

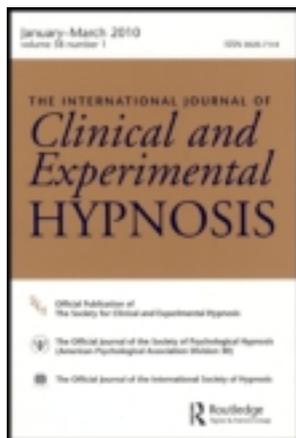
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Publisher: Routledge

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International Journal of Clinical and Experimental Hypnosis

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/nhyp20>

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Version of record first published: 15 Nov 2012.

To cite this article: Charles D. Gerson, Jessica Gerson & Mary-Joan Gerson (2013): Group Hypnotherapy for Irritable Bowel Syndrome With Long-Term Follow-Up, International Journal of Clinical and Experimental Hypnosis, 61:1, 38-54

To link to this article: <http://dx.doi.org/10.1080/00207144.2012.700620>

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GROUP HYPNOTHERAPY FOR IRRITABLE BOWEL SYNDROME WITH LONG-TERM FOLLOW-UP¹

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Abstract: This study tested whether group gut-focused hypnotherapy would improve irritable bowel syndrome (IBS). Several possible outcome predictors were also studied. Before treatment, 75 patients completed a Symptom Severity Scale, a Mind–Body attribution questionnaire, and a Quality of Relationship Inventory (QRI). The symptom scale was completed posttreatment, 3, 6, and 12 months later. There was significant symptom reduction at each data point ($p < .001$). Sixty percent had a reduction of more than 50 points, indicative of clinical improvement. Initial severity score ($p = .0004$) and QRI conflict ($p = .057$) were directly correlated with a response to hypnotherapy, while attribution of symptoms to mind (emotional) causation was inversely correlated ($p = .0056$). The authors conclude that group hypnotherapy is effective in patients with IBS.

Manuscript submitted March 22, 2011; final revision accepted September 28, 2011.

¹This study was supported by a grant from the Ping Y Tai Foundation and the J.T. Tai & Co. Foundation. Statistical assistance was provided by Fen Ye of the Biostatistics Department at Mount Sinai School of Medicine and technical assistance by Caitlin Reilly.

Dr. Charles D. Gerson helped design the study, analyzed and interpreted the data, contributed to drafting the manuscript, and approved the final submitted draft. Dr. Jessica Gerson conducted the hypnotherapy sessions, contributed to drafting the manuscript, and approved the final submitted draft. Dr. Mary-Joan Gerson helped design the study, analyzed and interpreted the data, contributed to drafting the manuscript, and approved the final submitted draft.

Potential competing interests and potential conflicts: None.

This study is registered with National Clinical Trial as Irritable Bowel Syndrome Hypnotherapy, 01248013.

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Irritable bowel syndrome (IBS) has been described as a gastrointestinal illness with both biological and psychological features (Drossman, 1996). Because of the circular relationship between the mind and gastrointestinal tract in IBS, and the limited success of medical treatment, psychological therapy can be an important adjunctive treatment modality. Successful reduction in IBS symptoms has been reported with psychodynamic psychotherapy (Guthrie, Creed, Dawson, & Tomenson, 1991), cognitive behavioral therapy (Drossman et al., 2003), collaborative (C. D. Gerson & Gerson, 2003) or multicomponent therapy (Heymann-Monnikes, Florin, Herda, Melfsen, & Monnikes, 2000), and hypnotherapy (Palsson, Turner, Johnson, Burnett, & Whitehead, 2002; Whorwell, Prior, & Faragher, 1984).

Hypnotherapy, using a gut-focused protocol, was first shown to be effective in patients with IBS by Whorwell et al. in 1984. This protocol is directed at general relaxation and control of intestinal motility through visualization and creation of a sense of warmth in the abdomen and includes the use of an audiotape for self-induced hypnosis at home. Since then, success with this approach has been replicated in a number of publications (Galovski & Blanchard, 1998; Palsson et al., 2002) and has been extended to chronic functional abdominal pain (Vlieger, Mendo-Frankenhuys, Wolfkamp, Tromp, & Benninga, 2007), nonulcer dyspepsia (Calvert, Houghton, Cooper, Morris, & Whorwell, 2002), and noncardiac chest pain (Jones, Cooper, Miller, Brooks, & Whorwell, 2006). In all published reports thus far, with a few limited exceptions, patients have been treated on a one-on-one basis.

This article is the first report of treatment using a group approach with a substantial number of subjects and long-term follow-up data. The primary objective of the study was to determine whether gut-focused hypnotherapy, in a group setting, yielded significant clinical improvement, and the primary end point was the change in the symptom score 1 year following termination of treatment. The secondary goal was to determine whether outcome predictors could be identified. The study subjects had intractable symptoms despite prior medical treatment. In the absence of a comparator treatment group, the results must be considered preliminary.

In regard to group hypnotherapy, there have been only two reports in the literature, one (Harvey, Gunary, Hinton, & Barry, 1989) with a small number of patients and short-term follow-up data and the other (Taylor, Read, & Hills, 2004) using a protocol that combined 20 minutes of hypnotherapy, cognitive behavioral therapy, and an education component. Harvey used Whorwell's method, and 6 of 17 patients treated in a group format were symptom-free 3 months posttreatment. Because Taylor combined different psychological therapies, the role of hypnotherapy is unclear.

Other group treatment programs for IBS patients have been reported. Poitras et al. (2002) utilized a group psychotherapeutic method and found significant improvement in gastrointestinal symptoms with long-term follow-up, in contrast to a waiting list control group, which did not improve. In another study (Vollmer & Blanchard, 1998), group cognitive therapy, individual cognitive therapy, and a waiting list control group were compared, albeit with a relatively small number of patients and only a 3-month follow-up. Significant global symptom improvement was found in 64%, 55%, and 10% of subjects, respectively, in the three categories. Finally, a report by Blanchard et al. (2007) compared group cognitive therapy, a psychoeducational support group, and a symptom-monitoring group. Improvement was similar in the first two groups but was quite modest in scale, making interpretation difficult.

MATERIALS AND METHODS

Participants

At their first or second visit, IBS patients were offered entry into a group hypnotherapy program. Eighty-nine patients agreed to participate; 14 dropped out after one or two sessions, and 75 patients completed the group hypnotherapy program. The major reason for dropping out was schedule conflict. Among the completers, there were 46 females (61%) and 29 males (39%). Their ages ranged from 21 to 82 years with a mean of 47 years. The mean number of patients per group was 4.41 with a median of 4.0 and a range from 2 to 8. There were 17 groups of patients studied. The dropouts explain some of the variation in group size. Initial questionnaire scores were similar for study subjects and dropouts. The dropouts were lost to follow-up, so we were unable to obtain follow-up data on them.

Inclusion criteria included Rome II criteria (Thompson et al., 1999) for the diagnosis of IBS and age of 20 or greater. Exclusion criteria were limited to age less than 20 and major psychological disorder. All patients had previously been seen by other gastroenterologists for their IBS. Of the 74 patients with histories available for review, 57 (77%) had prior colonoscopy and 68 (92%) were taking medication for their IBS. Twenty-seven (36%) were taking antidepressants, and 20 (27%) were taking antispasmodics at the time of the initial visit. Patients were either referred by other gastroenterologists, friends, or self-referred via the Internet. Our Internet site is an educational site about IBS, which includes mention of multiple services offered at our center including hypnotherapy. At the time of study, there was no mention of success rates of hypnotherapy on our Web site.

Patients were asked to complete a series of questionnaires before the beginning of therapy including the IBS Severity Scale (SSS; Francis,

Morris, & Whorwell, 1997), the Mind–Body IBS questionnaire (C. D. Gerson et al., 2008), and the Quality of Relationship Inventory (QRI; Pierce, Sarason, & Sarason, 1991). The SSS was filled out again at four subsequent time intervals: immediately after the last session and at 3 months, 6 months, and 1 year after treatment had been completed. This study was approved by the Institutional Review Board at Mount Sinai School of Medicine in 2005.

Questionnaires

IBS Severity Score (SSS). This measure consists of five different symptom self-assessments, each with a Likert-scale value from 0 to 100 with a maximum score of 500. Subscales include abdominal pain, distension, bowel habit, and interference with life experience. This scale has been validated and, in the original publication, total scores were divided into four different clinical categories, remission (0 to 75), mild (75 to 175), moderate (175 to 300), and severe (> 300), based on clinical assessment of the patients. A sensitivity and specificity analysis of SSS score change was performed in patients who had shown substantial improvement after hypnotherapy and a 50-point decrease in SSS was found to correspond to clinical improvement.

Mind–Body IBS Belief Scale. This is a validated scale that asks patients to grade 20 randomized attribution statements that IBS symptoms are due to psychological influence (mind) or physical (body) factors (Table 1). Each statement is graded from 1 (*agree very much*) to 4 (*disagree very much*).

In a previous study using this measure (M.-J. Gerson et al., 2006), attribution of symptoms to psychological influence correlated with lower IBS symptoms, whereas physical attribution correlated with higher IBS symptoms. This suggested that attribution of symptoms may be an important determinant, at least in part, of a patient's symptom experience and might affect their response to hypnotherapy treatment. We believe that this questionnaire is very promising as a tool in IBS research.

Quality of Relationship Inventory (QRI). The QRI is a validated scale that measures three aspects of a subject's most intimate relationship: support, depth, and conflict. It consists of 25 questions, seven regarding support, six regarding depth, and 12 related to conflict. Answers are on a 4-point scale from 1 (*not at all*) to 4 (*very much*). QRI results in the study quoted above showed that IBS patients with relationship support had reduced symptom severity, whereas patients experiencing conflict had higher symptom severity. In the social and interpersonal setting of a group program, a patient's relationship experience may have an

Table 1
Mind–Body IBS Questionnaire

I believe that because I am too nervous my stomach and colon are upset.	My stomach bothers me because I have allergies.
I think that I have stomach problems because I don't absorb my food.	Sometimes I think that I am being punished for something I did wrong, and that is why I am sick.
I think that too much anger, in particular, causes me distress.	I have stomach trouble because of medicine I took in the past.
I think my intestinal problem is caused by infection.	My health is better when there is peace in my family.
I think that too much thinking about myself and my problems is making me sick.	I worry that I may get even sicker in the future.
I think I was born with a weak body.	I think my stomach bothers me because I don't exercise enough.
I think I am living with intestinal problems because it runs in my family.	My shame about my stomach problems makes me even sicker.
I wish that my family would worry less about me because their worries are making me sicker.	The people who love me actually make me feel worse because they don't understand me and my illness.
I believe that I have an intestinal parasite that the doctors can't find.	I am not well because I eat the wrong foods.
If my life were more in balance, I would be able to get better.	I believe that my sickness can lead to cancer.

effect on their response to treatment. This led us to include the QRI as a possible outcome predictor in this study.

Method of Treatment

The hypnotherapy protocol used a script based on Palsson's individual therapy model (Palsson, 2006), which, in turn, was derived from Whorwell's original description (Whorwell et al., 1984), with one important exception—patients were seen in groups.

Seven biweekly sessions, each lasting 45 minutes, were led by a clinical psychologist trained in Palsson's model. The first 15 minutes consisted of a brief "check-in," an opportunity for patients to discuss questions and concerns regarding the treatment, as well as share information about IBS in general, such as information about treatment and personal issues regarding stress and/or symptoms. Time permitting, the leader would also introduce a theme along with structured questions, for example, "How does IBS affect your life" or "How do relationships

impact IBS?" The last 30 minutes constituted the hypnotherapy process. A hypnotic state was induced via mental relaxation of mind and body, followed by a visualization of a specific scene (different each session), followed by suggestions specifically pertaining to the gut. Some of the specific suggestions that were administered in the biweekly sessions after patients had entered a state in which their bodies and minds were deeply relaxed, included imagining that one's insides are being coated and protected, that one's pain sensitivity is decreasing with less attention to unpleasant bodily sensations. Suggestions on the CD focused on filling one's intestines with a warm, soothing, comfortable feeling. Patients received their own CDs with a 12-minute script recorded by the psychologist in her own voice, consisting of instructions to relax both mind and body with a special emphasis on the intestines. Patients were told to listen to the CD every day until the next session. At the end of the seven sessions, patients were told to continue to listen once or twice a week for a month, and then as much or as little as needed after that.

Statistical Methods

Paired *t* tests were used to assess changes in SSS scores from baseline to various times of follow-up. Pearson correlation coefficients were calculated for measuring the relationship between pairs of continuous variables. Chi-square tests were used for assessing associations between categorical variables. The kappa statistic was used to measure agreement between baseline and follow-up for IBS category. Logistic regression methods were used to assess the impact of different variables as predictors of improvement, with improvement measured as a binary variable (yes/no).

RESULTS

Baseline Data

The usual predominance of females was true for our subjects with a ratio of 1.7:1. The mean length of years with IBS of 18 years illustrates the chronicity of illness in our patient population. The most common symptom pattern was mixed diarrhea and constipation (45%) followed by diarrhea (28%) and constipation (17%), respectively.

Before treatment was begun, the SSS ranged from 98 to 445 with a mean of 258 points. Based on Whorwell's clinical categorization, the majority of patients had moderate-to-severe IBS before beginning treatment. At baseline, mean female and male scores were 270 and 237, respectively, with no significant difference. When the Mind-Body Scale was correlated with the initial SSS, the mind score was inversely correlated with SSS ($p = .005$). In other words, the greater the weight given to emotional influence, the lower the SSS. With regard to the QRI, the

conflict score was inversely correlated with emotional attribution ($p = .016$), support ($p < .005$), and depth ($p = .036$).

Symptom Severity Score

We first performed an intention-to-treat analysis of the original 89 subjects, with the assumption that the 14 dropouts had zero improvement. The mean SSS showed significant improvement from an initial mean of 259 to a final mean of 196 ($p < .05$).

Of the 75 treatment completers, 67 (89%) returned the 1-year follow-up SSS questionnaire, 1 patient failed to return any subsequent questionnaires, 2 only submitted the posttherapy questionnaire, and 4 subjects and 1 subject submitted their last SSS at the 3- and 6-month mark, respectively. The final questionnaire received was considered to be the outcome data for that patient.

Figure 1 shows individual data points for each of the 75 patients who completed treatment. Mean SSS improved from 258 to 183 after 1 year ($p < .0001$). In addition to change in the total score, reduction in each of the components, abdominal pain, distension, bowel habit, and interference in life experience also improved significantly (Table 2). Eighty-one percent of patients showed some improvement; only 19%

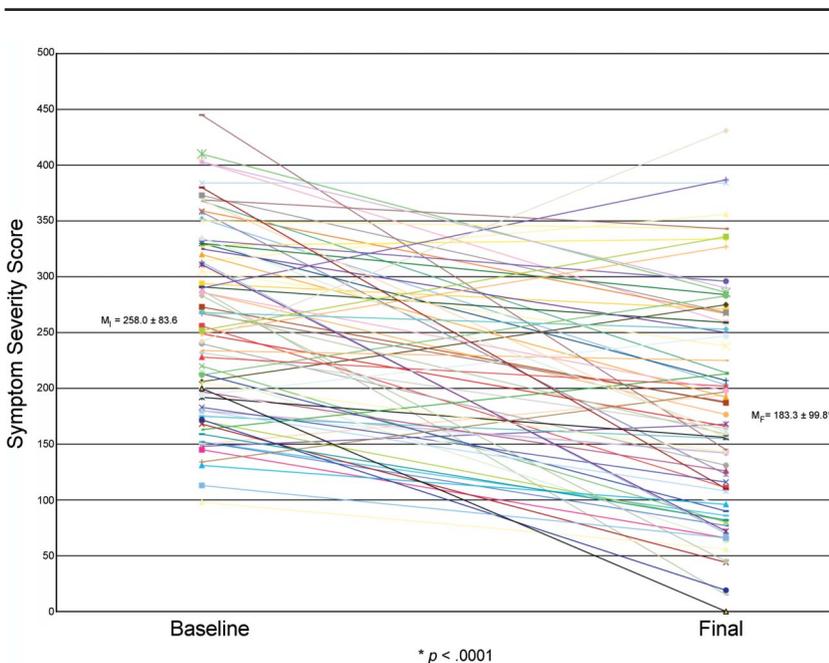


Figure 1. Initial and final symptom severity scores (color figure available online).

Table 2

Severity Score Components: Differences Between Baseline and 1-Year Follow-Up

Severity Score Component	Mean Difference (95% confidence interval)	T value	p value
Abdominal Pain	9.31 (1.55, 17.07)	2.40	<.020
Number of Days with pain	14.91 (7.00, 22.81)	3.77	<.001
Abdominal distension	9.76 (2.71, 16.81)	2.76	<.010
Bowel satisfaction	20.83 (14.30, 27.37)	6.37	<.001
IBS interference	19.88 (14.00, 25.75)	6.76	<.001
IBS severity score	77.06 (52.92, 101.20)	6.37	<.001

did not improve. Including the 8 patients who did not submit questionnaires at the 1-year mark, 45 of the 75 subjects (60%) had final reduction of SSS of more than 50 points, a measure of clinical improvement. Of the 8 patients who did not return the final 1-year questionnaire, only 3 had greater than 50-point improvement. When the different groups were compared, there was no significant difference in response, indicating no change in effectiveness over time.

Figure 2 shows data at the four different time periods after termination of therapy along with the number of questionnaires returned. SSS was compared to pretreatment results for the patients who had returned their questionnaire at each particular time. At every interval, posttreatment, 3, 6, and 12 months, scores were significantly lower than pretreatment ($p < .001$). Scores were most reduced at the 3-month mark, rose somewhat at 6 months but remained significantly reduced at 1 year

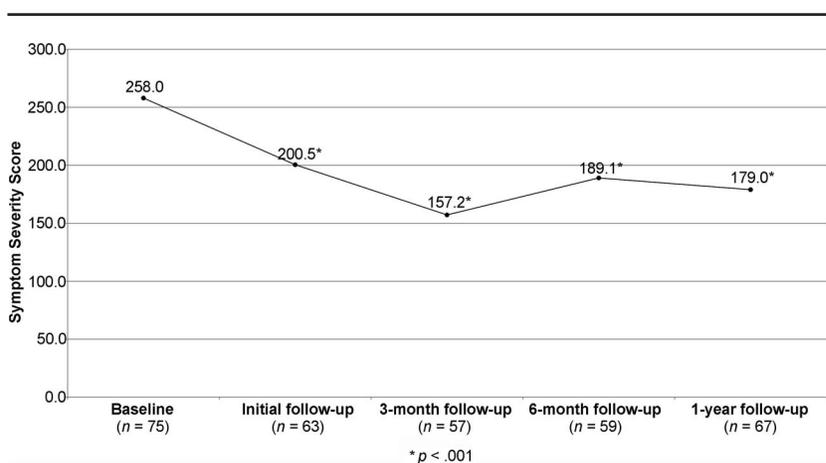


Figure 2. Mean symptom severity score across time periods after treatment.

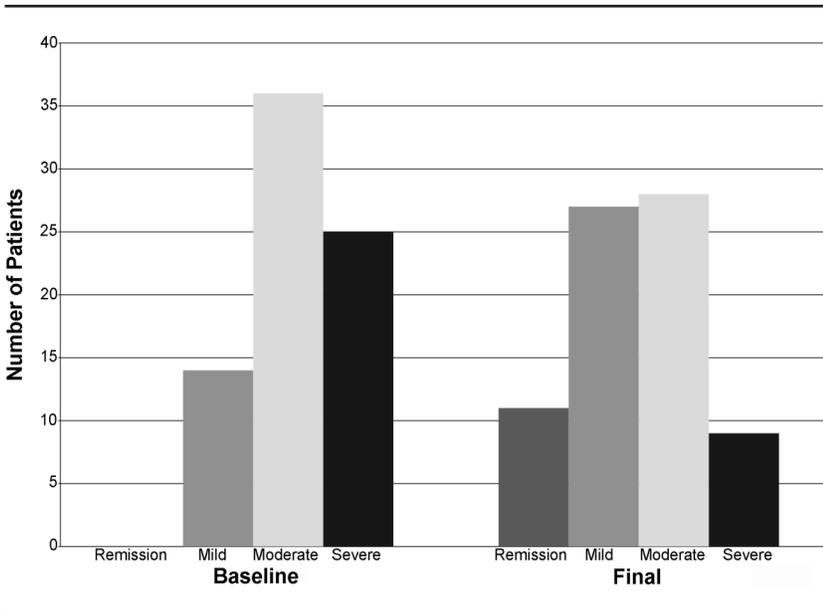


Figure 3. Change in clinical category after treatment.

demonstrating a sustained result. At the 3-month mark, scores were reduced by 39% and at 1 year by 31%, compared to baseline.

Figure 3 shows the change in clinical category after treatment. Whereas most patients were in the severe or moderate category before treatment, most patients were in mild or remission category after treatment. After 1 year, the most dramatic changes from pretreatment to 1-year posttreatment were the reduction in the severe group from 25 to 9 and an increase in the number of patients in remission from 0 to 11.

Thirty-five patients responded to an inquiry regarding their use of the hypnotherapy tape during the 1-year period following termination of treatment. Nineteen did not continue listening to the tape, 10 used it infrequently, and 6 used it frequently. There was no correlation between continued use and decrease in SSS ($r = .031$, $p = .836$).

Outcome Predictors

Initial SSS was highly correlated with a reduction in SSS at 1 year ($r = .421$, $p = .0004$), suggesting that patients with more severe IBS were more responsive to hypnotherapy. Age, gender, years of symptoms, and bowel pattern did not predict treatment outcome.

We also determined whether clinical improvement at the termination of the hypnotherapy sessions, measured as more than a 50-point decrease in SSS, predicted a more than 50-point decrease at the final

data point. Seventy-seven percent of patients who had more than a 50-point improvement immediately posttreatment had a more than 50-point improvement at final score while 44% of patients who had less than a 50-point improvement posttreatment had a more than 50-point improvement at final score. This difference was statistically significant ($p = .006$).

The Mind–Body scale yielded significant results. There was a significant inverse correlation between psychological attributions and reduction in SSS ($r = -.326$, $p = .0056$; Figure 4). In other words, the more that patients attributed their symptoms to psychological factors, the less likely they were to respond to hypnotherapy. Similarly the ratio of psychological to physical factors was a significant negative predictor ($p = .023$) of successful treatment. Attribution to physical causality did not correlate with outcome.

Of the three components of the QRI—support, depth, and conflict—only conflict was significantly correlated with change in SSS score at a borderline level ($r = .23$, $p = .057$). This suggests that a patient with a conflicted intimate relationship may be more responsive to the gut-focused hypnotherapy protocol.

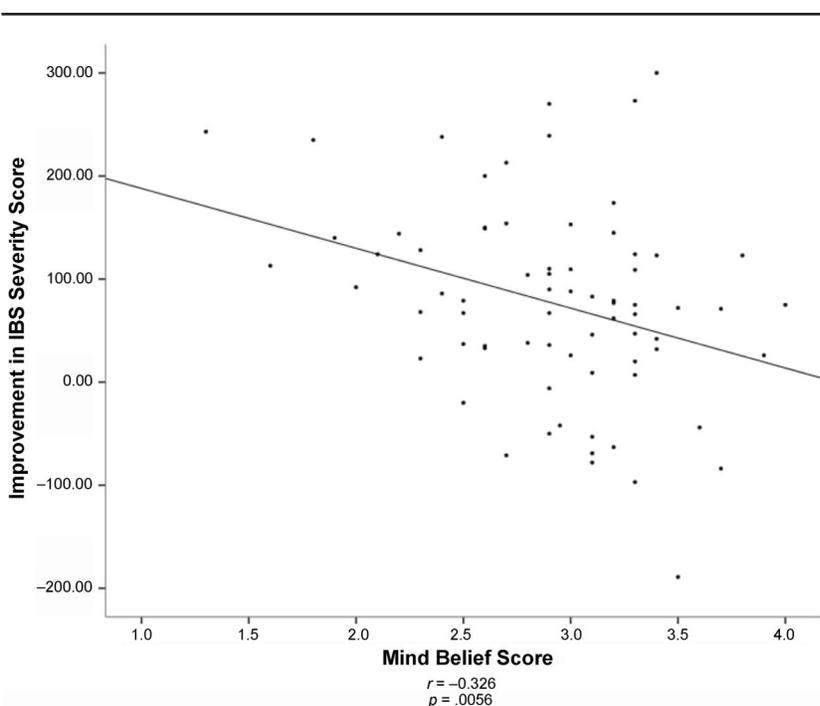


Figure 4. Correlation between mind score and improvement in symptom severity.

DISCUSSION

This is the first study documenting the effectiveness of hypnotherapy for IBS in a group format with a substantial number of patients and long-term follow-up. In addition, significant outcome predictors were found. The patient population studied had already received medical treatment by gastroenterologists and continued to have symptoms, consistent with a number of studies that have documented the chronic nature of IBS despite medical treatment (Jerndal, Ringstrom, Agerforz, & Simren, 2009; Palsson et al., 2008).

Significant improvement occurred at all time periods after termination of therapy and was sustained throughout the length of the study. According to the IBS symptom severity score, 60% of subjects reported significant symptom reduction at the time of their final questionnaire, 1 year after termination of therapy. In addition, there was a marked shift in symptom category (Francis et al., 1997) from severe and moderate to mild and remission. The continued use of the tape after the end of treatment did not appear to be necessary for sustained clinical improvement, consistent with the report by Gonsalkorale, Houghton, and Whorwell (2002).

Pretreatment symptom severity score was strongly correlated with response to hypnotherapy. This is the first publication to document this particular correlation. Since patients with the most severe symptoms may have been the most resistant to prior medical treatment, the results underscore the effectiveness of hypnotherapy. However, regression to the mean may explain this result, at least in part. Age, duration of illness, and symptom pattern were not significant predictors. We found no gender differences in response to treatment. One other publication (Gonsalkorale, Miller, Afzal, & Whorwell, 2003) looking at predictors of successful hypnotherapy outcome found that males versus females with diarrhea were less responsive to hypnotherapy, which was not confirmed in our study.

We also compared two groups of patients, those who did and did not have significant reduction of SSS immediately posttherapy. Seventy-seven percent of the early responders continued to have significant improvement at the final data point, compared to 45% of the early non-responders. The latter group may benefit from an alternative approach to address their symptom distress.

Strengths of this study include the long-term follow-up of 1 year after termination of treatment, the fact that 89% of patients submitted their final SSS questionnaire, and the finding that outcome predictors chosen for this investigation yielded significant results. There is a paucity of published data about hypnotherapy treatment, despite its apparent effectiveness, and this data almost exclusively describes individual treatment.

Could the results have been caused by a placebo effect? This seems highly unlikely. While placebo response rates in IBS have been reported to be quite high, this may not apply to patients already treated by gastroenterologists, as was the case with almost all of our patients. In addition, reduction in symptom severity score was greater 1-year posttreatment than immediately after treatment termination. One would expect a placebo effect to tail off over the course of a year. However, our results should be seen as preliminary until confirmed by a randomized control study. A randomized control group study in IBS has been recently reported where meditation was compared to a support group control (Gaylord et al., 2011). At 3 months after termination of treatment, there was a 38% decrease in IBS SSS in the meditation group compared to 12% in the support control group. In our study, SSS decrease at 3 months was almost identical at 39%.

While hypnotizability per se was not formally assessed, many patients spontaneously offered descriptions of how much they subjectively perceived themselves capable of relaxing, being open, and “getting into it” during the group sessions or while listening to the CD at home. The patients who had the most dramatic success seemed to be those who described themselves as finding it easy to become deeply relaxed, a likely expression of hypnotizability. More skeptical patients asked, “How do you know when you are being hypnotized?” or stated, “I don’t feel like I am being hypnotized.” Interestingly, it was often these patients who saw themselves as anxious and who believed that their IBS symptoms were clearly impacted by “stress.” It is the group leader’s sense that patients who were concerned about their anxiety and its physiological effects tended to report less improvement, as if their preoccupation with mind–body linkages inhibited a release to a hypnotized state.

The obvious question about group hypnotherapy concerns the therapeutic role of group support versus hypnotherapy itself. The success of our study may depend on complementary effects of both group support and hypnotherapy. We found that patients were able to talk to each other about IBS—symptoms, methods of relief, psychological consequences—in a confidential, supportive environment. This may have had a psychologically therapeutic effect in terms of the stigma and isolation associated with IBS.

One of the goals of this study was to measure psychological factors in relation to symptom reduction. The Mind–Body IBS questionnaire has two components: attribution of symptoms to psychological causes and to physical causes such as allergy, parasites, etc. The baseline data in this study showed that psychological attribution correlated inversely with severity of symptoms, confirming results of a previous study (M.-J. Gerson et al., 2006). We hypothesized that psychological attribution scores would correlate with therapeutic response. Surprisingly,

we found that patients who attributed their symptoms to psychological factors were less responsive to hypnotherapy.

This finding may be a reflection of hypnotherapy's mode of action. Hypnotherapy is an image-driven treatment in which patients are trained to suspend their personal self-consciousness and self-reflection. It may not be the best approach for patients who are naturally and continuously self-reflective, for whom psychodynamic or cognitive behavioral treatment might be most productive. However, because hypnotherapy invites suspension of characteristic defensive functioning, it may still be useful to some patients who mainly attribute their illness to psychological variables.

The mechanism through which hypnotherapy works in IBS is not clear. We believe, based on the experience of our patients, that the visualization that accompanies this treatment reconfigures associations between pain, urgency, and self-control, relieving a level of anxiety that may perpetuate a negative brain-gut interaction. In previous reports, rectal sensitivity in patients with a hypersensitive response to rectal distension normalized after hypnotherapy (Lea et al., 2003). In another report, recording of cerebral-evoked potentials in normal individuals undergoing rectal electrical stimulation, before and after hypnotherapy, suggested that hypnotherapy reduced cerebral responsiveness (Watanabe, Hattori, Kanazawa, Kano, & Fukudo, 2007).

The QRI has three components: support, depth, and conflict. The importance of incorporating family assessment and dynamics in IBS treatment has been described (M.-J. Gerson & Gerson, 2005). In a previous study (M.-J. Gerson et al., 2006), relationship support and depth correlated with lower symptom severity while conflict correlated with higher scores. While support and depth were not significantly correlated with results, conflict with an intimate was correlated directly with improvement. It is possible that the calming imagery used in gut-focused hypnotherapy was particularly effective for patients who suffer ongoing interpersonal conflict. Of course, these patients could still benefit from couples therapy focused directly on their relationship difficulties.

In conclusion, we have demonstrated that gut-focused hypnotherapy in a group setting results in a significant reduction in symptoms, which is sustained for 1 year after termination of treatment. We have also identified some interesting and unexpected outcome predictors that may shed light on the mechanism of effect. IBS is an extremely common gastrointestinal illness. Many different treatments are available for IBS patients, and we realize that patients vary in their treatment needs. Published data concerning the comparative effectiveness of hypnotherapy are impressive (Ford, Talley, Schoenfeld, Quigley, & Moayyedi, 2009). Yet, as Palsson (Palsson & Whitehead, 2002) has emphasized, there is a relative paucity of centers offering this approach.

With our demonstration that a group protocol is effective, we hope that this more cost-effective approach will encourage other centers to include hypnotherapy in their armamentarium for chronically suffering IBS patients.

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Gruppen-Hypnotherapie für Reizdarmsyndrom mit Langzeit- follow-up

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Abstrakt: Diese Studie hat getestet, ob bauchfokussierte Gruppentherapie Reizdarmsyndrom (RDS) verbessern würde. Verschiedene mögliche Ergebnisprädiktoren wurden ebenfalls untersucht. 75 Patienten füllten vor der Behandlung einen Fragebogen zur Symptomstärke, einen Fragebogen zur Körper-Geist-Zuordnung und eine Bestandsaufnahme

zur Qualität von Beziehungen aus. Die Symptomskala wurde direkt nach der Therapie, sowie 3, 6 und 12 Monate später erhoben. Es fand sich eine signifikante Symptomreduktion an jedem Datenpunkt ($p < 0,001$). Sechzig Prozent erfuhren eine Reduktion von mehr als 50 Punkten, was auf eine klinische Verbesserung hinweist. Die anfängliche Schwere ($p = 0,0004$) und der QRI Konflikt ($p = 0,057$) wurden direkt mit der Antwort auf Hypnotherapie korreliert, während die Symptomzuschreibung zu seelischer (emotionaler) Ursache invers korreliert wurden ($p = 0,0056$). Die Autoren fassen zusammen, daß Gruppenthypnotherapie bei Patienten mit RDS wirksam ist.

STEPHANIE REIGEL, MD

L'hypnothérapie de groupe avec suivi à long terme à l'intention de personnes atteintes du syndrome du colon irritable

Charles D. Gerson, Jessica Gerson et Mary-Joan Gerson

Résumé: cette étude avait pour but de vérifier si une hypnothérapie de groupe ciblant l'intestin pourrait soulager les symptômes du colon irritable. Plusieurs prédicteurs de résultats possibles ont également été étudiés. Avant le traitement, 75 patients avaient répondu à trois questionnaires : un sur la gravité de leurs symptômes; un sur l'attribution de l'origine des symptômes à l'esprit et au corps; et un sur la qualité de leurs relations interpersonnelles (QRI). Les patients ont répondu au questionnaire sur la gravité de leurs symptômes à trois reprises, soit trois mois, six mois et douze mois après l'administration du traitement. On a constaté une réduction significative des symptômes à chaque point de données ($p < 0,001$). Soixante pour cent montraient une réduction de plus de 50 points, indiquant ainsi une amélioration clinique. L'indice de gravité initial ($p = 0,0004$) et la présence d'un conflit dans l'inventaire de QRI ($p = 0,057$) étaient directement corrélés à la réaction à l'hypnothérapie, alors que l'attribution des symptômes était inversement corrélée à la causation intellectuelle (émotionnelle) ($p = 0,0056$). Les auteurs en concluent que l'hypnothérapie de groupe est efficace chez des patients atteints du syndrome du colon irritable.

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Hipnoterapia grupal para el síndrome del intestino irritable con un seguimiento a largo plazo.

Charles D. Gerson, Jessica Gerson, y Mary-Joan Gerson

Resumen: Este estudio evaluó si la hipnoterapia grupal enfocada al intestino mejora el síndrome del intestino irritable (IBS). También se estudiaron varios posibles predictores de los resultados terapéuticos. Antes del tratamiento, 75 pacientes completaron una Escala de Severidad de Síntomas, un Cuestionario de Atribuciones Mente-Cuerpo, y el Inventario de Calidad de Relaciones. La escala de síntomas fue completada en el posttratamiento, 3, 6, y 12 meses después. Se encontró una reducción significativa de síntomas en

cada uno de los periodos ($p < .001$). Sesenta por ciento presentó una reducción mayor de 50 puntos, indicativo de un mejoramiento clínico. La puntuación inicial de severidad ($p = .0004$) y el conflicto QRI ($p = .057$) estuvieron directamente correlacionadas con la respuesta a hipnoterapia, mientras que la atribución de síntomas a causas mentales (emocionales) se correlacionó inversamente ($p = .0056$). Los autores concluyeron que el grupo de hipnoterapia es efectivo en pacientes con IBS.

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