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COVERT SENSITIZATION REVISITED: SIX CASE STUDIES

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Abstract

This is an up to date study in which covert sensitization – a technique that seems to have gone into disrepute since the 1970s – is employed to treat a variety of maladaptive behaviours. The following six case studies illustrate the value of covert sensitization for the treatment of alcoholism, nail tearing, cigarette smoking, cannabis smoking, overeating and chocolate addiction. The treatment focuses on the craving rather than the actual carrying out of the unwanted behaviour. This study shows that covert sensitization is a rapid and cost effective form of treatment: many patients are able to eliminate the unwanted behaviour in a small number of sessions. Copyright © 2005 British Society of Experimental & Clinical Hypnosis. Published by John Wiley & Sons, Ltd.

Key words: alcoholism, aversion therapy, covert sensitization, self-hypnosis

Introduction

Aversion therapy and covert sensitization have both been employed in the treatment of a wide variety of disorders, such as smoking and obesity, and they are often associated with the 1950s and 1960s respectively; however, an extensive view of the literature indicates that there are many earlier references going back as early as the 1840s. The first reference seems to point to JW Robbins who, in 1843, used posthypnotic suggestions of an aversive nature in the treatment of a female patient's diet (Deleuze, 1843). At that time, Charles Morley (1847) published a small volume in which he discussed various techniques associated with 'animal magnetism', which preceded the term 'hypnosis'.

In 1920, Watson and Reyner demonstrated a procedure which showed that pairing an aversive stimulus with a neutral object led to a withdrawal; this in turn generated an interest in aversion therapy. Raymond (1956) effectively treated a fetishist with the use of the emetic apomorphine, and this generated further interest in chemical aversion therapy. For example, Liberman (1968) used apomorphine for the treatment of drug addiction. An alternative treatment to chemical aversion was the use of electrical aversion therapy; one of the earliest references was Max (1935) who used electric shocks when treating a homosexual patient. Maguire and Vallance (1964) reported the successful treatment of an alcoholic patient who was given an electrical shock when he sniffed a tube containing whisky. At that time, Rachman (1965) argued that electrical aversion therapy was superior to chemical aversion therapy, while Kellam (1969) also used electrical shocks in the successful treatment of a female shoplifter. Interestingly, Franks (1958) had already pointed out that there were limitations to chemical aversion therapy in the treatment of alcoholism: he underlined the difficulties in controlling the pairing of the conditioned stimulus (CS) and unconditioned stimulus (UCS). The unpleasant nature of electrical aversion therapy may well have led to the development of covert sensitization, a procedure that is done in the imagination.

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In the 1960s, chemical and electrical approaches were largely replaced by this new technique – covert sensitization, sometimes referred to as 'verbal aversion'. This approach was a great improvement as it involved neither chemical agents nor electrical shocks, and the whole process was carried out in the imagination with the assistance of hypnosis (Cautela, 1966, 1967).

Covert sensitization was a highly reliable and effective form of treatment. It was used successfully in the treatment of alcoholism (Anant, 1967; Ashem and Donner 1968), compulsive gambling (Seager, 1969), obesity and juvenile delinquency, including car stealing and glue sniffing (Cautela, 1967). This treatment approach may also be applied to cigarette smokers, and there are favourable results here especially when compared to other techniques. It is important to note that in the case of alcoholism, one can use covert sensitization to remove the desire for a specific type of drink – such as whisky –without stopping the patient drinking other alcoholic beverages (Cautela, 1966).

In the present study the value of covert sensitization will be illustrated by six cases: fingernail tearing, cannabis smoking, overeating, cigarette smoking, chocolate addiction and alcoholism.

Treatment procedure

When the patients are first seen, the senior author (TK) describes the aversion procedure to the patients. He explains that the aim is to pair the craving for the maladaptive behaviour with a noxious stimulus, and that these suggestions are all carried out under conditions of hypnosis. After the first session, and away from the consulting room, patients will occasionally experience nausea or, more rarely, may actually vomit when attempting to carry out the unwanted behaviour. However, the treatment focuses solely on the craving which is responsible for the undesirable behaviour, and it is not the author's intention to induce actual vomiting. In the treatment session, the whole process is carried out in the imagination; whether the patient wants to stop smoking, lose weight, or stop nail biting, the nausea and vomiting are applied long before the patient actually reaches for the cigarette, the high calorie food or the fingernails.

In hypnosis, direct suggestions, which focus on feelings of nausea and vomiting, are followed immediately by a return to the special place where they feel comfortable and relaxed. Often, I will include an additional sentence to the effect that they are enjoying being in the special place, and that they feel a sense of well-being. The aversion is applied to the craving for the behaviour rather than the behaviour itself. As Dengrove (1970) points out, it is important in the therapeutic situation to focus on interrupting the pathway between the cue to smoke and the actual lighting of the cigarette. For example, with regard to smoking, it is suggested that as soon as the patient wants to smoke a cigarette, they become queasy, start to vomit or feel ghastly; the therapist emphasizes that they do not wish to smoke and should not smoke under any circumstance whatsoever. It is important here to vary the sequence of words, as this appears to enhance the power of the direct suggestion. For instance, on one occasion I might say, 'you are feeling nauseated; you will vomit all over the place; you do not *want* to smoke and you do *not* smoke ever'. On the next occasion I might say, 'you have a dreadful headache and you feel absolutely ghastly', and the same sequence is followed as before. Three identical trials – involving several repetitions of the same imagery – are given for the following six times: first thing in the morning; mid-morning; lunch-time; mid-afternoon; early evening; and late evening. The reason for this is that unless all the times of the day are covered the patient might find a loophole where they feel that it would be all right to smoke.

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In the case of overeating, patients are asked to imagine a noxious stimulus in connection with the wish to eat high calorie foods such as chocolate and biscuits; again, after the noxious stimulus has been applied three times, they are returned to the special place.

In the treatment of alcoholism, the patients are asked to imagine feelings of being sick and vomiting as soon as they have the desire to drink, and this may be applied to all times of the day or whenever alcohol consumption is a problem. If patients confine their drinking to evenings only, it would be advised to concentrate most of the therapy on that time of day. Here, the aim of the treatment is to ensure that the patient achieves complete abstinence from alcohol. If the patient wishes to continue drinking alcohol in moderation, then an alternative approach is needed, and this involves a process of systematic desensitization to social anxiety situations. This is a much lengthier process, but it does allow the patient to continue drinking socially (Kraft, 1968). Similarly, with regard to nail biting, one deals with the desire to approach the nails (to bite them), and not the actual nail-biting behaviour.

At the end of the first hypnosis session, patients are given the post-hypnotic suggestion that they carry out self-hypnosis, and that they should find the time to give themselves ten minutes of aversion daily. In this ten-minute period, patients first return to their special place, while the remainder of the time is spent re-experiencing a condensed version of the treatment session.

Case one: fingernail tearing

Brian was a 20-year-old single man whose problem was chronic fingernail tearing. He had been tearing his fingernails since the age of 4 and he described it as 'mutilation'. He was given the standard aversion therapy programme and his special place was lying on the grass on his own at home. In this first session, I taught him the use of self-hypnosis, using the word 'calm' as the association word. He commented that, during the hypnosis, he could have quite easily opened his eyes and walked away, though he did not actually do so. There was time distortion in that he felt that hypnosis had lasted 10 to 15 minutes, whereas, in fact, it was nearer 40 minutes.

When he came for the second session five days later, Brian reported that he had only torn one of his nails and had not torn the other nine. The aversion programme was repeated and he was encouraged to use self-hypnosis daily. In the third session, he was pleased to report that for the past nine days he had not torn his nails at all; but, although he had done some self-hypnosis, he was not as diligent about it as he should have been. Again, I reinforced the efficacy of self-hypnosis.

There was a marked improvement in the fourth and final session. Brian was delighted to tell me that there was only one occasion when he felt tempted to tear his fingernails; importantly, he refrained from doing so, and for the first time in his life he used a pair of nail clippers. In addition, his fingernails had grown and he was able to see the crescent-shaped white part of the nail for the first time in his life.

At six months follow-up, Brian wrote to say that he no longer had any problems with regard to tearing his fingernails.

Case two: cannabis smoking

Leanne was a 24-year-old single woman who was eleven weeks pregnant and who had an addiction to smoking cannabis. She told me that she had been smoking a mixture of

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cannabis and tobacco for the past six years, but during the past year she had been smoking this mixture on a daily basis and had explained that this was a reward for doing her daily chores. She was keen to conquer this cannabis habit.

I varied the aversion programme to suit her specific needs as she only used cannabis between 7 pm and midnight. Aversion was focused on 7 pm, 9 pm, 11 pm and midnight. The special place was being comfortable in her bed at home. I also encouraged her to use self-hypnosis on a daily basis.

At the end of the first hypnosis session, I asked whether she had any desire to smoke cannabis now, and she was mystified as to what the question was about.

When Leanne came for her second hypnosis session, she said that she had not smoked any cannabis whatsoever since the first aversion session. In the past when she had tried to give up cannabis, she had always felt dreadful and this caused her to sweat profusely. On this occasion, however, she did not develop any symptoms, and she was agreeably surprised how easy it had been to give up the cannabis. She added that, when she was in the presence of someone who was smoking cannabis, she had felt quite nauseated. Although she had not smoked any cannabis, I felt that the aversion should be reinforced and she agreed to have a further aversion session. She was quite happy to stop the treatment at this stage, and I said that, should she require a booster session at any point, she could always contact me.

When I spoke to her two years later, Leanne said that she had not smoked at any time during that two-year period and that she felt perfectly well.

Case three: overeating

Anne was a 13-year-old school girl who had put on six kilograms during the past year and now weighed 65 kilograms. This somewhat alarmed her mother who was present in the consulting room for all treatment sessions. Anne admitted that she had a predilection for bread and chocolate and that she tended to eat a lot between meals. It was emphasized that the aversion would focus on the excessive eating of chocolate and bread, but, at the same time, I pointed out that the aversion would not apply to normal eating.

Although Anne was not a particularly good hypnosis subject, she was, nevertheless, able to achieve an adequate level of relaxation. She was given an aversion to chocolate and bread, focusing particularly on eating between meals. I also advised her to carry out self-hypnosis for ten minutes daily.

A week later, Anne reported that she had carried out self-hypnosis every night and she had been able to curb her excessive eating, apart from one day when there was a school outing and each child was given a large packed lunch. This lead to considerable overeating and both mother and daughter were rather disappointed about this. I pointed out that, in fact, she had managed to eat sensibly on the other six days, and I felt that it was important to congratulate her on this.

In the third session, ten days later, I focused on snack meals: the aversion concentrated on snacks during the course of the morning, in the afternoon and in the period between supper and bedtime. It was during this session that her mother wanted to talk to me about her own childhood problems and said that she had suffered from bulimia nervosa which she had attributed to a lack of love from her own parents. For this reason, she was determined to give both Anne and her sister, Victoria, a lot of love.

In Anne's fourth session, her last, attention was focused both on snack meals and chocolates. Anne reported that she was feeling extremely well, that she no longer ate food between meals and that she had done well in her recent examinations.

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In a follow-up telephone conversation six months later, Anne's mother was extremely pleased with the treatment result: Anne was no longer eating between meals and had lost two kilograms in weight.

Case four: cigarette smoking

Janet was a 34-year-old woman who lived with her boyfriend. She was keen to give up cigarettes and was well motivated because her smoking interfered with her horse riding: she was a keen horserider and took part in one-day events, but she had noticed that the smoking had caused her to be breathless. When she came for treatment, she was smoking approximately fifteen cigarettes a day and she was keen to become a non-smoker.

Janet was a good hypnosis subject and her special place was being in the living room at home, watching television on her own. The aversion comprised suggestions of nausea and vomiting long before reaching for the cigarette, and this was followed by the return to the special place. This sequence was given three trials for six different times of the day – first thing in the morning, mid-morning, lunch-time, mid-afternoon, early evening and late at night. I then suggested that she carry out 10 minutes of self-hypnosis daily and stressed that this was an essential part of the treatment programme.

A week later, when she came for her second hypnosis session, she reported that she had not smoked at all, and that the thought of cigarettes had not even entered her mind. Later, she admitted that she had been tempted on one occasion, and yet she still did not smoke. She was pleased to tell me that at the end of a cross-country ride she had been able to gallop for five minutes and jumped 20 fences without feeling breathless, and this gave her the confidence that she could continue with her horse riding at a high level. In the hypnosis session that followed, I repeated the aversion programme even though she had not smoked during the previous week.

The following week, Janet could not come for her third hypnosis session, and her personal assistant confirmed that she had not smoked a single cigarette since the beginning of therapy.

Case five: chocolate addiction

Maria was 41-year-old single woman who had always found it difficult to resist eating chocolate. After she had had a hysterectomy eighteen months earlier, her craving for chocolate had increased to a very high intensity and thus she was motivated to come for treatment. She had also gained a considerable amount of weight since the operation, which she attributed to eating large quantities of chocolate. She was keen to have aversion therapy for chocolate eating to ensure that she would not put on any further weight.

In the first session, I explained that I would give her an aversion to chocolate biscuits, and that I would ensure her ability to drink coffee without the need for chocolate. The aversion consisted of suggestions of nausea, vomiting and a strong veto to eating chocolates. The stimulus was then withdrawn and she was then taken to her special place which consisted of sunbathing in the Middle East.

After the first session, Maria went to a sandwich bar and suddenly saw some chocolates. She did not in fact buy the chocolate, which was most unusual for her, but she did recognize that she needed another treatment session.

In the second aversion session, I gave her an aversion to chocolate, biscuits and

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chocolate biscuits and, again, the special place was sunbathing in the Middle East (as the relief response).

When Maria came for her third session, she told me that she was going to test herself to see whether she was able to buy a chocolate bar without eating it. In fact, she brought the chocolate to the session and left it on the desk for me.

The aversion session followed the same lines as the previous ones, and, at the end of the session, she said that she would like to see how things went and did not book a further appointment.

In a telephone follow-up interview session three months later, Maria was delighted and proud to be able to say that the aversion had been effective, that she had not eaten any chocolate whatsoever since the treatment, and that her weight had stabilized. She had not lost any weight but she was pleased that she was no longer craving chocolate.

Case six: alcoholism

Sheila was a 52-year-old single woman who suffered from alcoholism. Thirteen years earlier, she had seen a hypnotherapist for smoking and this had been successful; now, she was looking for treatment for her alcoholism and had high expectations for the outcome. Sheila told me that she would drink white wine on her return from work, and continued drinking wine during the course of the evening when socializing. Typical of alcoholics, she found that once she started to drink she couldn't stop herself. She also made light of the total quantity of white wine that she drank during the week.

Sheila was an excellent hypnosis subject and was able to obtain a high degree of arm levitation. She was particularly comfortable in her special place which consisted of being perched on top of a rock near Lands End, where she felt peaceful and relaxed. The aversion to alcohol concentrated mainly on the evening and at lunchtimes during the weekends. She was given three trials for 6 pm, 7 pm, 8 pm, 9 pm and lunchtime on Saturdays and Sundays. I also taught her self-hypnosis so that she could practise at home on a daily basis.

A week later, Sheila reported that she had not drunk any alcohol at all and felt disgusted when passing a public house. On returning home after a hard day at work, she felt quite stressed, but was able to use self-hypnosis rather than resorting to alcohol. In the next session, the third, Sheila said that she was still not drinking any alcohol; she went out with her friends who all drank with their meal, and this did not worry her at all. She also commented that she had had a particularly hard day at work, and that previously this would have led to her drinking a whole bottle of wine; but now, she was able to calm down without the use of alcohol.

Sheila remained abstinent for a period of ten months, but then was tempted to drink a glass of champagne that she saw on an adjacent table in a restaurant. She then continued drinking all evening – she couldn't stop. In fact, this re-activated her old programme of drinking wine every evening. She contacted me for a booster session, and she wanted reassurance that this was not 'out of the ordinary'. She therefore decided to have three further treatment sessions focussing mainly on evening drinking. I stressed that this form of treatment demanded zero tolerance and she would not be allowed to drink any alcohol. At six months follow-up, Sheila rang to say that she was feeling extremely well and was not drinking any alcohol; a further follow-up was carried out nine months later, and not only was she feeling very well but she was also proud to report that she had not drunk any alcohol for fifteen months.

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Comment

This is a very rapid form of treatment in that it very quickly removes the undesirable behaviour (see Table 1). The great advantage of this approach is that it effectively counteracts the craving for the maladaptive behaviour.

Table 1.

Name of patient	Maladaptive behaviour	Number of sessions
Brian	Nail biting	4
Leanne	Cannabis smoking	2
Anne	Overeating	4
Janet	Cigarette smoking	2
Maria	Chocolate addiction	3
Sheila	Alcoholism	3 + 3 booster sessions

Not all patients respond to this form of treatment, but it is effective in 90% of cases. With regard to the treatment of alcoholism, while it is possible to focus on a specific alcoholic beverage such as whisky, this form of treatment, on the whole, involves total abstinence. Some patients enquire whether it is possible to drink socially after this form of treatment; it is pointed out to them that the only way that this can be achieved is to adopt a much lengthier programme which involves the systematic desensitization to social anxiety (Kraft, 1968). This latter programme would only be recommended when treating mild cases of alcoholism. If there were any evidence of liver or brain damage, the patient would only be given the option of having covert sensitization with zero tolerance.

When treating patients who are overweight, it is important to establish whether there is a specific food they wish to eliminate from their diet, such as chocolate, biscuits or crisps; this, then, becomes the focus of the treatment. Alternatively, if the problem is one of eating between meals, then the attention has to be focused on what is referred to as 'snacking'.

This paper demonstrates the efficacy of covert sensitization and its ability to treat rapidly and successfully a wide variety of maladaptive behaviours.

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References

Anant SS (1967) A note on the treatment of alcoholics by a verbal aversion technique. The Canadian Psychologist 8a(1): 19–22.

Ashem B, Donner L (1968) Covert Sensitisation with alcoholics: a controlled replication. Behaviour Research and Therapy 6: 7–12.

Cautela JR (1966) Treatment of compulsive behaviour by covert sensitization. Psychological Record 16: 33–41.

Cautela JR (1967) Covert Sensitization. Psychological Reports 20: 259–468.

Deleuze, JPF (1843) Practical Instruction in Animal Magnetism, revised edition. With an appendix of notes by the translator, and letters from eminent physicians and others, descriptive of cases in the

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United States. (TC Hartshorne, trans.). New York: D. Appleton, 290.

Dengrove E (1970) A single-treatment method to stop smoking using ancillary self-hypnosis: discussion. The International Journal of Clinical and Experimental Hypnosis 18 (4): 251–6.

Franks CM (1958) Alcohol, alcoholism and conditioning. A review of the literature and some theoretical considerations. Journal of Mental Science 104: 14–83.

Kellam AMP (1969) Shop lifting treated by aversion to a film. Behaviour Research and Therapy 7: 125–7.

Kraft T (1968) Desensitisation and the treatment of alcoholism. British Journal of Addiction 63: 19–23.

Liberman R (1968) Aversive conditioning of drug addicts: a pilot study. Behaviour Research and Therapy 6: 229–31.

Maguire RJ and Vallance M (1964) Aversion therapy by electric shock: a simple technique. British Medical Journal 1: 151–3.

Max L (1935) Breaking a homosexual fixation by the conditioned reflex technique. Psychological Bulletin 32: 734.

Morley C (1847) Elements of animal magnetism; or process and applications for relieving human suffering. New York: Fowler and Wells.

Rachman, S (1965) Aversion therapy: chemical or electrical? Behaviour, Research and Therapy 2: 289–99.

Raymond MJ (1956) Case of fetishism treated by aversion therapy. British Medical Journal 2: 854–6.

Seager P (1969) Learning not to bet. Mental Health (Winter): 19–21.

Watson JB and Reyner R (1920) Conditioned emotional reactions. Journal of Experimental Psychology 3: 1–14.

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