human and financial costs of tobacco smoking it is not surprising that there is large demand from individuals and from governments for products or techniques which may help the cessation of smoking. The market for nicotine replacement products alone is estimated at \$1bn dollars annually and £80m per year in the UK.

¹ New Scientist, February 1993

2. Hypnosis and other interventions for smoking cessation

Effectiveness of hypnotherapy in bringing about smoking cessation compared to other methods

High quit rates for hypnosis compared to other methods

A larger meta-analysis of research into hypnosis to aid smoking cessation (Chockalingam and Schmidt 1992) (48 studies, 6,020 subjects) found that the average quit rate for those using hypnosis was 36%, making hypnosis the most effective method found in this review with the exception of a program which encouraged pulmonary and cardiac patients to quit smoking using advice from their doctor (such subjects are obviously atypical as they have life-threatening illnesses which are aggravated by smoking and therefore these people have very strong incentives to quit).

	% who quit smoking	no. of subjects	no. of trials
Advice (cardiac patients)	42	4553	34
Hypnosis	36	6020	48
Miscellaneous	35	1400	10
Advice (pulmonary patients)	34	1661	17
Smoke aversion	31	2557	103
Group withdrawal clinics	30	11580	46
Acupuncture	30	2992	19
Instructional methods in workplace	30	976	13
Other aversive techniques	27	3926	178
5 day plans	26	7828	25
Educational (health promotion initiatives)	24	3352	27
Medication	18	6810	29
Physician interventions (more)	18	3486	16
Nicotine chewing gum	16	4866	40
Self-care (self-help)	15	3585	24
Physician advice	7	7190	17

Table 1: Effectiveness of different types of intervention to achieve smoking cessation adapted from data in Chockalingam and Schmidt (1992)

Law and Tang (1995) looked at 10 randomized trials, carried out between 1975 and 1988, of hypnosis in smoking cessation. They found that the effect of hypnosis was highly statistically significant². The research they examined involved 646 subjects and cessation rates at 6 months post-treatment ranged from 10% to 38% (the average figure was 24%).

Type of intervention	% who quit	no. of subjects	no. of trials
Supportive group session (heart attack survivors)	36	223	1
Hypnosis	24	646	10
Supportive group session (healthy men in high risk for heart attack group)	21	13205	4
Nicotine patch (self-referral)	13	2020	10
Nicotine gum (self-referral)	11	3460	13
Supportive group session (in pregnancy)	8	4738	10
Advice from GP (additional sessions)	5	6466	10
Gradual reduction in smoking	5	630	8
Nicotine patch (GP initiated treatment)	4	2597	4
Nicotine gum (GP initiated treatment)	3	7146	15
Acupuncture	3	2759	8
Advice from GP (one-off)	2	14438	17
Supportive group session	2	2059	8
Advice from nurses in health promotion clinics	1	3369	2

Table 2: Effectiveness of different types of intervention to achieve smoking cessation (adapted from data in Law and Tang 1995)

Table 2 (above) shows that the meta-analysis of Law and Tang confirms, to a large extent, the meta-analysis of Chockalingam and Schmidt (1992); in both cases hypnosis appears as the most effective form of intervention to achieve smoking cessation with the exception of groups who are highly motivated to quit for medical reasons, such as those with existing heart or pulmonary problems.

A more recent study, by Ahijevych et al (2000), produces a similar overall figure for the success of hypnosis. This study looked at a randomly selected sample of 2,810 smokers who participated in single-session, group hypnotherapy smoking cessation programs sponsored by the American Lung Association of Ohio. A randomly selected sample of 452 participants completed telephone interviews 5 to 15 months after attending a treatment session. 22% percent of participants reported not smoking during the month prior to the interview.

² Combined results were statistically significant at the .001 level, meaning that there is less than a one in a thousand chance that these results happened by chance.

Other interventions for smoking cessation

(1) Nicotine replacement therapy

Although this can consist of gum, spray, tablets or patches, the latter are by far the most popular form of nicotine replacement. Nicotine replacement patches became available over the counter (without prescription) in the UK in November 1992, and became free (the user only pays the prescription charge) to smokers in 2001, on condition that the smoker's GP consider this form of therapy advisable. In effect this means that the UK government has subsidized the use of nicotine replacement therapy, in the hope of offsetting the huge annual costs of smoking-related diseases to the NHS. There is a growing discussion about whether nicotine replacement therapy is an effective way of encouraging smoking cessation.

The New Scientist (editorial comment: vol 137 issue 1860 Feb 93, p.3) points out that in the U.S. patches are perceived as merely one component of a quitting program- manufacturers of NRT are in fact expressly forbidden to suggest that their products can alone be a successful means to quitting smoking - no such regulation exists in the UK as yet leading to what some people might feel is a misconception that patches alone can result in successful cessation of smoking.

The evidence on the efficacy of NRT, considered alone, is fairly clear; it is better than quitting without any form of intervention and support but only to a limited extent in absolute terms (e.g. Hughes 1993). The meta-review of smoking cessation interventions referred to previously (Law 1995) found that, for subjects³ who were recommended nicotine gum or patches by their GP, without prior request from the subject for advice on giving up smoking, the quit rates were 3% for gum and 4% for patches. Quit rates for self-referred smokers (i.e. those specifically consulting their GP for advice on giving up smoking) were considerable higher at 11% (gum) and 13% (patches). The quit rates using gum or patches, even amongst those who have specifically come forward seeking help in quitting, are many times lower than the quit rates which were found for hypnotherapy in the same review, and are in fact amongst the least successful of all the smoking cessation interventions which were reviewed. Tang et al (1994) claim that with higher doses of nicotine replacement and more careful targeting of subjects based on their current level of dependence, it may be possible to achieve a quit rate of one-third amongst self-referred smokers.

Chockalingam and Schmidt (1992) found an average quit rate of 16% for the 4,866 subjects in 40 studies which looked at the efficacy of nicotine gum. This equates to less than half the average quit rate achieved using hypnosis (36%), which they found in the same review (referred to earlier).

Davidson et al (1998) (in a study carried out after the two meta-analyses discussed above) evaluated the efficacy and safety of nicotine patches in an over-the-counter setting. They used a multi-site, double-blind, randomized, placebo-controlled design in a trial of 6-week duration with 18 weeks of follow-up.

³ GP-initiated treatment was examined in 7146 subjects in 15 studies (gum) and 2597 subjects in 4 studies (patch); 3460 subjects in 13 studies (gum) and 2020 subjects in 10 studies who referred themselves for advice were examined.

The randomized sample consisted of 802 adults (mean age, 39 years) and was 89% white and 54% female. A smoking history of at least 20 cigarettes per day for 1 year and a score of 5 (on a 10-point scale) on a motivational assessment questionnaire were required for enrolment. Post study follow-up was limited to those who had quit smoking at the end of 6 weeks. Nicotine patches were provided at the shopping mall. Guidance consisted only of package instructions and a smoking cessation self-help booklet. Quit rates were defined as total abstinence from smoking for 4 consecutive weeks (treatment weeks 3-6), post prevalence smoking status at week 6, or non-smoker at week 6 and week 24 (6-month post quit date). Smoking status was assessed by diaries, and verification for the first 2 quit rates was obtained by confirmation of carbon monoxide of 8 ppm⁴ or less in expired breath. Safety was evaluated by self-reported adverse events.

At 24 weeks, 8.2% of non-smokers in the active treatment group and 4.0% in the placebo group remained non-smokers. The authors conclude that '...the nicotine patch was used in an over-the-counter setting, quit rates were comparable to those reported for medical settings. A 2:1 quit rate advantage was achieved at week 6 and was maintained at 24 weeks. This 8% quit rate is in the range found in the studies already mentioned, and is far from impressive.

It may be that, as Cepeda-Benito (1993) suggests, following a meta-analysis of 33 studies using nicotine gum in different combinations with cognitive and behavior therapy, that the real advantages of nicotine replacement is as an aid to other methods of smoking cessation, rather than as a 'stand-alone' treatment.

Before looking at the comparative merits of different smoking cessation strategies let us attempt to make a comprehensive lists of these strategies.

(2) Non-nicotine Pharmacological Treatments

There are other pharmacological treatments available for smoking cessation, apart from nicotine, which basically work thorough replacement, blockade, withdrawal relief or making intake aversive' (see Hughes 1993:751). Law and Tang (1995) reviewed 10 trials of clonidine hydrochloride (which acts to reduce the acuteness of withdrawal symptoms in a range of drugs) and found that the average quit rate for the 1082 subjects included in these trials was 10%. If trials which did not use biochemical markers are excluded the quit rates declines to 7%. The same authors reviewed 4 trials (687 subjects) using silver acetate gum or spray (which creates an unpleasant taste in the mouth when it reacts with compounds of nicotine). The quit rate using this technique was 4%. Chockalingam & Schmidt (1992) found that 18% of subjects (from 29 studies involving 6,810 subjects) quit smoking.

Zyban is a drug which has recently come onto the market in the UK; Jorenby et al (1999) found quit rates of around 18% with Zyban, and 22.5% with Zyban and a nicotine patch combined. Some researchers have argued that there are issues to do with side-effects from Zyban which have yet to be resolved.

⁴ Parts per million

(3) Intervention by health practitioners

Smoking cessation interventions by GPs, nurses and dentists have been cited in the research; these vary widely in nature, duration and effectiveness and may involve in-patient or out-patient subjects. There is no standardization in terms of the type of intervention made, making it difficult to compare results across studies. The Department of Public Health & Policy (1992:4) states that:

'...brief advice in one study may be defined as the usual anti-smoking advice given by the doctor, which will obviously vary between doctors, whereas in another study, the doctors are asked to follow a definite protocol. Interventions are frequently combined so it is not possible to assess the relative effectiveness of different components.'

Richmond et al (1986) shows a quit rate of 35% following detailed advice and for follow up meetings between the smoker and the GP, however most studies give much lower figures. Law and Tang (1995), in a review of 27 trials involving over 20,000 subjects found that between 2% and 5% of smokers had quit at 6 months after receiving advice. In summary it can be said that interventions from GPs, nurses or dentists, in whatever permutation, may have a positive effect but it is an approach which is likely to be effective only for a minority of the smoking population.

(4) 'Self-help' Interventions

These may take the form of self-help manuals, or other written or audio materials, which the would-be quitter can use in a time and a place that suits them. They have the potential advantage of being extremely cheap to produce and distribute (particularly, for example, via the internet). There is some evidence of a demand for aids to cessation which are less intensive and can be controlled by the user in terms of where and when they take place (Fiore et al 1990)⁵. Curry (1993) carried out a meta-review of 19 studies in this area and finds that long-term cessation (i.e. those not smoking 12 months after treatment) was as high as 38% in one case, although the vast mass majority of outcomes were between 2% and 10%. Chockalingam & Schmidt (1992) looked at 24 studies (involving 3,585 subjects) and found that the average quit rate for what they term 'self-care' programs was 15%.

(5) Acupuncture

Chockalingam & Schmidt (1992) examined 19 studies (involving 2,992 subjects) and found an average quit rate of 30%. This contrasts sharply with the review of 8 trials (2,759 subjects) carried out by Law and Tang (1995) who found an average quit rate of only 3%. It is likely that the true efficacy of acupuncture lies somewhere between these two findings

⁵ Curry, p. 790

(6) Other Methods of Facilitating Smoking Cessation

There are other strategies which have been employed by governmental or health bodies to try and reduce smoking, including control of advertising and sponsorship, anti-smoking advertising campaigns and high levels of taxation on cigarettes. These are not dealt with in this report as the intention is to briefly compare the options which are available to the individual seeking to stop smoking nicotine products.

Other Methods—Summary

The meta-analysis by Law and Tang shows that most forms of smoking cessation intervention achieved quit rates of less than 10%. The two large reviews of research (meta-analysis) give smoking quit rates for hypnosis of between 10% and 60%, with a crude average for both reviews of 30%. An average 'success rate' of just under a third may not sound particularly impressive **but it must be borne in mind that this is extremely high compared to many other methods of facilitating smoking cessation.**

3. Tailored' Hypnosis—Taking it to the Next Level

The results discussed so far indicate that when the bulk of random trials are considered hypnosis is shown to be the most effective intervention for achieving smoking cessation. Yet this is only half the story - many of the trials discussed so far have used very brief sessions, using standardized hypnosis techniques, many have in fact taken place in group sessions (making it difficult to tailor to each individual's needs) and have not necessarily been carried out by expert practitioners of hypnosis. If, under these circumstances, hypnosis can achieve such positive outcomes in terms of enabling smokers to quit, then what might be achieved using programs of hypnosis which are carried out by expert hypnotists and are tailored to the needs of the individual who wants to stop smoking?

Nuland and Field (1970) found **an improvement rate of 60% in treating smokers with hypnosis**. The increased effectiveness was achieved by a more personalized approach, including feedback (under hypnosis) of the client's own personal reasons for quitting. These researchers also employed a technique of having the client maintain contact by telephone between treatments and utilized self-hypnosis in addition.

Hall and Crasilneck (1970) developed a 'tailored' approach over a number of years. They had been looking for a way in which hypnosis could be used as a means of controlling the habit of cigarette smoking without excessive frustration, craving for tobacco, and also without substituting some other habit (such as over-eating). They also wished to find a treatment that was effective in terms of time and money so that it could be used with the maximum number of people.

Hall and Crasilneck used their technique on a series of 75 consecutively treated adult male cigarette smokers, most of whom had been referred by physicians, because their cigarette smoking was complicating some medical problem. Diagnosis included coronary artery disease, chronic bronchitis, asthma, and Buerger's disease, although the most frequent medical problem was emphysema.

Their technique, based on trials of various formats over a period of years, consisted of a screening interview for each patient, during which the personality structure was investigated. A determination was made as to whether the use of tobacco was serving a major neurotic need. Those who were found to have extremely severe depression and those who had psychotic problems, especially if they were of a paranoid nature, were usually excluded. During the screening they answered any questions that the patient had about the nature of hypnosis. An attempt was made to minimize any unrealistic anxieties concerning trance induction. All patients were told that they could later be seen for psychotherapy should there be other problems besides smoking. Every attempt was made to encourage the patient to feel free to communicate any discomfort or disturbance, either during the time of treatment or afterward. Hall and Crasilneck felt that this greatly decreased the danger of significant substitute symptoms.

Following the screening interview, patients were then seen for four hypnotic sessions. The depth of hypnosis gradually increased with the repeated inductions, even though depth of trance did not necessarily correlate with effectiveness of treatment.

Suggestions included:

"You will not crave excessively for a habit negatively affecting your health..."

'Your mind can block the perception of discomfort, as when your finger felt insensitive to the pressure of the sharp nail file ... Your mind *will* function in such a manner that you *will* no longer crave for a habit that has negatively affected your life with every drag of cigarette smoke you have taken into your lungs. . . *You will* block the craving for tobacco ... a habit that is causing your heart and *your* lungs to work much harder than necessary, forcing your lungs to labor beyond all necessity, stressing and straining these vital organs . . . like a car constantly driven in *low* gear. . . constantly laboring uphill . . . stressing and straining the motor. . . But because of the great control of your unconscious mind, the craving for this *vicious* and lethal habit *will* grow steadily and markedly less until it rapidly reaches a permanent zero level. . . You simply *will* not crave for cigarettes again. . . . *You will be* relaxed and at ease, pleased that you are giving *up a habit* which has such a negative effect upon your life and well-being. . . You are improving your life by giving *up* cigarettes and *you will* continue to do so... *You w/y/not* smoke cigarettes again. . . *You will* not be hungry or eat excessively . . . your craving *will* reach a permanent zero level."

After each use of hypnosis the patient was encouraged to discuss unusual dreams, thoughts, or feelings that he might have experienced.

The first three hypnotic sessions were given on consecutive days. Between the third session and the fourth, which was scheduled one month later, the patient was instructed to call the office daily for the first week, twice the second week, and then once a week until the fourth induction of hypnosis. In some cases, where reinforcement was deemed very important, the patient was asked to call daily for the entire month. The patient was told that each call would reinforce the posthypnotic suggestion and increase his resistance to smoking. This telephone report was usually given to a secretary, though they talked to the patient directly if there was some unusual difficulty. They requested that each patient walk at least one mile each day as a means of decreasing tension and improving pulmonary ventilation. If the patient wished, other forms of exercise might be substituted. Each patient returned one month after the third induction for their last hypnotic session.

A questionnaire was sent to the 75 patients to determine if they were still non-smokers. All subjects who received the questionnaire had gone at least one year beyond their last visit, although the range between the last hypnotic session and the time of sampling varied between one and four years, with a mean of 26 months. In addition to the structured questionnaire, spontaneous comments were solicited; anonymity was suggested if it would permit the respondent to be more frank

Of the 75 questionnaires sent, 67 were returned, an 89% response rate. Of those responding, **82% had not smoked cigarettes at all since the fourth reinforcement session.** Of these, 78% had not substituted any 'oral habit'. Of those who had substituted, however, no substitute seemed as serious as the previous habit of cigarettes. Several who substituted indicated that they now smoked cigars or a pipe or had begun to chew gum regularly. The cigar smokers uniformly claimed not to inhale smoke.

Of the total group, 64% were no longer smoking, nor substituting any other oral habit. Some 18%, however, had continued smoking at the pre-treatment rate. The remaining 18% were not smoking cigarettes; they had substituted another oral habit, usually of the comparatively innocuous type previously mentioned.

Prior to treatment these men had smoked cigarettes for a mean time of 27 years, with an average consumption of forty cigarettes per day. Over 90% had made major previous efforts to stop smoking, but their average length of abstinence before treatment was only one week. Of those who successfully discontinued smoking, only 3% felt that they still had a definite craving for tobacco, although 14% had an occasional desire; 83% felt that they had no further desire for tobacco.

Since many patients had feared that giving up smoking would lead to overeating and weight gain, it was encouraging to find that the average weight gain had been only four pounds. This may have been the result of including an explanation in the waking state that when smoking was stopped, food would begin to taste better. The patients were cautioned that this improved taste might tempt them to eat more. Instead, it was proposed that in both the hypnotic and the waking states they eat the same amount of food as before but enjoy more thoroughly the improved taste.

Those who had resumed smoking and were considered treatment failures had usually gone back to cigarettes following some traumatic incident involving frustration or anger. None reported that they later had quit smoking once they had spontaneously resumed the habit. None of the questionnaires indicated any psychological disturbance, in either the structured questions or the free-response comments. Most comments were of appreciation, were void of hostility, and seemed to emphasize a sense of pride and self-esteem at having accomplished a worthwhile goal.

Kline (1970) examined the use of extended group hypnotherapy for aiding smoking cessation. He conceptualized smoking as a dependence reaction, similar to drug addiction in structure. In one of his therapy groups polygraph recordings were taken as well as recordings of upper thoracic respiratory excursions. Before treatment (smoking) tracings were slower and more regular and lower in amplitude than after the patients had refrained from smoking for 12 hours prior to hypnotic treatment, at which time the tracings were slower, wider in amplitude, and more erratic. After the group treatment using hypnosis, tracings were again as calm as in the pretreatment recordings, though the patients were now not smoking. Kline concluded that the hypnotic treatment objectively helped to decrease the discomfort associated with withdrawal from smoking. Kline reported that a 12-hour group therapy session, utilizing hypnosis and other techniques, **was successful in controlling smoking in 88% of those treated.**

Von Dedenroth (1968) devised an innovative unique approach which appears to have been extremely successful. He began by inquiring how long the individual had smoked, whether they recalled why they had begun, whether they had ever tried to stop smoking, why they wanted to stop smoking at this particular point in time, what benefit, if any, they felt that they derived from smoking, at what specific times they felt the need most strongly (after meals, before breakfast etc.), and finally he asked them how many cigarettes they smoked. Von Dedenroth believed that answering these questions not only tended to increase rapport but also revealed, at least in part, the smoker's own feelings regarding his smoking and his reasons for wanting to give up the habit. The therapy proper did not begin until the second session, and at this time the smoker was told that 'Q Day' or 'Quitting Day' would be 21 days from that point. The smoker was also told to change his favorite brand of cigarettes and resolve to never smoke that brand again. The smoker is then told that they are not to smoke at all:

1. Before breakfast.
2. For one half-hour after each meal

3. For 30 minutes before retiring

The smoker was told that, at the times mentioned above, he was to get into the habit of going to the bath-room, gargling with mouthwash and cleaning his teeth. He should have a glass of fruit juice upon awakening and he was told to notice the fresh feeling in his mouth in the morning and following each of these routines. After his breakfast, he was to clean his teeth again and use the mouthwash, paying close attention to the clean feeling in his mouth. Thirty minutes later he was allowed to have a cigarette, but not before. This tended to break the association between the taste of food and the inevitable cigarette that usually followed a meal. He was also told to get a small notebook to carry with him, and to write down, from time to time, his reasons for giving up smoking (physical, financial and personal). Then a trance state was induced and the above suggestions, given in the waking state, were repeated and consequently greatly reinforced. Following the trance, the patient was encouraged to ask questions, and the next appointment arranged.

The third session occurred around one week later (and a week before 'Q' day) - in this session the smoker was told that they should not drink alcohol at all, or at least to drink alcohol only with meals, with the intention of breaking the association between alcohol and smoking. A trance state is again induced and all the previous instructions reinforced. It is also suggested that smoking will no longer be enjoyable. In particular the smoker was told that the first puff of a cigarette may be enjoyable, the second less enjoyable, and the third may possibly irritate the nose, throat or chest. The aim of this is that by the time 'Q Day' arrives the smoker may only be taking a few puffs of each cigarette a day; as the number of cigarettes smoked, and the amount of each of those cigarettes smoked, has declined, then it should be less painful for the individual to quit.

Von Dedenroth believed that the fact that the individual is able to reduce and stop smoking (with the aid of hypnosis) gives the individual a great feeling of self-accomplishment. 'Q day' begins with the induction of a trance state and it is emphasized continually to the smoker that bad habits have been replaced by good ones, and that for several weeks cigarettes have become more and more unpleasant.

The study by Von Dedenroth, described above, has the highest quoted success rate for hypnosis in achieving smoking cessation which has been reported in the literature to date; ***Von Dedenroth found that his use of hypnosis enabled 94% of 1000 subjects to stop smoking (when checked at 18 months).***

In the next section a study carried out in 2000, involving the use of hypnosis to aid smoking cessation, is examined. The findings presented here, of the study carried out by Stop Smoking in One Hour™, show that the standard therapy they used and what they have termed 'advanced therapy' both have success rates considerably above what has been reported in the literature to date.

4. Stop Smoking in One Hour™ Study (2000)

This research was carried out on 300 subjects (beginning in January 2000 and continuing until March 2002)⁶ who responded to an advertisement. A 'blind trial' technique was used - subjects were not aware that they were taking part in a research project although they all ticked a box on their intake forms saying that they understood that the hypnotist's methods were always being measured tested and improved, and that results would be collated and studied. Client confidentiality was assured so that their data could be used but not their names and these subjects were randomly allocated to receive either 'standard' hypnotherapy or a special formulation of hypnotherapy which Stop Smoking in One Hour™ has termed 'advanced therapy'. 51% of respondents were male and 49% female; the median age of all subjects was 44 years.

No respondents had previous experience of hypnosis - 51% of subjects had tried nicotine patches, 14% had tried nicotine gum, 7% had tried acupuncture, 6% had tried using a nicotine inhaler and 30% had previously tried to quit using will-power alone. 11% of subjects had not previously tried to quit smoking.

For all subjects:

The client was interviewed to make sure that they wanted to stop smoking for their own reasons, and were not being pressured into it by someone else (doctor, loved one etc.).

The price was kept high (£250) to establish commitment, and to avoid people who were casually or speculatively trying hypnosis (as opposed to those who have some commitment, confidence or belief that hypnosis would help them to stop smoking).

All subjects waited a minimum of three weeks for an appointment in order to build expectancy - subjects were already thinking about, and planning being, a non-smoker for weeks before the treatment began.

Before the actual hypnosis, the client (or subject) is asked a series of questions about their smoking habit and their beliefs. This allows the hypnotherapist and the client to build rapport and also lets the hypnotherapist become aware of any thought patterns based on myths or misconceptions that need to be cleared up before the hypnosis. They are asked, for example:

'Do you believe you are addicted to nicotine?'

'What fears do you have about stopping?'

'What do you know about hypnosis?'

Hypnosis was then fully explained to the client, as well as how the conscious and the unconscious mind works, and any myths debunked (such as, you cannot make someone do something they don't want to do, hypnosis is not sleep or unconsciousness, you will be aware of everything that is going on and will remember everything that happened in hypnosis after the session, you can stop the session at any time, etc.). This is called the "pre-talk".

⁶ These clients were seen by Dr. Barry Neale, Ph.D. in his practice, The Accelerated Change Centre (UK).

A hypnotic contract is then entered into, in which the client agrees to go along with all techniques and to accept all the suggestions that are for their benefit.

For subjects treated with the standard technique:

The client then reclines in the chair, and a basic stop smoking script is read. This type of standard technique doesn't allow for much in the way of personalizing a session, as it is the same for every client. The wording of some of the best basic techniques uses hypnotic language patterns (Neuro Linguistic Programming). The client is then emerged.

For subjects treated with the advanced technique:

Hypnosis is induced using a progressive test induction tailored to the client. Ideo motor techniques are used to gain unconscious communication. The client's own motivations, Meta programs, and values are utilized in the session using a combination of metaphor and suggestion. NLP sub-modality and anchoring techniques are used according to the client's processing style. At the end of the session, the client is emerged from hypnosis and the change is tested, then future paced and ratified.

Findings

Quit rates were established through telephone interviews 1 month and 6 months after the first session of treatment.

After 1 session 95% of those who received 'advanced therapy' had quit smoking.

The remaining 5% received a second session of treatment leading to a further 1.3% of the group quitting smoking. In total therefore, at 6 months, 97% of those who received 'advanced therapy' had quit smoking.

Of those who received 'standard therapy' 51% quit smoking after one session and a further 6% quit after a second session—a total of 57% had quit smoking at 6 months.

Those who were still smoking at 6 months did not differ from those who had successfully quit in terms of gender, age or therapies previously tried. These results mean that for both standard treatments and the 'advanced treatment' quit rates are extraordinarily high and well above what has hitherto been reported in the literature. Results for both treatments were significant at the 0.001 level (chi-square).

Outcomes for the 'advanced therapy' are considerably higher than any findings previously reported in the literature. In addition, the success rate achieved using the standard technique was considerably higher than expected and this may be due to the fact that the elements that the standard treatment and 'advanced treatment' have in common (price, waiting period for the session, advertising exposure, and pre-talk etc.) have powerful effects on outcomes.

5. Conclusions

As the evidence which has been presented demonstrates, hypnosis would seem to be one of the most effective methods in aiding smoking cessation (and arguably the most effective). The study carried out by Stop Smoking in One Hour™ achieved quit rates very close to 100% and indicated what can be achieved with hypnosis when it is appropriately tailored to the individual seeking help to quit smoking.

Given the apparent superiority of hypnosis as a smoking cessation intervention it is worth considering why hypnosis is not more widely used and, in particular, why the NHS and its international equivalents have not attempted to promote or subsidize hypnotherapy to any significant degree. Some of the possible reasons for this are examined below.

There are a variety of methodological issues in relation to many smoking cessation studies and these are not restricted to those studies looking at the use of hypnosis. Cepeda-Benito (1993:827) says that:

'...a serious problem with the studies reviewed was the overall lack of consistency across research teams regarding what and how variables were measured. This was mainly manifested in the description of the subjects' characteristics and smoking histories, the great diversity of cutoff values used to validate abstinence within each of the biochemical verification methods, the various definitions of abstinence, and the specificity with which the experimental procedures were described'.

The Department of Public Health & Policy (1992:2) point out that:

'Studies of smoking cessation interventions have traditionally been plagued by inadequate sample sizes. In order to detect clinically meaningful differences in outcome between intervention and control groups, and therefore attribute cessation rates to the intervention rather than other factors, a minimum of 100 subjects per group is needed'.

Further methodological problems of smoking cessation studies are outlined by Chockalingam and Schmidt (1993) and Berglund et al (1974) who draw attention to the problem of non-response during the follow-up to studies. Most of the primary studies are based on participants who reply to follow-up calls or questionnaires - it may be that these people disproportionately represent the successful quitters, which would result in a response bias. It is quite possible that there may be a social desirability effect pertaining to people who are simply asked if they have refrained from smoking over a given period - they may want to give the answer which they perceive the interviewer would like them to give. Chockalingam and Schmidt suggest countering this through comparing the quit rates of the experimental and control groups (rather than just quoting the quit rate of the experimental group). Response bias can be countered by assuming that those not contacted have in fact started smoking again (this is basically a way of erring on the side of caution).

However, the only way to be sure about whether or not individuals have given up smoking is through the use of blood tests. Lando (1989) found that in studies using self-reports of cessation, 25-28% of subjects who had claimed to have stopped smoking are in fact found to be smoking when their smoking status is validated using biochemical tests.'

In some, if not all studies of smoking cessation through hypnosis, there is no use of biochemical markers (blood tests) in follow-up. This may be because such studies are conducted by people who haven't been trained in a classical 'medical paradigm'. Nonetheless, if comparisons of hypnosis and other methods are to be valid then there needs to be standardization of methods and procedures.

There was great variability in the range of results from the meta-analysis carried out by Chockalingam (1992) and that carried out by Law (1995). This confirms the points made earlier in this paper about the difference between a 'bespoke' program of hypnosis and very general hypnotic procedures carried out under less than ideal conditions. In other words it may be that even 'basic' hypnotic techniques are very effective in helping people to quit smoking but that the real power of hypnosis can only be released in the hands of skilled practitioners who are sensitive to the needs of their clients. Research is obviously required to isolate those techniques and procedures that are particularly effective.

It is worth noting that sections of what might be termed the 'western medical establishment' is biased towards 'medical' treatments and against 'alternative' therapies (which is how many would see hypnosis). Although there is some progress in changing old prejudices against non-pharmacological interventions there is still much conservatism in this area.

One other factor may be that, although it would seem that hypnosis has a higher rate of effectiveness in achieving smoking cessation than other types of intervention, this does not mean that there will necessarily be a high take up of hypnosis amongst the public, even if it were to be subsidized or made free. Unlike a nicotine patch, hypnosis does require a certain amount of commitment from participants and it is certainly the case that many people still associate hypnosis with being out of control or somehow making themselves vulnerable.

If hypnosis is to be adopted as a 'mainstream' treatment for smoking cessation then it will be necessary at some stage for hypnosis to prove itself within the medical paradigm of the health establishment in the UK and elsewhere. This could best be done by large randomized clinical trials and, crucially, these trials should adopt a methodology of confirming smoking cessation through the use of biochemical markers (i.e. blood tests) as this is one of the most frequently raised challenges to the high rates of success which appear to pertain in relation to hypnotherapy for smoking cessation.

Finally, it is worth bearing in mind that individuals have different needs and desires in terms of the smoking cessation therapy which is suitable for them. Shiffman (1993: 719) argues that, 'The era of the single-approach program is over. Smoking cessation has come to be dominated by multi-component, all-inclusive programs that combine elements of many approaches.' It is perhaps time that hypnosis moved from being considered an alternative therapy to being used as a key part of a national smoking cessation program.

6. References/Bibliography

1. Public health focus: effectiveness of smoking-control strategies-United States (1992). MMWR Morb.Mortal.Wkly.Rep.. 41. 645-7, 653.
2. Abbot, N. C, Stead, L. F., White, A. R., Barnes, J., & Ernst, E. (2000). Hypnotherapy for Smoking Cessation. Cochrane. Data base. Syst. Rev. CD001008.
3. Agee, L. L. (1983). Treatment procedures using hypnosis in smoking cessation programs: a review of the literature. J.Am.Soc.Psychosom.Dent.Med., 30, 111-126.
4. Ahijevych, K., Yerardi, R., & Nedilsky, N. (2000). Descriptive outcomes of the American Lung Association of Ohio hypnotherapy smoking cessation program. Int.J.Clin.Exp.HvDn.. 48. 374-387.
5. Baer, L., Carey, R. J., Jr., & Meminger, S. R. (1986). Hypnosis for smoking cessation: a clinical follow-up. Int.J.Psychosom., 33, 13-16.
6. Barber, J. (2001). Freedom from smoking: integrating hypnotic methods and rapid smoking to facilitate smoking cessation. Int.J.Clin.Exp.Hypn., 49, 257-266.
7. Bayot, A., Capafons, A., & Cardena, E. (1997). Emotional self-regulation therapy: a new and efficacious treatment for smoking. Am.J.Clin.Hypn., 40, 146-156.
8. Bello, S. (1991). [Treatment of smoking]. Rev.Med.Chil.. 119, 701-708.
9. Bjornson, W., Rand, C., Connett, J. E., Lindgren, P., Nides, M., Pope, F., Buist, A. S., Hoppe-Ryan, C., & O'Hara, P. (1995). Gender differences in smoking

- cessation after 3 years in the Lung Health Study. Am.J.Public Health, 85, 223-230.
10. Brian, R. K. (1992). Hypnosis. J.R.Soc.Health. 112. 312.
 11. Byrne, D. G. & Whyte, H. M. (1987). The efficacy of community-based smoking cessation strategies: a long-term follow-up study. IntJ.Addict., 22, 791-801.
 12. Capafons, A. & Amigo, S. (1995). Emotional self-regulation therapy for smoking reduction: description and initial empirical data. Int.J.Clin.Exp.Hypn., 43, 7-19.
 13. Cepeda-Benito, A. (1993). Meta-analytical review of the efficacy of Nicotine Chewing Gum in Smoking Treatment Programs. Journal of Consulting and Clinical Psychology. 61. 822-830.
 14. Covino, N. A. & Bottari, M. (2001). Hypnosis, behavioral theory, and smoking cessation. J.Dent.Educ.. 65. 340-347.
 15. Crasilneck, H. B. & Hall, J. A. (1968). The use of hypnosis in controlling cigarette smoking. South.Med.J.. 61. 999-1002.
 16. Crasilneck, H. B. (1990). Hypnotic techniques for smoking control and psychogenic impotence. AmJ.Clin.Hypn., 32. 147-153.
 17. Curry, S. J. (1993). Self-Help Interventions for Smoking Cessation. Journal of Consulting and Clinical Psychology. 61. 790-803.
 18. Department of Public Health & Policy (UK) (1992). Smoking Cessation Interventions. (PHP Departmental Publication ed.) (Vols. 6; 1992).

19. Dick, B. O. (1993). Hypnotism curse or cure-October 1992. J.R.Soc.Health. 113, 50.
20. Durcan, M. J., White, J., Jorenby, D. E., Fiore, M. C., Rennard, S. I., Leischow, S. 1, Nides, M. A., Ascher, J. A., & Johnston, J. A. (2002). Impact of prior nicotine replacement therapy on smoking cessation efficacy. Am J. Health Behav., 26, 213-220.
21. Frank, R. G., Umlauf, R. L, Wonderlich, S. A., & Ashkanazi, G. S. (1986). Hypnosis and behavioral treatment in a worksite smoking cessation program. Addict.Behav., 11, 59-62.
22. Frederick, C. & McNeal, S. (1993). From strength to strength: "inner strength" with immature ego states. AmJ.Clin.Hypn., 35, 250-256.
23. Gonzales, D. H., Nides, M. A., Ferry, L. H., Kustra, R. P., Jamerson, B. D., Segall, N., Herrero, L. A., Krishen, A., Sweeney, A., Buaron, K., & Metz, A. (2001). Bupropion SR as an aid to smoking cessation in smokers treated previously with bupropion: a randomized placebo-controlled study. Clin.Pharmacol.Ther. 69, 438-444.
24. German, A. (1992). Another perspective on hypnotism. J.R.Soc.Health, 112, 312.
25. Gravitz, M. A. (1988). Early uses of hypnosis in smoking cessation and dietary management: a historical note. AmJ.Clin.Hypn., 31, 68-69.
26. Green, J. P. & Lynn, S. J. (2000). Hypnosis and suggestion-based approaches to smoking cessation: an examination of the evidence. Int.J.Clin.Exp.Hypn., 48, 195-224.

27. Hall, J. A. & Crasilneck, H. B. (1970). Development of a hypnotic technique for treating chronic cigarette smoking. Int.J.Clin.Exp.Hypn., 18, 283-289.
28. Hall, J. A. & Crasilneck, H. B. (1978). Hypnosis. JAMA. 239, 760-761.
29. Haustein, K. O. (2000). Pharmacotherapy of nicotine dependence. Int.J.Clin.Pharmacol.Ther. 38, 273-290.
30. Haxby, D. G. (1995). Treatment of nicotine dependence. AmJ.Health Syst.Pharm., 52* 265-281.
31. Hays, J. T., Croghan, I. T., Schroeder, D. R., Offord, K. P., Hurt, R. D., Wolter, T. D., Nides, M. A., & Davidson, M. (1999). Over-the-counter nicotine patch therapy for smoking cessation: results from randomized, double-blind, placebo-controlled, and open label trials. Am.J.Public Health, 89, 1701-1707.
32. Hays, J. T., Croghan, I. T., Schroeder, D. R., Offord, K. P., Hurt, R. D., Wolter, T. D., Nides, M. A., & Davidson, M. (1999). Over-the-counter nicotine patch therapy for smoking cessation: results from randomized, double-blind, placebo-controlled, and open label trials. AmJ.Public Health, 89, 1701-1707.
33. Hempstead, J. S. (2001). Clinical hypnotherapy for smoking cessation. Prof.Nurse, 17*265.
34. Holroyd, J. (1991). The uncertain relationship between hypnotizability and smoking treatment outcome. Int.J.Clin.Exp.Hypn., 39, 93-102.

35. Horwitz, M. B., Hindi-Alexander, M., & Wagner, T. J. (1985). Psychosocial mediators of abstinence, relapse, and continued smoking: a one-year follow-up of a minimal intervention. Addict.Behav., 10, 29-39.
36. Hughes, J. A., Sanders, L. D., Dunne, J. A., Tarpey, J., & Vickers, M. D. (1994). Reducing smoking. The effect of suggestion during general anaesthesia on postoperative smoking habits. Anaesthesia, 49, 126-128.
37. Hyman, G. J., Stanley, R. O., Burrows, G. D., & Home, D. J. (1986). Treatment effectiveness of hypnosis and behaviour therapy in smoking cessation: a methodological refinement. Addict.Behav., 11, 355-365.
38. Jamerson, B. D., Nides, M., Jorenby, D. E., Donahue, R., Garrett, P., Johnston, J. A., Fiore, M. C, Rennard, S. I., & Leischow, S. J. (2001). Late-term smoking cessation despite initial failure: an evaluation of bupropion sustained release, nicotine patch, combination therapy, and placebo. Clin.Ther., 23, 744-752.
39. Janik, A. J. (1993). Hypnotism curse or cure-October 1992. J.R.Soc.Health, 113, 50.
40. Jeffrey, L. K. & Jeffrey, T. B. (1988). Exclusion therapy in smoking cessation: a brief communication. Int.J.Clin.Exp.Hypn., 36, 70-74.
41. Jeffrey, T. B., Jeffrey, L. K., Greuling, J. W., & Gentry, W. R. (1985). Evaluation of a brief group treatment package including hypnotic induction for maintenance of smoking cessation: a brief communication. Int.J.Clin.Exp.Hypn., 33, 95-98.

42. Johnson, D. L. & Karkut, R. T. (1994). Performance by gender in a stop-smoking program combining hypnosis and aversion. Psychol.Rep., 75, 851-857.
43. Jorenby, D. E., Leischow, S. J., Nides, M. A., Rennard, S. L, Johnston, J. A., Hughes, A. R., Smith, S. S., Muramoto, M. L., Daughton, D. M., Doan, K., Fiore, M. C, & Baker, T. B. (1999). A controlled trial of sustained-release bupropion, a nicotine patch, or both for smoking cessation. N.Engl.J.Med., 340. 685-691.
44. Kaufert, J. M., Rabkin, S. W., Syrotuik, J., Boyko, E., & Shane, F. (1986). Health beliefs as predictors of success of alternate modalities of smoking cessation: results of a controlled trial. J.Behav.Med., 9, 475-489.
45. Kinnunen, T. (2001). Integrating hypnosis into a comprehensive smoking cessation intervention: comments on past and present studies. Int.J.Clin.Exp.Hypn., 49^ 267-271.
46. Kline, M. V. & Under, M. (1969). Psychodynamic factors in the experimental investigation of hypnotically induced emotions with particular reference to blood glucose measurements. J.Psychol., 71, 21-25.
47. Kline, M. V. (1970). The use of extended group hypnotherapy sessions in controlling cigarette habituation. Int.J.Clin.Exp.Hypn., 18, 270-282.
48. Kline, M. V. (1971). Research in hypnotherapy: studies in behavior organization. Bibl.Psychiatr., 147. 67-87.
49. Kline, M. V. (1972). The production of antisocial behavior through hypnosis: new clinical data. IntJ.Clin.Exp.Hypn., 20. 80-94.

50. Kline, M. V. (1979). Hypnosis with specific relation to biofeedback and behavior therapy. Theoretical and clinical considerations. Psychother.Psychosom., 31, 294-300.
51. Lambe, R., Osier, C., & Franks, P. (1986). A randomized controlled trial of hypnotherapy for smoking cessation. J.Fam.Pract., 22, 61-65.
52. Lando, H. A. (1996). Smoking cessation products and programs. Alaska Med., 38, 65-68.
53. Law, M. & Tang, J. L. (1995). An analysis of the effectiveness of interventions intended to help people stop smoking. Arch.Intern.Med., 155, 1933-1941.
54. Lynn, S. J., Kirsch, L, Barabasz, A., Cardena, E., & Patterson, D. (2000). Hypnosis as an empirically supported clinical intervention: the state of the evidence and a look to the future. Int.J.Clin.Exp.Hvpn., 48, 239-259.
55. Lynn, S. J. & Shindler, K. (2002). The role of hypnotizability assessment in treatment. Am.J.Clin.Hvpn., 44, 185-197.
56. Molimard, M. & Hirsch, A. (1990). [Methods of stopping smoking]. Rev.Mal Respir., 7, 307-312.
57. Murray, R. P., Bailey, W. C., Daniels, K., Bjornson, W. M., Kurnow, K., Connett, J. E., Nides, M. A., & Kiley, J. P. (1996). Safety of nicotine polacrilex gum used by 3,094 participants in the Lung Health Study. Lung Health Study Research Group. Chest, 109, 438-445.
58. Murray, R. P., Nides, M. A., Istvan, J. A., & Daniels, K. (1998). Levels of cotinine associated with long-term ad-libitum nicotine polacrilex use in a clinical trial. Addict.Behav., 23, 529-535.

59. Murray, R. P., Anthonisen, N. R., Connett, J. E., Wise, R. A., Lindgren, P. G., Greene, P. G., & Nides, M. A. (1998). Effects of multiple attempts to quit smoking and relapses to smoking on pulmonary function. Lung Health Study Research Group. J.Clin.Epidemiol 51. 1317-1326.
60. Myles, P. S. (1992). Cessation of smoking following tape suggestion under anesthesia. Anaesth.Intensive Care, 20, 540-541.
61. Myles, P. S., Hendrata, M., Layher, Y., Williams, N. J., Hall, J. L., Moloney, J. T., & Powell, J. (1996). Double-blind, randomized trial of cessation of smoking after audiotape suggestion during anesthesia. Br.J.Anaesth., 76, 694-698.
62. Neufeld, V. & Lynn, S. J. (1988). A single-session group self-hypnosis smoking cessation treatment: a brief communication. Int.J.Clin.Exp.Hypn., 36, 75-79.
63. Nides, M., Rand, C., Doice, J., Murray, R., O'Hara, P., Voelker, H., & Connett, J. (1994). Weight gain as a function of smoking cessation and 2-mg nicotine gum use among middle-aged smokers with mild lung impairment in the first 2 years of the Lung Health Study. Health Psvchol. 13. 354-361.
64. Nides, M. A., Tashkin, D. P., Simmons, M. S., Wise, R. A., Li, V. C., & Rand, C. S. (1993). Improving inhaler adherence in a clinical trial through the use of the nebulizer chronolog. Chest. 104. 501-507.
65. Nides, M. A., Rakos, R. F., Gonzales, D., Murray, R. P., Tashkin, D. P., Bjornson-Benson, W. M., Lindgren, P., & Connett, J. E. (1995). Predictors of initial smoking cessation and relapse through the first 2 years of the Lung Health Study. J.Consult Clin.Psvchol. 63. 60-69.

65. Nuland, W and Field P.B.(1970). Smoking and Hypnosis. IntJ.Clin.Exp.Hypn 18, 290-306
66. Page, R. A. (1999). Identifying hypnotic sequelae: the problem of attribution. Am.J.Clin.Hypn.. 41. 316-318.
67. Parameswaran, P. G. (2001). Try hypnotherapy and acupuncture. Tex.Med., 97, 9-10.
68. Rabkin, S. W., Boyko, E., Shane, F., & Kaufert, J. (1984). A randomized trial comparing smoking cessation programs utilizing behaviour modification, health education or hypnosis. Addict.Behav., 9. 157-173.
69. Schoenberger, N. E. (2000). Research on hypnosis as an adjunct to cognitive-behavioral psychotherapy. IntJ.Clin.Exp.Hypn., 48, 154-169.
70. Schwartz, J. L. (1979). Review and evaluation of methods of smoking cessation, 1969-77. Summary of a monograph. Public Health Rep.. 94. 558-563.
71. Schwartz, J. L. (1991). Methods for smoking cessation. Clin.Chest Ned., 12. 737-753.
72. Shewchuk, L. A. (1976). Smoking cessation programs of the American Health Foundation. Prev.Med., 5. 454-474.
73. Shewchuk, L. A., Dubren, R., Burton, D., Forman, M., Clark, R. R., & Jaffin, A. R. (1977). Preliminary observations on an intervention program for heavy smokers. Int.J.Addict., 12. 323-336.
74. Shiffman, S. 1. (1993). Smoking Cessation Treatment: Any Progress? Journal of Consulting and Clinical Psychology. 61, 718-722.

75. Simon, E. P. & James, L. C. (1999). Clinical applications of hypnotherapy in a medical setting. Hawaii Med.J. 58. 344-347.
76. Sorensen, G., Beder, B., Prible, C. R., & Pinney, J. (1995). Reducing smoking at the workplace: implementing a smoking ban and hypnotherapy. J.Occup.Environ.Med., 37, 453-460.
77. Spiegel, D., Frischholz, E. J., Fleiss, J. L., & Spiegel, H. (1993). Predictors of smoking abstinence following a single-session restructuring intervention with self-hypnosis. Am.J.Psychiatry. 150, 1090-1097.
78. Stanton, H. E. (1991). Smoking cessation in a single session: an update. Int.J.Psychosom. 38, 84-88.
79. Sykes, V. C. (1992). Hypnosis. J.R.Soc.Health. 112. 312.
80. Tashkin, D., Kanner, R., Bailey, W., Buist, S., Anderson, P., Nides, M., Gonzales, D., Dozier, G., Patel, M. K., & Jamerson, B. (2001). Smoking cessation in patients with chronic obstructive pulmonary disease: a double-blind, placebo-controlled, randomised trial. Lancet, 357, 1571-1575.
81. Tonnesen, P. & Wennike, P. 1 (1999). [Hypnosis for smoking cessation]. Uaeskrlaeqer. 161. 4270-4272.
82. Tori, C. D. (1978). A smoking satiation procedure with reduced medical risk. J.Clin.Psvchol. 34. 574-577.
83. Valbo, A. & Eide, T. (1996). Smoking cessation in pregnancy: the effect of hypnosis in a randomized study. Addict.Behav., 21, 29-35.

84. Viswesvaran, C. 1. & Schmidt, F. L. (1992). A Meta-Analytic Comparison of the Effectiveness of Smoking Cessation Methods. Journal of Applied Psychology.77(4): 554-561. August 1992.
85. Von Dedenroth, T. E. (1968). The use of hypnosis in 1000 cases of "tobaccomaniacs". Am.J.Clin.Hypn.. 10. 194-197.
86. Wagner, T. J., Hindi-Alexander, M., & Horwitz, M. B. (1983). A one-year follow-up study of the Damon Group Hypnosis Smoking Cessation Program. J.Okla.State Med.Assoc.. 76, 414-417.
87. Wick, E., Sigman, R., & Kline, M. V. (1971). Hypnotherapy and therapeutic education in the treatment of obesity: differential treatment factors. Psvchiatr.Q.. 45. 234-254.
88. Williams, J. M. & Hall, D. W. (1988). Use of single session hypnosis for smoking cessation. Addict.Behav.. 13. 205-208.
89. Wong, M. & Burrows, G. (1995). Clinical hypnosis. Aust.Fam.Physician, 24, 778-81, 783.
90. Rigotti, N. (1997). Efficacy of a Smoking Cessation Program for Hospital. Arch.Intern.Med.. 157, 2653-2660.