Hypnotherapy¹ as an adjuvant for the management of inflammatory bowel disease: A case report

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Abstract
Idiopathic inflammatory bowel diseases (IBDs) significantly affect the quality of life of sufferers. Improved quality of life and patient symptom management may be achieved through integrating psychological/behavioral interventions with pharmacologic treatments. Here is our experience with hypnotherapy as an adjuvant management for an 18-year-old female with Crohn’s Disease (CD) in remission (patient I) and a 24-year-old female with CD in active phase (patient II). The patients participated in 12 weekly one-hour sessions of hypnotherapy. Gut-directed, ego-strengthening, and post-hypnotic suggestions and immune-directed imaginations were used. After the hypnotherapy course, symptoms, psychological state, and quality of life improved in patient I, but not patient II (according to questionnaires). After a 6 month follow-up, symptoms and quality of life were the same as at the end of hypnotherapy sessions in both patients. The patients reported the greatest benefit of hypnotherapy was in helping them to cope better with their disease and also in improving their psychological state. Hypnotherapy may improve quality of life of IBD patients in remission and help them to cope better with their disease. Well-designed controlled clinical trials are needed in this field.

Keywords: Inflammatory bowel disease, Crohn’s disease, hypnotherapy, complementary, psychological, coping, quality of life.

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Hypnotherapy for IBD

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Ulcerative Colitis (UC) and Crohn’s Disease (CD; collectively termed Inflammatory Bowel Diseases (IBDs)) are worldwide chronic disorders of the gastrointestinal system. UC is characterized by diffuse mucosal inflammation limited to the colon and CD is characterized by patchy, transmural inflammation, which may affect any part of the gastrointestinal tract. The prevalence of UC and CD in general population is about 1-2% and 0.5-1%, respectively. Both UC and CD are diseases of young people with a peak incidence between the ages of 15 and 30 years (Hanauer, 2006).

Symptoms of IBD include chronic diarrhea, with blood and mucous, abdominal pain, weight loss, and sometimes vomiting (Carter, Lobo, & Travis, 2004). Fatigue is often prominent and perceived as disabling by patients (Minderhoud, Oldenburg, van Dam, & Berge Henegouwen, 2003). The clinical course of IBD is variable, with periods of remission and recurrent attacks for long terms. These attacks may require frequent hospital visits and periods of hospitalization (Carter, Lobo, & Travis, 2004).

The course of the disease is unpredictable and there is no realistic hope for cure in patients with IBD. Treatment must focus on prevention of complications, induction and maintenance of remission, and also improvement and preservation of quality of life (Carter, Lobo, & Travis, 2004). Like other chronic diseases, IBD causes significant long-term morbidity, healthcare resource use, and impaired quality of life (Drossman et. al., 1991; Pizzi et. al., 2006), particularly because the presentation of the disease often occurs at a young age and has the potential to cause lifelong ill health. Factors found to influence the quality of life of patients with IBD include the severity of symptoms, symptoms of Irritable Bowel Syndrome (IBS) during remission, recurrence of the disease, destructive coping strategies with the disease, psychological disorders, cognitive representation of the disease, sleep disturbances, knowledge about the disease and etc. (Guthrie et. al., 2002; Han et. al., 2005; Levenstein, 2004; Minderhoud, Oldenburg, Wismeijer, Berge Henegouwen, & Smout, 2004; Ranjbaran et. al., 2006; Sainsbury & Heatley, 2005; Simren et. al., 2002). To improve the quality of life in patients with IBD, clinicians’ attention needs to be drawn toward these factors.

Hypnotherapy is a complementary therapy that has the potential to affect many of those above mentioned factors. Evidence has demonstrated that hypnotherapy is effective in reducing symptoms of functional gastrointestinal disorders and related anxiety and depression (Calvert, Houghton, Cooper, Morris, & Whorwell, 2002; Gholamrezaei, Khanpour Ardestani, & Emami, 2006) and in improving cognitions related to the disease (Gonsalkorale, Toner, & Whorwell, 2004). It is also a powerful stress-management strategy (Stanley, Norman, & Barrows 2001) which may have therapeutic benefits for patients with IBD (Milne, Joachim, & Niedhardt, 1986). Moreover, evidence showed that hypnosis with immune-directed imaginations can be a modulator of cellular immune dysregulation during acute stress (Gruzelier, Smith, Nagy, & Henderson, 2001; Kiecolt-Glaser, Marucha, Atkinson, & Glaser, 2001); one of the important factors that can cause recurrence of the disease in patients with IBD (Duffy et. al., 1991).

Here is our experience of hypnotherapy as an adjuvant for the management of one patient with CD in remission and one with active CD. The aim of this report is not to show the effectiveness of hypnotherapy for IBD, as well-designed trials are needed to achieve this aim. However, our goal was to show the reasonability and feasibility of using gut-directed hypnotherapy with immune-directed suggestions and imaginations for IBD patients with the hope that it will promote future well designed trials. At first, we presented a brief description of each case, then the method of intervention and its results are explained.
Case history

Case one
The client was an 18-year-old, unmarried female referred to the Hypnotherapy Unit, seeking complementary management for IBD. She was diagnosed with CD (with the involvement of stomach) four years earlier. Her symptoms at the time of referral included mild, occasional abdominal pain and fatigue. She was on mesalazine, talidomid, cellcept, imipramine, triflupirazine, and predenizolone. Although administration of the Hospital Anxiety and Depression Scale (HAD; Montazeri, Vahdaninia, Ebrahimi, & Jarvandi, 2003) did not show severe depression (score = 4) or anxiety (score = 4), corresponding physicians stated that she was suffering from significant depression. Her quality of life was measured by the short form IBDQ (Casellas, Alcala, Prieto, Miro, & Malagelada, 2004) and showed impairments in systemic symptoms and emotional functions.

Case two
The client was a 24-year-old, newly married female referred to the Hypnotherapy Unit seeking complementary management for IBD. She had received a diagnosis of CD (with the involvement of the colon and terminal ileum) one year earlier. Her symptoms at the time of referral included severe and frequent abdominal pain, unexplained chest pain, and diarrhea. She was also suffering from a severe gastroesophageal reflux disease associated with hiatal hernia. She was on lansoprazole, azathioprine, asacol, famotidine, and loperamide. Administration of the HAD scale showed significant depression (score = 15) and anxiety (score = 12). Her quality of life was measured by the short form IBDQ and showed impairments in all dimensions; bowel symptoms, systemic symptoms, emotional functions, and social functions.

Gut-directed hypnotherapy

Patients participated in 12 weekly one-hour sessions of hypnotherapy on a one-to-one basis with the same therapist (AG). Sessions were conducted during the afternoon. A quiet room was selected so there would be no surrounding disturbances. Also, a special chair appropriate for relaxation was provided for the patients.

Session one
Our purpose in the first session was to allow the patient to become familiar with hypnosis and the treatment setting. The patient also received information about IBD including its pathophysiology, symptoms, treatments, and the contribution of psychological factors. Myths about hypnotherapy were sought, discussed, and corrected (Dowd, 2000). Content and procedure of hypnotherapy and its possible mechanisms and expected results were explained. Questions were answered, consent form was completed, and a standard method of hypnotic relaxation with deep breathing was done. The patient was asked to practice relaxation until the next week.

Session two
In the second session, gut-directed, ego-strengthening, and post-hypnotic suggestions were added. Gut-directed suggestions were based on what is used in the management of IBS which included hand warmth on abdomen associated with imagination of a safe haven and direct suggestions about gastrointestinal symptoms: “...the power of the mind being channeled into the gut, soothing it and comforting it, developing control over
Hypnotherapy for IBD

it and putting it back to normal…”, “…no more rushing, no more hurrying, but there again, no delays, no hold-ups…”, “…and the lining of the gut becoming less sensitive, less reactive, just normal sensitivity…” (Gonsalkorale, 2006). The tree metaphor was used for ego-strengthening (Heap & Aravind 2002). Posthypnotic suggestions consisted of reminding the patient that by practicing these techniques, she will gradually gain more control over the digestive system. Also, she was reminded that the process naturally takes time and practice, patience, and persistence, but she will do it and she can more readily reduce symptoms when needed, by putting the hands on the abdomen, and feeling the warmth and comfort (Gonsalkorale, 2006).

Session three

At the beginning of the third session, some pictures related to mucosal layer of the gut and its immune system and cells were shown to the patient. A picture was shown about aggressive reactions of immune cells to villi of the gut. The patient was told that in this session she would find a way to control these decontrolled immune cells. After induction and deepening procedures, the patient was asked to imagine that with each inhalation she directs the healing light into the inside. Then, this healing light (associated with warmth) moves through the gastrointestinal tract part by part and makes every part lighter and warm. Suddenly, she finds a part of gut with decontrolled immune cells which are attacking the villi of the gut. Then, the patient imagines conducting the light and warmth to those cells, so they became controlled and relaxed. After this immune-directed imagination, direct suggestions related to symptoms and posthypnotic suggestions were used: “…less and less pain, less and less discomfort…more and more energy…”; “…and whenever you need to control your gut, all you have to do is to put your hands on your tummy and you’ll feel this same sense of warmth and comfort…” After the third session, the patient received a specific compact disk of hypnotherapy for homework. It contained two 45-minute sessions: one with gut-directed suggestions and one with immune-directed imaginations. The patient was asked to listen to the compact disk twice a week (each time listening to one session).

Session four to twelve.

Subsequent sessions involved repetition of the gut-directed and immune-directed techniques and modifications were made as necessary, based on feedback from the patient and progress made.

Results

Both patients completed the course, although they did not follow their homework completely. The patients could clearly visualize gut-directed, immune-related, and ego-strengthening suggestions.

After the hypnotherapy course, symptoms, psychological state, and quality of life significantly improved in case one. After 6 months follow-up, symptoms and quality of life were the same as at the end of hypnotherapy. In this follow-up period, case one was practicing a relaxation technique, but rarely used the compact disk (because its length of 45 minutes is too long). Corresponding physicians stated that the most significant change was improvement in the patient’s mood.

In case two, symptoms, depression, anxiety, and quality of life were not improved after the hypnotherapy course. However, she reported that she could cope better with her disease. Six month follow-up did not demonstrate any improvement, though she participated in three additional sessions.

Both patients reported that the greatest benefit of hypnotherapy was in helping them to cope better with their disease and also improved psychological state.
Discussion

Psychological factors are known to have a long-term effect on the physiological system, particularly on gastrointestinal motility and the immune response (Bhatia & Tandon, 2005; Collins, 2001). Stressors may affect the expression of symptoms in patients with IBD (Bhatia & Tandon, 2005; Collins, 2001; Garcia-Vega & Fernandez-Rodriguez, 2004). Evidences have suggested that stress due to both psychosocial events and negative emotions mainly affect the course of the disease by exacerbating the primary symptoms and suggest a stress-symptom association with IBD (Bhatia & Tandon, 2005; Collins, 2001; Mittermaier et. al., 2004). Both psychological and physical stresses can adversely increase epithelial permeability. This barrier dysfunction may initiate and/or promote pathogenic immune reactions. Therefore, it must be put in context with stress-induced immune dysfunction when dealing with symptoms and disease flare-ups related to stress in patients with IBD (Soderholm & Perdue, 2001).

Considering these evidences, we can hope that interventions aimed at improving patients’ stress tolerance, depressive symptoms, and coping capacities might not only improve perceived quality of life (Guthrie et. al., 2002), but could potentially decrease bowel inflammation and reduce some patients’ need for toxic medications or surgery (Levenstein, 2004).

There are several reasons for using hypnotherapy in the management of IBD patients. 1) Hypnosis can help the patient to achieve a deep relaxation state, particularly if the therapist instructs the patient to practice self-hypnosis regularly. Relaxation has some positive outcome for immunity (Gruzelier, 2002). Moreover, self-hypnosis and relaxation procedures are of proven benefit for insomnia (Heap, & Aravind 2002). Insomnia is one of the factors that affects the quality of life and symptoms of patients with IBD in remission (Ranjbaran et. al, 2006). 2) Hypnosis can be used as a powerful stress management technique and helps patient to cope better with daily stresses. In this way, it may prevent the recurrent attacks of the disease (Stanley, Norman, & Barrows 2001). 3) Controlled studies showed that gut-directed hypnotherapy is effective in decreasing symptoms of IBS and functional dyspepsia (Calvert, Houghton, Cooper, Morris, & Whorwell, 2002; Gholamrezaei, Khanpour Ardestani, & Emami, 2006). IBS-like symptoms affect the quality of life of patients with IBD in remission (Minderhoud, Oldenburg, Wismeijer, Berge Henegouwen, & Smout, 2004; Simren et. al., 2002). Also, patients with IBD may suffer from esophageal hypersensitivity (Galeazzi et. al, 2001). A new controlled study showed that hypnotherapy is effective in treating unexplained chest pain where one of its causes is esophageal hypersensitivity (Jones, Cooper, Miller, Brooks, & Whorwell, 2006). 4) Some studies have shown modulating effects of hypnotic imaginations related to the immune system on immunity (Gruzelier, Smith, Nagy, & Henderson, 2001; Gruzelier, 2002). An interesting finding was that immune up-regulation (measured by salivary IgA) only occurred in those given specific immune-related imagery compared to those given non-specific relaxation imagery (Olness, Culbert, & Uden, 1989). 5) Hypnotherapy could be added to cognitive-behavioral therapy, which has been used successfully for IBD patients (Mussell, Bocker, Nagel, Olbrich, & Singer, 2003). This combination may enhance therapeutic effects (Kirsch, Montgomery, & Sapirstein, 1995).

In summary, though hypnotherapy is not a panacea, it is a useful complementary treatment for gastrointestinal diseases. Hypnotherapy with gut-directed suggestions and immune-directed imaginations seems to be a promising complementary management tool for patients with IBD in remission. The benefit of hypnotherapy for IBD patients in remission is also reported by a recent study (Keefer & Keshavarzian, 2007). Although our patient with active CD did not achieve significant positive results from hypnotherapy, this was a single case report with several limitations (most importantly sample size and lack of the control
Hypnotherapy for IBD

group) and so without definite conclusion. More recently, a trial of gut-directed hypnotherapy for 15 patients with severe or very severe IBD who did not respond to medication (corticosteroids) showed significant improvement in severity of the disease and quality of life (Miller & Whorwell, 2008). It is hoped that these reports (Keefer & Keshavarzian, 2007; Miller & Whorwell, 2008; Schafer, 1997) stimulate further research by means of well designed placebo controlled trials into the effectiveness of hypnotherapy for IBD (Jensen & Patterson, 2005; Gholamrezaei & Emami, 2008 for conducting placebo controlled trials on hypnotherapy). Recommendations for conducting well-designed research trials on the efficacy of hypnotherapy for IBS (Gholamrezaei, Khanpour Ardestani, & Emami, 2006; Talley, Owen, Boyce, & Paterson, 1996) are also applicable in the case of IBD.

Footnote

1For this article, “hypnotherapy” is defined as a combination of hypnosis and therapeutic interventions.

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Hypnotherapy for IBD


