

# **The Treatment of Irritable Bowel Syndrome (IBS) Through Gut Orientated Metaphor**

Leading to a

## **Certificate in IBS Treatment by Gut Orientated Metaphor**

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### **Modules**

#### **Part 1: The Research Evidence and Understanding NICE Guidelines**

1. Introduction, Learning Outcomes and Background Information
2. Hypnosis and IBS: The Research of Professor Peter Whorwell (and others) and NICE Guidance
3. What is IBS and Therapist “Don’ts”
4. Diagnostic Criteria

#### **Part 2: Therapeutic Interventions**

5. Measuring Impact and Therapeutic Gains
6. Gut Orientated Metaphors and Creating Scripts
7. Changing Modalities for Pain Management
8. Dietary Advice, Other Hypnotic Approaches and Summing Up

### **Certification Exam**

This distance learning course, delivered in conjunction with its author and founder of IBSHelp.org.uk, is aimed at two groups, hypnotherapists and those that have been trained in guided imagery techniques.

The purpose of the course is to accurately inform the student about the research supporting the treatment of IBS through Gut Orientated Metaphor, explain what IBS is and the diagnostic criteria now used in Primary Care, and to enable the student to be able to effectively construct sessions and manage the treatment of clients presenting with a clinical diagnosis of IBS. Thanks go to Helen Bremner (Nurse Hypnotherapist) of Sandwell PCT for proof reading the course and ensuring clinical accuracy.

There is a lot of research included in the course documents this is to enable the practitioner to firstly gain a comprehensive understanding of IBS mechanisms, as currently accepted and secondly to help the practitioner explain to clients how the efficacy of this treatment approach has been measured. Whilst this might not be the lightest of reading material it is essential knowledge.

There is not just one way to approach IBS from a psychological approach and within hypnotherapy there are other approaches. Gut Orientated Metaphor (GOM) is used by the author in preference to other approaches and having studied them; more importantly it is the approach that has been most rigorously tested by research. A second reason for the use of GOM is that it is empowering for the client, giving life-long tools to them.

Formal assessment is made on the submission of a script of approximately 30 minutes duration that would be used in a Gut Orientated Metaphor session.

Successful completion of the course will qualify that therapist to be listed on IBSHelp.org.uk's website, subject to meeting other quality criteria and the payment of the annual subscription cost. It will also enable GHR registrants to join the GHR's IBS Specialist Register.

Please enjoy the course.

## **Module 1**

### **Introduction, Learning Outcomes and Background Information**

#### **Introduction**

#### **Need For Guideline**

#### **Working through the course**

#### **Learning Outcomes**

#### **Background Information**

#### **What is Hypnosis/Hypnotherapy?**

#### **How Hypnosis Relates to Guided Imagery**

#### **Summary Module 1**

#### **Introduction**

This course is aimed at therapists interested in working with people who have been clinically diagnosed with Irritable Bowel Syndrome (IBS) helping them gain back control of their lives by regaining control of their gut. IBS is a functional disorder: that is a disorder showing symptoms for which no physiological or anatomical cause can be identified. It is not a disease. A disease is a health condition in which there is an observable and measurable disease process, e.g. inflammation or tissue damage.

It is not intended that this course will make you an expert in the clinical aspects of IBS – leave that to the medics; rather it is to ensure you understand IBS and can explain IBS to your clients in a way that will make sense to them and help them understand the role of the therapeutic approach. IBS is simple to treat, the protocol is simplicity itself and the results are usually outstanding.

There is a superb resource available online, and free, [www.ibscare.org](http://www.ibscare.org) which is part of the South Manchester Functional Bowel Service and has all of Whorwell's published papers available as PDFs. It is an important resource for any therapist treating IBS.

In a decision that seems to be specifically supported by the research findings of Whorwell (et al) hypnotherapy was also included from the 2008 NICE [National Institute for Health and Clinical Excellence] clinical guidelines, under psychological interventions, as an option with which to treat intractable IBS in individuals who have had the syndrome for over 12 months and have little or no improvement in their symptoms. First line treatments for the management of IBS immediately post diagnosis are diet and medication.

The course is not a medical dissertation on IBS, so various aspects such as diagnostic blood and other tests will be mentioned for awareness purposes but will not be discussed in depth, they are only relevant to diagnosis, and as a therapist, not a physician, you will not be diagnosing anyone with IBS.

There are other approaches to the treatment of IBS through drugs, diet, CBT (Cognitive Behavioural Therapy) etc other than hypnotherapy. However the detailed research on the use of hypnotherapy as a treatment approach is significant and so are the results of treatment with an 80% success rate demonstrated (Whorwell et al, 2002). Even in hypnotherapy there are different approaches used. The guided imagery of the 'Manchester Model' or Gut Orientated Therapy is simplistic in its approach and delivery and is focussed on the client's response rather than the therapist's role. Thus making it far more client focussed, sensitive and empowering.

IBS used to be diagnosed through colonoscopy, which even in 2006 was described as being an outdated approach (Irritable bowel syndrome: diagnosis and management A Agrawal and P J Whorwell *BMJ* 2006;332;280-283) – when a camera as a flexible tube is inserted up through the anus and right along the colon and biopsy samples are sometimes taken. IBS is more usually diagnosed now in primary care by the Rome II criteria from the presentation of symptoms in the absence of organic disease and according to the NICE Guidelines (*or Rome III criteria - more on this later*). Diagnosis is made by ruling out diseases through blood tests such as Coeliac Disease, Bowel Cancer, Crohn's Disease, Ulcerative Colitis (the last two are examples of Inflammatory Bowel Disease which is totally different from IBS). If blood tests suggest the presence of a disease, further tests are performed, which can include colonoscopy. Therefore only medically qualified doctors or nurse endoscopists or other suitably qualified clinical staff should diagnose IBS – you as a therapist cannot.

A large percentage of students will probably have had previous training in hypnotherapy; however it has also been demonstrated through research undertaken by Galovoski and Blanchard (1998) that an individual's hypnotic ability is not a factor in determining a successful outcome in treatment for IBS. Thus the extent of the hypnotic experience (i.e. depth of hypnosis) is not an important factor in successful treatment for IBS. All hypnosis is also effectively self-hypnosis, so therapists that have been trained in facilitating guided imagery, such as students of the Human Givens approach, will find this course useful too.

### **Need For Guideline**

NICE in their 2008 guidance ([www.nice.org.uk/nicemedia/pdf/IBSFullGuidline.pdf](http://www.nice.org.uk/nicemedia/pdf/IBSFullGuidline.pdf)) page 34 state the following:-

#### ***“2.5 Clinical need for the guideline***

*“Irritable bowel syndrome (IBS) is one of the most common functional gastrointestinal disorders. It is a chronic, relapsing and often life-long disorder, characterised by the presence of abdominal pain/discomfort associated with defecation, a change in bowel habit together with disordered defecation (constipation or diarrhoea or both), the sensation of abdominal distension, and may include associated non-colonic symptoms. These morbidities may cause dehydration, lack of sleep, anxiety and lethargy which may lead to time off work, avoidance of stressful or social situations and significant reduction in quality of life. People may present with differing symptom profiles, most commonly ‘diarrhoea predominant’, ‘constipation predominant’, and alternating symptoms. Clinical management will inevitably be directed by the presenting symptoms, but different symptom types may have differing prognoses that assist in determining the type and urgency of investigations and subsequent*

*management. Symptoms sometimes overlap with other gastrointestinal (GI) disorders such as non-ulcer dyspepsia, or with Coeliac Disease.”*

And continues a couple of paragraphs later

*“IBS most commonly affects people between the ages of 20 and 30 years and is twice as common in women as in men. The prevalence of the condition in the general population is estimated to lie somewhere between 10 and 20%. Recent trends indicate that there is also a significant prevalence of IBS in older people; therefore, IBS diagnosis should be a consideration when an older person presents with unexplained abdominal symptoms. The true prevalence of IBS in the whole population may be higher than estimated, because it is thought that many people with IBS symptoms do not seek medical advice; NHS Direct online data suggest that 75% of people using this service rely on self-care. In England and Wales, the number of people consulting for IBS is extrapolated to between 1.6 and 3.9 million. Evidence suggests that age and race have no consistent effect on the incidence of symptoms. Healthcare professionals need to be sensitive to and take into consideration cultural, ethnic and communication needs of people for whom English is not a first language or who may have cognitive and/or behavioural disabilities. Appropriate action should be taken to facilitate effective consultation.*

*“Causes of IBS have not been adequately defined, although gut hypersensitivity, disturbed colonic motility, post-infective bowel dysfunction or a defective antinociceptive (anti-pain) system are possible causes. Stress commonly aggravates the disorder and around half of IBS outpatients attribute the onset of symptoms to a stressful event. Lactose, gluten or other food intolerance is also identified as an antecedent. Colonic flora may be abnormal in IBS patients.*

*“People with IBS tend to alter their diet to alleviate symptoms of IBS, often this is self directed or guidance is sought from inadequately qualified nutritionists. Excluding individual foods or complete food groups without appropriate supervision can readily lead to inadequate nutrient intakes and ultimately malnutrition. In addition, symptoms often remain unresolved leading to further inappropriate dietary restriction.”*

The effect of IBS on an individual's quality of life cannot be underestimated as for those who suffer from it to such an extent that they need to use the specialist units and intervention of Tertiary Care have a reported incidence of 38% of sufferers having suicidal thoughts or an intention to end their own lives solely due to their bowel condition (Irritable bowel syndrome: diagnosis and management A Agrawal and P J Whorwell *BMJ* 2006; 332; 280-283).

Whilst it is always useful to have clinical guidance and information there is no real reason to read the whole of the IBS Full Guideline, as it deals with other interventions, both clinical and CAMs; however the background to the need for the guidelines (above) and pages 441 – 458 are of particular interest in understanding why NICE gave approval for hypnotherapy as a psychological intervention due to its demonstrated efficacy.

As this course is more multi-disciplinary than solely hypnotherapy there is a brief explanation of hypnosis and hypnotherapy and the role of self-hypnosis in the use of guided imagery; so hypnotherapists please accept that this is there for the benefit of others.

About 20% of adults it is estimated (Jones 1992, Harvey 1983 and Cook 1987) in the UK will suffer from IBS at some point in their lives, usually suffering in silence and in fear of incontinence, often curtailing their social and family lives to a devastating extent. Of those that present with IBS to their GPs (General Practitioners) in our Western society women outnumber men 4:1; however the incidence of IBS occurring is (NICE 2008) approximately 2:1 females to males, perhaps apart from biological differences demonstrated by some females' experiences of IBS being worse when menstruating, men are possibly more uncomfortable about going to their doctors about their bowel habits.

The cost to the NHS and private health care companies was huge with research (Harvey 1983) reporting that it accounted for 50% of a Consultant Gastroenterologist's workload a significant reason with the development of the Rome II Criteria for the move to primary care for diagnosis and management.

### **Working through the course**

The course is based on self-assessment, with an exam at the end. Self-assessment questions are there to help raise your awareness and understanding, so make sure you work through them all. Even though they are not submitted for formal assessment they will play a part in your final exam in various ways. The exam is there to be completed when you feel ready and is sent in to the Tutorial Team at the College in order to ensure that you meet the required quality level to gain your certification.