DYNAMIC HYPNOSIS, IBS, AND THE VALUE OF INDIVIDUALIZING TREATMENT:
A Clinical Perspective

SUSANNA CAROLUSSON

Abstract: Hypnosis has already been proven efficient in treatment of irritable bowel syndrome (IBS). The author was responsible for the hypnotherapy in a Swedish study and adds her clinical experience with IBS patients within and beyond that study. The hypnosis was labeled dynamic, and the treatment utilized the therapists’ clinical competence and individually tailored techniques, including gut-oriented symptom relief and hypnoanalysis, separately or in combination. The author presents 2 cases, 1 with a focus on symptom relief and 1 on exploring traumatic causes. She illustrates her clinical rationale for technical flexibility from trauma resolving hypnoanalysis to symptom-alleviating suggestive hypnosis, including dynamics beyond the symptom when such are part of the case history.

Evidence in support of hypnosis as the primary treatment of intractable irritable bowel syndrome (IBS) is strong and frequently published in prestigious medical journals. IBS is a functional diagnosis in the sense that, although certain symptoms such as distention, gas production, and bowel motility can be physiologically examined and measured, no specific somatic cause of the condition can be found. The most common symptoms of IBS are the following: severe pain in the bowels, especially after food intake; stomach distention; gas production; fast-working intestines; cramp in the colon; diarrhea and/or constipation; an abnormally high level of mucus production in the bowels; and in certain cases even nausea. ¹ Most gastroenterologists use the Rome III criteria (see footnote 1) for a correct diagnosis, not the least in order to make a good differential diagnosis (Drossman & Dumitrascu, 2006). Hefner

¹The criteria used by gastroenterologists to set an IBS diagnosis are found in the Rome III Criteria, published in 2006 in the Journal of Gastroenterology. Before considering IBS, IDB (inflammable bowel disorder), ulcerative colitis, and Crohn’s disease should be discounted. One should even discount or consider other ailments such as gluten- and lactose-intolerances since they require a special diet. The Rome criteria for IBS are
and colleagues (2009) mention the impact of hypnosis on colorectal sensitivity, colorectal motility, and mental strain such as anxiety, depression, and maladaptive cognitions. Peter Whorwell, a senior clinical researcher on IBS, concludes that hypnosis should be integrated into the ongoing medical care (Miller & Whorwell, 2009). There are many other publications adding to the support of hypnosis in IBS treatment, among them are Palsson, Turner, Johnson, Burnett, and Whitehead (2002); Simrén, Ringstrom, Bjornsson, and Abrahamsson (2004); and Simrén (2006). The most clear-cut proponent for protocol-based hypnosis is probably Palsson (Palsson & Whitehead, 2002), who has published articles and a seven-session protocol. Whorwell from Manchester was the first to demonstrate and document a high success rate with gut-oriented hypnosis in the treatment of IBS (Whorwell, Prior, & Faragher, 1984).

**Background and Design of the Sahlgrenska University Hospital Study**

The Department of Gastroenterology at Sahlgrenska University Hospital in Göteborg designed the research upon which this article is based, in the form of a randomized, controlled study (RCT) of the use of hypnotherapy with patients suffering from severe IBS. The study took place between 2001 and 2007.

In this study at Sahlgrenska University Hospital, I was consulted to organize, to prepare, and to conduct the clinical work, that is, the hypnotherapy, within the framework defined by the medical team. The medical team made the assessments—physical as well as questionnaires of psychosocial status. All patients were assessed by the medical team, including the control group. The medical team performed somatic examinations: pain sensitivity in the colon, motility speed of the whole stomach/bowel system, and gastroscopy. A self-assessment questionnaire, the Hospital Anxiety and Depression Scale, developed by Zigmond and Snaith (1983), was used to measure levels of depression and anxiety. In order to estimate how IBS symptoms were affecting general health and well-being, a quality-of-life assessment was also used. The scale was in a version printed by Glaxo and was originally tested on a Swedish population at the department of Rheumatology, Sahlgrenska University Hospital, Sweden (Burckhardt, Archenholtz, & Bjelle, 1992).

The patients’ “sense of coherence” was measured by the instrument with the very same label, which was developed by Antonovsky (1991). The results of these questionnaires have yet to be published. The abdominal pain or abdominal discomfort at least 3 days a month in the last 3 months, where at least two of the following were also true: The pain/discomfort was relieved by defecation and/or the start of the pain/discomfort was associated with altered stool frequency and/or the start of the pain/discomfort was associated with altered stool form (appearance).
baseline test results were withheld from the treating psychologists and were repeated after the treatment and at 1- and 2-year follow-ups for statistical processing and assessment of outcome. The control group received customary medical treatment in the form of support and advice. The control treatment included consultations with doctors and nurses, dietary advice, and relaxation training with a physiotherapist. Preliminary findings have been published in Simrén (2006) and Simrén et al. (2004). An analysis of the results showed that the hypnosis group achieved significantly better results than the control group regarding pain and intestinal motility (e.g., the speed in which bowels work). When one considers that the control group was not left untreated, the results, which significantly favor hypnotherapy, are even more impressive. I learned later, in conversation with Simrén (personal communication, May 10, 2006) that the favorable results persisted and that many of the hypnotherapy patients who had shown insignificant improvements directly after the treatment period showed obvious improvements 1 to 2 years later. This was of no surprise, as a part of the treatment involves giving suggestions about long-term improvements in lifestyle and symptom relief.

After baseline assessments were done, the clinicians/hypnotherapists met the patients for their clinical interviews.

**Purpose**

The complexity and artistry of psychological/psychotherapeutic practice in general and hypnotherapy in particular is rarely highlighted in medically oriented research publications. IBS is a good example, as it is a medical diagnosis with a primarily psychological etiology that can be influenced by purely psychological interventions, such as consultation and hypnosis. My ambition is to inspire clinicians who use hypnosis in the context of research to allow themselves the kind of technical flexibility that usually is offered to patients by professional therapists in clinical practice. I also wish to inspire researchers to design studies that allow flexibility in the selection of hypnosis techniques. I question the contemporary trend to design specific protocols for specific diagnoses and to conclude from statistically significant study outcome data that the protocol will help patients with this diagnosis. Two case studies illustrate that clinical flexibility can be beneficial for the results of treatment, which can be regarded as a rationale to consider the design of clinical studies.

**Method**

A number of features derived from the clinical experiences of the study, as well as from other clinical experiences with IBS patients, are presented.
I had the responsibility of coordinating the clinical implementation of the study on hypnosis for the treatment of IBS at Sahlgrenska University Hospital in Göteborg. The hypnosis was offered within the context of a multiyear RCT study, that is, the patients were randomly placed in either a control or a treatment group. The therapeutic method was characterized by individualized, flexible treatment, as was the selection of hypnotic techniques, which were adjusted according to the patient’s background, current situation, psychosocial and mental resources, and the level of unconscious dynamics behind the somatic symptoms. The techniques included a combination of bowel-focused suggestions for symptom relief, self- and resource-enhancement suggestions, insight-promoting hypnosis, and/or a combination of all these. Two cases that show the clinical value of technical flexibility are examined: One is a typical bowel-focused hypnosis; the other focuses upon the treatment of a trauma, where the hypnosis aimed at providing insight and strengthening resources. Owing to its complexity, the latter case is given more space.

A Rationale for Dynamic, Individualized Hypnosis

The hypnotherapy was carried out by three psychologists and psychotherapists. My purpose in distributing the clinical implementation between three therapists was to achieve a good match between patient and therapist. This is common practice within private psychotherapy and psychological treatment. The chances of achieving a good match are considered to increase when the patient and therapist are able to test whether there are grounds for a trustful cooperation between them. With three different therapists, one man and two women, with different personal styles, the likelihood of a good match is improved. The patients were informed that they could be referred to another therapist if the interviewing hypnotherapist was experienced as difficult to confide in.

One of the conditions I made regarding the clinical treatments was that the hypnosis had to be designed individually according to the patient’s personality, possible mental defense-function of the symptoms, as well as the patient’s mental and social resources. The clinical value of and rationale for estimating the defense-function of symptoms has been thoroughly discussed by McWilliams (1994). Since hypnosis goes deep and deals not only with conscious cognitive processes, I presented the treatment to the patients as dynamic hypnosis. This label indicates that the patient is diagnosed and treated by the psychologists according to knowledge based upon psychodynamic theory. The medical IBS diagnosis is thus supplemented by a psychological case history, projective imagination exercises (Shorr, 1998), and judgments
about transference and countertransference during both the interview and treatment. During treatment, the patients are encouraged to explore subconscious causes and maintenance functions behind the symptoms. The result of such dynamic exploration was in some cases traumatic material, family patterns of communication through somatic symptoms, identification with a role model, or so-called secondary gains, the somatization of anxiety, etc.

As a consequence of the notion of personalized hypnosis interventions and consultations for each patient, the psychotherapists adjusted the hypnosis inductions as well as the choice of suggestions and imagery individually for each patient. As a result, the psychologists in this project could vary the form of the hypnotherapy. Despite the fact that such a framework complicates the documentation needed to create a replicable protocol that can be tested and measured effectively, which experimental research often desires, my clinical experience implies that individualized inductions and suggestions have a longer lasting effect than standardized methods. This notion is supported in a research report by Barabasz and Barabasz (2006). They found that, although the individually tailored hypnosis in psychotherapy did cause some stress by the end of treatment accompanied by separation problems, it actually showed better results at a 10-month follow-up than the group that had received a manualized, protocol-based treatment. Palsson et al. (2002), in sharp contrast to Barabasz and myself, have a different opinion. On a Web site for requiring the IBS protocol, Palsson (n.d.) writes:

It has become clear that some clinicians who are using highly individualized treatment approaches which deviate significantly from the empirically tested methods (for example, use insight-oriented hypnotherapy approach, which is generally neither necessary nor advisable with this condition) sometimes achieve much less progress and lower success rate, and may even cause exacerbation of symptoms.

One can reflect upon the reason why certain patients’ symptoms worsened after treatment by therapists using individualized and insight-oriented treatments. Perhaps it was during or just after the period of treatment that the exacerbation occurred. It is possible that the therapies were not long enough to achieve the deep, long-lasting improvements that psychodynamic, insight-oriented treatments aim at achieving. According to clinical experience, insight-oriented treatment can potentially uncover denied or dissociated suffering, leading to a period that can be painful, sad, and heavy for the patients. It would be interesting to know more about the experience and competence of those therapists that carried out the treatments in those studies referred to by Palsson (n.d.), because a higher relational competence is required when working in an individualized manner than when following a
delimited, bowel-focused, and manualized protocol. Individualizing hypnosis demands a large portion of resonance, a wide experience, and a well-developed intuition, leading to a strengthening of the intensity of the therapeutic relationship. The temporary stress at the end of therapy that was reported by Barabasz and Barabasz (2006) can most probably be understood in the light of separation from a secure and unique relationship and that a certain amount of separation anxiety can be associated with ending the therapy. Thus, it is not necessary to draw the same conclusion as Palsson (n.d.), that is, that insight-oriented hypnosis is unsuitable for patients with IBS. Rather, we can conclude that the hypnotherapist who chooses an individualized psychodynamic hypnosis ought to be familiar with the treatment of separation, to be prepared to extend and deepen the treatment, allowing the treatment to include phenomena beyond the IBS symptoms, and to deal therapeutically with transference phenomena. In our study, dynamic hypnosis was based on such knowledge and skills.

Another possible explanation for the problems of individualized, insight-oriented hypnosis as discussed by Palsson is that the responsive hypnotherapists used insight-oriented therapy in all their cases, including those where bowel-focused, symptom-relieving, suggestion-based hypnosis treatment had been a better choice. The ability to choose among the whole range of hypnotic and psychological techniques ought to be the optimal qualification, as far as I understand. My hope is that the case studies illustrate this hypothesis.

HOW WE INTRODUCED DYNAMIC HYPNOSIS TO PATIENTS

About a week before treatment started, patients in the treatment group received a letter with information about dynamic hypnosis. The aim of the letter was to provide reasonable information about hypnosis and to decrease unrealistic expectations. The patients were informed that self-hypnosis exercises between treatment sessions would be an important part of therapy. They were also informed that the interviewing psychologist would refer the patient to one of the other two colleagues if either the patient or psychologist felt that a different pairing of therapist and patient would work better. The letter prepared the patients for a bowel-focused and dynamic approach:

Dynamic hypnotherapy for irritable bowel syndrome. Patient information from the psychologists in private practice.

Hypnotherapy always begins with a diagnostic interview. The interview aims at assessing whether the psychologist feels that the method is suitable for you and helps you determine whether you feel comfortable working with the psychologist. If we decide that this form of treatment is appropriate and that our “personal chemistry” is comfortable, we can make a plan for the first few sessions.
Some information about hypnosis

We want to emphasize that hypnosis is rarely perceived as being a state of “absence,” sedation, without control or any other mystical state, a picture that is unfortunately conveyed in so-called stage hypnosis. You will participate actively and in a way that feels right for you. You will learn how to use your imagination so that, in a state of relaxation, you will be able to concentrate on your gut in a way best suited to the way you think and feel. If we find that there is a connection between your gut condition and the rest of your life, part of the treatment will focus upon this. In order to get good results, you will practice self-hypnosis in between sessions on a regular basis both during and after the treatment period. You will have access to cassettes offering a variety of programs: deep relaxation, sleep induction, stress management, and physical healing, in order to help the body achieve a healing balance between activity and rest.

The first clinical meeting took place at the psychologists’ clinics, in the form of a diagnostic interview, focusing on the onset and history of the symptoms, the patient’s own views about the physical, social, and psychological causes of or connections to the symptoms, the patient’s social situation, family, and relationships, and personal and relational resources. The psychologists assessed whether there appeared to be unconscious dynamics, conflicts, or maintenance forces behind the symptoms. The aim was to gain a deeper understanding of the patients and to be prepared to utilize or analyze possible resistances within the hypnotherapy. The patients were also asked to describe what they had tried already to relieve their IBS symptoms. The interview also included an assessment of the patient’s self-knowledge, defense mechanisms, and their tendencies toward transference that could affect the hypnotherapy’s content and form.

The Scope of the Treatment

Patients who lived in the neighborhood had, after the initial assessment interview, one visit per week for 12 weeks. Patients who lived at a distance were offered 2 hours every 2 weeks, so that, in view of the fact that travel for people with IBS represents an additional stress, they would have a reasonable balance between treatment benefits and travel distress. These patients received 12 treatment sessions but spread over six occasions. All were offered a follow-up session 1 year and 2 years after the end of treatment. These follow-ups were intended to evaluate the effect of the treatment in the longer term. Follow-ups were expected to have the advantage of extending the patients’ experience of therapeutic contact and of avoiding an abrupt separation. We assumed that the knowledge that one would be meeting one’s therapist again would serve as psychological support and encouragement to continue practicing the self-hypnosis they had learned.
Hypnosis Techniques

The method of hypnosis ranged from being strictly gut oriented to the exploration of relational or traumatic experiences beneath the symptoms. Our strategy was to offer every patient a bowel-focused, symptom-relieving hypnosis. Symptom-focused hypnosis was expected to be particularly helpful for those patients who fit into a category that I would define with the psychological term “basic trust” in contrast to “basic fault” (Balint, 1992). These patients were well motivated for symptom-relieving suggestions, and they showed no tendency toward obstructive transference or signs of resistance that would complicate a bowel-focused hypnosis.

Another group of patients had a fragile or damaged self-esteem, traumatic experiences, insecure relationships, symptoms of posttraumatic stress disorder, or generalized anxiety. Some had attended some form of psychotherapy in the past and were of the opinion that their IBS was primarily a somatic response to psychological or social problems, such as loneliness, stress, anxiety, or worry. These patients were primarily motivated to receive help with their emotional, cognitive, and social reactions to difficult current or past life circumstances. Some of these could be expected to belong to the category with “basic fault” of relational trust and holding. Balint developed the psychoanalytic technique to become more individualized and more flexible for this group of patients, since he found that their lack of trust and ego strength demanded a more flexible approach from the therapist, compared with the rigid psychoanalytic techniques of interpretation (Balint, 1992). Balint’s observation is similar to mine, with regard to hypnotic technique. However, not all patients belonged to only one or the other group. Many patients needed a combination of both methods: bowel-focused and insight-oriented hypnotherapy.

Case Illustration

First, I will describe the hypnosis techniques mostly used when trying to alleviate or reduce symptoms, the so-called gut-oriented hypnosis. I will start this methodological presentation with a short case history. Subsequently, I will describe a patient for whom exploratory, therapeutic hypnotherapy was chosen and where the dissociative defense from a trauma was judged to be a part of the etiology of her IBS.

Bowel-Focused Hypnosis and Imagery

Genny represents well the patients who received bowel-focused hypnotherapy. She was 42 years old at the onset of treatment. She had
the most common criteria of IBS: diarrhea, abdominal pain, swollen gut, extreme gas production, leakage, and a fast-working bowel. She was forced to defecate many times a day, causing her discomfort at work. She was mostly disturbed by the thought that her workmates were being disturbed. In this respect, being ashamed of running to the toilet abnormally often, she was a typical example of sufferers of IBS. The IBS symptoms had arisen 17 years earlier in connection with her second pregnancy, when she was 25 years old. The delivery itself was so difficult that Genny described it as traumatic. Her relationship to her mother was aloof, and she described how she wanted to keep her cold, self-centered mother at a distance. I got the impression during the interview that this relationship had been deficient from an early age. In my psychological assessment of Genny’s personality, which formed the basis for the choice of hypnotic approach, I predicted that she might have some psychological problems and a weak sense of self, based on the fact that she was ashamed of her frequent toilet visits, that she had had a traumatic childbirth, and that she had a poor relationship with her mother. Some degree of therapeutic, analytically oriented hypnosis could be envisaged. But when I assessed her psychological and social resources, I found strong evidence that she was a well-developed, mature, socially competent woman, as evidenced in how she related to me. I have a clinical experience that strong signs of transference in the interview can forecast the necessity of an exploratory psychotherapy for the patient. There were no such signals in this case. I judged her to have a mature personality with capable mental health resources regarding relationships. She was in a happy marriage with love, tolerance, and mutual respect. Genny was a good mother to her children and a valued colleague. She had no rigid or restrictive mental defenses. Bowel-focused hypnosis was, thus, the primary choice, even though a certain readiness to deepen the relationship-motif was necessary should unresolved problems stemming from the traumatic delivery or her relationship to her mother show up during treatment. Bowel-focused hypnosis proved to be the correct method for her through, and she experienced significant improvements after 3 months with additional symptom relief after 1 year, and she was almost completely symptom-free at the 2-year follow-up.

I will now present the bowel-focused hypnosis imagery in general from which I made the individual choices for her.

*Communication from brain to stomach.* To allow the patient to visualize and feel how the head can send love, care, or calm (the choice of words that the patient feels most comfortable with) to the bowels by means of the neck, arms, and hands, which lie dormant on the stomach. The love/care/calm that is sent down will be perceived as a peaceful feeling, word, color, shape, or sensation. In order to evoke such imagery, I use...
phrases such as “You do not consciously need to choose how it’s done, your body can decide how it wishes to receive this healing sensation.” In this way, I eliminate unnecessary feelings of having to perform, and this will increase confidence in the fact that the body has undiscovered, unconscious resources for healing and relief.

*Consult the unconscious about diet.* The suggestions can read approximately as follows:

Close your eyes, imagine two tables in front of you, on one table is food that you should avoid or minimize. On the second table there is food that is good for you and your stomach. Imagine that you close your eyes, and that the knowledge of the unconscious, i.e., your body’s knowledge, decides what should be on each table. You close your eyes while the table is prepared. When you imagine that you open your eyes, you pay attention to what’s on the table. You choose which table to start with. Tell me what you see.

While the patient is describing what he or she sees on the tables, I make notes so that we can talk afterward about whether these lists can inspire the patient to a good diet.

*Eating habits.* “Sit quietly, with no stress or undue pressure to be sociable. Enjoy the food. Concentrate on the food.” Suggestions are made to promote peaceful eating habits. They are concrete and detailed, and I also describe how each organ of the digestive system works quietly and optimally when the body is calm. The process is described from the mouth, chewing and salivation, through the stomach, intestines, bowels, and rectum. I describe how each part informs every other part so that they adjust their speed to the person’s condition: not in a hurry but calm.

*Ego-strengthening hypnosis.* The literature on hypnosis has many good examples of ego-strengthening suggestions, such as a personal, beautiful place in nature, a real or imaginary figure, person, or animal, which strengthen the patient’s energy, healing ability, and self-esteem. It may be a safe place or a memory that can strengthen a feeling of worthiness. It may also be the memory of an important relative, teacher, or role model who confirmed the patient in the present or the past.

*Boundaries may need to be strengthened.* Many patients with IBS feel that they are beset by criticism or unreasonable demands from parents, their boss, or their own conscience. Exercises in saying “no” or negotiating in a dignified manner can be performed in hypnosis. Those who have difficulty saying “no” can think or say “no” or “I do not know, yet” with a friendly, calm, and dignified feeling within the body. The choice of wording is preferably made by the patient herself so that she can find the wordings that promote health and prioritize her need for self-care.
**Shorr-inspired notions of animals as a spokesman.** “Imagine that an animal represents your abdomen. What does the animal feel? What does the animal need?” More information, in the form of unfinished sentences, can be found using this projective method. The inventor, Shorr (1988), illustrated a theory that the animals represent aspects of the patient, which can be projected and identified in this way. Patients are often surprised but feel that this information, which has been inaccessible to their conscious thinking, is true. The exercises are used diagnostically and during treatment. The patients’ amazing knowledge of what they actually need in order to feel better, expressed through the animals’ finishing of incomplete sentences, is very useful, making the picture much clearer than in the clinical verbatim interview.

The patients can imagine their abdomen as an infant: fragile, vulnerable, and in need of warmth, love, and protection against unwanted external influences. They can be encouraged to visualize and feel this protection, like a shield that is localized in their own chest. The aim is to strengthen patients’ acceptance of their vulnerability and sensitivity and to guard against impressions that would otherwise go “straight in.” I have drawn inspiration for this body-focused hypnosis from body-oriented psychotherapy, including the methods I learned in the European body-therapy tradition, based on object relations theory (Wrangsjö, 1987). Whether these methods are chosen depends upon the patient’s situation and is particularly appropriate for those patients who, without reflection, help others at the expense of their own health or live in close proximity to people who have a negative impact upon them. Exercises with the aim of deepening their breathing contribute to body awareness and self-care. Methods for focusing on the body are described by Wrangsjö, and breathing exercises are specifically described in a chapter by Laurén. Downing’s theory of five levels from primitive senso-motoric experience and expression to cognitive perception with verbal expression are described in detail by Ramberg in the same book (Wrangsjö, 1987).

One gut-focused hypnotic suggestion is to ask the patient to imagine the large intestine’s peristalsis as being calm and harmonious. This can be described concretely, which is suitable for people who enjoy realistic, concrete notions. I have noticed that patients who have a medical care profession often prefer to visualize the bowel as it is and not through a metaphor. An otherwise popular metaphor is a “slow river.” The first to investigate and publish this effective visualization metaphor in hypnosis for IBS was Peter Whorwell and his colleagues (1984).

**Suggestions for reduced mucus.** Many patients report the swelling of the gut as accompanied by abundant mucus in the stool. They can also have an urgent need to defecate or release gas, leading to a leakage of mucus. My theory, about which the gastroenterologists I asked have
agreed as being likely, is that this may be an immunological reaction although not as extensive as in ulcerative colitis. I use here the same metaphor as in hypnosis for people with allergies; they visualize the immune system exactly as it might look like in a microscope or, metaphorically, as soldiers. They ask the defending elements, for example, the soldiers, to rest and refrain from attack. I ask them to implore the defense to only attack the real enemies, not those whom they confuse with enemies. These are just harmless strangers or maybe even useful for stool consistency. The defense elements are asked to intake a relaxed pose so that they can distinguish enemies from harmless strangers. This is meant to be a metaphor for the psychosomatic interrelation; a relaxed, quiet mind is anxiety and stress reducing, and this condition is communicated to the body’s internal environment. By the same token, conversely, if one can visualize the body’s defense cells as relaxed and aware when resting, the aim thus is to affect the endocrine system, including the stress hormones.

Suggestions about increased tolerance toward food. Many patients feel that swelling, pain, and flatulence increase significantly after the intake of onions, legumes, and fiber-rich products. Common advice to IBS patients, in contrast to others with an upset stomach, is to avoid high-fiber food. It is good advice if it works. Many patients, however, develop a generalized hypersensitivity to an increasing number of products until they almost do not tolerate anything other than unseasoned fluids. With these symptoms, I use the same logic as in the example above, namely that the gut defense agents are mistaken and believe that milk products, proteins, apples (I use the patient’s own concrete examples of the food she or he cannot tolerate) are hostile but that the defenses may now rest and that “the war is over.” The patients who come to hypnosis treatment have been thoroughly examined, and most of them are not lacto-intolerant, even though they themselves might feel that they are.

Pain relief through imagery. One option that many patients experienced as effective is to imagine a blockade of a synapse cleft that leads a pain impulse from the bowels/intestines to the spine, where the impulse is carried over to the next nerve pathway in the spine. At the site of the transfer is a transmitting station that can easily be visualized as a small space between the transmitting and receiving fiber or nerve. The patient can imagine placing a rubber pad into this gap, which effectively stops all pain impulses from further transport. The visualization is done in detail; the pain signals may look like small ping-pong balls that bounce off the rubber pad and fall down. When the transmitting nerve does not get rid of its balls, it loses force. The transmission is blocked and the signals cease. I strengthen the analgesia with the suggestion that the rubber pad is becoming stronger with each ping-pong ball that it dampens. In some cases, patients preferred to imagine the rubber pad blockade
at a lower site in the intestinal pain receptors. There are also patients who are more motivated to maintain the body’s sensitivity to bowel movements and only want to accept and tolerate the pain. In such cases, it may be appropriate to give suggestions about a different interpretation of pain at the central level, meaning that the brain reinterprets the pain as a harmless pressure in the gut, a pain that is completely neutral and therefore nothing to worry about. The patient can then be relaxed about the typical IBS pain or cramp, which I reframe from “pain” to “pressure.”

The anal sphincter can be strengthened. Patients who are afraid to leak feces due to the strong urge to defecate and have diarrhea can, in hypnosis, imagine the sphincter muscle and how it strengthens with stimulus, so that it does not release anything until the patient requests it to do so.

Posthypnotic suggestion (PHS) about continued self-hypnosis and the harmonization of the entire gastrointestinal tract was used for all IBS patients.

Explorative Therapeutic Hypnosis

In cases where IBS is one of several symptoms of childhood trauma or of a current, untenable situation, we used hypnosis as an aid in the processing of denial, repression, dissociation, and other nonconstructive defense mechanisms after trauma. As an example of a patient with IBS and posttraumatic stress, I will use the case of Ann, 40 years old.

The interview revealed the following information that influenced my choice to use hypnosis as part of an exploratory psychotherapy: Ann had severe separation anxiety. All relationships, whether in love or friendship, were affected by her persistent fear of being abandoned. She had had love affairs with men who, for various reasons, did not want to deepen the relationship. She was extremely jealous of both male and female friends. Her posture and facial expression was pleading and searching. Her body appearance expressed submission and an appeal for protection. The initial imaginative method from the inductions created by Shorr (1998) is reproduced here in detail.

The animal that answered from the abdomen, a large black panther, said: “I feel ashamed. I need to be purified. I will leave you. My secret is that I should not be here.” I asked the panther what it wanted with Ann. Ann conveyed to me that it said that it wanted to eat her up. I asked for more information. The panther said: “I thought I was saving Ann from being destroyed. I wish it were possible to convert my power.”

The hypnosis began by focusing on the abdomen and what it had to tell. In the second meeting, Ann, spontaneously, in hypnosis, saw herself as a 5-year-old, scared, with a dead gaze and a ruined body, and totally abandoned. She ended up in a situation with her grandfather, and she recounted it to me in the present tense, as if she was there:
Grandfather holds her hand and says something reassuring. A dark cloud appears and grandfather leads her across a meadow to a neighbor, who rapes her. “You little whore,” says the rapist. Ann wanted to scream in my room but did not dare. She feared going mad if she did so. The third session began with Ann asking me: “May I be small here?” I said that she could and she replied: “Good.”

Her IBS symptoms subsided and her emotions became stronger. She felt and gave expression to her anxiety. A mounting anger turned into sadness. The abdominal pain was relieved but moved around the body, mainly along the right side, to the hip, thigh, shoulder, arm, and head. After six sessions, I repeated the Shorr imagery, with animals in the head and abdomen. A cat replied from Ann’s head. It felt tired, in need of warmth and appreciation but lacked faith. It had given up and its head was too big. The cat’s secret was that it let the head take all the energy, even though it was the abdomen that actually suffered from pain. The animal in the abdomen was once again a panther. It said that it felt awkward and false, that it was acting a role. It needed to be loved “for who I am.” When I asked what it was going to do, it said that it would “throw a fit if I do not get it!” (I understand this as a strong need to be loved for who she is). The panther’s secret consisted of being very friendly and good.

In the seventh session of hypnosis, the trauma theme reappeared. It was that summer holiday when her mother left Ann with her grandparents, where the rapes took place. She now felt hatred and helplessness.

I continued working with her sense of shame, of being unpleasant and weak. I helped her to see her right to be a child, to comfort the child, and to help the child talk. Through a lot of pain, many nasty details were unraveled, piece by piece. I made no attempts at guessing or trying to formulate what was happening. In explorative hypnosis, no interpretations or suggestions are given, since these can lead the patient to “create” memories. The patient is asked to describe what she experienced after hypnosis; my role is to witness and support. During the tenth meeting, Ann recalled a sexual assault made by a friend of her mother, when she was about 3 years old. Anger, guilt, and fear rose to the surface. Again, she reflected upon what she needed, and she chose purification rituals. During the two subsequent hypnosis sessions, she devoted herself to purification and restoration. Then she was ready to quit, well aware of the 12-session restriction of this research study.

Ann’s IBS symptoms had eased significantly during this short treatment. In that sense, she added to the positive evidence, according to the statistical measures that apply to a CRT study. However, she still needed continued therapy. She decided to resume therapy after the follow-up sessions after 1 and 2 years in the study. We met again after 1 year for the first follow-up. She was more optimistic; she gave the impression
of greater self-confidence, and she had become aware that her intense need of attaining friends’ and colleagues’ understanding was regressive and unrealistic. Ann was no longer troubled by any IBS symptoms, and the abdominal pain she interpreted directly as body memories from the sadistic rapes. She took body pain as a hint to be extra careful and to consider what was going on within her. She resumed her treatment with me in an open-term contract. She managed to sustain an evolving therapy process, despite visits as few as once a month. Even though the 2-year follow-up had not yet been done, I took her on because her treatment of 12 sessions provided insights about her personal needs, one of them was more therapy. In Ann’s case, in which 12 therapy sessions decreased the symptoms of IBS, another treatment outcome was that she seemed to care more for herself. Hence, she wanted to gain a deeper self-knowledge and continue psychotherapy with hypnosis, making use of the trusting relationship we had built. In that light, the decision to continue therapy can be deemed to be positive.

**Discussion**

In the Sahlgrenska University study, from which the above case examples are taken, a correlation between hypnosis and positive outcome has been demonstrated statistically significant, and, thus, evidence showing hypnosis as a viable method of treatment has been further strengthened. However, the hypnotic technique is not generalizable at a detailed level and was not protocol based in the current study, which is unusual in the medical publications on IBS and hypnosis. There are recognized hypnosis protocols (Palsson et al., 2002) that are evidence based, in a statistical sense. A problem that I have illustrated with my case examples is that you lose the overall picture if you apply the same techniques to patients who have anxiety, depression, or trauma lurking behind their IBS. Even these patients often end up with a gastroenterologist who can hardly dismiss them just because they have other problems. In diagnosis- and protocol-based designs, patients as well as health care representatives see one problem at a time and, in practice, distinguish between medical (physical) disorders and psychological/psychiatric disorders. When IBS patients are treated according to a protocol, they can get relief from symptoms, but the underlying psychological distress present in quite a few of these patients will remain untreated and can cause other symptoms (known as symptom shift). An example of this would be Ann, who, despite relief from IBS symptoms, subsequently felt pain in other areas of the body, something she did not tell the medical research team. She was not the only patient in this study who, after getting symptom relief, presented with psychological/social problems that apparently had been there all
the time, covered by abdominal occupation. My impression is that 25% of the 80 patients in this study had repressed somatized psychological problems.

My clinical experience that patients who lack basic trust test the therapist’s reliability before they are able take advantage of hypnotic techniques is exemplified in case Ann. Therapeutic relational quality and its development during treatment can hardly be manual based. The relational factors, in psychodynamic terminology, that are called transference, countertransference, and resonance, play an important role in the patient’s experience of what can be tolerated and included in the treatment. One patient in the study said: “I do not really think that the doctor liked me, because it seemed as if he just wanted to hear about the typical IBS symptoms.”

Variations in Pain Perception in Relation to the Impact of Hypnosis Interventions

Another notion that may be true generally but not always individually is that hypnosis increases pain threshold. Such suggestions may be included in a manual, with the result that individual variations are being missed. We found that at least 1 patient reframed her previously unbearable pain to be harmless gut spasms. Such results were not documented as improvements since the patient reported that her actual pain level remained unchanged. The fact that the pain no longer bothered the patient is actually a qualitative improvement. Qualitative aspects, such as the patient’s subjective experience and interpretation of symptoms, are of primary importance for the patient’s general health.

Therapist Variables

As my cases illustrate, there are qualitative benefits with individualized hypnosis. The art of individualizing a treatment depends upon the therapist, and the result can therefore also be attributed to what, in a research context, is called “therapist variables.” The results of the study raise important questions about what actually helped the patients. The hypnosis treatment in this study was conducted by experienced psychologists with a psychotherapist license and at least 25 years of developing their hypnosis competence.

Psychotherapists with knowledge of unconscious processes and defense mechanisms are, owing to their training, professionals who have great knowledge about symptoms’ communicative value and have the competence to use such communication in a healing restructuring psychotherapy within which hypnosis is a valuable tool. How we present the treatment will influence what patients allow themselves to tell us. How they perceive us and our therapeutic framework will decide what they believe will fit into the therapeutic context, whether
they are expected to adapt to our manual or if we are prepared to adapt to their personality and idiosyncratic complexity.

**Symptom Relief by Dissociation—A Question for Further Research**

I am a bit concerned about the IBS patients who have underlying psychological problems, such as in the example of Ann. In the cases of dissociated or repressed trauma or loss, the timeframe of 12 treatment sessions can be sufficient for reducing IBS symptoms. Clinical hypnosis thus can add to the evidence in an RCT study, provided the treatment approach avoids a holistic or dynamic investigation. It is not always the case that a patient who suffers from IBS is aware of the relationship between IBS and residue from psychological trauma. People who suffer from posttraumatic stress often use dissociation as a defense, which may even be manifested in the clinical context. They can consult a psychotherapist for phobias and anxiety and, at the same time, seek help from doctors for various bodily ailments without seeing a connection.

What will happen to them if they get symptom relief following protocol-based gut-focused hypnosis? Will they continue to dissociate body from psyche, so that the bodily symptoms can be cured while the underlying psychological problems are manifested in a different manner? In this case, these patients may well contribute to providing evidence of successful gut-focused protocol-based hypnosis. The risk is that they remain misunderstood, that their underlying problems come to be expressed in new ways, and that they seek treatment elsewhere without ever understanding their internal psychosomatic communication.

**References**


Dynamische Hypnose, IBS und der Wert der individuellen Behandlung: eine klinische Perspektive

Susanna Carolusson


Stephanie Reigel, MD

L’hypnose dynamique, le syndrome du côlon irritable et la valeur d’un traitement individualisé: une perspective clinique

Susanna Carolusson

Résumé: L’hypnose s’est déjà révélée un traitement efficace du syndrome du côlon irritable (SCI). L’auteure avait déjà été chargée de l’hypnothérapie
utilisée dans le cadre d’une étude effectuée en Suède. Elle apporte à la préparation de cet article son expérience clinique acquise auprès de patients atteints du SCI au cours de cette étude et hors du cadre de celle-ci. L’hypnose a été décrite comme étant dynamique, et la compétence clinique et les techniques personnalisées de la thérapeute ont été utilisées dans un traitement comprenant le soulagement des symptômes intestinaux et l’hypnoanalyse, de façon séparée ou combinée. L’auteure présente deux cas, l’un portant sur le soulagement des symptômes, l’autre sur l’exploration de causes traumatiques. Elle illustre la justification clinique de son choix de flexibilité technique, depuis l’hypnoanalyse en vue de la résolution d’un problème traumatique jusqu’à l’hypnose suggestive visant le soulagement des symptômes, y compris la dynamique externe aux symptômes, lorsque ceux-ci font partie des antécédents.

Johanne Reynault
C. Tr. (STIBC)

Hipnosis dinámica, Síndrome del Intestino Irritable, y el valor del tratamiento individualizado: Una perspectiva clínica

Susanna Carolusson

Resumen: Se ha comprobado la eficiencia de la hipnosis en el tratamiento del síndrome del intestino irritable (SII). La autora fue la responsable de la hipnoterapia en un estudio Sueco y agrega su experiencia clínica con pacientes con SII dentro y fuera del estudio. La hipnosis fue descrita como dinámica, y el tratamiento utilizó la competencia clínica del terapeuta y técnicas personalizadas individualmente, incluyendo el alivio orientado hacia los síntomas del intestino e hipnoanálisis, de forma separada o en combinación. La autora presenta dos casos, uno enfocado hacia el alivio de síntomas y el otro explorando causas traumáticas. Ilustra su razonamiento clínico para la flexibilidad técnica, desde el hipnoanálisis para resolver traumas hasta la sugestión hipnótica para el alivio sintomático, incluyendo dinámicas que van más allá del síntoma cuando estas son parte de la historia clínica.

Omar Sánchez-Armáss Cappello, PhD
Autonomous University of San Luis Potosi, Mexico