

EFFECTIVE MANAGEMENT OF IRRITABLE BOWEL SYNDROME — THE MANCHESTER MODEL

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Abstract: Over the years, researchers have shown that hypnotherapy can be exceptionally helpful in the management of refractory irritable bowel syndrome. However, it is a labor-intensive modality with a finite success rate and is not suitable for everyone. It is therefore best incorporated into a program of graduated care that has a contingency plan for dealing with individuals who do not respond to this particular form of treatment. This paper describes how hypnotherapy has been successfully integrated into the functional gastroenterology service in Manchester.

Descriptions of trance phenomena can be found dating back to antiquity, but it was not until the 18th century that the activities of Franz Anton Mesmer (Wyckoff, 1975) brought all this into sharp focus. For a time, mesmerism became very fashionable, but subsequently its application became the victim of cycles of popularity and unpopularity. It is interesting to note that the term *hypnosis* was coined by a Manchester surgeon, James Braid (Braid, 1843) working in the early part of the 19th century, although the new nomenclature that he introduced did nothing to prevent the waxing and waning of interest and enthusiasm for the subject over successive decades. We would like to think that the activities of our unit have brought hypnotherapy back to Manchester and helped to improve its legitimacy.

Irritable bowel syndrome (IBS) presents a number of different problems when it comes to providing effective management. This is because, in addition to frequently causing a wide variety of extremely intrusive symptoms, it also erodes quality of life, tends to be a lifelong affliction and, especially when severe, can be very difficult to treat. Unfortunately, it is often regarded as a rather trivial condition, a view that is supported by the notion that “everything is normal” on investigation and the perception that it is not life threatening. Hopefully, this latter view may change to some degree now that there is evidence that these patients have an extraordinarily high prevalence of suicidal ideation (Miller, Hopkins, & Whorwell, 2004), which is not necessarily related to depression.

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Over the years, IBS has gained the reputation of being rather unrewarding to treat. As a consequence, physicians are inclined to adopt the approach of ensuring that there is nothing "seriously wrong" by a process of thorough investigation but not necessarily offering a great deal of help in terms of how to cope with the condition. However, we have found that by adopting a graduated care program with a team approach to management, we can achieve extremely high levels of satisfaction in patients and fulfillment in staff.

When a patient is first seen in our department, they are dealt with in exactly the same way as any other gastroenterological referral, although investigation is on an "as necessary" basis rather than being exhaustive. Physiological assessment is also available in our laboratory and can be useful diagnostically, although it also serves the purpose of helping a patient to understand the mechanisms that might be involved in their symptomatology. Once the diagnosis of IBS is established, this is conveyed to the patient in a positive way rather than informing them that "everything is normal" or there is "nothing else" wrong. Special attention is paid to the extraintestinal manifestations of IBS (Whorwell, McCallum, Creed, & Roberts, 1986), such as the urological and gynecological symptoms in addition to the backache and lethargy that are so frequently present. Not only do patients find it a relief to know that all these different symptoms are related to their IBS, but it also prevents them from seeking referral and possibly unnecessary treatment from other specialties. However, it is worth warning them that these particular symptoms are often quite difficult, although not impossible, to treat.

The majority of patients are convinced that food or some form of dietary allergy plays a part in their IBS and nearly always ask if they can have a "diet sheet." Many have tried high-fiber diets despite compelling evidence that this approach, at least in secondary care, may result in patients being made worse rather than better (Francis & Whorwell, 1994). Thus, simple exclusion of cereal fiber is worth trying on an empirical basis for a period of approximately 3 months. It is also worth educating the patient about the normal cephalic phase of digestion so that they understand that it may be the process of eating, rather than what they eat, that is stimulating their bowel and thus exacerbating their symptoms.

Once the patient has gone through this initial process, they are offered the usual first-line medications, such as antispasmodics, laxatives, or antidiarrheals as appropriate. Combinations of such medications or their "on demand" usage are not necessarily discouraged. In addition, the more recently introduced receptor-modifying drugs would also now be regarded as first line. We feel that it is not justified to offer hypnotherapy to patients with relatively mild IBS who respond to these interventions, as hypnotherapy is labor-intensive, costly to provide, and only has an

evidence base in refractory cases. However, if, after the use of these standard measures, a patient has shown no signs of improvement, they are then offered the option of hypnotherapy. It is unfortunately almost impossible to predict which patients will respond to therapy, so we have adopted the policy of letting most of them go into the program. However, we do exclude those with severe psychiatric disturbances, as we feel such individuals are outside our competence and would probably do badly anyway. It has been shown that chronic, severe social stress adversely affects the prognosis of IBS, and similarly such circumstances are likely to detract from the efficacy of hypnotherapy. Thus, for instance, individuals with ongoing domestic strife may not be expected to do so well, although treatment would almost certainly improve their coping skills for such a situation.

Following the success of our hypnotherapy trials (Gonsalkorale et al., 2002; Whorwell, Prior, & Faragher, 1984), we have established a unit staffed by eight therapists. When therapists are recruited to the unit, they will have had a formal training in hypnosis but are not expected to have an in-depth knowledge of either gastroenterology in general or IBS in particular. They are then trained in our gut-focused technique and are expected to attend the outpatient clinic until they are well versed in IBS, its diagnosis, and medical management.

On referral to the unit, a patient is allocated to one particular therapist for the duration of his or her treatment, with up to twelve sessions being allowed before treatment is considered unsuccessful. During the course of treatment, the therapists are encouraged to discuss individual cases with each other and also to have regular meetings with the head of the department (P JW) where problems can be addressed. They also have free access to any of the physicians on the team to ensure that any real or potential medical problems that might arise while they are in the program are promptly resolved. This is important, because patients are frequently more forthcoming with a therapist with whom they have established a close rapport, especially about more personal issues.

It is essential that any dependency on the therapist is avoided, and this is facilitated by encouraging the patient to firmly believe that they are making themselves better with the therapist only acting as a catalyst in this process. Another way of helping to overcome this problem is to reduce the frequency of visits towards the end of treatment so that it does not come to an abrupt end. Some individuals require top-up sessions and these are allowed as long as they do not become too frequent. One of the most gratifying aspects of hypnotherapy is that all symptoms, including the extraintestinal manifestations (Gonsalkorale et al., 2002), improve. This is in sharp contrast to pharmacological approaches where often relatively few symptoms are resolved. Even when patients' symptoms do not respond to therapy, we have found from our follow-up surveys that more than 95% state that the experience has benefited them in other ways and has therefore been worthwhile.

Not surprisingly, the patients who continue to be severely troubled by their IBS despite hypnotherapy can present major problems, especially the tertiary care subjects who will have unsuccessfully tried every other conceivable form of treatment. These individuals frequently feel that they are “a failure” or have let the therapist and the unit down in some way. Thus, we believe that it is vital that the department has a system for dealing with nonresponders. For the more straightforward patients, the next step is referral back to the clinic where they are offered a low dose tricyclic antidepressant or occasionally a selective serotonin reuptake inhibitor, although it is our experience that the latter are not so effective in IBS. If this approach fails, we consider the use of an exclusion diet based on IgG food antibodies, which we have recently shown to have some value in improving the symptoms of IBS (Atkinson, Sheldon, Shaath, & Whorwell, 2004).

If all these measures are unsuccessful, or with the tertiary care hypnosis nonresponders, we first consider further investigation to ensure nothing else is being overlooked. If the diagnosis still seems secure, they are referred to our specialist nurse who takes over monitoring their care. At this point, it is essential that the objectives of management are reframed for the individual. They are told, as sympathetically as possible, that significant improvement is unlikely and that management will henceforth be of a supportive nature with attempts to control symptoms where possible. By the time a patient reaches this stage, pain is usually the worst symptom and strong analgesia, even in the form of opiates, has to be sometimes considered. For the very severe cases, a short “respite” admission to our 5-day ward is often arranged, and this can be repeated on a 4- to 6-month basis. All that is usually required during their admission is some fine-tuning of their medication and an occasional ultrasound scan or blood test to reassure the patient and the team that nothing else has supervened.

Over the years, we have found that the approach outlined above can not only make IBS an extremely rewarding condition to manage but can also result in exceptionally high levels of patient satisfaction.

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Effektive Handhabung des Reizdarmsyndroms — Das Manchester-Modell

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Zusammenfassung: In den vergangenen Jahren haben Forscher nachgewiesen, daß Hypnosetherapie außerordentlich hilfreich im Umgang mit refraktärem Reizdarmsyndrom ist. Allerdings handelt es sich um eine laborintensive Behandlungsmodalität mit begrenzter Erfolgsrate, die nicht für jeden gleichermaßen geeignet ist. Am besten läßt sie sich daher in ein "graduated-care"-Programm integrieren, welches über einen Alternativplan für die Behandlung von Patienten verfügt, falls diese nicht auf die besondere Behandlungsform ansprechen. In diesem Artikel wird beschrieben, wie Hypnosetherapie erfolgreich in das Konzept der funktionellen Gastroenterologie in Manchester integriert wurde.

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Gestion effective du syndrome du côlon irritable – Le modèle de Manchester

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Résumé: au fur et à mesure des années, les chercheurs ont montré que l'hypnothérapie peut exceptionnellement s'avérer utile dans la gestion du syndrome du côlon irritable réfractaire. Cependant, c'est un travail de dur labeur avec un taux de succès limité et qui n'est pas pour tout le monde. C'est pour cela qu'il vaut mieux l'intégrer à un programme de soins progressifs avec un plan de contingence pour s'occuper des patients qui ne répondent pas à cette forme particulière de traitement. Cet article décrit comment l'hypnothérapie a été intégrée avec succès dans un service de gastro-entérologie fonctionnelle à Manchester.

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Manejo Eficaz del Síndrome de Colon Irritable: El Modelo de Manchester

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Resumen: A lo largo de los años, los investigadores han mostrado que la hipnoterapia puede ser excepcionalmente útil en el manejo del Síndrome de Colon Irritable. Sin embargo, es una modalidad que requiere mucho esfuerzo y tiene un éxito limitado, y no es conveniente para todos. Es por lo tanto mejor incorporarla en un programa de cuidado graduado con planes de

contingencia para tratar a los individuos que no responden a esta forma particular de tratamiento. Este artículo describe cómo se ha integrado exitosamente a la hipnoterapia en el servicio funcional de gastroenterología en Manchester.

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