

Hypnotherapy for Irritable Bowel Syndrome: A Role in Pediatric Practice?

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Over the centuries, hypnosis has been used to treat a wide variety of conditions and before the advent of anesthetics was often used to control the pain associated with surgery. Unfortunately, much of the literature supporting its use is anecdotal and this, taken with the activities of stage hypnotists, has led to much skepticism surrounding the whole subject. Therefore, if hypnosis is ever going to gain any respectability, research into the phenomenon must conform to modern scientific standards. Our unit has been endeavoring to undertake such research into the use of hypnotherapy in functional gastrointestinal disorders for many years and hopefully our efforts may encourage others to adopt what could be potentially a useful adjunct to conventional therapeutic approaches to medicine.

Our first trial compared the effect of seven, thirty minute sessions of hypnotherapy spread over twelve weeks with that of an equal time devoted to supportive therapy in thirty patients with irritable bowel syndrome (IBS). At the end of the treatment period the hypnotherapy group experienced significantly greater improvement in abdominal pain, bloating, bowel habit and general well being than those receiving supportive therapy (1). Subsequently, further studies confirmed this preliminary finding and also showed that treatment had a positive impact on quality of life (2,3). Many patients with IBS also suffer from a wide range of extra colonic features such as nausea, fatigue, back-ache as well as urological and gynecologic symptoms which also seem to respond to hypnosis (3). These positive results enabled us to establish a National Health Service hypnotherapy unit staffed by seven therapists who could provide treatment to patients referred from the gastroenterology clinic or their general practitioners. An audit of the work undertaken by this unit demonstrated that, even when provided by a diverse group of therapists, outcomes remain favorable (4). An additional consistent theme in all our studies has been that patients report a significant decrease in their medication needs, less time off work and a marked reduction in the number of consultations with either general practitioners or hospital consultants (4). A further study in patients with functional dyspepsia revealed very similar

results with both symptoms and quality of life improving and an even more dramatic reduction in medication needs and consultation behavior (5).

Hypnotherapy is a time consuming form of treatment which is consequently expensive to provide and should therefore only be reserved for patients who have failed to respond to other therapeutic approaches. However, even in these refractory patients, it is essential that any beneficial effects are sustained, preferably without the need for further sessions, if it is going to be a practical solution for these individuals. To answer this question, we have recently completed a study assessing the long term benefits in patients who have previously been treated by the unit. Symptom and quality of life scores were compared before, immediately after, and up to five years after a course of hypnotherapy. 83% of original responders remained well during the follow up period with a marked reduction in medication needs and far fewer consultations with their doctor (6).

The mechanisms involved in the induction of hypnosis are very poorly understood and it is therefore not surprising that very little is known about how the phenomenon mediates its benefit. Of the wide range of pathophysiological mechanisms involved in IBS it seems likely that motility, visceral sensation, psychologic factors, cognitive function and central processing would seem to be those most likely to be amenable to modification by hypnosis. We have evidence that hypnosis can reduce colonic phasic contractions (7) and visceral sensation also appears to be normalized (8,9). In those subjects who have heightened visceral sensitivity, this is reduced and in hyposensitive individuals there is a tendency for sensation to increase (9). This improvement in visceral sensation does not correlate with a reduction in anxiety levels suggesting that the changes observed are not just reflections of psychologic factors being alleviated. However, anxiety and depression levels do consistently improve in patients following hypnotherapy (4) and must undoubtedly contribute to a favourable impact on the patient's overall wellbeing even if they do not influence the observed physiological changes.

Cognitive function does appear to be disturbed in IBS, with patients tending to think much more negatively about their condition. A cognitive scale for functional gastrointestinal disorders has been developed which

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enables this problem to be quantified (10). We have found highly significant improvements in cognitive function following hypnotherapy (11) which is of interest as our therapeutic approach does not directly seek to change the cognitive process. It therefore seems that patients intuitively learn to positively improve their cognitions without necessarily being specifically advised on how to achieve this.

There is increasing evidence that the central processing of afferent signals is different in IBS patients when compared with controls (12) and although the data are not entirely consistent, one area of the brain that seems to be affected by this process is the anterior cingulate cortex. In previous brain imaging studies it has been shown that hypnotically induced analgesia is accompanied by a reduction in the activation of the anterior cingulate cortex but not the somato-sensory cortex (13). This is of interest as not only is this the location of the emotional response to pain but also one of the areas effected in IBS. Thus, it is tempting to speculate that hypnotherapy might at least mediate some of its beneficial effect in IBS through this cortical sub-region.

We have estimated that the overall response rate to hypnotherapy is in the region of 75% in females and somewhat less in males, where response is much more dependent on bowel habit with the diarrhoea predominant sub-group being least responsive (4). Thus, for every one hundred patients we treat, at least 25 will fail to respond. It would therefore be extremely useful if there was some way of predicting responders so that resources could be concentrated on those most likely to do well and we could avoid disappointing patients unlikely to derive benefit from this particular approach. This latter point is especially important as for many of these individuals, hypnotherapy represents their last chance of finding some relief from their symptoms. Unfortunately, we have not been able to identify any factors of predictive value and hypnotic susceptibility does not seem to be important. This latter observation is probably not surprising as only a small proportion of the population are "deep" hypnotic subjects and if this was essential one might only expect an approximately 5–10% response rate. At present therefore our current policy is to offer this treatment to all those requesting it with the exception of those with significant psychiatric disease. We are well aware that we are a gastroenterology and not a psychiatric unit and feel that it is vital that these boundaries are well recognised.

Hypnosis is an easy technique to learn but its application takes a considerable amount of skill and practice. In the field of gastroenterology, the benefits seem to be maximised by a "gut focused" approach rather than just offering general relaxation to the patient (14). Hypnotherapy is very time consuming to provide and is therefore not really suitable for the busy physician to undertake on a personal basis. We have shown that it can be readily provided by a team of qualified, non-medical therapists, under the supervision of a specialist gastroenterologist who can provide the necessary medical back-up. The response rate is impressive and it has

recently been suggested that "it is becoming increasingly hard to ignore the notion that the skills of the hypnotherapist should be made routinely available to patients with functional GI disorders" (15). This is probably not yet practical but certainly the technique is worthy of consideration by departments specialising in functional gastrointestinal disorders. The provision of such a service leads to a large number of referrals and because it only has a finite response rate, it is important to have a contingency for caring for patients who do not respond. In our department we achieve this goal by having a nurse counsellor to provide continuing support for these individuals.

There has been very little research into the use of hypnotherapy for functional gastrointestinal disorders in the pediatric setting. However, the technique has utility down to at least the age of six years' old and therefore its use in pediatric gastroenterology is certainly worthy of further exploration.

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