Hypnosis in the Management of Chronic Fatigue Syndrome

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ABSTRACT. During the past 30 years hypnosis has become recognised as a useful adjunct to traditional medical therapies, and has become part of mainstream medicine. Hypnosis societies provide training for health professionals to obtain registrable qualifications. The modality has been incorporated in the management of many medical conditions and diseases, with opportunities for symptom control, building confidence and enhancing the benefits of regular therapies. There are many opportunities for using hypnosis as an adjunctive therapy in the management of Chronic Fatigue Syndrome, despite some early difficulties. Problems likely to be encountered are discussed and the structure of the hypnosis session is outlined. Suggestions are given for practitioners to construct useful scripts, which can be used to teach self-hypnosis. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2004 by The Haworth Press, Inc. All rights reserved.]

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For many years hypnosis was condemned by the medical profession as being unscientific and bordering on charlatanism and quackery (1). During the last 30 years however hypnosis has become part of mainstream medicine as its benefits have been acknowledged by practitioners around
the world. Many medically recognised hypnosis societies have been formed such as the European Society of Hypnosis, the American Association of Clinical and Experimental Hypnosis, the International Society of Hypnosis, New Zealand Society of Hypnosis, etc. These organisations have strict criteria for membership, which usually includes registered medical practitioners, dentists and psychologists only. To obtain certification to practice hypnosis these practitioners have to undertake suitable training with written and practical examination requirements. There are however many lay hypnotists and stage hypnotists around the world with minimal qualifications giving a false impression of the potential for hypnotic intervention in a clinical situation. In some countries, such as in parts of Australia, hypnosis by lay practitioners is outlawed.

Hypnosis is best described as a state of altered awareness (2) coupled with heightened suggestibility (3). Healing in the trance state is one of the oldest medical arts, practised by primitive man and formalised by Mesmer, using elaborate apparatus in the eighteenth century. Well known British surgeons James Braid and James Esdaile both reported on the use of hypnosis for surgical procedures in the mid 1800s. Practitioners such as Freud and Erikson expanded the art and clinical hypnosis is now recognised in medicine as a useful adjunct to regular therapy. Hypnosis has been used in many different medical conditions and success is largely dependent on the hypnotisability of the patient. Clinical scales of hypnotisability have been produced and the Stanford Clinical Scale of Hypnotisability (SCSH) while rather long to administer, is one of the most useful benchmarks. Using this scale, approximately 5% of the population are highly hypnotisable, 5% non-hypnotisable and the remainder fall along the normal distribution curve. However, a number of shorter hypnotisability scales have been produced and can be administered easily by experienced practitioners.

Before hypnosis is considered, a thorough medical and psychological case history must be obtained if possible, though this may not be appropriate in an emergency room situation (4). Discussion with the patient regarding the possible benefits of hypnosis in their particular condition, forming a rapport and reassurance are important parts of the initial consultation. The actual hypnosis session consists of induction, deepening, therapeutic intervention, post-hypnotic suggestion and return to normal level of consciousness. The suggested interventions used during therapeutic intervention are listed in the Appendix. Adequate time for discussion after the experience must be allowed. All of these stages are equally important and cannot be rushed. Sessions may be recorded to enhance the success of learning self-hypnosis. Many lay practitioners rely on fre-
quent follow up sessions, but in reality, learning self-hypnosis should be the optimum aim, so that the patient is no longer reliant on the hypnotist for induction of trance. Long term, self management, constructing one’s own self hypnotic scenario is very successful, once one has learnt the basic steps (5).

Many medical conditions can be helped through hypnosis, but it should rarely be a stand alone therapy. It should be viewed as a complementary adjunct to regular therapy. The therapist should have a thorough understanding of the underlying medical condition, and should not venture into the unknown. In other words, a therapist should only use hypnosis as part of the treatment for a condition with which he/she is already familiar, and should not be intervening in areas in which he/she would not normally be involved. For example, it would be inappropriate for a dentist to get into obstetric hypnosis or for a family doctor to be involved in deep psychoanalysis without suitable background training.

**CONDITIONS SUITABLE FOR HYPNOTIC INTERVENTION**

Because hypnosis is usually associated with deep relaxation, it is a technique which can be beneficial to a large number of patients with a variety of medical conditions. It can be viewed as a very useful means of alleviation of stress, which itself has a major impact on most illnesses. Even those of low hypnotisability can learn some useful self-help strategies. Interventions include relief of many symptoms such as pain, nausea, anxiety, insomnia, abnormal fears, irritable bowel, migraine, etc. Confidence building and seeing oneself as well are important adjuncts to other routine therapies. Further more specific interventions have proved successful in eliciting changes in the cardiovascular system, such as slowing of heart rate, lowering blood pressure, and in modulation of the immune system (6,7), hormonal output, etc. Simonton and Simonton (8) have taken it a step further using hypnotic techniques to aid visualisation in the management of cancer patients. Patients are guided through imagery to visualise, for example, cancer cells being gobbled up by killer white cells. Remarkable results are obtained, but the Simontons continually stress that their techniques are only part of the therapeutic approach which should include regular chemotherapy, radiotherapy, etc., and are viewed purely as a further arm in the overall management. Laidlaw and Booth have shown that it is possible to alter the allergic response under hypnosis (9). However, to obtain maximum benefit and ongoing successful responses, a patient needs to be highly motivated, have a belief that the
technique will work and continue to practice self-hypnosis regularly. Hypnosis can, for example, work well to help with smoking cessation, but there will be a tendency to relapse over time if the practice is not maintained.

There are a number of patients for whom hypnosis may not be useful. These would include those of low hypnotisability, those with sceptical disbelief, those with whom one does not form good trusting rapport, those strongly opposed to psychological intervention, and there are some religious groups for whom hypnosis maybe unacceptable. Old age may also be a contra-indication as ability to concentrate may decline. By contrast, young children, with their vivid powers of imagination are usually highly hypnotisable.

Hypnosis should be used with caution in those with major depression or psychoses, and therapists in these patient groups should have appropriate qualifications in psychological medicine. A seriously depressed patient could find that hypnotic intervention could provide them with sufficient motivation and energy to commit suicide. In all patients undergoing hypnosis adequate time for post-hypnotic discussion and follow up consultations to monitor progress are essential. Occasionally patients will have serious abreactions during hypnosis and the practitioner needs adequate time and experience to deal with these crises.

Hypnosis in CFS

There have been very few studies looking at the use of hypnosis in CFS. This maybe in part due to the lack of suitable practitioners working in both the fields of CFS and hypnosis. An early unpublished study undertaken by the author (presented for discussion at the ME symposium, Dunedin, Feb 1995) using the Stanford Clinical Scale of Hypnotisability on 10 CFS patients, showed poor hypnotisability with 90% scoring below the 30th percentile. This scale takes 30-40 minutes to administer, and with increasing experience, and the use of shorter induction techniques and incorporating some of the indirect Eriksonian approaches, it became increasingly evident that patients with CFS do match the norms in hypnotic ability. Numerous reasons were hypothesised as to why the earlier measures had produced such poor results.

The sessions were long, and those with CFS in general do have difficulties with sustaining concentration for lengthy periods of time. Sitting for a long time can also be difficult because of pain, cramp, etc. The techniques involved eye fixation as part of the induction and this can be very difficult for those with CFS, as eyes become tired and achey. A number of
the patients were very tense with rigid analytical personalities with a very real fear that if a hypnotic intervention worked, it might “prove” that they did in fact have a psychological illness—the very concept against which they had been battling. Many had a fear that their illness could thus be labelled by others as psychological. There may have been a lack of understanding of how hypnosis could work and skepticism of psychological modalities. Many patients with CFS are also impatient for instant success and the process of achieving successful hypnotic trance and learning self-hypnosis may be prolonged.

Collinge in his treatise on Scientific Rationale for Behavioural Medicine in CFS indicated that for those with CFS use of complementary behavioural self help strategies, such as guided imagery under hypnosis have better outcomes than those which rely solely on medical intervention alone. He cites numerous studies where alterations in NK activity, antibody titres and cytokine release can be altered (10). EEG biofeedback combined with self hypnosis was utilised in a study by Hammond on a CFS patient with severe cognitive difficulties. Considerable improvement in fatigue, vigour and confusion were noted (11). Changes were maintained at 9 month follow-up. DiClementi compared CFS patients with healthy controls looking at the effects of information processing on the subjective experiences of cognitive deficits in CFS and found that levels of suggestibility differed significantly compared to healthy controls (12). The National Institute of Neurological Disorders and Stroke (NINDS) in Maryland, US has been undertaking a trial looking at the hypnotic responsiveness of patients with chronic orthostatic intolerance (many of whom have overlapping symptoms with those with CFS). Results are not yet available (13).

Ronald Shone reported a study in the European Journal of Clinical Hypnosis suggesting that hypnosis could be used to help emotional difficulties associated with ME, and could also be used to help sufferers deal with symptoms such as muscle fatigue, cognitive fatigue and CNS responses (14).

Before attempting any hypnotic intervention with a patient with CFS, there must be a clear diagnosis and review of symptoms. A thorough understanding of the illness and hypnosis by both therapist and patient is essential. The environment can then be structured correctly with attention to such things as a comfortable chair, minimal extraneous noise such as telephones and noisy traffic, muted lighting to avoid eyestrain, adequate warmth or fresh air which can easily be adjusted to suit the patient’s needs, freedom from odours or allergens, availability of drinking water, tissues (crying under hypnosis is not unusual) and staff should be advised
not to disturb during the session. Tape or CD recording should be available, as the patient will feel comforted to know that the session will be taped, and nothing will be missed and nothing untoward is likely to happen. This too provides the basis of self-hypnotic learning. Many therapists may utilise music in the waiting area or consultation room, as music has been shown to enhance hypnotic induction, suggestibility and imagery (15).

The pre-hypnosis consultation should involve history taking, explaining what hypnosis is about, discussion about how hypnosis may help in symptom management, dispelling myths and mystification about hypnosis and building rapport. Many patients will have preconceived ideas as a result of stage and TV hypnosis, and will need much reassurance regarding the difference in the use of hypnosis clinically. The patient needs to understand that there is no “control” being exerted by the therapist, rather the patient is going to learn a sense of self-control and confidence in their own ability to use hypnosis. The hypnotist is acting purely as a navigator advising how best to access and explore the subconscious mind, with the patient finding their own eventual route to success. It is also important to ascertain that the patient is confident and well motivated in wanting to make change, as without motivation, hypnosis is likely to fail. At this stage the patient should be given the opportunity to opt out of this form of therapy if they do not feel it is right for them at this time. Written information should be given to take home and a follow up appointment made for therapy. There should be plenty of time allowed for this next appointment as neither patient nor therapist should feel rushed at any stage.

At the following appointment the patient is now knowledgeably prepared for hypnosis, but any remaining doubts or concerns must be addressed. Because some visual imagery may be used and avoidance of abreaction is important, underlying fears and phobias should be discussed openly, as under hypnosis the person will be highly suggestible, and inadvertent mention of anything frightening may provoke reaction. Induction maybe traditionally direct or of the indirect Eriksonian variety. This may depend on the personality style of both patient and therapist. But for patients with CFS, the gentler non directive Eriksonian approaches are often quicker and more comfortable, avoiding such things as eye fixation, eye roll or progressive relaxation, which may prove long and difficult. Once in a light trance the deepening phase maybe enhanced by the use of imagery, music or attention to kinaesthetic experiences. Some patients will be encouraged to use finger signalling or to speak to indicate what they are experiencing. The experienced therapist however will be able to gauge when a deep trance state is achieved. At this stage the
therapeutic intervention will be undertaken. Times of silence for self-
exploration may be encouraged and can offer profound insight, but use of
metaphor, story telling or direct suggestions can be employed. During
this phase post-hypnotic suggestions may be introduced. The patient is
then slowly brought out of hypnosis, and again guided imagery can be
used, or the patient can be given the freedom to find their own route back
to full consciousness. They should be encouraged to bring back what ever
they need from the whole experience and to remember clearly as much as
they wish. Some post hypnotic amnesia is not uncommon for those
achieving deep states unless the post hypnotic suggestion includes re-
membering the experiences clearly. The time in each of these stages can
vary enormously, but for most of those with CFS, shorter sessions are
probably more useful and appropriate to avoid undue fatigue.

Adequate time afterwards is essential for discussion of experiences,
particularly if any difficulties have been encountered. It is not unusual for
the patient to become tearful as sometimes deep memories may be in-
voked. Many patients will describe revisiting their childhood, as age re-
gression is one of the phenomena of hypnosis. Occasionally ongoing
counselling maybe required. It is certainly not difficult for the inexperi-
enced practitioner to implant false memories under hypnosis, and this
must be avoided (16).

Most patients will require several follow up sessions and before each
subsequent induction, discussion of previous hypnotic experiences will
give both therapist and patient insight into which approaches may or may
not be useful. The next session can then be focussed on the most valuable
aspects. For example, some will prove to be excellent at visual imagery,
other have greater auditory or kinaesthetic experiences. Exploration of
emotional areas maybe useful both in and out of hypnosis. Discussion
should look at which symptoms may have improved, and which should
now be reviewed further under hypnosis. Some patients may report diffi-
culties such as lack of opportunity or motivation to practice, and may not
wish to pursue this form of therapy (they will usually be those who are the
least hypnotisable group), while some have developed sufficient insight
in now being able to make positive suggestions as to how further hypno-
sis could help. Once a person sees that some positive change has been
possible, enthusiasm increases. Rarely will a patient describe hypnosis as
other than a pleasant experience as long as one adheres to all the above
recommendations. Many patients will be ready to “go it alone” quite
quickly, and long-term dependence on the therapist is to be avoided.

Hypnosis is an adjunctive therapy with minimal risks in the hands of
well qualified professionals. The management of abreaction, repressed
memories and dependence need careful handling and one should not undertake this therapy unless one is qualified to deal with these issues. In symptom management, it is important not to invoke a strategy for the patient to remove a symptom such as pain completely. The pain may have a useful component in helping the patient manage the illness properly, and removing it completely may give a false sense of wellbeing, leading to overactivity and relapse. Or in the longer term, a new pain may have particular significance, and again the ability to remove it completely may mean a new symptom, and perhaps serious warning is ignored.

Other factors which may influence the CFS patient’s opportunity to gain benefit from hypnosis include cost and travel. In a private practice situation, payment may be beyond the ability of the patient, particularly if on a sickness benefit. In New Zealand, however, there is often a special disability allowance to cover such treatment. Health insurance may also cover costs. Group sessions may be an option to help defray cost. Some patients do find travel difficult, and there may be a paucity of health professionals with qualifications and experience in hypnosis in their area.

The aim in the management of CFS should be to enhance the chances of making a recovery, and the use of hypnosis is only one arm of treatment. Other possible therapeutic options should never be abandoned totally in its favour, but a multi-dimensional approach encompassing mind-body techniques may be in the patient’s best interests, encouraging motivation and inspiring confidence. As Alexander Pope said in his Essay on Man “it is part of the cure to wish to be cured.”

REFERENCES.


**APPENDIX**

Suggested interventions that maybe useful in hypnosis in CFS once trance has been successfully induced and deepened:

*Mental imagery*—useful for stress reduction, pain relief etc. Patient is given suggestion to imagine self in a comfortable and enjoyable place. This should have been discussed in advance to get ideas from the patient as to the sort of places which would be visited in real life when well. A beach or bush scenario is frequently suggested. Patient then sees self maybe standing at the water’s edge with waves breaking gently over feet, and as waves recede so the stress is felt to leave the body. Gentle comfortable breathing is encouraged, with a sense of drawing fresh clean air into the lungs to nourish and refresh. As the stress leaves the body, so the pain or other symptoms could be felt (or seen) to begin to flow away until it is a small dot on the horizon—the small dot representing the tiny fragment of pain left for safety. Feelings of confidence, control and wellness are suggested and the patient may see a reflection of self looking well, moving freely and easily. The posthypnotic suggestion may include feelings of energy and mental clarity.

*Metaphor*—An activity is viewed in a symbolic way to promote some unraveling or exploration of emotional issues which maybe impinging on the body’s ability to heal itself. For example, the simple act of peeling an apple—as the outer skin is removed, one sees what lies within—there maybe areas of bruising to be removed—deep within are the seeds representing new life, growth and health.
Under hypnosis the patient will usually see these actions as significant and utilise them naturally and usefully.

*Story-telling*—a simple, often childlike story or fairy tale is told, whereby the patient can identify with a character in the story. This may be a particularly useful approach for those who have been found to experience regression to childhood when under hypnosis. The character may be someone small and weak who manages to succeed in some way against all odds. The inference of building confidence and growing in strength is obvious.

*Physiological imagery*—based on the Simonton approach.—The Army General: Patient is encouraged to develop a sense of control over the illness. It is explained that there is some research evidence that there is overactivity of the immune system in CFS, such as increased cytokine production. The “troops” (immune chemicals) are normally stationed in the barracks, but in CFS are scattered and in action. A battle is in progress (creating symptoms), but the enemy has gone (initial viral illness). The “troops” can therefore be called back to barracks, and then remain stationed in barracks on alert. They begin to relax as the battle is finally over, some may be deployed, but reserve “troops” are always available if needed for a future battle (new infection). In some cases of CFS, NK cells have been shown to be decreased—these could be viewed as the reserve “troops” and more could be called up to reside in barracks in case they are ever needed for action.