International Journal of Clinical and Experimental Hypnosis

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/nhyp20

Hypnosis for Irritable Bowel Syndrome: The Empirical Evidence of Therapeutic Effects

William E. Whitehead

a University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA

Published online: 16 Feb 2007.

To cite this article: William E. Whitehead (2006) Hypnosis for Irritable Bowel Syndrome: The Empirical Evidence of Therapeutic Effects, International Journal of Clinical and Experimental Hypnosis, 54:1, 7-20, DOI: 10.1080/00207140500328708

To link to this article: http://dx.doi.org/10.1080/00207140500328708

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HYPNOSIS FOR IRRITABLE BOWEL SYNDROME:
The Empirical Evidence of Therapeutic Effects

WILLIAM E. WHITEHEAD

University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA

Abstract: Irritable bowel syndrome (IBS) is a complex and prevalent functional gastrointestinal disorder that is treated with limited effectiveness by standard medical care. Hypnosis treatment is, along with cognitive-behavioral therapy, the psychological therapy best researched as an intervention for IBS. Eleven studies, including 5 controlled studies, have assessed the therapeutic effects of hypnosis for IBS. Although this literature has significant limitations, such as small sample sizes and lack of parallel comparisons with other treatments, this body of research consistently shows hypnosis to have a substantial therapeutic impact on IBS, even for patients unresponsive to standard medical interventions. The median response rate to hypnosis treatment is 87%, bowel symptoms can generally be expected to improve by about half, psychological symptoms and life functioning improve after treatment, and therapeutic gains are well maintained for most patients for years after the end of treatment.

Irritable bowel syndrome (IBS) is a prevalent and complicated functional gastrointestinal disorder with poorly understood etiology, which has proven difficult to treat for both primary care medicine and gastroenterology. Many IBS patients experience little or no relief in their bowel symptoms from conventional medical interventions. For example, we recently found in a large HMO survey (Whitehead et al., 2004) that only 49% of patients who visited primary care doctors for IBS reported that their symptoms were at least somewhat better 6 months later.

Because of this limited effectiveness of standard medical care, many alternative or complementary treatments for IBS have been tested. These have included several psychological therapy modalities: biofeedback, relaxation training, brief psychodynamic therapy, behavioral and cognitive interventions, and various combinations of these treatments. Although all of these psychological treatment modalities...
have been reported to have some impact on IBS in published work, some have shown indifferent outcomes and few have been extensively tested. Hypnosis and cognitive-behavioral therapy are the two psychological treatments that have been most investigated for IBS and show promise for making a substantial difference in the disorder.

The first study reporting successful application of hypnosis for IBS treatment was published in 1984 (Whorwell, Prior, & Faragher, 1984). Since that time, the empirical literature on the use of hypnosis in IBS has grown to a body of 15 publications, but only 11 of these (Forbes, MacAuley, & Chiotakakou-Faliakou, 2000; Galovski & Blanchard, 1998; Gonsalkorale, Houghton, & Whorwell, 2002; Gonsalkorale, Miller, Afzal, & Whorwell, 2003; Gonsalkorale, Toner, & Whorwell, 2004; Harvey, Hinton, Gunary, & Barry, 1989; Houghton, Heyman, & Whorwell, 1996; Lea et al., 2003; Palsson, Turner, Johnson, Burnett, & Whitehead, 2002; Prior, Colgan, & Whorwell, 1990; Simren, Ringstrom, Bjornsson, & Abrahamsson, 2004; Vidakovic-Vukic, 1999; Whorwell, Houghton, Taylor, & Maxton, 1992; Whorwell, Prior, & Colgan, 1987; Whorwell et al., 1984) focused on therapeutic effects—the others are studies of mechanism (Lea et al., 2003; Prior et al., 1990; Simren et al., 2004; Whorwell et al., 1992). Without exception, the 11 hypnosis studies that have reported on therapeutic outcome in IBS, summarized in Table 1, have reported hypnosis to be effective in ameliorating the bowel symptoms of large proportions of the treated patient samples. However, the research methodology and the quality of the work have varied greatly. In this article, I will briefly summarize the evidence for the effectiveness of hypnosis treatment that these studies provide and discuss what can be concluded from this body of work about the benefits that hypnosis can be expected to afford IBS patients. I will also highlight some of the current limitations and future needs in this research domain.

**SUMMARY OF THE EVIDENCE**

**Controlled Studies**

It is a generally accepted minimum standard for research assessing the effectiveness of any medical therapy to use one or more control groups and randomly assign subjects to the groups to be compared. This is important, because such a design provides controls for many kinds of potential confounding influences on outcome, such as patient expectancy of improvement, spontaneous changes in the symptom course over time, and some types of experimenter bias. To date, four studies on hypnosis for IBS have been published that satisfied these two basic design criteria, and one additional study was a controlled comparison without randomization.
Table 1  
Studies Reporting Therapeutic Benefits of Hypnosis Treatment for IBS

<table>
<thead>
<tr>
<th>Authors and Year</th>
<th>Beneficial Effects:</th>
<th>Hypnosis n</th>
<th>Hypnosis Success Rate</th>
<th>Control Group</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Randomized Controlled Treatment Studies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whorwell et al., 1984</td>
<td>A, B</td>
<td>15</td>
<td>100%</td>
<td>Psychotherapy &amp; Placebo Pills</td>
<td>Hyp. Superior</td>
</tr>
<tr>
<td>Forbes et al., 2000</td>
<td>B</td>
<td>25</td>
<td>76%</td>
<td>Audiotape</td>
<td>Hyp. Superior</td>
</tr>
<tr>
<td>Palsson et al., 2002 (Study II)</td>
<td>A, B, S</td>
<td>24</td>
<td>87%</td>
<td>Waiting list controls</td>
<td>Hyp. Superior</td>
</tr>
<tr>
<td><strong>B. Nonrandomized Controlled Treatment Studies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Houghton et al., 1996</td>
<td>B, D, H, Q</td>
<td>25</td>
<td></td>
<td>Standard Medical Care</td>
<td>Hyp. Superior</td>
</tr>
<tr>
<td><strong>C. Uncontrolled Treatment Studies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harvey et al., 1989</td>
<td>B</td>
<td>33</td>
<td>61%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palsson et al., 2002 (Study I)</td>
<td>A, B, S</td>
<td>18</td>
<td>93%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whorwell et al., 1987</td>
<td>B</td>
<td>50*</td>
<td>95% for classic IBS 60% for cases with comorbid psychopathology 43% for atypical IBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vidakovic-Vukic, 1999</td>
<td>B</td>
<td>27</td>
<td>89%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonsalkorale et al., 2002, 2003</td>
<td>A, B, H, Q, S</td>
<td>250</td>
<td>71%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonsalkorale et al., 2004</td>
<td>A, B, C, Q, S</td>
<td>78</td>
<td>Not reported</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A = Affective symptoms, B = Bowel Symptoms, C = Cognitions, D = Disability, H = Health Care Utilization, M = Medication use, S = somatization/extra-colonic symptoms, Q = Quality of Life.

* included the 15 patients reported in Whorwell et al. (1984).
Two of the randomized and controlled studies compared hypnosis treatment to another therapy that was likely to carry expectancy of therapeutic benefit. The first of these was the study by Whorwell and colleagues published in the *Lancet* in 1984 (Whorwell et al., 1984), which also was the first study in this research domain. The investigators randomly assigned 30 patients who had severe IBS that was refractory to standard medical care to either seven sessions of hypnosis treatment, delivered over a 12-week period, or to a control group that received the same amount of psychotherapy plus placebo pills (thus receiving a double placebo, as the psychotherapy was presumed to have little effectiveness). The hypnosis group showed very substantial improvement in all the central IBS symptoms after treatment and was significantly more improved on all outcome variables than the control group, which only showed minimal improvement (slight decrease in abdominal pain and bloating). Remarkably, every single IBS patient treated with hypnosis in this study improved, and a later paper (Whorwell et al., 1987) reported that all the patients remained better at 18-month follow-up, although a couple of them had needed further hypnosis sessions to counter relapses. Even though this study was small, it was a landmark trial in this research domain both because it was the first study demonstrating the potential for hypnosis as a therapeutic modality for IBS and because it is to date the only study to use a placebo control.

Forbes and colleagues (2000) randomly assigned 56 patients to either 6 sessions of gut-directed hypnotherapy (25 patients) or an audiotape home intervention (27 patients) that contained elements of patient education, stress reduction training, hypnosis-type suggestions, and coping skills training. The gastrointestinal symptoms of the hypnosis group improved significantly more ($p < .05$) compared to the audiotape group. The responder rate among the hypnosis subjects was also numerically higher (76% vs. 59%), although that difference did not achieve statistical significance. Although psychological and quality-of-life scores were also measured in this trial, the investigators were unable to obtain posttreatment responses for nearly half of the sample, and the findings on these parameters (although reported as nonsignificant trends toward improved psychological well-being and quality of life) are therefore not interpretable.

The other two trials that were both randomized and controlled used symptom monitoring, i.e., patients who were waiting for the test treatment, as a control condition. This is a markedly weaker design than parallel comparisons with an alternative treatment because it does not control for patient expectancy of therapeutic gain and may in fact create negative expectancy (that is, patients may expect not to get any better while waiting for treatment). However, the waiting-control design does safeguard against spontaneous changes in symptoms over time. This may be useful in studies of disorders such as IBS that have
a fluctuating-symptoms course and especially in studies on medical patients seeking clinical care. Patients with chronic disorders are likely to seek treatment (including research treatments) during peaks in symptom severity and may thus be expected to show some spontaneous improvement in the subsequent months, which might create a false impression of therapeutic effect from clinical interventions.

Palsson et al. (2002) randomized 24 patients to either a waiting list or immediate hypnosis treatment. The hypnosis patients were treated with a sequence of seven hypnosis sessions over a 3-month period, using a standardized protocol where the entire treatment course followed the same verbatim scripts for all patients. Significant reductions in all bowel symptoms were seen in the hypnosis group after treatment, but there were no improvements in the control group after an equal period of time. Once the waiting group had completed treatment, the combined response rate for the whole sample was 87% (21/24), as determined by a combination of subjective rating of improvement and reduction in bowel symptoms on symptom diaries. Abdominal pain and abnormal bowel functioning (number of days with hard or watery stools) were reduced by about half on symptom diaries after treatment, and abdominal bloating showed a smaller but significant improvement. Anxiety and somatization symptoms were also markedly reduced. All treatment responders remained improved at follow-up 10 months after treatment.

Galovski and Blanchard (1998) likewise randomized six pairs of IBS patients to immediate hypnosis treatment or a waiting control condition, but 1 patient was removed from analysis, resulting in data on 11 patients being reported. Patients who received hypnosis treatment were significantly more improved on a composite bowel-symptom scale after treatment compared to waiting control subjects, and all bowel symptoms were found to be improved significantly after treatment when the pre- and posttreatment values for the whole sample were analyzed.

Houghton and colleagues (1996) conducted a controlled comparison of 1-year follow-up outcomes for 25 IBS patients who completed a course of hypnotherapy in addition to receiving standard medical care versus 25 patients with equivalent bowel-symptom severity who received only standard medical care. In addition to greater improvement in their physical symptoms, the individuals in the hypnosis group showed greater reduction in extra-colonic symptoms (general physical symptoms outside the gastrointestinal tract) and greater gain in quality-of-life scores, took significantly less time off work after treatment if they were employed and were more likely to return to work if they had been unable to work (of 4 patients who were not working in the hypnosis group, 3 resumed working, whereas none of the 6 control patients not working returned to work).
Uncontrolled Studies

Of the six uncontrolled outcome reports in the literature, two reports from the Manchester group on the same sample of patients deserve the greatest attention because of the large sample size (greater than the samples in all the other studies combined), the thoroughness and detail of outcome data collected and reported, and the long follow-up period. These publications provide the best information to date on the overall potential for hypnosis treatment in routine use for management of IBS. The first of these reports (Gonsalkorale et al., 2002) details the outcomes of a series of 250 consecutive IBS patients treated by several hypnotherapists in the investigators’ Manchester clinic with a course of hypnosis of 12 or more weekly sessions according to the well-delineated protocol developed by Whorwell. The median post-treatment bowel-symptom severity score for the group was 53% lower than before treatment; median ratings of all bowel symptoms were reduced by more than half; anxiety and depression scores were substantially decreased; and quality-of-life scores were improved. The second report (Gonsalkorale et al., 2003) complemented the previous one with long-term follow-up data on 204 patients from the clinic’s case series. The follow-up was conducted annually for up to 5 or more years after treatment. The authors reported that 71% of patients could be classified as treatment responders (defined as all patients who rated themselves very much better or moderately better after treatment). Follow-up assessments showed that 81% of treatment responders retained their improvement up to 5 or more years beyond the end of treatment. The percentage of patients remaining better did not decrease with years from end of treatment, indicating that the maintenance of benefit does not degrade much over the subsequent years. The investigators found that the great majority of patients had continued to further improve in their bowel symptoms after treatment and that most of the 19% who reported deterioration at follow-up reported only partial worsening rather than full relapse. Furthermore, patients were significantly less likely to use medications for IBS and consult physicians after treatment and had far fewer nongastrointestinal symptoms (like back pain or headache).

Palsson et al. (2002) reported an uncontrolled study on the treatment of 18 subjects that, even though small and primarily aimed at examining the mechanism of the therapeutic effects, is noteworthy because it was the first test of an entirely scripted 7-session therapy protocol, the same as used in their controlled study described above. Seventeen out of 18 patients were judged improved from treatment in this trial. Abdominal pain, bowel-functioning abnormality, and bloating all improved substantially after treatment, as did anxiety, overall psychological distress, and somatization scores.
Harvey and colleagues (1989) published a report on treatment of 33 patients that was unusual compared to other studies in this domain in two ways. First, the intervention was the shortest one tested to date, consisting of only four hypnosis sessions over 7 weeks. Second, some of the patients were treated in groups of up to 8 and some individually. The investigators found that 20 of the 33 patients (61%) improved from the treatment and reported that 11 of those had lost all their symptoms.

Whorwell, Prior, and Colgan (1987) reported on outcomes for 50 patients treated with a course of hypnotherapy in a report that included the sample of 15 hypnotherapy patients from their 1984 study. They found different success rates based on the characteristics of patients and symptoms. Patients who had classic IBS symptoms had a 100% success rate in treatment if they had no comorbid psychopathology and 60% success if they did have comorbid psychopathology; atypical IBS cases had a 48% success rate; and patients over age 50 generally did poorly, with only 25% rate of success. These early conclusions regarding the poor prognosis of older patients and those with comorbid psychiatric symptoms have been superseded by the group’s later analysis of predictors of outcome in a much larger sample (Gonsalkorale et al., 2003), which showed only very small adverse effects of age or psychopathology on outcome.

Gonsalkorale et al. (2004) investigated cognitive changes following a 12-session course of hypnotherapy in 78 IBS patients, using a scale designed to measure dysfunctional cognitions related to functional bowel disorders. Unhelpful bowel-related cognitions improved significantly, with reduction seen in the total cognitive score and all component themes related to bowel function. Overall symptom reduction correlated with improvement on the cognitive scale. The authors also described clinical outcomes for this sample and these were in line with their previous reports, but since these patients were also in the larger sample described in the investigator’s prior papers (Gonsalkorale et al., 2002), the outcomes will not be detailed here.

Finally, Vidakovic-Vukic (1999) in Holland reported “significant” improvement in 24 out of 27 IBS patients treated with a course of 10 to 14 hypnosis sessions but provided no statistical results in what appears to have been a preliminary report that was never followed by the intended report of the more complete study.

OVERALL CONCLUSIONS

Success Rate

As stated earlier, hypnosis has been reported to be successful in impacting IBS symptoms in all the 11 outcome studies published to date. Where success rates have been reported, they have ranged from
61% to 100% (see Table 1) with a median success rate of 87% (for this calculation, Whorwell et al.’s 1987 report is excluded, because it included multiple success rates for different subgroups and partly included subjects from their previous 1984 study). Although investigators have not used a consistent approach to deciding who is a treatment responder, it nonetheless appears clear from these high rates of success that the great majority of IBS patients treated with hypnosis enjoy marked improvement. This is a strikingly high degree of success considering the fact that most of these studies have documented that they only enrolled subjects who had already failed standard medical treatment, and many of the treated patients had already tried multiple other interventions without benefit. This is a fact often overlooked in discussions of this form of treatment for IBS and highlights a great potential for hypnosis as an adjunct to medical treatment to enhance outcomes in management of the disorder.

**Degree of Impact on Symptoms**

Due to the heterogeneity of outcome methods in the published studies and lack of detail in many of them, it is hard to get an overall sense of the degree of impact on symptoms. Some of the studies have reported only the statistical significance of change rather than the actual pre- and posttreatment scores. The two research groups that have published repeated studies using consistent treatment protocols, the Manchester group in England and our team at UNC-Chapel Hill, have also been the ones providing the most detailed outcome data, but they have used very different assessment methods and different statistics (medians vs. means) to report the treatment changes. The Manchester group has used a 10-day retrospective bowel-symptom questionnaire (Francis, Morris, & Whorwell, 1997), whereas our group has used 2-week summary scores of 5-point daily symptom diary ratings where respondents are asked to rate the worst instance of each symptom each day.

It is not possible to know if the outcomes from the two teams are equivalent, because it is unknown how similarly these measures respond to change. However, regardless of how it is measured, the impact on symptoms documented by both groups has been very substantial. Both teams have consistently found abdominal pain severity and bowel-habit dysfunction to be reduced by half or more in the patient samples. The Manchester group has also found bloating severity to improve by more than half, whereas our studies show a mean reduction of one-fourth or less in bloating (Palsson et al., 2002).

The best single quantitative summary of the impact of hypnosis treatment on IBS is perhaps the reduction from a score of 334 to 155 (values calculated from data presented in the paper) on the composite bowel-symptom severity index, reported by Gonsalkorale and...
colleagues (2002) in their sample of 250 patients. Published cut-offs for classifying IBS severity on this scale (Francis et al., 1997) place IBS patients with scores above 300 in the severe range and those with scores of 175 or less in the mild range. In other words, the Manchester group has demonstrated in their large case series that the median severity of IBS moves from a severe case to a mild case after a course of therapy with hypnosis.

**Scope of Therapeutic Benefits**

In addition to changes in bowel symptoms, the studies that have measured other outcomes have consistently found anxiety, depression, somatization, and the number of extra-intestinal symptoms to also be substantially reduced after treatment and quality-of-life scores to be enhanced. These changes correlate moderately with the degree of therapy-related bowel-symptom reduction (Gonsalkorale et al., 2002) and are sufficiently large to be a marked extra benefit to patients beyond bowel-symptom improvement. These changes in psychological symptoms associated with treatment are furthermore highly clinically significant: Using conventional clinical cut-offs for the Hospital Anxiety and Depression Scale, the Manchester group calculated that hypnosis treatment reduced by half or better the percentage of individuals who had clinical anxiety (34.3% vs. 69.3%) or depression (14.6% vs. 36.1%) in their series of 250 patients (Gonsalkorale et al., 2002).

**Predictors of Treatment Response**

As described above, an early report by Whorwell and colleagues (1987) indicated that patients older than 50 were substantially less likely to benefit from hypnosis intervention. Later work by this group has confirmed that there is some statistically significant negative effect of greater age, but the impact on therapy responsiveness seems to be quite small, accounting only for about 2% in outcome scores. Age is therefore unlikely to be a significant barrier to benefit from this treatment.

Whorwell and colleagues also reported in 1987 that patients with identified psychopathology were less likely to respond to treatment. Little data have been published since then to confirm or disconfirm that observation. Galovski and Blanchard (1998) reported a significant positive correlation between therapeutic response and the presence of psychiatric diagnoses, but this result is likely to be unreliable because of the shortcomings of the statistics (Pearson correlation using ordinal data from only 11 subjects). In short, the relationship between psychopathology and treatment response remains unclear and needs to be investigated in future work.

Finally, Gonsalkorale et al. (2002) found in their analyses of 250 patients that males with diarrhea-predominant bowel pattern had
a significantly lower average response rate than other IBS patients. This is an interesting and unexplained observation and this interaction between gender, bowel-habit type, and therapeutic response should be investigated in future work.

**Maintenance of Therapeutic Gains**

All available data indicate that most patients who experience significant symptom relief after a course of hypnosis treatment can expect to stay better for 1 or more years after treatment. Two small studies (Palsson et al., 2002; Whorwell et al., 1984) showed that all patients who responded to treatment were still reporting improvement at 10 months and 18 months after treatment, respectively. Gonsalkorale et al.’s (2003) long-term follow-up of 204 patients demonstrated that approximately 4 out of every 5 patients who respond to treatment fully retain their therapeutic benefits for years (outcome assessed for 1 to 5 years after treatment) and that most continue to see further improvement in bowel symptoms after the end of the treatment course.

**Limitations of Current Research and Need for Future Work**

a. **Design limitations.** The chief factor limiting the impact of the growing empirical literature on hypnosis for IBS is the design of most of the studies published to date. It is clear from review of this body of publications that more and better randomized controlled trials are sorely needed in this domain, especially studies comparing hypnosis treatment to other interventions with demonstrated impact on IBS (Whitehead, 2004). For most of the time period that this research covers, no IBS-specific medications were available, and there were no particular medications with recognized efficacy in treating IBS. Now, however, there are two IBS-specific drugs on the market and more on the way, and a recent meta-analysis confirms that antidepressants help IBS (Jackson et al., 2000). Hypnosis intervention should be compared side-by-side to these medications in randomized trials. The effects of hypnosis and cognitive-behavioral therapy (the best established other psychological treatment for IBS) should also be compared in a parallel fashion. Furthermore, combinations of hypnosis and medications that are effective for IBS are likely to achieve even better results than either hypnosis alone or medications alone, since hypnosis presumably achieves its impact on symptoms via different mechanisms than medications, and trials should therefore be conducted on such combined interventions.

b. **Varied and unclear nature of the tested interventions.** The hypnosis interventions that have been tested for IBS in the 11 studies described above have varied considerably. The number of treatment sessions has ranged from four to twelve or more. The study by Harvey and colleagues (1989) that used the shortest course of treatment (four
sessions over 7 weeks) was also the one with the lowest success rate. At the other end, the use of 12 or more sessions, which is now the norm for the Manchester group, does not seem to add anything to success rates, as the studies with the highest success rates have used 7-session protocols (Palsson et al., 2002; Whorwell et al., 1984). However, the Manchester group’s outcome data with a 12+ session therapy course (Gonsalkorale et al., 2002) suggest that they may be achieving greater general impact on symptoms than other investigators (although this is not possible to determine directly due to different measurement methods), so there could be some advantage to a long sequence of sessions. Determining the optimal “dose” that achieves the fullest benefit for most patients while remaining cost-effective is an important goal for future research in this area.

c. Heterogeneity of outcome measures. Comparison of the effectiveness of therapy across studies requires basic comparability in outcome measures. This has not been achieved in research on hypnosis for IBS. Bowel symptoms, emotional symptoms, and quality of life have all been measured in several different ways. Success rates have also been determined in ways that vary from study to study and make direct quantitative comparison questionable. It is important that investigators make a concerted effort to achieve uniformity in outcome measurement, as this is a major weakness in achieving a cumulative body of evidence in this research area. Our team has recently adopted Francis et al.’s (1997) IBS severity scale as an outcome measure in our hypnosis work, partly to make our outcomes directly comparable to those of the Manchester group, which has published most research in this area. It would be highly desirable for other groups to do the same.

d. Lack of detailed description and standardization of treatment. The description of the hypnosis treatment tested in the published studies has often been entirely inadequate to give other investigators or therapists an idea of the therapy approach that was used. This problem is somewhat lessened by the fact that the bulk of the studies have followed Whorwell’s Manchester protocol or our North Carolina protocol, both of which are available in detail from the investigators. However, published studies that do not follow such well-delineated and generally available methodologies need to contain a thorough description of the intervention, detailing the kind of therapeutic suggestions and imagery that were used, if they are to be of value to the field.

SUMMARY AND CONCLUSIONS

The literature on hypnosis treatment for IBS is to date a collection of studies that are generally small and sometimes poor in design. However, these studies report consistent IBS symptom reduction that
is very substantial, is associated with broad improvement in psychological well-being and life functioning, can be just as readily achieved by patients who have not had relief from standard medical care, and may generally be expected to last for years. The cumulative weight of this research, which now includes a placebo-controlled trial, four other controlled trials, and a very large case series with long-term follow-up, leaves little doubt that hypnosis is the best choice, rivaled only by cognitive-behavioral therapy, for effective treatment of severe IBS patients who fail to respond to medical management.

REFERENCES


Hypnose beim Reizdarmsyndrom: Empirische Evidenz für therapeutische Effekte

William E. Whitehead


RALF SCHMAELZLE

University of Konstanz, Konstanz, Germany

L’hypnose dans le traitement du syndrome du côlon irritable: évidence empirique d’effets thérapeutiques.

William E. Whitehead

Résumé: Le syndrome du côlon irritable (Irritable bowel syndrome -IBS) est un trouble intestinal complexe qui prévaut dans les troubles gastro-intestinaux et qui est traité avec une efficacité limitée par les soins médicaux standards. Le traitement hypnotique est, avec la thérapie cognitivo-comportementale, la thérapie la mieux documentée en tant qu’intervention pour l’IBS. Onze études, incluant 5 études contrôles, ont évalué les effets thérapeutiques de l’hypnose dans le traitement de l’IBS. Bien que les
informations aient des limites significatives telles que la taille de l’échantillon et le manque de comparaisons en parallèle avec d’autres formes de traitement, le corpus de la recherche montre de façon consistante que l’hypnose a un impact thérapeutique substantiel sur l’IBS, même chez des patients insensibles aux traitements médicaux standards. Le taux médian de réponse au traitement hypnotique est de 87%; on s’attend généralement à une amélioration de moitié des symptômes du côlon, des symptômes psychologiques et d’une amélioration du quotidien de la vie après le traitement. Ces avantages thérapeutiques sont bien maintenus chez la plupart des patients des années après la fin du traitement.

Victor Simon
Psychosomatic Medicine & Clinical Hypnosis Institute, Lille, France

Hipnosis para el Síndrome de Colon Irritable (SCI): Evidencia Empírica de Efectos Terapéuticos

William E. Whitehead
Resumen: El Síndrome de Colon Irritable (SCI) es un trastorno gastrointestinal, predominantemente funcional, para el que el tratamiento médico convencional tiene una eficacia limitada. El tratamiento hipnótico, junto con la terapia cognitivo-conductista, es la terapia psicológica mejor investigada como intervención para el SCI. Once estudios, incluyendo 5 experimentales, han evaluado los efectos terapéuticos de la hipnosis para el SCI. Aunque esta literatura tiene limitaciones importantes, como muestras pequeñas y falta de comparaciones con otros tratamientos, la investigación muestra consistentemente que la hipnosis tiene un impacto terapéutico substancial en el SCI, aún para pacientes que no responden a las intervenciones médicas convencionales. La tasa mediana de respuesta al tratamiento con hipnosis es 87%, con una expectativa de reducción de síntomas intestinales de la mitad, y mejora en síntomas psicológicos y funcionamiento vital después del tratamiento; la mayoría de los pacientes mantienen las ganancias terapéuticas años después de finalizar el tratamiento.

Etzel Cardeña
University of Texas, Pan American, Edinburg, Texas, USA