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How do people with refractory irritable bowel syndrome perceive Hypnotherapy? : qualitative study

Matthew Krouwel BA*, Professor Kate Jolly PhD, Professor Sheila Greenfield PhD.

Institute of Applied Health Research, University of Birmingham, Edgbaston, Birmingham, B15 2TT

*Corresponding author at 80, Hawkesley Mill Lane, Northfield, Birmingham B31 2RI
Mattkrouwel@gmail.com

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Highlights

- The people we interviewed all appeared to be open to hypnotherapy for their irritable bowel syndrome.
- Several barriers to the use of hypnotherapy by people with IBS were identified, including a lack of awareness, a lack of understanding of how it worked for IBS, time and cost.
- Group hypnotherapy was less popular than one to one treatment but was still acceptable to most.
- Hypnotherapy for IBS being available in a primary care setting was generally preferred to secondary care settings.

Summary

Objectives - Hypnotherapy is recognised in the UK's National Institute for Health and Care Excellence (NICE) guidelines as a potential treatment for Irritable Bowel Syndrome (IBS). However, little is known about the views of people with IBS regarding hypnotherapy. This qualitative study aimed to identify perceptions of and barriers to hypnotherapy for IBS by people with the condition.

Design - One–to-one semi-structured interviews using thematic analysis**.**

Setting - Convenience sampling in the UK**.** Participants were recruited by poster advertising and online IBS support groups. Interviews were conducted at the interviewees' preferred location or via video calling.

Participants 17 people (15 female, 2 male) who self-identified as having refractory IBS according to a provided definition.

Results – Four hypnotherapy related themes arose from the data: conceptualisation of hypnotherapy, hypnotherapy for IBS, barriers to hypnotherapy for IBS, ideal format of hypnotherapy for IBS. Participants saw hypnosis as an altered state in which change was possible, but many had not considered it for IBS. They were broadly open to hypnotherapy for IBS, but a variety of potential barriers were apparent, including cost and therapist validity. Group hypnotherapy was less acceptable than

one-to-one treatment. Hypnotherapy via video call was seen as convenient, but there were concerns about its effectiveness.

Conclusion – People with IBS may be put off hypnotherapy by a lack of understanding of how it works for their condition and lack of awareness of it as a therapeutic option. Uptake may be improved through effective promotion of the approach which addresses its mechanisms of effect.

1. Introduction

Irritable bowel syndrome (IBS) is a common condition[1] characterised by abdominal discomfort and a high level of variability in bowel movement frequency and form.[2] IBS has multiple potential causes for which conventional medicine has had limited success resulting in many people with IBS seeking help through complementary and alternative medicine (CAM).[3]

Hypnotherapy is an approach which proved sufficiently effective in treating the refractory form of IBS to warrant inclusion in the UK's National Institute of Health and Care Excellence (NICE) guidelines for refractory IBS.[4] Refractory IBS is defined as IBS which has not responded to pharmacological intervention and where a continuous profile of symptoms is present twelve months or more after diagnosis.[4] Hypnosis, a state characterised by reduced peripheral awareness and increased responsiveness to suggestion[5] is the basis of hypnotherapy, a therapeutic approach that combines hypnosis with suggestion and metaphor.[6] Gut directed hypnotherapy (GDH) is the main hypnotherapeutic approach to treating IBS.[7] GDH is a treatment protocol typically taking between seven[8] and twelve sessions[9] which uses metaphor, imagery and suggestion to encourage digestive calm and regularity.[7] Effectiveness has been confirmed in multiple reviews of trial data.[10-13]

Hypnotherapy appears acceptable to the public, conditional upon its endorsement by the medical or psychological establishment.[14] Only one previous study carried out in the UK in 2008 has looked at the acceptability of GDH for people with IBS.[15] Although hypnotherapy was viewed as acceptable there is however little evidence that acceptability translates into usage, with the only identified study covering the topic, a US study also in 2008, finding only 1.4% of people with IBS had used hypnotherapy for their condition.[16] This suggests a gulf between what is theoretically acceptable and what is actively sought. There are many potential reasons for this gap, which could include negative media stereotypes,[17] popular myths and misconceptions[18] or people not feeling they have enough evidence.[15] Equally, lack of awareness, resources or opportunities may be factors.

Qualitative interviews, with their ability to capture the nuanced human perspective[19] are the appropriate method to help understand and gain insight into what is causing the gap between the apparent acceptability of hypnotherapy for IBS and actual usage. There already exists a wide body of qualitative research into people with IBS,[20-36] covering their experience of living with IBS,[20, 24-27, 29, 30, 33, 35-37] their encounters with clinicians,[24-28, 31, 34-36] and attitudes to specific interventions.[21-23] Even in the one paper which addresses hypnotherapy, in which people were asked to outline any reasons for the non-acceptability of treatment, hypnotherapy is only one of many treatments touched upon, resulting in, fewer than forty words of speech published regarding non-acceptability of hypnotherapy for IBS. This provides some limited insight into why people may be eschewing hypnotherapy, and included questions of safety, as with one respondent's concerns about the safety of the method "What if hypnotherapy goes wrong?" and not seeing how a psychological approach would benefit a physical disorder.[15]

This study aims to identify factors which may be inhibiting the use of hypnotherapy for IBS by people suffering from it and thus provide useful insights on how to formulate patient education materials, where to locate services and who should deliver them for healthcare providers considering referral to or the provision of GDH services.

2. Methods

This study used one-to-one, face-to-face, semi-structured interviews.[38] Age, gender, and self-described ethnicity were collected and a fourteen-question topic guide was used. The first four questions covered the interviewee's experience of IBS and treatment, these were included to get the participants talking before moving into the remaining ten hypnotherapy related questions, this paper is concerned solely with these ten questions. These questions were designed to identify barriers, by asking what anxieties and limitations they were aware of and to explore possible unconscious barriers by asking about their image and understanding of hypnosis. A

convenience sample[39] of participants was recruited via poster advertising around the campuses of several universities in the West Midlands region (UK), by providing leaflets to IBS groups and via online Facebook IBS support groups. Initial contacts were made through telephone, text, and Facebook, responses to enquiries were made in kind, eligibility criteria confirmed, and interviews conducted as soon after contact as possible. Both in-person and video calling interviews were conducted until data saturation was achieved, judged to be the point three interviews after substantial numbers of new codes have stopped emerging from the analysis of the transcripts.[40, 41] Video calling[42] was added later in the interview process to take advantage of an influx of recruits from social media who may otherwise have been lost due to the wait between contact and interview that in-person interviews would have required. An additional question regarding the use of video calling for hypnotherapy was therefore added to the topic guide and those participants who had not been asked about it were contacted. Interviews were conducted and transcribed by the lead author (MK), a practicing hypnotherapist. The decision was made to not actively disclose this to prevent it from biasing participants' responses, however if directly asked, MK would disclose, however none of the participants did ask.

2.1 Inclusion and exclusion criteria

2.1.1 Inclusion criteria were:

a. Potential participants have stated that they have a medical diagnosis of IBS.

b. At least 18 years of age.

c. Fulfil, by self-report, the NICE criteria[4] for referral for psychological intervention: 'people with IBS who do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile'.[4] This was assessed at first contact with the question "Would you say that you have continued to experience symptoms for 12 months or more following pharmacological treatment?"

2.1.2 Exclusion criteria:

1) Previous experience of hypnotherapy for IBS.

2) Health care and allied professions with a specialism in gastrointestinal problems.

2.2 Consent

Consent was sought by the provision of an information sheet prior to interview and confirmed at multiple points both in writing and verbally. For video-call interviews written consent was obtained by post. Ethical approval was given by the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee ERN_15-1473.

2.3 Thematic analysis

Thematic analysis was used to analyse the data.[43] A multiple stage process was undertaken consisting of open coding the transcripts, then reducing the number of codes identified by amalgamating them and removing those irrelevant to the topic, the transcripts were then re-coded using the new codes.[44] Data analysis was led by MK, SG a medical sociologist and KJ a medical academic, independently read early examples of the transcripts and related coding as a quality measure and monitored the consolidation of codes following the open coding phase.

3. Results

3.1 Participants

Seventeen participants, predominantly female (88%) and mostly white (88%) with a duration since diagnosis ranging from 2-40 years (11.2 mean) were interviewed (Table 1). Interviews took place at the participant's home, local library, or on the campus of the University of Birmingham (UoB). Nine in-person interviews were in the Midlands (UK), eight video-call interviews covered other areas of the UK. Interviews lasted an average of 38 minutes (range 27-55).

3.2 Themes

Four key themes emerged from the interviews: (1) conceptualisation of hypnotherapy; (2) hypnotherapy for IBS; (3) barriers to hypnotherapy for IBS; (4) ideal hypnotherapy for IBS, each with several subthemes. These are explored below with illustrative quotes.

3.2.1 Conceptualisation of hypnotherapy

3.2.1.1 Media influenced imagery

It was apparent that people's perception of hypnosis had been influenced by media presentations, with stage show imagery appearing in their discourse, however many were conscious of this.

> *"you've seen on TV where you've got people running around like a chicken but I'm sure that's stage presence" (0015)*

3.2.1.2 Special state

The idea of hypnosis as a special state was mentioned by several participants.

> *"I know that you go under some sort of trance" (0001)*

An alternative term to trance was sleep, it was noted that this was not true sleep.

> *"like you're not really asleep but maybe you're in like in bit of a bubble" (0012)*

3.2.1.3 Presentation of the hypnotherapist

There appeared to be a dualism in the perception of the hypnotherapist with expressions of associations with popular entertainment sitting alongside more mainstream images.

> *"if I was to go into a room now to be hypnotised it would automatically have that sort of funfair comedy magician thing at the back of my mind" (0001)*

"I'm associating a hypnotherapist with maybe a psychologist?" (0001)

Despite the idea of eccentricity around the hypnotherapist the anticipated presentation was of a professional, smartly dressed, middle aged or older. However, hints at idiosyncrasy remained.

"everyone gets an idea which is a very sort of academic individual and that's a particular look, and maybe a little bit quirky as well," (0003)

3.2.1.4 How hypnotherapy creates change

The main concept expressed was that hypnosis allowed access to the unconscious.

"it's a matter of having my subconscious made available, like really tapping into, it's like tapping in to dream world really for me (laughs), not having the barrier of consciousness" (0009)

The suggestion was that new concepts can be incorporated by the mind in this state.

"you're in a state of mind where you're more susceptible to like positive suggestions" (0013).

Some also referenced memory work and metaphorical approaches.

"talking to you with a story or a scenario to get, the subconscious mind sounds a bit cheesy, but to get you thinking about things that you forget about." (0015)

3.2.2 Hypnotherapy for IBS

3.2.2.1 Mechanism of effect

How hypnotherapy worked for IBS was difficult to conceive for some.

"I actually wouldn't have a baldie to be honest with you, I don't, I wouldn't have a clue how they actually remove the actual physical symptoms," (0005)

It appears that this conceptual difficulty may be due to hypnotherapy being perceived as a psychological therapy, whereas IBS is seen as a physical problem.

"I don't know I can't picture it full on as an actual medical, cos I can picture it in my mind for more sort of mental disorders like anxiety, depression, even OCD" (0001)

Some thought that hypnotherapy might work by reducing stress, be this specifically in the gut brain or more generally.

"I wonder if it would be possible for someone to tell my gut-brain to stop being so stressed" (0016)

Other elements which participants mentioned as possible ways in which hypnotherapy could address IBS included distraction from symptoms, memory work and promotion of healing.

"I think it could be multifaceted, I think it could be helping a person possibly understand the root causes or possibly the history of what's happened with the gut," (0009)

3.2.2.2 Advantage of hypnotherapy

Hypnotherapy was seen as safer because nothing physical, which may aggravate the IBS, was used.

"you are not putting anything in your body with hypnosis other than thoughts" (0007)

"at the end of the day it's not an intrusive or invasive thing that's gonna hurt" (0011)

3.2.2.3 Willingness to use hypnotherapy for their IBS

All participants indicated that that they would use hypnotherapy, the degree of positivity varied from the mild and conditional to enthusiastic and largely appears to be based upon being open to any treatment option.

> *"I've blimin tried everything else so I'd be willing to give it a go (laughs)" (0010)*

3.2.2.4 Group hypnotherapy for IBS

Most of the participants expressed an openness to group hypnotherapy for IBS, albeit with a degree of reticence.

> *"I don't think I'd have a problem with that, when you just said that I thought no I would want it one to one, but no why would I want that" (0017)*

Some found group hypnotherapy acceptable if everyone had similar symptoms and some expressed a potential social benefit.

> *"groups are good in the respect that if you all suffer from the same thing and understand that it's hard work and you're not on your death bed but it's a chronic thing a chronic niggling miserable condition quite frankly and if you can kind of share that with other people it's quite a positive thing" (0004)*

Group hypnotherapy raised the problem of social inhibition, both generally and in the context of discussing symptoms.

> *"yeah, if you like had to talk about your past and or even saying about your toilet habits like, I've just overcome being able to go to the toilet in public I don't want to start talking in public" (0014)*

3.2.2.4 Hypnotherapy via video calling

The initial response to hypnotherapy by video-call for some was one of uncertainty, with concerns about dropped calls and a lack of relationship expressed.

> *"it's good to kind of feel that you can trust them (the hypnotherapist), so it's good to almost be there with them" (0002)*

However, following the initial uncertainty all four who responded to this question were open to the idea to varying degrees, from enthusiastic to reservedly open.

3.2.3 Barriers to hypnotherapy for IBS

3.2.3.1 Lack of awareness

Perhaps the most fundamental barrier was not knowing that hypnotherapy could be used to treat IBS.

> *"I've never really thought about it before because I've never really come across it before, never thought about linking it (hypnotherapy) to IBS" (0006)*

3.2.3.2 Practical barriers

Cost and time were barriers for many, the former highlights the sparsity of NHS services.

> *"oh god no, if I could get hypnotherapy I would be in there in a minute, but I'm not prepared to pay privatised prices" (0005)*

> *"for me it was about getting the times to attend and get the treatment because of being a carer and then working full time" (0003)*

When questioned as to how much time they could commit, most participants felt that once a week or once every two weeks was manageable.

3.2.3.3 Fear of the unknown

Several participants expressed a fear of the unknown, often with an accompanying desire for explanation.

> *"I would want someone to literally sit with me and say right you're gonna have this, this, this and this like this is what's gonna happen like this is what might happen" (0006)*

Further there were questions about the effectiveness and possible side effects.

> *"because I know so little about it, whether it takes sort of other parts of your mind, whether you can forget other things that you don't want to forget" (0007)*

3.2.3.4 Vulnerability

The issue of possible abuse was raised.

"what happens if they put you under hypnosis, how deep they can put you under, and there's nobody around and you're just in that very vulnerable state with a random person that you've only just met, that's quite a vulnerable situation to put yourself into" (0011)

3.2.4 Ideal hypnotherapy for IBS

3.2.4.1 Interpersonal skills and characteristics

Participants identified a raft of desirable characteristics for a hypnotherapist such as understanding, friendliness, kindness and being non-judgemental.

> *"you'd want them to have a certain demeanour which means that you feel comfortable," (0004)*

Some participants identified specific behaviours that they would want to encounter in a hypnotherapist, such as smiling, eye contact, using first names and concise explanations. For some, a flexibility in approach was important.

> *"if I said something, I'd like to recognise that they could then, based on something I'd said they could go off on a tangent then deal with that rather than just ignoring it"(0014)*

3.2.4.2 Qualifications and experience

Most participants wanted a hypnotherapist to have a formal qualification, however the preferred level of qualification was variable.

> *"it needs to be someone who has done some sort of training, it doesn't necessarily have to be a PhD" (0003)*

> *"Masters would be a definite" (0014)*

For some experience was more important.

> *"I don't think it really would maybe matter the standard of the …the qualification or the level, if they have the experience with regards to treating people with IBS with hypnotherapy" (0010)*

As with the accepted level of qualification the acceptable level of experience was variable, but several expressed that specific experience with hypnotherapy for IBS was important, as was experience with a wide variety of people.

> *"they should at least have practiced it, they've done it on people before" (0002)*

> *"I don't necessarily mean experience in terms of 20 years' service I think just experience with a variety of people" (0001)*

3.2.4.3 Appearance

Although appearance was a minor issue to many, some had strong opinions. Scruffiness and a new age presentation were actively disliked in favour of a casual version of professional attire, consisting of trousers or skirt with shirt or blouse.

"not sort of scruffy, long haired type" (0007)

"they would have to look I suppose quite professional, not business like because that's not how I, that would make me feel intimidated" (0013)

3.2.4.4 Gender

The few participants who expressed a preference favoured a female hypnotherapist, notably this included both male participants.

"I know it sounds weird but somehow I get on more with females than males" (0002)

"I would probably for my own historical reasons prefer a female hypnotherapist" (0009)

3.2.4.5 Location of therapy

Most participants expressed a desire for hypnotherapy services to be within the NHS. For some it was likely that this was driven by issues of cost, it was also apparent that it would validate the approach.

'if I could get it on the NHS I would be down, I would be wherever I could get in XXXX in a heartbeat so I would' (0005)

"if the NHS doctors referred me for it I don't think I'd have any reservations" (0017)

Specifically, there was a desire for services to be provided at their local general practice or a small healthcare centre. Hospitals were more problematic, being the preference of some but actively rejected by others.

"probably not a hospital, I'd find that too clinical just in a building or a like um oh what are they called like a health centre" (0014)

Of greater importance to many of the participants was the therapeutic space, this needed to feel safe and comfortable.

"to me it wouldn't be a specific where the room would have to be as long as I felt comfortable in the room" (0010)

4. Discussion

This qualitative study has identified some key themes in the opinions of people with IBS for hypnotherapy as a potential treatment for their condition. People's ideas about hypnotherapy showed the influence of entertainment,[17] however, a dualism was present with an awareness that these ideas are media generated and for some the image of the hypnotherapist is paralleled with that of the psychotherapist or counsellor. It is possible these media derived images are presenting a barrier to acceptability; however, this is not certain.

Concepts of how hypnosis creates change acknowledged a 'special-state'[45] but how a psychological therapy might affect a predominantly physical condition was confusing to many. No consistent explanation of mechanisms for change emerged, which reflects the current understanding of researchers,[46] and may be a block to acceptability. Some participants said they did however find hypnotherapy's lack of a physical aspect refreshing and it was perceived to potentially be relatively safe, which reflects the low level of side effects observed in trials.[47]

Perhaps the most important finding is whilst all participants said they would be open to using hypnotherapy for their IBS, numerous explicit barriers to the use of hypnotherapy for IBS were cited. These can be broadly seen as time, cost, lack of awareness, vulnerability and a fear of the unknown. Awareness is possibly the most fundamental of these barriers. Mechanisms of awareness previously identified for CAM therapies cite word of mouth and active searches as the most important,[48] however these routes appeared to be ineffective for hypnotherapy amongst the study

participants. It is possible that people keep IBS private due to embarrassment[49] and as such word of mouth is limited; equally, active searching, particularly through the medium of the internet, may only be effective if the appropriate search terms are used, and people may not think to use 'hypnotherapy'. Inclusion within the NHS, which was universally popular among participants, would likely overcome cost issues and for many would validate both the approach and practitioners. Services are likely to be more acceptable if practitioners conform to the expressed preferred stereotypes[50] of appearance of the practitioner and therapeutic space (primary care facility, comfortable and private).

The idea of group hypnotherapy, which offers comparable effectiveness at a lower cost to individual therapy,[51] was acceptable to most. Some participants predicted a supportive element to this, which matches the findings of other studies into group psychological work,[52] however, it was clear that social fears over the need to actively participate were present. How much social anxiety would affect uptake is unclear, several anxiety types are more prevalent amongst people with IBS, but social anxiety appears to be no more common than amongst the general population.[53] Should such a group programme be implemented appropriate measures should be taken to offset social fears by addressing them in patient literature or in an initial one-to-one meeting.

The idea of hypnotherapy via video-call is relatively new and its unfamiliarity was apparent from some of the participants' responses, however it is being used within NHS IBS services based in Manchester.[54, 55] It holds several potential practical advantages for healthcare providers, such as cost savings, and participants identified several potential benefits to its use. Participants suggested that there may be a loss of therapeutic relationship using the video medium, and current research suggests that it may be a less effective approach[55]

4.1 Strengths and Limitations

These data substantially deepen the understanding of what people with IBS think about hypnotherapy. The requirement to ensure that participants were aware that most of the questions related to hypnotherapy for IBS in the initial advertising and the self-selecting nature of volunteer recruitment may have impacted upon the type of people presenting, however the study encompassed a wide variety of people with IBS, which included people from around the UK, a spread of ages and longevity of symptoms. The inclusion of the alternative interview format of the video call allowed for interviews with people whose movements were potentially limited by their condition but who might not have been comfortable to have a stranger in their home. The study is substantially stronger for the diverse team, including a hypnotherapist (MK), a medical sociologist (SG) and a medical academic (KJ) who were involved in the analysis. The addition towards the end of the study of a question regarding the use of video calls for the delivery of hypnotherapy for IBS meant that most participants had disengaged by the time they were re-contacted with this question and ultimately only four answered it, this means on this specific topic data saturation was not achieved, although it was elsewhere.

5. Conclusion

IBS is a chronic condition for which there is a desire amongst people with the condition for wider treatment options to be explored and as such our participants were open to hypnotherapy. Participants did not immediately think of hypnotherapy in relation to IBS and neither did they automatically see how it could help them, suggesting that the provision of information materials is important. Beyond this there was concern about their vulnerability in the hypnotherapeutic situation as well as experiencing practical barriers of time and cost. It was apparent that many of these barriers would be removed for hypnotherapy for IBS by it being included within the standard healthcare system, which provides payment and validity. Acceptability of services could be further improved by adhering to anticipated norms of professional presentation for the psychological professions and delivering services in the primary care setting. Group hypnotherapy appeared to be acceptable to a smaller number of

people because of social anxieties and concerns about a lack of individualisation. Hypnotherapy via video-call was seen to have many practical advantages although concerns were raised around technical issues and the possibility of lost rapport.

This study focused upon the views of people with IBS, other potential causes for the low use of hypnotherapy for IBS may exist. To identify these, further research into doctors' awareness, attitudes and the availability of services is necessary.

Ethical approval and consent to participate

Ethical approval was given by the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee ERN_15-1473. All participants gave their written consent for inclusion in the study.

Consent to publish

All participants gave consent for their anonymised words to be used in academic publication.

Declaration of interest

MK is a practicing hypnotherapist. SG and KJ are part funded by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care West Midlands.

The views expressed in this article are those of the author(s) and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care**.**

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Table.1 – participant characteristics

Interviewee	Age	Gender	Ethnicity (self-identified and in their own words)	In-person	Video interview	Estimated time since diagnosis (years)
1	23	Female	White British	x		5
2	22	Male	British Asian	x		2
3	56	Female	White British	x		10
4	43	Female	White British		x	20
5	32	Female	White Irish		x	2.5
6	26	Female	White British		x	10
7	63	Female	White British	x		40
8	36	Female	White Scottish		x	2
9	36	Female	White European		x	2
10	36	Female	White Irish		x	5
11	42	Female	White British		x	10
12	41	Female	White Irish		x	16
13	41	Female	Eurasian	x		17
14	25	Female	White British	x		25
15	51	Female	White British	x		12
16	24	Male	White British	x		7
17	50	Female	White British	x		5