

Main Articles

Client centred hypnotherapy in the management of tinnitus – is it better than counselling?

J. D. T. MASON*, D. R. ROGERSON†, J. D. BUTLER‡

Abstract

The aim of this study was to assess whether client centred hypnotherapy (CCH) which required three sessions with a trained therapist was superior to a single counselling session in reducing the impact of tinnitus.

Patients were randomly allocated to receive either counselling (n = 42) or CCH (n = 44). The outcome measures were: tinnitus loudness match, subjective tinnitus symptom severity score, trend of linear analogue scale, request for further therapy and whether the patient had an impression of improvement in their tinnitus after treatment.

CCH was no better than counselling in reducing the impact of tinnitus using the three quantitative measures of tinnitus, and requests for further follow up.

The only significant difference between the two therapies was that 20 (45.5 per cent) of the CCH group reported a general sense of improvement compared to six (14.3 per cent) in the counselling group, this is significant $p < 0.01$. The study did not demonstrate whether this was a genuine hypnotic effect or simply a response to the additional attention from the therapist.

Key words: Tinnitus; Hypnosis; Counselling

Introduction

Hypnosis has been reported as beneficial to patients with tinnitus since 1950 (Pearson and Barnes, 1950). It is unlikely to have any effect on the underlying pathology of tinnitus. When patients with tinnitus are subjected to psychometric analysis they are described as having increased levels of tension and anxiety (Briner *et al.*, 1990; Collet *et al.*, 1990; Halford and Anderson, 1991). Hypnotherapy helps by reducing this anxiety and tension, enhancing relaxation and improving their ability to cope with tinnitus by increasing their personal control over this intrusive symptom. Four prospective studies claim varied success (Brattberg, 1983; Marks *et al.*, 1985; Attias *et al.*, 1990; Attias *et al.*, 1993). Beneficial effects have been reported in between 36 per cent and 73 per cent of the patients studied. The numbers in the groups undergoing hypnosis were between 12 and 32. The populations selected were either army personnel or patients who had failed to respond to any other form of tinnitus treatment.

To test the value of hypnosis as a management option for clinicians we measured changes in the patient's perception of their tinnitus after treatment

with client centred hypnotherapy (CCH). We studied a group of patients from a general ENT clinic and compared CCH with an established treatment option, a single counselling session in a matched group. A counselling session was used as a comparison because this is the generally accepted first step of tinnitus management (House, 1989; Coles, 1992; Luxton, 1993). This study was designed to test the claims of other studies about the value of hypnosis for tinnitus in a practical clinical setting. The investigators did not intend to demonstrate or refute genuine hypnotic effect, thus the counselling group is not a classical control group. The counselling group is a 'yardstick' by which CCH can be compared to a standard therapy.

Patients and methods

Patients were entered into the study if they were referred to the ENT department, and wanted treatment for their tinnitus. They were then randomly allocated for either counselling or hypnosis.

Patients were excluded from the trial for the following reasons: they complained of dizzy

From the Departments of Otorhinolaryngology,* Anaesthesia and Clinical Hypnosis,† and Audiological Services,‡ Derbyshire Royal Infirmary, Derby, UK.

Accepted for publication: 16 December 1995.

symptoms. They had clinical depression. After careful assessment they needed further investigation, or required surgical or medical treatment for related conditions. They had had any form of therapy in the past five years for their tinnitus.

They were assessed with pure tone audiometry, a tinnitus loudness match (TLM) in dB HL (hearing loss was not subtracted from the TLM), and a pitch match frequency using a bracketing technique; a linear analogue scale (0 = no tinnitus, 10 = the worst tinnitus ever experienced); a subjective symptom severity questionnaire which was converted into a score.

The counselling session was conducted by a post-fellowship ENT registrar (J.M.). The tinnitus sufferer was given ample opportunity to talk specifically about their tinnitus and its associated problems. This was followed by a discussion of the possible origins or tinnitus and reassurance that it was not a sign of sinister pathology. All the available treatment options were explained to the patients and the advantages and short comings of each were discussed. If they requested a particular treatment they were provided with this and excluded from the trial. Each patient was given an opportunity to ask questions. Finally advice was given regarding background masking, maintaining general health, getting adequate rest, and avoiding alcohol, nicotine, aspirin and noise abuse. They were given a tinnitus advice sheet at the end of the session. This open-ended session lasted between 30 minutes and one hour.

The hypnosis group had three sessions of CCH conducted by a consultant anaesthetist who had been trained in hypnotherapy (D.R.). The underlying aim of the three sessions of the CCH was to teach self-hypnosis, a condition of enhanced concentration on a specific target stimulus. While in this trance state the subject would learn to control the tinnitus, reduce the influence the tinnitus has on the subject and improve relaxation. The initial session lasted one hour during which Barber's Creative Imagination Scale (Barber and Wilson, 1978) was used to identify high scoring suggestions which were later used as the target stimulus to induce hypnosis. Self-hypnosis was taught with post-hypnotic suggestions to practise twice daily. The second and third sessions each lasted half an hour during which the relaxation techniques under self hypnosis were taught.

Whilst in hypnosis the subjects were allowed to imagine a miniature of themselves wandering about

TABLE I
DETAILS OF PATIENTS WHO COMPLETED THE FOLLOW-UP IN EACH GROUP

	Hypnosis	Counselling
No. of patients	44	42
Male	26	21
Female	18	21
Age range	26-80	22-80
Mean age	54	55
Hearing impaired (>30 dB loss better hearing ear)	11	8
Use hearing aid	9	6
TLM range for the group	20-100 dB	10-100 dB
TLM mean for the group	58 dB	53 dB
PMF mean for the group	3726 Hz	3684 Hz

TABLE II
SUBJECTIVE TINNITUS SYMPTOM SEVERITY SCORES IN THE TWO GROUPS, PRE-TREATMENT, ONE WEEK POST-TREATMENT AND THREE MONTHS POST-TREATMENT

	Hypnosis	Counselling
<i>Pre-treatment</i>		
Mean	11.0	11.1
Range	2-28	6-21
Median	10.7	10.1
<i>One week post-treatment</i>		
Mean	10.3	10.2
Range	2-25	0-20
Median	10.9	10.2
No. of patients with:		
Reduced score	22 (50%)	18 (42.9%)
Static score	11 (25%)	15 (35.7%)
Increased score	11 (25%)	9 (21.4%)
<i>Three months post-treatment</i>		
Mean	10.0	10.0
Range	0-25	0-20
Median	9.7	8.7
No. of patients with:		
Reduced score	24 (54.5%)	23 (54.8%)
Static score	6 (13.6%)	8 (19.0%)
Increased score	14 (31.8%)	11 (26.2%)

their minds looking for the source of the tinnitus, and empower them to use whatever auditory and visual imagery they found most helpful to improve the full-sized person's perception of the tinnitus. This tinnitus signal reduction was to be practised by the subject along with relaxation techniques while under self-hypnosis. The combination of tinnitus signal reduction and relaxation would hopefully reduce the severity and the associated symptoms of the tinnitus (Attias, 1993).

The pre-intervention assessment was repeated one week and three months post-treatment. Patients were asked by a clinic nurse who was blind to their treatment whether they felt that the treatment they had undergone had led to an improvement in their tinnitus. At three months they were asked if they wanted further treatment.

Results

Ninety-two patients were randomly allocated to either group. Hypnosis was offered to 46 patients, two found it unacceptable objecting to it on religious grounds. Forty-four patients completed the hypnosis limb of the trial. Forty-six patients were offered a counselling session, all accepted and 42 of them completed the follow-up at three months. Three dropped out because they wanted to try other therapies before completing the follow-up, and one failed to attend follow-up because of relocation. The two groups were well matched for age, sex and hearing (Table I).

TABLE III
TREND IN LINEAR ANALOGUE SCORES (LAS) POST-TREATMENT

	Hypnosis	Counselling
Reducing scores	25 (56.8%)	21 (50.0%)
Static scores	8 (18.2%)	7 (16.7%)
Increased scores	11 (25.0%)	14 (33.3%)

TABLE IV
REQUESTS FOR FURTHER TREATMENT AT THREE MONTHS FOLLOW-UP.

	Hypnosis	Counselling
No further follow-up or treatment	37 (84.1%)	35 (83.3%)
Masker	5 (11.4%)	3 (7.1%)
Hypnosis	—	3 (7.1%)
Follow up by audiological Physician	1 (2.3%)	1 (2.4%)
Follow up by psychotherapist	1 (2.3%)	0

The subjective tinnitus symptom severity score (Table II) showed a similar slight trend down in each group as did the linear analogue scales (Table III). Just over 80 per cent of each group did not want further treatment (Table IV), and the TLM for each group showed a random pattern (Table V).

The only parameter of treatment success to show a difference between the two groups was a subjective impression of improvement. Chi-squared shows a significant difference between the two groups, $X^2 = 8.47$, $df = 1$, $p < 0.01$, (Table VI).

Discussion and comparison with other studies

The treatment of tinnitus is difficult. Hypnosis met with little objection from the patients, only two refusing the treatment on religious grounds. It is not surprising though that unconventional therapy gains credence when conventional medicine and surgery have had only partial success (Eisenberg *et al.*, 1993).

This study was unable to demonstrate a significant difference between the CCH group and the counselling group in reducing the tinnitus subjective symptom severity score (STSSS) using CCH, 55 per cent of both groups showing a reduction in STSSS. Whereas Attias (1993), demonstrated a significant difference between the hypnosis group and an attentiveness group. Brattberg (1983) reports that 69 per cent of the subjects in her study showed improvement in symptom profile, the length of follow-up ranged between two months and two years, there was no control group in her study.

We were also unable to demonstrate a reduction in tinnitus volume, that had been reported by Attias in 1990 for 73 per cent of patients during hypnotherapy. Subjective amelioration of the intrusion of tinnitus without reduction in the volume of tinnitus has been similarly reported for biofeedback (Podoshin *et al.*, 1991; Landis and Landis, 1992).

Over 50 per cent of the subjects in this study reduced their linear analogue scales. Marks (1985)

TABLE V
CHANGE IN TINNITUS LOUDNESS MATCH (TLM) AT ONE WEEK AND THREE MONTHS FOLLOW-UP

	Hypnosis	Counselling
One week		
Reduced TLM	15 (34.1%)	20 (47.6%)
Static TLM	7 (15.9%)	8 (19.0%)
Increased TLM	22 (50.0%)	14 (33.3%)
Three months		
Reduced TLM	18 (40.9%)	14 (33.3%)
Static TLM	16 (36.4%)	12 (28.6%)
Increased TLM	10 (22.7%)	16 (38.1%)

TABLE VI
PATIENT'S OVERALL SUBJECTIVE IMPRESSION OF BENEFIT GAINED FROM TREATMENT FOR THEIR TINNITUS

	Hypnosis	Counselling
At one week		
Feel Better	20 (45.5%)	6 (14.3%)
Temporary improvement during treatment	5 (11.4%)	0
Feel worse	0	1 (2.4%)
Unaltered	19 (43.2%)	35 (83.3%)
At three months		
Feel Better	20 (45.5%)	6 (14.3%)
Temporary improvement	5 (11.4%)	0
Feel worse	1 (2.3%)	1 (2.3%)
Unaltered	18 (40.9%)	35 (83.3%)

also used an analogue scale but only one out of 14 patients showed a reduction. Marks' study was using patients who had been resistant to other forms of treatment, and this difference between subject groups must be taken into account.

Tinnitus loudness matching showed a random change without any evidence of a trend in either direction in our study, and Marks (1985) describes the same pattern. Attias (1993) reports no alteration in the audiological assessment of the subject's tinnitus after hypnosis.

Ours is the only study where the tinnitus sufferers were asked if they would like further management of their condition. Over 80 per cent in each group were satisfied with what had been done. This suggests that counselling is as effective at producing an 'I've learnt to live with it' state as hypnosis. If this is a satisfactory outcome, then a single counselling session is cheaper than three sessions of CCH requiring a trained therapist.

The only difference between the two groups in the study was that 45 per cent of the CCH group had a real feeling that the tinnitus had improved whereas only 14 per cent of the counselling group had the same impression. It is the authors' opinion that this sense of improvement is what the tinnitus sufferer requires, if their tinnitus volume cannot be reduced, and this has to be regarded as a successful clinical outcome. This superior impression of improvement is probably because hypnotherapy produces relaxation that deals with the psychological disturbance of tinnitus and the stimulus reduction gives the subject power over the tinnitus, particularly when it is the most troublesome. The obvious objection is that this subjective sensation of improvement is a response to the attention of the therapist and not a genuine hypnotic effect. For the attention of the therapist to have a positive effect that lasts three months is unlikely, and it is more likely that this sensation of improvement is due to the ability to control the tinnitus through self-hypnosis. Attias (1993) attempted to control for therapist attention by using attentiveness sessions that lasted for a similar length of time as the hypnosis sessions. He reported that the hypnosis group did significantly better than the attentiveness group for their overall tinnitus symptom profile, but as far as a general feeling of improvement the was no difference between the two

groups. His post-treatment assessment was only one week after completion of treatment, and this is too short a period to judge a chronic condition.

Five of the patients described a temporary improvement with hypnosis that was not maintained after the therapy session ended. Tapes to aid patients achieve trance have been promoted and these may well improve the long term success of the treatment (Brattberg, 1983).

This study has demonstrated a definite success using CCH to sustain a superior subjective amelioration in the effect of tinnitus compared to a counselling session. There was no difference between the two groups in reducing the level of tinnitus or its associated symptoms. Further studies are required to demonstrate that hypnotherapy is better than simple counselling in reducing the impact of tinnitus by genuine hypnotic effect. Otherwise it is difficult to justify the large amount of specialist therapist time required.

References

- Attias, J., Shemesh, Z., Shoham, C., Shahar, A., Haim, S. (1990). Efficacy of self-hypnosis for tinnitus relief. *Scandinavian Audiology* **19**: 245–249.
- Attias, J., Shemesh, Z., Sohmer, H., Gold, S., Shoham, C., Faraggi, D. (1993) Comparison between self-hypnosis, masking and attentiveness for alleviation of chronic tinnitus. *Audiology* **32**: 205–212.
- Barber T. X., Wilson, S. C. (1978) The Barber Suggestibility Scale and the Creative Imagination Scale in experimental and clinical applications. *American Journal of Hypnosis* **21**: 84–108.
- Brattberg, G. (1983) An alternative way of treating tinnitus: relaxation hypnotherapy primarily through the home use of recorded audio cassette. *International Journal of Clinical and Experimental Hypnosis* **31**: 90–97.
- Briner, W., Risey, M., Guth, P., Norris, C. (1990) Use of the Million Clinical Multi-axial Inventory in evaluating patients with severe tinnitus. *American Journal of Otolaryngology* **11**: 334–337.
- Coles, R. (1992) A survey of tinnitus management in national health service hospitals. *Clinical Otolaryngology* **17**: 313–316.
- Collet, L., Moussu, M., Disant, F., Ahami, T., Morgon, A. (1990) Minnesota Multiphasic Personality Inventory in tinnitus disorders. *Audiology* **29**: 101–106.
- Eisenberg, D., Kessler, R., Foster, C., Norlock, F., Calkins, D., Delbanco, T. (1993) Unconventional medicine in the United States. Prevalence, costs, and patterns of use. *New England Journal of Medicine* **28**: 246–252.
- Halford, J., Anderson, S. (1991) Anxiety and depression in tinnitus sufferers. *Journal of Psychosomatic Research* **34** (4–5): 383–390.
- House, J. (1989) Therapies for tinnitus. *American Journal of Otolaryngology* **10**: 163–165.
- Landis, B., Landis, E. (1992) Is biofeedback effective for chronic tinnitus? An intensive study with seven subjects. *American Journal of Otolaryngology* **13**(6): 349–356.
- Luxton, L. (1993) Tinnitus: its causes, diagnosis and treatment. *British Medical Journal* **306**: 1490–1491.
- Marks, N., Karl, H., Onisiphorou, C. (1985) A controlled trial of hypnotherapy in tinnitus. *Clinical Otolaryngology* **10**: 43–46.
- Pearson, M. N., Barnes, L. J. (1950) Objective tinnitus aurium: Report of two cases with good results after hypnosis. *Journal of Philadelphia General Hospital* **1**: 134–138.
- Podoshin, L., Ben-David, Y., Fradis, M., Gerstel, R., Felner, H. (1991) Idiopathic subjective tinnitus treated by biofeedback, acupuncture and drug therapy. *Ear, Nose and Throat Journal* **70** (5): 284–289.

Address for correspondence:
Mr J. Mason,
Department of Otolaryngology,
Queen's University Hospital,
Nottingham NG7 2UH.

Fax: 01602 709196

APPENDIX 1: The Subjective Symptom Severity Score. The scoring system in **heavy type** does not appear on the questionnaire given to the patient.

SUBJECTIVE TINNITUS SYMPTOM SEVERITY SCORE.

Please answer all questions honestly, there is no right and wrong answer.

1. When does your tinnitus really trouble you?
(Score 2 points for every situation described.)

Please tick the appropriate response

2. For how much of the time can you hear your tinnitus?
Occasionally _____ [] (1)
Some of the time _____ [] (2)
Most of the time _____ [] (3)
All the time _____ [] (4)
3. Does your tinnitus stop you getting to sleep?
All the time _____ [] (3)
Most of the time _____ [] (2)
Some of the time _____ [] (1)
Never _____ [] (0)
4. Does your tinnitus wake you up?
Never _____ [] (0)
Some of the time _____ [] (1)

- Most of the time _____ [] (2)
All the time _____ [] (3)

5. Does your tinnitus spoil your concentration?
Never _____ [] (0)
Some of the time _____ [] (1)
Most of the time _____ [] (2)
I find it very difficult to do anything requiring concentration _____ [] (3)

6. Does your tinnitus affect your relationship with your family friends or colleagues?
I find it difficult to get along with anyone _____ [] (3)
Often I have difficulty getting on with others _____ [] (2)
Occasionally I am more irritable with others _____ [] (1)
It does not affect my relationships _____ [] (0)

7. Does tinnitus affect your mood?
Never _____ [] (0)
Occasionally I am more depressed because of it _____ [] (1)
I am often depressed because of it _____ [] (2)
I am always depressed because of it _____ [] (3)

8. Does your tinnitus irritate you?
It does not affect me _____ [] (0)
I am sometimes irritated by it _____ [] (1)
I am regularly irritated by it _____ [] (2)