Hypnosis Home Treatment for Irritable Bowel Syndrome: A Pilot Study

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HYPNOSIS HOME TREATMENT FOR IRRITABLE BOWEL SYNDROME: 
A Pilot Study

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Abstract: Hypnosis treatment often improves irritable bowel syndrome (IBS), but the costs and reliance on specialized therapists limit its availability. A 3-month home-treatment version of a scripted hypnosis protocol previously shown to improve all central IBS symptoms was completed by 19 IBS patients. Outcomes were compared to those of 57 matched IBS patients from a separate study receiving only standard medical care. Ten of the hypnosis subjects (53%) responded to treatment by 3-month follow-up (response defined as more than 50% reduction in IBS severity) vs. 15 (26%) of controls. Hypnosis subjects improved more in quality of life scores compared to controls. Anxiety predicted poor treatment response. Hypnosis responders remained improved at 6-month follow-up. Although response rate was lower than previously observed in therapist-delivered treatment, hypnosis home treatment may double the proportion of IBS patients improving significantly across 6 months.

Irritable bowel syndrome (IBS) is a common disorder characterized by abdominal pain and altered bowel function, which is ineffectively treated by conventional medical methods. Less than half of patients with severe symptoms report satisfactory relief 6 months after seeing doctors for their bowel condition (Whitehead, Levy, et al., 2004). The disorder is associated with substantial disability and quality-of-life impairment (Chang, 2004) and increases the average healthcare costs of individuals by 49% and nearly doubles their number of healthcare visits (Levy et al., 2001; Levy, Whitehead, Von Korff, & Feld, 2000).

A number of psychological treatments have been tested for the purpose of improving on the limited success of medical treatments for IBS. Among psychological therapy modalities tested for this purpose, cognitive-behavioral therapy and hypnosis currently have the best research evidence of success. Both of these treatments have been found

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in a number of studies, including randomized controlled trials (Drossman et al., 2003; Palsson, Turner, Johnson, Burnett, & Whitehead, 2002; Payne & Blanchard, 1995; Whorwell, Prior, & Faragher, 1984), to substantially benefit the majority of treated IBS patients.

Even though most published studies on cognitive-behavioral therapy and all the studies on hypnosis treatment have reported a significant therapeutic impact on IBS symptoms and these benefits have been demonstrated to last for years after treatment is completed (Gonsalkorale, Miller, Afzal, & Whorwell, 2003; Whorwell, Prior, & Colgan, 1987; Van Dulmen, Fennis, & Bleijenberg, 1996), wide implementation of these psychological treatments as adjunctive interventions for IBS faces significant obstacles. One problem is the added cost of such services. Successful psychological interventions for IBS generally require a course of clinical treatments that ranges from six to twelve or more sessions. The expense of such multiple treatment visits and the limited insurance reimbursement for psychological treatments of IBS keep these therapies unavailable to many patients.

Another barrier to widespread use of psychological treatments for IBS is the lack of availability of clinicians proficient in treating the disorder with these methods. Even though thousands of clinicians offer therapy with cognitive-behavioral therapy and clinical hypnosis, most of them do not have training and knowledge in the special gut-focused applications of hypnosis or cognitive-behavioral therapy for IBS. Further, clinicians using these techniques are unavailable in many places outside major urban population centers.

Our research team at the University of North Carolina (UNC) in Chapel Hill developed and tested a seven-session scripted protocol for the treatment of IBS and found it to be effective for improving IBS in two studies (Palsson, Turner, et al., 2002). Abdominal pain, bloating, and stool-form abnormality (hard or watery stools) all improved substantially after hypnosis treatment with this protocol. Most patients (87.5% and 94%) responded to this standardized treatment in the two studies, and improvement was well maintained at 10-month follow-up.

The availability of a written protocol that could benefit most patients when delivered verbatim opened the possibility of home treatment via audio recordings. We felt that if it were possible to deliver this treatment in an automated format, without the need for therapist contact, it would be an appealing option to reduce the cost and make hypnosis available as an adjunctive treatment to the many IBS patients who do not have access to such treatment with a clinician.

Hypnosis treatment administered via audio recordings has previously been reported to be effective for controlling a number of medical problems, including tinnitus (Brattberg, 1983), blood loss during oral surgery (Enqvist, Von Konow, & Bystedt, 1995), and postoperative nausea and vomiting (Enqvist, Bjorklund, Engman, &
Jakobsson, 1997). Only one prior published study (Forbes, MacAuley, & Chiotakakou-Faliakou, 2000) has tested audio recordings as IBS therapy. The investigators found that IBS symptom scores improved in 59% of the patients who used the tape recordings at home. However, the home intervention in that study was not hypnosis but rather a mix of patient education, stress-reduction training, hypnosis-type suggestions, and coping-skills training. The present study is therefore the first study of home hypnosis treatment for IBS.

AIMS

The primary aim of the study was to assess in a preliminary fashion whether hypnosis home treatment, delivered without contact with a therapist or added care by healthcare providers, improves IBS symptom severity and health-related quality of life above what may be expected from standard medical treatment. Secondary aims were to assess predictors of treatment response and the maintenance of the therapeutic effect after treatment ended.

METHOD

Subjects

Hypnosis participants were recruited through announcements on the Web site and in the newsletter of the UNC Center for Functional Gastrointestinal and Motility Disorders. To qualify for participation, subjects had to have been diagnosed with IBS by a physician and meet Rome II criteria (Drossman, Corazziari, Talley, Thompson, & Whitehead, 2000) for IBS. The primary physicians of enrolled patients were contacted, with the patients’ written permission, to confirm the patients’ clinical diagnosis and enrollment criteria.

To ensure that participants were in an active phase of their disorder, only subjects who reported at least one weekly episode of abdominal pain in the past 4 weeks were enrolled in the study. To minimize the risk of complications arising from unsupervised home practice of hypnosis, patients who had ever been diagnosed or treated for dissociative disorders, posttraumatic stress disorder, or borderline personality disorder or had a history of any other psychiatric disorder that included psychotic features were excluded from the study. Participating subjects could also not be on psychotropic medications (i.e., antidepressant, antipsychotic, or antianxiety medications) or be currently receiving psychological treatment for their IBS symptoms.

A total of 25 subjects were enrolled for hypnosis treatment. Of these, 19 subjects (76%) completed the study treatment protocol and evaluations, and the data from these subjects is reflected in the analyses below. One subject was disqualified during treatment due to false
reporting of exclusion criteria, and two dropped out during the treatment phase due to difficulty with maintaining regular home treatment. Three subjects signed up for the study but terminated contact with the investigators prior to beginning treatment.

To obtain an estimate of the advantage of hypnosis treatment over what could be expected from standard medical care alone, the hypnosis recipients were compared to matched IBS patients not in the study. The control subjects were 57 systematically selected Rome II IBS patients from a separate observational study of standard medical care in a large health maintenance organization, described elsewhere (Whitehead, Levy, et al., 2004), who had participated in a questionnaire study of clinical outcomes from standard medical care (73% completion rate). The control patients were matched three to one to hypnosis subjects who completed participation. The triple match for each hypnosis subject was done to minimize the bias from chance individual variability in the control group due to the small size of the hypnosis group. Control subjects were matched to hypnosis subjects on (a) gender, (b) age (+/− 1 year), (c) IBS severity at baseline (to the closest degree possible), and (d) race. As Table 1 shows, excellent match was achieved between the groups on all of these variables.

Table 1
Comparison of Subject Characteristics in the Two Groups at Baseline

<table>
<thead>
<tr>
<th>Variables</th>
<th>Hypnosis Patients (N = 19)</th>
<th>Control Patients (N = 57)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>43.7 (16.6)</td>
<td>43.5 (16.3)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Gender (% Female)</td>
<td>78.9%</td>
<td>78.9%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Race (% White)</td>
<td>94.7%</td>
<td>94.7%</td>
<td>n.s.</td>
</tr>
<tr>
<td>IBS Severity Score</td>
<td>288.4 (73.8)</td>
<td>288.5 (104.5)</td>
<td>n.s.</td>
</tr>
<tr>
<td>IBS-QOL Score</td>
<td>50.3 (21.0)</td>
<td>65.3 (21.66)</td>
<td>.011</td>
</tr>
<tr>
<td>BSI-Anxiety</td>
<td>54.9 (12.5)</td>
<td>50.2 (9.5)</td>
<td>n.s.</td>
</tr>
<tr>
<td>BSI-Depression</td>
<td>56.4 (13.2)</td>
<td>53.3 (10.3)</td>
<td>n.s.</td>
</tr>
<tr>
<td>BSI-Somatization</td>
<td>54.8 (8.8)</td>
<td>56.9 (8.7)</td>
<td>n.s.</td>
</tr>
<tr>
<td>BSI-General Severity Index</td>
<td>56.7 (11.26)</td>
<td>54.4 (9.1)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Number of Comorbid Medical Conditions</td>
<td>1.6 (1.9)</td>
<td>2.6 (2.4)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Completion rate (% of patients completing both baseline and posttreatment outcome data)</td>
<td>76%</td>
<td>73%</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

*aControl subjects were systematically selected from the HMO study pool of IBS patients to match hypnosis subjects on these variables
Questionnaires

The IBS Severity Scale (IBSS). The IBSS (Francis, Morris, & Whorwell, 1997) consists of five questions covering the frequency and severity of abdominal pain, severity of abdominal distention, dissatisfaction with bowel functioning, and life interference from IBS symptoms. These individual responses can be analyzed separately or added together for an overall index of IBS severity. The scale has been shown to discriminate patients from controls and discriminate between patients with mild, moderate, and severe symptoms as classified by clinical assessment. Test-retest reliability was judged to be excellent (Francis et al., 1997), but no correlation coefficient was given. This scale has been found to be sensitive to treatment change from hypnosis in several prior IBS studies (Gonsalkorale, Houghton, & Whorwell, 2002; Gonsalkorale et al., 2003).

IBS-QOL. This is a 34-item disease-specific, quality-of-life measure for IBS, which has high internal consistency (Cronbach’s alpha = .95) and high reproducibility over a 7-day interval (ICC = .86) (Patrick, Drossman, Frederick, Dicesare, & Puder, 1998). Drossman, Patrick, et al. (2000) assessed the responsiveness of the IBS-QOL to treatment in 156 female patients with functional bowel disorders and showed that changes in the IBS-QOL are modestly but significantly correlated with changes in pain reports on a 14-day diary (r = .25) and with changes in total scores on the Sickness Impact Profile (r = .28). The IBS-QOL was found to differentiate responders from nonresponders in a trial of cognitive-behavioral treatment and antidepressant trial for IBS. Thus, the scale is reliable, valid, and responsive to treatment.

Brief Symptom Inventory (BSI) 18. The 18-question BSI (Derogatis, 2000) is a brief version of the Symptom-Checklist-90-Revised (SCL-90-R). Respondents rate how much each symptom has bothered them in the past week on a 4-point ordinal scale. The inventory provides scores on three symptom scales for anxiety, depression, and somatization, as well as a general severity index score. Internal consistency (Cronbach’s alphas) for the scales ranges from .74 to .89, and the correlations with corresponding scales on the SCL-90-R are .91 to .96.

Tellegen Absorption Scale (TAS). The TAS (Tellegen & Atkinson, 1974) contains 34 true/false questions and is designed to measure a person’s capacity for absorption and imaginative involvement in his or her life experiences. It has internal reliability of .88 and a test-retest reliability of between .85 and .91 (Tellegen, 1985; Tellegen & Atkinson, 1974). The TAS has good construct validity and is normally distributed in the general population. This scale was included because it has been found to partly predict hypnotizability (Dixon,
Labelle, & Laurence, 1996), which may influence responsiveness to hypnosis treatment.

Comorbid Medical Conditions Questionnaire (CMCQ). This is an IBS-specific questionnaire that asks the respondent to report whether he or she has been diagnosed with each of 16 comorbid medical conditions. This questionnaire was developed and validated in our laboratory. It has an internal consistency of .67, test-retest reliability of .95, and a correlation of .64 with the Cornell Medical Index, another medical-history questionnaire (Palsson, Jones, Turner, Drossman, & Whitehead, 2002). The CMCQ was included in this study because IBS patients with comorbid medical conditions have sometimes been found in past work to respond more poorly than other patients to treatment.

Design

Assessment. Hypnosis subjects completed the IBSS, CMCQ, BSI, IBS-QOL, and TAS questionnaires at baseline, prior to beginning their hypnosis home treatment. During the 12-week home-treatment period, they completed weekly online logs on a password-protected web page of their home practice and their symptoms (these diary symptom ratings were secondary measures for exploratory purposes and are not presented in this paper). Hypnosis subjects also completed the IBSS, IBS-QOL, and BSI at the end of the treatment period as well as 3 and 6 months after the end of treatment.

The control subjects completed the same questionnaires as the hypnosis subjects at baseline, with the exception the TAS. They completed the IBS-QOL, IBSS, and BSI again 6 months after baseline measurement (at a time point equivalent to the 3-month posttreatment follow-up for the hypnosis group).

Treatment. The scripted seven-session hypnosis treatment protocol used in our two prior studies (Palsson, Turner, et al., 2002) was recorded verbatim by the principal author (OSP) and duplicated on a set of five audio compact disks (CDs). The recorded protocol consisted of seven different biweekly sessions, each of which was about half an hour in length, and a shorter (13 minute) hypnosis audio exercise for daily use. The total treatment period of this structured home-treatment sequence was 12 weeks. The session frequency and total treatment duration was the same as in our previous studies. An instruction booklet that explained the nature of hypnosis and the use of the CDs was created and provided to subjects with the CD set. Hypnosis subjects were instructed to initiate the 12-week home treatment immediately following their completion of the baseline questionnaires. Each subject’s compliance with the audio sessions was tracked via their weekly online log entries. The hypnosis subjects were advised to continue
medical care and treatments for their IBS provided by their physicians while participating in the study.

Control subjects received only the standard medical care provided by their physicians during the 6-month comparison interval. No control subject received psychological treatment during the time period reflected in the collected data.

All assessments of hypnosis subjects were completed through mail and the Internet to minimize contact with personnel that might have a therapeutic effect independent of the home treatment under investigation. The only direct contacts with investigators were e-mail communications with the study coordinator (and in the case of a couple of subjects, phone calls) to resolve practical matters regarding study participation and data collection. Control subjects completed all assessments (baseline and 6-month follow-up questionnaires) through mail.

The institutional review board at the University of North Carolina at Chapel Hill approved the study prior to subject enrollment.

**Data analysis.** Fisher’s exact tests were used to evaluate group differences in categorical data, and analyses of variance (ANOVA) tests were used to test group differences in continuous variables. Because the two patient groups were significantly different in IBS-QOL scores at baseline, analysis of covariance (ANCOVA) with the subjects’ baseline values as covariate variable was used to assess treatment changes in IBS-QOL scores.

Based on our prior analysis of different methods to measure therapeutic effects in IBS research (Whitehead, Palsson, et al., 2004), we selected a stringent criterion of a 50% or greater reduction in IBS symptom severity as the most appropriate definition of a treatment responder. Prior data show that, overall, 22% of clinical IBS patients receiving medical care can be expected to be treatment responders by this definition (Whitehead et al., 2004) at 6-month follow-up.

The primary time point selected for assessing treatment response was 3 months after the end of hypnosis treatment. This was done because it enabled us to compare outcomes directly to those of the matched control group after an equivalent time interval from baseline. However, scores on the main outcome measures were also obtained from the hypnosis group immediately after the end of treatment and at 6-month follow-up.

To test the effects of clinically significant psychological distress on treatment response, we first converted BSI scores to T-scores (scores reflecting standard deviation distance from the gender group mean) to adjust for gender differences. As suggested in the test manual (Derogatis, 2000), we classified patients with BSI T-scores of 63 or greater as clinically significantly distressed.
RESULTS

Comparison of Group Characteristics

Due to systematic matching, subjects in the hypnosis and control groups were nearly identical in regard to age, gender ratio, racial composition, and mean IBS severity at baseline. There were no significant group differences between the groups in psychological symptoms or comorbid medical conditions at baseline. However, baseline IBS quality-of-life scores were significantly lower in the hypnosis group compared to the control group (mean ± standard deviation: 50.3 ± 21.3 vs. 65.3 ± 21.6; \( p = .01 \)). This difference was corrected for by using baseline scores of the subjects as covariates in the IBS-QOL outcome analysis. The comparisons of baseline group characteristics are summarized in Table 1.

Treatment Outcomes

The main treatment outcomes for the two groups are presented in Figure 1. Fifty-three percent (10/19) of the subjects who completed hypnosis home treatment responded to treatment by 3-month follow-up, i.e., had ≥50% reduction in IBS symptom severity on the IBSS. In contrast, only 26%
(15/57) of controls met the same criterion for treatment responder. This group difference was statistically significant (Fischer’s exact test $p < .05$).

According to published score ranges for the IBSS (Francis et al., 1997), 6 of the 10 hypnosis treatment responders scored in the severe range (IBSS $\geq 300$) before treatment, and the remaining 4 responders were in the moderate range (IBSS $> 175$ and $< 300$). All 10 of these subjects converted to mild IBS severity scores ($< 175$) by 3-month follow-up.

ANCOVA results with baseline scores as covariates to control for baseline group differences showed that hypnosis subjects improved more in their IBS-QOL health-related quality of life scores compared to controls, $F(1, 78) = 14.08, p = <.0001$.

**Maintenance of Therapeutic Effects**

As shown in Figure 2, the improvements in IBS symptom severity and quality-of-life scores seen in hypnosis treatment responders at the end of treatment were fully preserved at 3- and 6-month follow-up. The nonresponders showed similar stability of their posttreatment severity levels.

![Figure 2](image-url)
Post-hoc Analyses of Changes in Psychological Symptoms After Hypnosis Treatment

All psychological symptom scores on the BSI were unchanged at the 3-month follow-up evaluation point compared to pretreatment scores for the hypnosis subject sample as a whole. Separate analyses of the BSI scores of the nonresponder and responder subgroups showed no changes in nonresponders. In the treatment responder group, somatization scores were significantly reduced after treatment ($T$-score mean $+/-$ standard deviation: $47.1 +/- 7.7$ vs. $52.4 +/- 7.6; p = .03$), but all other BSI variables were unchanged.

Assessment of Predictors of Treatment Response

Baseline scores on the TAS, CMCQ, IBS-QOL, IBSS, and scores for all the scales of the BSI 18 were compared for hypnosis responders and nonresponders in an effort to identify predictors of treatment response (see Table 2). Of the tested variables, only the BSI anxiety scores alone were significantly different in these subgroups. Only 14% ($1/7$) of patients with clinically significant anxiety met criteria for treatment responders after hypnosis treatment, whereas 75% ($9/12$) of nonanxious subjects were responders.

Table 2
Comparison of Predictor Variables in Responders vs. Nonresponders within the Hypnosis Group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Hypnosis Subgroup</th>
<th></th>
<th></th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Responders ($n = 10$)</td>
<td>Nonresponders ($n = 9$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>46.0 (15.2)</td>
<td>41.1 (18.5)</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Years with IBS</td>
<td>7.6 (8.8)</td>
<td>13.6 (13.3)</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>IBS Severity Score at baseline</td>
<td>298.5 (54.6)</td>
<td>277.2 (92.9)</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>IBS-QOL Score at baseline</td>
<td>57.4 (18.9)</td>
<td>42.6 (21.5)</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Significant Anxiety ($BSI t$-score $&gt; 63$)</td>
<td>10%</td>
<td>67%</td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>Significant Depression ($t$-score $&gt; 63$)</td>
<td>10%</td>
<td>22%</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Significant Somatization ($t$-score $&gt; 63$)</td>
<td>10%</td>
<td>44%</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Significant General Severity ($t$-score $&gt; 63$)</td>
<td>10%</td>
<td>33%</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Number of Comorbid Medical Conditions (CMCQ)</td>
<td>2.0 (1.0)</td>
<td>1.2 (0.6)</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Tellegen Absorption Scale Score</td>
<td>20.5 (9.1)</td>
<td>20.0 (6.3)</td>
<td>n.s.</td>
<td></td>
</tr>
</tbody>
</table>
Compliance with the home hypnosis treatment was good, based on the diary results. On the average, subjects completed a home practice session 5.3 times a week. There was no difference between the frequency of practice of responders and nonresponders. No adverse effects of the hypnosis treatment or practical difficulties with the audio treatment program were reported by the patients.

DISCUSSION

The findings of this study provide preliminary data that suggest that hypnosis home treatment by means of audio recordings may substantially increase the probability of favorable symptom change in IBS patients. Our data indicate that home hypnosis with the protocol we tested might double the proportion of IBS patients experiencing significant improvement in their overall symptoms across 6 months and that the therapeutic benefits in treatment responders remain undiminished beyond 6 months after treatment termination. Our results further indicate that this treatment is well received and free from practical obstacles, as no adverse effects or pragmatic difficulties were reported, and compliance with home practice was good.

It must be noted, however, that the treatment response rate observed in this study was substantially lower than seen in our previous studies of therapist-delivered treatment with the same scripts. Although the present study used a more stringent criterion to define treatment responders than our previous work, our examination of the outcome data for the individual nonresponders in the present study shows that all of them would also have been classified as nonresponders in our previous studies (Palsson, Turner, et al., 2002).

The study findings suggest that the home treatment mode of delivery may not benefit patients who have significant levels of anxiety, as indicated by the dramatic difference of 14% versus 75% response rate of anxious versus nonanxious patients. It is also likely that other measures of psychological distress will be found to attenuate the response to treatment in a larger study of this home treatment, judging from the numerically higher percentages of other psychological distress variables in the nonresponders in Table 2, even though those differences did not reach statistical significance in this comparison of small groups. Also, some patients may not have the time or inclination to complete this intensive 3-month home treatment course on their own (as represented by 2 individuals dropping out of our initial test sample of 25 for that reason).

It seems likely, if the lower response rate to home-based hypnosis treatment compared to face-to-face treatment persists in future tests, that in-person treatment by a therapist will continue to be the gold standard of psychological treatment for IBS. Home treatment may nonetheless be an appealing option for enhancing rates of clinical improvement for
patients who cannot access such care by a therapist and who do not have psychological distress. However, future studies with a more definitive design and larger samples will be needed to confirm the therapeutic value of the home treatment version of our IBS hypnosis protocol.

This first test of hypnosis home treatment for IBS was only designed to provide preliminary answers to the study questions, and as a pilot study it had significant limitations. The main limitations pertain to the fact that the selection of subjects into groups was not randomized and that the patients in the control group were not participating in the same kind of study as the hypnosis patients. Because the subjects who enrolled in the hypnosis group knew that their study participation entailed treatment with hypnosis, it is possible that self-selection bias of people open to participating in hypnosis treatment affected the outcome. However, the same kind of self-selection would also determine which medical patients would accept and use a hypnosis home treatment package when offered by their healthcare providers, so this bias is unlikely to affect the conclusions that can be drawn from our results about the potential benefits of this intervention method.

The study did not control for this effect, favoring better outcomes for the hypnosis group, which may have come simply from enhanced positive expectancy of benefit due to receiving a credible intervention in additions to standard medical care alone. However, that same advantage would again apply if patients were offered this intervention as an adjunctive treatment in medical settings.

Although the two groups of patients compared in this pilot study were from different samples, the validity of the results is strengthened by the high degree of comparability of subjects in the two groups on key characteristics, due to the availability of a very large sample of control patients from which to select patients for matching. The fact that the groups were practically identical in gender, age, IBS severity, and race composition reinforces our confidence in the results of the outcome comparisons.

We conclude based on the promising results of this trial that the home treatment version of our standardized IBS treatment protocol warrants further study, especially in light of its very low cost of delivery, absence of any added burden on healthcare providers, and easy application to large numbers of patients.

REFERENCES


**Hypnotische Behandlung des Reizdarmsyndroms im natürlichen Milieu:**
*Eine Pilotstudie*

Olafur S. Palsson, Marsha J. Turner und William E. Whitehead


Ralf Schmaelzle
*University of Konstanz, Konstanz, Germany*

**Traitement par l’hypnose à domicile du syndrome du côlon irritable: une étude pilote.**

Olafur S. Palsson, Marsha J. Turner, and William E. Whitehead

Résumé: le traitement hypnотique améliore souvent le syndrome du côlon irritable (irritable bowel syndrome, IBS) mais les coûts et la dépendance vis à vis des thérapeutes spécialisés limite sa disponibilité. Une version de traitement à domicile de 3 mois d’un protocle d’hypnose précédemment
transcrit a prouvé une amélioration de tous les symptômes centraux de l’IBS après avoir été complété par 19 patients souffrant d’IBS. Les résultats ont été comparé à ceux des 57 patients assortis d’une étude séparée ayant reçu un soin médical standard. 10 des sujets hypnotisés (53%) répondaient au traitement 3 mois après (la réponse est définie par plus de 50% de réduction de la gravité de l’IBS) contre 15 (26%) dans le groupe contrôle. Les sujets hypnotisés ont amélioré les scores de qualité de vie par rapport au groupe contrôle. L’anxiété prévoyait une réponse faible au traitement. Les personnes ayant réagit au traitement par l’hypnose montrait toujours une amélioration 6 mois plus tard. Bien que les taux de réponse étaient plus faibles que ceux observés lors d’un traitement transmis par un thérapeute, le traitement hypnotique à domicile pourrait doubler les proportions de patients souffrant d’IBS qui amélioreraient leur condition sur une période de 6 mois.

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Tratamiento Hipnótico en Casa para el Síndrome de Colon Irritable: Un Estudio Piloto

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Resumen: El tratamiento con hipnosis a menudo mejora al Síndrome de Colon Irritable (SCI), pero los costos y la dependencia en terapeutas especializados limitan su disponibilidad. Una versión del tratamiento hipnótico en casa con un protocolo completamente redactado de 3 meses que previamente había mostrado mejorar todos los síntomas centrales del SCI fue completada por 19 pacientes. Los resultados fueron comparados con los de 57 pacientes de SCI de un estudio separado que recibieron sólo el cuidado médico convencional. Diez (53%) de los sujetos hipnóticos respondieron al tratamiento en un seguimiento de 3 meses (se definió la respuesta como reducción de más de 50% en la severidad del SCI) vs. 15 (26%) de los controles. Los sujetos hipnóticos mejoraron más en calidad de vida que los controles. La ansiedad predijo mala respuesta al tratamiento. Quienes respondieron a la hipnosis mantuvieron su mejoría en un seguimiento de 6 meses. Aunque la tasa de la respuesta fue más baja que la observada previamente en el tratamiento controlado por el terapeuta, el tratamiento hipnótico en casa puede duplicar la proporción de pacientes de SCI que mejoran sensiblemente durante 6 meses.

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