Hypnotherapy and Refractory Irritable Bowel Syndrome: A Single Case Study

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The current study describes the successful administration of hypnotherapy with a subject suffering from refractory Irritable Bowel Syndrome (IBS) and Generalized Anxiety Disorder (GAD). The subject had suffered from IBS for 30 years and had unsuccessfully pursued multiple psychological treatments, both traditional and non-traditional. He was referred to the Center for Stress and Anxiety Disorders and commenced hypnotherapy directed primarily at the IBS symptoms. After 6 treatment sessions, his IBS symptomatology had improved 53%. He stopped treatment at that point and continued autohypnosis with the aid of treatment audiotapes provided by his therapist. Follow-up at 6 months indicated continued improvement (70%). A 2-year follow-up revealed an improvement of 38% in IBS symptomatology. Concurrent levels of depression and anxiety had also substantially decreased. Hypnotherapy is shown to be a viable, palatable, and enduring treatment option for an individual who had been refractory to many previous therapies.

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Irritable Bowel Syndrome (IBS) is a common functional disorder of the lower gastrointestinal (GI) tract. Recent epidemiological studies suggest that upwards of 17% of the adult population of the United States may be affected by this disorder. However, only a small percentage of those experiencing IBS symptoms ever seek medical treatment (Talley et al., 1991). Women are more often diagnosed with IBS than are men at a ratio of 2:1, and the diagnosis typically occurs in a person’s early twenties (Drossman et al., 1988; Lynn & Friedman, 1993; Blanchard et al., in press).

In the absence of other gastrointestinal diseases such as intestinal parasites, lactose intolerance, and inflammatory bowel disease, the diagnosis of IBS is made based on a symptom picture consisting of abdominal pain accompanied by altered bowel habit (diarrhea and/or constipation) (Thompson et al., 1992). Because there exists no consistent physiological, biochemical or structural abnormalities associated with this disorder, gastroenterologists and IBS patients alike are continually frustrated with the lack of effectiveness of existing medical treatment (antispasmodics, bulking

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agents, anti-diarrheals, etc.). As a result, IBS patients are often referred to mental health professionals given the efficacy of a number of psychosocial treatments for IBS symptoms.

A growing body of literature suggests that treatment-seeking IBS patients endorse a significantly elevated level of psychological distress (depression, anxiety, etc.) as indicated by scores on standardized psychological tests. Likewise, these patients also are diagnosed with more psychiatric disorders than other chronic pain populations (tension and migraine headache sufferers) and normal controls (Blanchard et al., 1986). The higher incidence of psychological distress in this population is arguably related to the incidence of GI distress. For a review of this literature, see Blanchard (2001).

Over the course of the last two decades, four different classes of psychosocial interventions for IBS have met with varying degrees of success in controlled treatment trials. These include brief psychodynamic psychotherapy (Guthrie et al., 1991), cognitive-behavioral intervention (Blanchard et al., 1992), cognitive therapy alone (Greene & Blanchard, 1994), and hypnotherapy (Whorwell et al., 1984). Whorwell’s work and results were successfully replicated across multiple sites (Harvey et al., 1989; Galovski & Blanchard, 1999). For a more thorough review of the literature regarding these psychosocial therapies, see Blanchard (1993).

Case Report

The client was a 55-year-old married father of one son. He was referred to the Center for Stress and Anxiety Disorders seeking treatment for IBS. He presented with a 30 year history of IBS and Generalized Anxiety Disorder (GAD). He had pursued a remarkable number and range of psychological and medical treatments targeting IBS over the course of a 25 year span. Such treatments included the following: two years of biweekly sessions of insight-oriented psychotherapy; two years of Eastern/Gurgiefian meditation at the Arica Institute; one year of group therapy involving batakas, expressed rage, scream therapy, etc.; three years of bioenergetic therapy; one year of biofeedback; five years (five times a week) of psychoanalysis; two years of transactional therapy; two years of marital counseling, and several medication regimens including diazepam (Valium), buspirone (BuSpar), and desipramine (Norpramin).

The client stated at the initial assessment that previous therapy had helped him to achieve closure on the “unresolved/conflicted issues in my upbringing,” but that this newly acquired insight had not affected his IBS symptom patterns. The daily medication regimen of buspirone (105 mg) and desipramine (40 mg) reportedly reduced his IBS symptomatology to some extent, but he endorsed continual unmanageable anxiety as well as persisting residual IBS symptoms. His conceptualization of his IBS symptoms appeared to be psychodynamic in that he attributed his symptomatology to repeated “tortured enemas” administered to him by his parents at a young age. This conceptualization left him to wonder if he had “insidiously internalized some sadomasochistic bowel-learning.”

At the initial assessment, I administered the SUNY IBS structured interview (Blanchard, 2001). I determined that the client did, in fact, meet the Rome Criteria (Thompson et al., 1992) for a diagnosis of IBS. He completed the Beck Depression Inventory (BDI; Beck et al., 1961) to assess for his current level of depressive symptomatology and the State Trait Anxiety Inventory (STAI; Spielberger, Gorusch,
& Lushene, 1970) to assess for levels of current and trait anxiety. I instructed the client to monitor his IBS symptoms on a daily symptom diary. I scheduled the first session for the following week.

Method

At the initial assessment, I asked the client to reconceptualize the IBS symptoms as a reaction to a given stressor or general anxiety. I elaborated on the connection between the body’s physiology and the mind. We discussed the rationale for treatment at this point. I explained that hypnotherapy acts on this mind-body connection by targeting the mind through hypnosis in order to bring the body’s physiology under control. In essence, the body’s natural, physiological processes (such as gut motility), which normally are controlled unconsciously or automatically, are now brought under conscious control. Hypnotherapy is thus a learning process during which the patient corrects gut spasm and pain, and returns the GI tract to normalcy.

After establishing a symptom baseline through a week of symptom monitoring, the client began treatment. I based the treatment on the protocol supplied by Whorwell et al. (1984). The specific intervention is identical to the one used in the controlled Albany trial (Galovski & Blanchard, 1999). The treatment consisted of 6 weekly sessions lasting approximately 50 minutes each.

All sessions began with a review of the previous week’s diaries and included trouble-shooting any problems, questions, or concerns that may have arisen. I induced hypnosis each session through an eye fixation technique and deepened with progressive relaxation. Session 1 primarily focused on ego-strengthening suggestions and utilized metaphoric guided imagery (i.e. likening personal growth and strength to an oak tree). Each subsequent session included progressively more gut-directed suggestions and imagery. Such imagery included smoothly flowing rivers and streams, waterfalls, etc. I compared such imagery with the human body’s gut motility. I instructed the client to place his hands on his gut and to generate a feeling of warmth and control that he could feel flowing into his intestines. This feeling was strengthened by his placing the second hand on top of the first as a reinforcing sensation of warming. Post-hypnotically, the placing of hands on the abdomen in this position served as a cue for the body to generate these feelings of warmth, soothing, and control. (A more detailed description of the sessions can be provided upon request.) As the sessions progressed, I used the client’s input as to what phrases and suggestions had been particularly helpful and implemented them into the current session. I taped the sessions and provided the client with the tape to practice on a daily basis during the week between sessions. In this manner, I customized the practice tapes to the client’s preferences in order to optimize the likelihood of continued weekly practice. The patient used tapes for practice rather than self-initiated self-hypnosis in accordance with previous trials (Whorwell et al., 1984; Galovski & Blanchard, 1999) demonstrating empirical support. Six months after the conclusion of treatment, the client completed one more week of monitoring through the use of the symptom diary, a second BDI and STAI as well as visual analog of global improvement. Twenty-four months after treatment conclusion, I got in touch with the patient and asked him to complete a final BDI, STAI, and week of symptom monitoring.

Results
Statistical Analysis

I calculated a single index, called a Composite Primary Symptom Reduction (CPSR) score, through the reduction of the data provided by the daily symptom monitoring diaries. This calculation follows the method used by Blanchard and Schwarz (1988) and has been used consistently throughout the Albany IBS Research Program. The CPSR score provides an index of overall change in IBS symptom level and serves the function of reducing Type I error stemming from the analysis of multiple symptoms. The CPSR score also provides a means for describing clinically significant changes in the symptom picture. The score can be conceptualized as an overall percent improvement score. The CPSR score is calculated as follows:

The calculation involves the primary symptoms of IBS with which the given individual presents. In this case, the subject’s primary symptoms included abdominal pain/tension, bloating, and flatulence. First one calculates symptom reduction scores (SRSs) for these primary symptoms as follows:

Bloating reduction score:

\[
\text{Bloating reduction score} = \frac{\text{Average pretreatment bloating rating} - \text{average post-treatment bloating rating}}{\text{Average pretreatment bloating rating}}
\]

These scores are then used to calculate the overall CPSR score as follows:

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\text{CPSR score} = \frac{\text{Bloating reduction score} + \text{flatulence reduction score}}{2} \text{ (or 3) (depending on the number of symptoms present)}
\]

The subject’s CPSR score was calculated as a 53 following 6 sessions of hypnotherapy. With continued practice, the CPSR score continued to improve at the six-month follow-up point and was calculated at 70. Finally, at the two-year follow-up point, the CPSR score was calculated at 38. Thus the subject can be considered to have improved 53% following treatment, 70% at the six month follow-up, and 38% at the two year follow-up in overall IBS symptomatology.

Blanchard and Schwarz (1988) established categories of *clinically* significant improvement based on the CPSR score. These categories are arbitrarily constructed and have been readily accepted in the IBS literature. These categories are utilized in nine of the Albany published outcome trials in peer-reviewed journals (Blanchard, 2001) as well as in independent laboratories (Lynch & Zamble, 1989; van Dulmen et al., 1996). These categories are as follows: CPSR scores of 50-100% are rated as “Improved”, CPSR scores of 25-49% are rated as “Somewhat Improved”, CPSR scores of 0-24% are rated as “Unimproved” and negative CPSR scores are rated as “Worsened”. This subject’s posttreatment score of 53% falls in the “Improved” range, the six-month follow-up score of 70% clearly pushes the high end of the “Improved” category, and the two year follow-up CPSR score falls into the “somewhat improved” category.

Psychological Tests

I administered the BDI and the STAI at the six-month and two-year follow-up points. The subject’s level of depressive symptomatology, as measured by the BDI decreased from a pretreatment score of 13 to a post-treatment score of 10 at six months, and to a score of 6 at the two-year point. More notably, the subject’s anxiety levels decreased as indicated by STAI scores. Prior to treatment, the subject scored a 49 on the state anxiety index. This score decreased to a 38 at post-treatment and to 36 at the
two-year follow-up point. Trait anxiety showed similar decreases from a pre-treatment score of 68 to a post-treatment score of 52 and finally to a 42 at the two-year follow-up point.

**Verbal Report**

At the six-month follow-up, the subject rated his level of symptom improvement on a visual analog scale. This scale allows a patient to rate level of overall improvement, improvement in abdominal pain/tension, bowel regularity and general well-being on a continuum anchored at one end by “−100” (representing “much worse” symptoms) to a “0” (representing “no change”) to a “+100” (representing “much improved symptoms”). At post-treatment, the patient reported 80% improvement in overall GI symptomatology, 80% improvement in abdominal pain/tension, 80% improvement in bowel regularity, and an 80% improvement in overall feelings of general well-being. He also reported a positive experience of weight gain of 10 pounds. He decreased buspirone by almost half. By the six-month follow-up, he had increased medication for depression but maintained his lowered dosage of buspirone. At the two-year follow-up point, the patient reported having discontinued buspirone altogether and having reduced desipramine.

Anecdotally, at the post-treatment point, the subject reported experiencing “incredible symptom free” weeks for the first time “in the past 30-odd years.” He described his realization of the connection between stress and anxiety and his IBS symptoms. He felt more equipped to cope with stress and the concurrent IBS symptoms as they arise and continues to use his auto-hypnosis tapes sporadically. Finally, the subject described his treatment gains as such: “Sound like routine IBS symptom amelioration to you? It may be, but not to me. But we still have to see where this is heading. I’m not out of the woods yet; but I am moving more freely among the trees and they are thinning out. Thanks.” Six months later, the subject’s overall improvement increased by 30%. At the two-year follow-up point, he reported continued, sporadic practice with hypnosis tapes when he feels the need and describes himself as “largely IBS symptom-free”.

**Discussion**

The effectiveness of hypnotherapy in treating IBS has been demonstrated across sites in several controlled clinical trials. A single case study can never rule out all alternative hypotheses. However, this study continues to provide support for the efficacy of this intervention in a very refractory IBS patient. The current subject had tried a wide variety of psychological treatments over the years to no avail. After 6 sessions of hypnotherapy, the subject realized 53% improvement in symptomatology. These results are similar to those published in the preceding controlled treatment trial where subjects improved an average of 52% at post-treatment (Galovski & Blanchard, 1999) adding support to the current conclusions. With time and continued autohypnotic practice, this improvement increased to 70% at the six-month point and decreased to a 38% at the two-year follow-up. Thus the effect of the hypnotherapy appears to be relatively enduring. Perhaps more importantly, the subject reports substantial relief from IBS symptoms for the first time in over 30 years. Concurrently, the subject also indicated substantial decreases in levels of state and trait anxiety. He was also able to decrease his medication regimen substantially.
Given the prevalence of IBS in the general population, hypnotherapy provides a viable treatment option for sufferers seeking psychological intervention. The lack of treatment drop-outs, the relatively short duration of treatment (6-12 sessions), and the ease of administration by experienced hypnotherapists makes this a highly palatable and viable treatment option for the IBS population.

References


