
COGNITIVE BEHAVIORAL HYPNOTHERAPY IN A CASE OF IRRITABLE BOWEL SYNDROME

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Abstract

The paper presents the cognitive-behavioral hypnotherapy intervention in a case of irritable bowel syndrome in a 32-year-old patient, by using the desensitizing technique, originally in the imaginary, over several hypnosis sessions interleaved with self-hypnosis sessions, and then in vivo, with exposure to symptomatology-activating life situations, such as exposure to the client's path to and from work. In order to eliminate catastrophic thoughts about the consequences of the onset of a diarrhea on the way to and from work, we used the Ellis ABC model applied in 5 rational-emotional and behavioral psychotherapy sessions. To improve sleep quality, we used techniques for the control of breathing, hypnosis and self-hypnosis. The evolution of this case was favorable.

Keywords: Irritable, bowel, syndrome, hypnotherapy, CBT, REBT

Introduction

Irritable bowel syndrome (IBS) is a chronic, recurrent gastrointestinal disorder characterized by abdominal pain, bloating and changes in intestinal transit (diarrhea, constipation, diarrhea-constipation alternation). For the diagnosis, the Roma group has established the following diagnostic criteria: recurrent abdominal pain and/or abdominal discomfort present for at least 3 days during a month in the last 3 months that associate 2 or more of the following features: amelioration after the removal of the stool, onset associated with a change in the frequency and shape of the stool (Drossman, 2006). There are 4 subtypes: predominantly with constipation, predominantly diarrhea, mixed and unclassified type.

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IBS is a functional bowel disorder, the symptoms of which include abdominal pain, distension, and altered bowel habit. Patients also commonly complain of associated extra-colonic symptoms, such as nausea, lethargy, and backache (Whorwell, *et al.*, 1986). This is a common condition and, although the majority of sufferers do not seek medical help, those who do account for up to half of the gastroenterologist's workload (Switz, 1976; Harvey *et al.*, 1983). Symptoms can be sufficiently severe and troublesome in some individuals as to impair their quality of life (Whorwell *et al.*, 1986; Drossman *et al.*, 1993). It is not uncommon for patients to have repeated consultations and investigations and patients tend to consult their own general practitioner for other minor ailments more frequently than other people (Maxton *et al.*, 1992). The socioeconomic impact of IBS is therefore considerable and patients account for significant healthcare resources. (Talley *et al.*, 1995)

Treatment of IBS by conventional means is often unsatisfactory, with symptoms failing to respond to an array of currently available medications. Gut directed hypnotherapy, however, has been shown previously to be extremely effective in the treatment of IBS, with the majority of patients showing improvement in symptoms, associated extra-colonic features and quality of life, (Whorwell *et al.*, 1984; Whorwell *et al.*, 1987; Houghton *et al.*, 1996), findings which have been confirmed by independent studies (Harvey *et al.*, 1989; Galovski *et al.*, 1998; Palsson *et al.*, 2002).

The study made by Gonsalkorale *et al.* (2003) presents the first long term follow up of 204 patients who have undergone hypnotherapy (HT) for IBS symptoms. Immediately after HT, 71% of patients considered their symptoms very much or moderately better and these patients were defined as "responders". Of these initial responders, 81% maintained the benefit of treatment or reported further improvement. In contrast, non-responders, with only slight or no improvement in symptoms with HT, had little or no change in symptoms over the follow up period.

IBS symptom scores were significantly improved after HT and remained so at follow up, with only a slight deterioration compared with post-HT levels. Similarly, extra-colonic features, quality of life, anxiety, and depression scores were still better at follow up compared with pre-HT levels.

The correct and early diagnosis of this syndrome by appropriate treatment improves the quality of life. Among the recommended therapeutic remedies are: modification of diet and lifestyle, drug therapy. Lifestyle changes insist on mental relaxation and stress avoidance in order to reduce mainly anxiety.

In order to properly monitor the course of the disorder, it is recommended that the client should fill out a weekly diary with the following quantified parameters on a scale of 0 to 10:

Pain: 0-no pain, 5-medium intensity, 10-sever intensity

Abdominal discomfort: 0-no discomfort; 5-partial; 10-sever

Intestinal transit: 0-normal, 5-constipation, 10-diarrhea

Stool consistency: 0-normal; 10 modified

The Irritable bowel syndrome (IBS) is a highly prevalent functional disorder with a remarkable clinical and economic impact. Data from published hypnotherapeutic interventions with approximately 800 patients show long-lasting symptom relief. The underlying mechanisms of action are not well understood. The studies show influences of hypnosis on colorectal sensitivity, colorectal motility and mental strain (anxiety, depression, maladaptive cognitions. Hefner et al. (2009) and Rilk et al. (2013) analyse the patient satisfaction after gut-directed hypnotherapy in irritable bowel syndrome. Gut-directed hypnotherapy is an effective treatment option for irritable bowel syndrome (IBS). However, clinical observations suggest that patient satisfaction with hypnotherapy is not always associated with improvement in IBS symptoms.

Impaired quality of life and psychological distress are common in irritable bowel syndrome (IBS) and may be associated with unhelpful cognitions. Gonsalkorale et al., 2004 emphasize that hypnotherapy (HT) is effective in improving both symptoms and quality of life in patients with IBS

A total of 78 IBS patients completed a validated symptom-scoring questionnaire, the Hospital Anxiety and Depression (HAD) Scale and the Cognitive Scale for Functional Bowel Disorders (FBDs), before and after 12 sessions of gut-focused HT. This study shows that symptom improvement in IBS with HT is associated with cognitive change. It also represents an initial step in unraveling the many possible mechanisms by which treatments such as HT might bring about improvement

The conclusions of the study carried out by Ballou et al. (2017) was that the Psychological Interventions for Irritable Bowel Syndrome and Inflammatory Bowel Diseases with the strongest evidence base include: cognitive behavioral therapy, hypnosis, and mindfulness-based therapies. The evidence for each of these therapies is reviewed here for both IBS and IBD. In general, there is a stronger and larger evidence base to support the use of psychological interventions in IBS compared with IBD. This is likely due to the high level of psychiatric comorbidity associated with IBS and the involvement of the stress-response in symptom presentation of IBS. Further research in psychosocial interventions for IBD is necessary. Finally, the importance of conceptualizing both IBS and IBD in a biopsychosocial model is discussed and several resources for accessing Clinical Health Psychology materials and referrals are provided. The case study was edited after the model of David *et al.*, 2001.

Case study

History of the case

"Elena" is a 32-year-old client. She is married with two children and is working in a supermarket. She lives together with her family at a 6 km distance from her workplace. She was diagnosed by the gastroenterologist with IBS and she was recommended to visit a private psychotherapy cabinet. The psychotherapeutic approach was pursued in an outpatient setting, with 5 sessions of therapy at 1 session/week.

Her symptoms manifested by the fear of having a diarrheal stool and fear of losing control of the anal sphincter, especially when she was on a bus or using another means of transport. The symptoms started 1 year before beginning psychotherapy, as a result of an episode involving higher fruit consumption, which resulted in flatulence and the elimination of gas and of a quantity of feces during the bus trip. As a result of this unpleasant incident with the dirty linen, the client developed a real fear of repeating the incident. Therefore, she resorted to crossing the road from home to work and vice versa exclusively on foot to have the opportunity to enter a toilet in the event of a recurrence of the situation, which would have not been possible if the bus was used. Consequently, the home-to-work journey lasted about 2 hours, which was having a significant effect on her quality of life, as she had multiple obligations - being married with two minors. Every attempt to use bus transportation services inflicted a state of excessive anxiety (emotional symptoms) on her, always accompanied by tingling in the hands, tremors, headaches, precipitated breathing (hyperventilation), muscular strain (physiological symptoms).

Due to these unpleasant physical symptoms, she resorted to restricting some activities (stopped using the bus, stopped socializing as before) (behavioral symptoms).

She thought erroneously that any bus ride was potentially dangerous, and that it might end up with an uncontrollable diarrheal stool that would compromise her image in front of the other people. It had a paternity of catastrophic thinking (cognitive symptoms). These symptoms have been around for a year, but have been greatly accentuated over the past 2 months, when the initial situation has been repeated, leading to her admission to Gastroenterology, where IBS diagnosis has been established following complex investigations.

Because of the problems outlined above, "Elena" has recently shown irritability, lower tolerance to frustrations and trouble falling asleep. Regarding personal physiological antecedents and pathological medical history, there were no special problems.

As a psycho-type, she could be described as more anxious, serious, and highly valuing the opinion of those around her. The gastroenterologist had recommended antispasmodic, antidiuretics and cognitive-behavioral psychotherapy, including hypnosis and self-hypnosis.

Diagnosis

Following the gastroenterological examination, she was diagnosed with IBS, and according to the WHO classification criteria (ICD-10) (1998) following Psychological Assessment Anxiety and Depressive Disorder, **Code 325 (F41.2)**. This disorder arose against a personality in the process of structuring with a good cognitive level. On the HADS scale (Zigmond *et al.*, 1983) for the assessment of anxiety and depression, prior to the initiation of therapy she was recorded with 16 for anxiety and 14 for depression, the values over 11 being psychopathologically

significant. The condition of the colon was evaluated on a scale from 0 to 10 prior to the initiation of psychotherapy.

Pain: 7 (0-no pain, 5-medium intensity, 10-sever intensity)

Abdominal discomfort: 8 (0-no discomfort, 5-part, 10-sever)

Intestinal transit: 8 (0-normal, 5-constipation, 10-diarrhea)

Stool consistency: 7 (0-normal; 10 modified)

Conceptualization

Precipitating factors

The stress of repeating the incident of dirty linen with fecal matter has undoubtedly led to the accentuation of the symptoms for about one year.

“Radiography” of current cognitions and behaviors

The current most stressful issue for “Elena” was the fear of repeating the embarrassing situation for her that caused her palpitations and hyperventilation, tremors and general somatic discomfort. At the same time, the following automatic thoughts appeared: "It's terrible to repeat the episode, I cannot bear for it to happen again, and I'm a fool".

Consequently, "Elena" used to restrict some activities: abandoning the means of public transport and social isolation.

Longitudinal analysis of cognitions and behavior

"Elena" grew up in a family where her mother was anxious and hyperprotective. From small ages, she had shown a slightly avoidable behavior in kindergarten. The traumatic event, or the soiling of lingerie, had triggered an avoidance behavior that further led to her isolation and excessive prolongation of the path to and from her workplace.

Treatment plan

A. List of issues: (1) Fear of "Elena repeating the intriguing incident"; (2) Lower irritability and tolerance to frustration; (3) Sleeplessness, (4) Depression and low self-esteem

B. Treatment Objectives: (1) Eliminating the fear of repeating the obscure incident, including erroneous thoughts related to it; (2) Increasing tolerance to frustration; (3) Normal sleeping, (4) eliminating depression with increasing self-esteem.

C. Plan of therapeutic intervention. We set out to eliminate primarily the fear of repetition and the erroneous thoughts related to it.

For this fear, we intervened through the technique of initial desensitization in the imaginary, during several hypnosis sessions interspersed with self-hypnosis sessions, then in vivo by exposure to a real bus journey, initially at a distance of one bus-stop, and then with the progressive increase of the distance traveled (Ladouceur *et al.*, 1993; Lupu, 2012). To eliminate catastrophic thoughts about the possibility of the incident being retold, we used Albert Ellis' (1994) ABC model, applied in several meetings of rational-emotional and behavioral psychotherapy. We also applied the same approach to increasing tolerance to frustration.

To improve the quality of sleep, we used breathing control techniques, hypnosis and self-hypnosis. Powerful techniques were applied to eliminate depression and increase self-esteem. Therapy was held during 5 sessions.

Session 1

In the first session, a customer discussion was held on the issues that triggered the therapy, related to: the fear of the intimidating incident of intimate lingerie being repeated, irritability, low tolerance to frustration, and sleeplessness. In the HADS test, a score of 16 for anxiety and 14 for depression was found. In order to assess the condition of the colon I applied a scale of 0 to 10 both before the initiation of psychotherapy and along the way. The condition of the colon was evaluated on a scale from 0 to 10 prior to the initiation of psychotherapy. Pain: 7 (0-no pain, 5-medium intensity, 10-sever intensity)

Abdominal discomfort: 8 (0-no discomfort, 5-part, 10-sever)

Intestinal transit: 8 (0-normal, 5-constipation, 10-diarrhea)

Stool consistency: 7 (0-normal; 10 modified).

I explained to "Elena" the correlation between fear-negative emotional tensions and the appearance of precipitated breathing (hyperventilation) and the other symptoms that bothered her when she was using the means of public transport (tingling, tremors, palpitations, headaches, irritability), which in turn accentuated fear, creating a vicious circle. Then the client was urged to hyperventilate for two minutes and to report the sensations that were overlapping, which largely overlapped with those that occurred during the bus travel. Then, she was taught to breath in 3 steps, each 4 seconds long: forced inhalation, maintaining the air using the Valsalva maneuver and forced exhalation, explaining to her that by practicing these exercises he will be able to control the unpleasant sensations feeling the fear promptly. She was given homework to exercise three times per day seven three-step breathings, until the next session.

Session 2

Albert Ellis (1994), the founder of rational-emotional and behavioral psychotherapy, explained the patient's ABC model, insisting on the importance of catastrophic cognitions in generating anxiety in general and the fear of repeating the nasty incident, in particular.

I told the patient to “rank” the most terrible things that could happen on a scale of 0-10 (10 being the worst possible). He considered the following:

- children's death-10,
- their illness-8,
- her illness-7,
- repeating the mischievous incident-5

We have relativized the idea of catastrophe in the event of a recurrence of the unpleasant incident, showing that this possibility is not a terrible but rather worrying thing, but that there are possibilities for competent medical assistance and psychology in such situations.

The meeting ended with a hypnosis session.

The induction was done through 3 breaths in 3 steps followed by progressive muscular relaxation and then by the method of the table (Holdevici, 1998; Goldberg, 2000), initially applied as a method of deepening the trench ("Write on an imaginary table successively the letters A to Z and as you wipe with the sponge, you relax more and more deeply") and then as a method of therapeutic intervention and problem solving, including the strengthening of the ego ("Please write the following words on the blackboard below: illness, fear of licking the linen, annoyance, low tolerance to frustration, insomnia, depression, baldness, abdominal pain, which you then wipe with your sponge and relax. Write the words: health, courage, self- tolerance, quiet sleep comfort and below: I will succeed, I will succeed, I will succeed...").

After the recovery from the trance, there were discussions with the client on the sensations during hypnosis, which were very pleasant, and she was given as "homework" the exercise of the table before bedtime, on the model shown above, preceded by the breath in 3 steps, suggesting she will sleep very well.

Session 3

At the beginning of the hearing, “Elena” s reported that she slept very well, feeling rested after practicing the exercise, not requiring hypnotics. Then a list of real or imaginary travel situations was drawn up with the patient, taking note of the distress experienced on a scale of 0 to 10 (10 representing the maximum distress). She reported in descending order the following scores:

- 10 to complete the bus route;
- 8 for crossing 4 km of the bus route;
- 6 for 2 km of the bus route;
- 4 crossing 1 km of the bus route;
- 2 for 4 km of the bus route in the imaginary;
- 1 for 2 km of the bus route in the imaginary;

Still proceeded to desensitization in the imaginary, as follows: After having previously performed 3-steps breathing, hypnotic induction was performed by Jacobson's progressive muscular relaxation, followed by a deepening of the trance

by counting from 0 to 20, then there were suggestions of deep relaxation followed by the successive imagination of stressful situations ranging from 1 to 6. When unease appeared in the imaginary, suggestions of calm and relaxation were presented again, after which exposure was reassumed. At the exit of the trance, made by counting from 1 to 10, "Elena" reported a decrease in the intensity of fear for each of the mentioned items. The homework given was the method of the table, preceded by 3-stage breathing.

Session 4

We explained to "Elena" that she would continue desensitization in imagination with in vivo. A hypnosis session was held in which positive healing suggestions and increased self-confidence were again given to her. She was also suggested to be able to withstand the bus journey. We continued to reproduce a fragment of the hypnosis session with the following suggestions: "You feel calm and relaxed You see in front of you a bus that comes in the station ... Continue to feel relaxed... Imagine that you get into it and as you go relax more and more.... more and more. You are calm and relaxed "

At the exit of the trance, accompanied by the therapist and without a prior modeling, was "Elena" faced in vivo exposure to a bus ride. Exposure was performed after the patient had been breathing in 3 steps. The distress experienced was noted at level 2.

The homework given was the continuation of self-hypnosis by the method of the table followed by imagery similar to that practiced during the hypnosis session.

Session 5

At the beginning of the meeting, "Elena" reported that she managed to perform very well the self-hypnosis exercise and the imagination exercise, feeling a minimal distress of 1. She received positive reinforcement from the therapist, after which she was asked to travel by bus at the end of the line and managed to do this with a distress level of 0, receiving congratulations again from the therapist. Then a new hypnosis session was held, which was induced by a special relaxation music tape, funded with positive suggestions for maintaining favorable therapy results, increasing self-confidence, restful sleep. The patient received the recommendation to keep doing self-hypnosis exercises.

The HADS test was applied again, indicating the following scores: 4 for anxiety and 3 for depression, which certified improvement in the patient's condition. In affine auto-evaluation of colon status, the following values were obtained:

Pain: 1 from 7 initial (0-no pain, 5-medium intensity, 10-sever intensity)

Abdominal discomfort: 0 from 8 (0-no discomfort, 5-part, 10-severe)

Intestinal transit: 1 from 8 (0-normal, 5-constipation, 10-diarrhea)

Stool consistency: 0 from 8 (0-normal; 10 modified).

After this last meeting, "Elena" was declared cured for fear of traveling by bus with significant improvement in terms of IBS symptoms, but she was recommended to continue self-hypnosis exercises at home.

Evolution

After the 5 therapy sessions, the problems for which "Elena" was sent to therapy disappeared. These beneficial results were maintained over time, both after 30 days of the last visit and after a later check at 6 months.

Conclusions

The case presented is illustrative of the combination of hypnosis, self-hypnosis and cognitive-behavioral and REBT blueprints and desensitization in imagination, followed by in vivo in order to heal busy phobia and IBS symptoms.

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