Question 45

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Will Hypnotherapy Help My Patients With IBS?

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It is well-known that there is tremendous variation in the severity of irritable bowel syndrome (IBS) symptoms, with many patients experiencing only relatively mild symptoms on an infrequent basis. However, at the other end of the spectrum, there are patients in whom the condition is much more severe with the potential to completely ruin their lives. In this group of patients, symptoms tend to be continuous with pain often being a predominant feature. Patients may also experience extremes of bowel dysfunction characterized by very infrequent bowel movements or diarrhea, the latter of which may be associated with urgency and incontinence. Typically, these individuals also suffer from a variety of "non-colonic" symptoms including lethargy, low backache, nausea, and a range of urinary as well gynecologic symptoms. Even though such patients represent a minority of the totality of IBS patients, because the condition is so common, they are still relatively numerous. Not surprisingly, these severely affected patients are challenging to treat, partly because their symptoms are so intense but also because their symptoms are so diverse; it is thus difficult to conceive of a pharmacological approach that might help all of them. The tricyclic antidepressants are the pharmacologic agents that possibly come closest to achieving this goal, but even these compounds only have a finite success rate. As a referral center, we see large numbers of such cases of severe IBS where treatment has been unsuccessful and the sufferer is becoming increasingly despondent about the prospects of any help in the future, especially as they have often been told "there is nothing more that can be done for you." It is in this group that we consider the possibility of trying hypnotherapy.

Unfortunately, hypnotherapy is very time consuming, as well as costly to provide, and even in our unit with five therapists, it can be associated with a long waiting list. Consequently, it is important to establish that the patient is truly refractory to medical and dietary therapy before embarking on a course of hypnotherapy. We, therefore, re-visit all of their previous medications, especially antidepressants, to ensure that they have been used at adequate doses for adequate periods of time, and we pay particular attention to their diet where we often achieve surprisingly good results with somewhat

unconventional manipulations. Even small improvements at this stage are worthwhile, as any reduction in symptoms means there is less for hypnotherapy to overcome. Patients often view hypnosis as their last hope of salvation and not surprisingly become very distressed if they fail to respond to this form of treatment. Consequently, it is essential to have a strategy for dealing with these individuals, which in our unit takes the form of at least providing continuing support and care, but also acknowledging the fact that any further improvement is rather unlikely.

The hypnotherapy that we provide is called "gut focused hypnosis." This is based on the premise that hypnosis can enable the subject to modify physiological functions not immediately accessible to conscious control, and we and others have accumulated evidence that this hypothesis is true in relation to the gastrointestinal system. Thus, the patient with IBS is taught strategies to try and control the various putative pathophysiological abnormalities that are thought to contribute to their condition in order to bring about symptom relief. We make absolutely no attempt to deal with or explore any deep-seated psychological or traumatic issues as we are a gastrointestinal unit and are not equipped to cross that boundary. However, it goes without saying that hypnosis is good for stress and anxiety, and we are perfectly happy to address this aspect of their problem. It therefore appears that hypnosis offers control of a wide range of parameters, and this might explain why it helps the whole symptom profile of the patient. Not only do the traditional symptoms of IBS improve, but so do all the "non-colonic" symptoms as well as features such as anxiety and depression. This is in stark contrast to pharmacological approaches, which often only help the abdominal pain or the bowel dysfunction depending on the drug and hardly ever help features such as lethargy or low backache.

Following our original controlled trial in 1984 demonstrating the efficacy of hypnotherapy in IBS, we have been continuously providing this form of treatment for sufferers, and despite the increasingly severe nature of the cases being sent to us these days, we still manage to achieve a success rate of approximately 70%. Obviously, this figure depends on how you define success, and for the purposes of audit and publication, we consider treatment has been successful if a patient says that compared with before treatment, his or her symptoms have been reduced by 50% or more. It is vital that the individual understands that IBS, just like conditions such as migraine or asthma, is not curable but we can teach them to control the condition. Furthermore, offering such a form of treatment would not make sense unless the beneficial effects were sustained and we have confirmed that the majority of successfully treated individuals remain well up to and beyond 5 years.

A response rate of 70% means that 30 of every 100 patients we treat fail to gain benefit from this modality, and it would be nice if we could predict responders to save the others the consequences of treatment failure, which can be emotionally quite traumatic. To date, we have not really been successful in this quest, although there are some common sense observations that can be made in the clinic, of which noting the patient's attitude is probably the best predictor of response. Healthy skepticism is not a problem but if there is a belief in a particular individual that this particular form of treatment is not going to work then it is probably not even worth trying. Patients need to know that they are learning a skill, and it is essential that they participate fully in the treatment process and practice the technique, preferably on a daily basis at least during the active treatment phase. In contrast to the usual doctor-patient interaction where patients are given a medication and passively wait for it to work, in our hypnotherapy unit, they are taught an active skill that

they then have to make work for themselves. Although we have never tried hypnotherapy in mild patients, we feel it may not be successful in this group, as there may not be sufficient motivation to practice enough to reach an adequate skill level. More recently, we have been assessing response to hypnotherapy in relation to the patients' imagery of their disease as well as how they perceive colors, and some interesting results are beginning to emerge. However, these data are far too preliminary for clinical application.

The success of our IBS hypnotherapy program has encouraged us to explore its utility in other functional gastrointestinal disorders, and we now have positive evidence in support of its use in functional dyspepsia as well as non-cardiac chest pain. In addition, we have some preliminary data suggesting that it may even be helpful in inflammatory bowel disease, and this and all the other research we have undertaken over the years is covered in detail in the review cited below.

References

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