

Hypnosis in psychosomatic medicine; IBS

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Key words: hypnosis, IBS, psychosomatic

Abstract

Hypnosis is a valuable tool in therapy with psychosomatic patients. The author regards IBS (Irritable Bowel Syndrome) as one of many diagnostic categories in the psychosomatic family. This paper deals with hypnosis as an adjunct within a psychotherapeutic approach, grounded in cognitive and psychodynamic knowledge.

Psycho-diagnostics: Diagnostic imagery helps the hypnotherapist to assess the patient's capacity to trust the therapist and the method, recognise psychological conflicts or deep-rooted needs, secondary gains or ambivalence.

Cognitive aspects: These aspects deal with mastering symptoms and becoming friends with the troubled part of the body, instead of worrying. Imagery and metaphors are used in order to influence the sensitivity and motility of the colon including pain management. Hypnosis is also used for strengthening self-esteem and boundaries.

Psychodynamic aspects: As it is true that hypnosis, at least partly, sets aside the patients habitual "defences", the patient needs to experience the therapeutic relationship as absolutely safe. A psychodynamic understanding of the patient's emotional hang-ups will guide the therapist in his/her professional approach.

The author will illustrate this with short case examples.

Background

My choice of title for this paper, i.e. to mention both *hypnosis* and *IBS* together with *psychosomatic*, is chosen in the aspiration to attract even those readers who used to be sceptical to hypnosis, but have heard about the promising results on IBS and hypnosis from Manchester, Umeå or Ersta and have become a bit curious: maybe hypnosis has a clinical and scientific value? As a clinician, I have gained some 20 years of clinical evidence, so called "expertise evidence", which is enough to convince me of the efficacy of hypnosis in therapy with psychosomatic and/or somatic patients. Having passed the hard years of learning techniques and rules for hypnotherapy, I now develop my clinical skill the way an artist does, by polishing my intuition. On the other hand, the hand of experimental research and science, I am engaged in a research project on IBS and hypnosis, managed by professor H. Abrahamsson and colleagues at Sahlgrenska University Hospital. I discussed these two pillars of hypnosis, the scientific and the artistic, in a European congress on hypnosis, documented in *hypnos* (Carolusson, 1996).

We have been treating IBS patients in this research project for three years now, combining clinical intuition in the favour of the unique patient, within a frame of common standards, for the benefit of scientific generalisation and replicability. The outcome of this study is still to be documented, but some promising results so far, shows that hypnosis has a significant influence on bowel motility (Simrén, et al. 2004).

My purpose with this article is to present some general clinical perspectives on hypnotherapy in psychosomatic medicine, with IBS patients for clinical illustration. I have also presented the content of this paper at an international congress in Gothenburg 2003, organised by ISMA (International Stress Management Association) and parts of it at the 1st Nordic Conference of Hypnosis in Oslo, 2004.

I define the concept *psychosomatic* widely; a constant mutual interference between psychological and somatic phenomena. These phenomena, mind and matter, are always affecting each other and

practically impossible to separate, although it is necessary to do so as we have clinical specialities, with either somatic or psychological competence. IBS is a very good example of a diagnostic label in the psychosomatic family. This paper deals with hypnosis as a therapeutic modality in a psychological approach grounded in cognitive and psychodynamic knowledge. My arguments for hypnosis being a therapeutic tool, subordinated any of the existing therapeutic schools of psychological theory and not a sovereign psychotherapy in its own right, are presented in the International Society of Hypnosis Newsletter, (Carolusson, 2001).

I have structured this paper in four subtitles: Definition of hypnosis, Psycho-diagnosis, Cognitive aspects and Psychodynamic aspects. In contrast to most societies for psychotherapists, the societies for hypnosis often combine and exchange cognitive and psychodynamic knowledge into an integration, as it is practised by its members. Cognitive and psychodynamic approaches in hypnotic work are well presented by Erica Fromm and Daniel Brown in *Hypnotherapy and hypnoanalysis* (Brown & Fromm, 1986).

Although hypnosis is renowned for its therapeutic efficacy, it is important to know that hypnosis is not a remedy with automatic inherent healing agents. The competence of a clinical hypnotherapist is not only technical, but due to the ability to manage the clinical challenges of communicating and empathising with unique and often unpredictable patients. Hypnotic interventions only have effect if correctly timed. Skilful clinical communication includes empathising with the patient's language, cognitive style and emotional world.

Definition of hypnosis

Clinical hypnosis can be defined as a therapeutic technique aiming at guiding a patient into a specific state of mind, also called hypnosis or trance, thus utilising man's capacity to alter his/her perception, to focus or widen attention, to evoke hidden resources, to uncover and reframe emotions, images and ideas into constructive healing processes and to do this for the purpose of attaining therapeutic goals.

Psycho-diagnostics

Hypnosis is a psychological modality and hence it must be tailored to suit the psychological characteristics of the individual patient. I assess three important aspects in a diagnostic session.

1) *The therapeutic relationship*: Does the patient have confidence in me? Do I feel confident with this patient, i.e., do I have a presentiment that this patient has a capacity for this therapeutic endeavour and hypnotic work?

Psychodynamic diagnosis is of great value for understanding and foreseeing relational aspects and how these aspects influence the therapy (Mc Williams, 1994, 1999).

2) *Psychological conflicts*: Patients often express a motivation to cooperate and to learn how to heal themselves but they can also reveal an opposite force of contempt for certain aspects of themselves. IBS patients often experience the abdomen as a frustrating and therefore despised part of their bodies.

3) *Secondary gain*: Secondary gains may be the reason why a patient honestly tells you she/he would do anything to get well, but is cancelling hours or presents new symptoms of the illness after any sign of improvement. This behaviour may be due to a conflict between the wish to get well and the gains of keeping the symptom.

4) *Resources as therapeutic allies*: In the diagnostic session I look for the unique strengths and resources of each patient. Keeping these in the back of my mind through the therapeutic process, I can continue to rely on and build upon my patient's capabilities, even through periods of setbacks.

So, how do I do this diagnosis? In the psychological anamnesis I explore the patient's motivation, communication style and cognitive (thinking) patterns. In addition to this, I also test the capacity for imagery and the content of this imagery gives me a clue to psychological conflicts or needs (Shorr, 1998).

Example:

Therapist: Let an animal represent your head.

Patient: A falcon.

T: Describe it!

P: It is wise.

T: How does it feel?

P: It feels suffocated.

T: What will it do?

P: It will become free.

T: What does it need?

P: It needs my (the patient's) cooperation.

T: Does it have a secret?

P: No, ...only my cooperation.

T: Now, let an animal represent your abdomen.

P: A disgusting snake!

T: Describe it!

P: It is evil.

T: How does it feel?

P: Frightened.

T: What will it do?

P: It will eat me.

T: What does it need?

P: It needs time.

T: Does it have a secret?

P: Yes, but it will not tell.

Cognitive aspects

Cognitive psychotherapy seems to be the contemporary “hardware” of psychology. Cognitive strategies often aim at changing irrational beliefs to constructive reactions and attitudes. Cognitive interventions are educational; they deal with negative attitudes and how to change a pessimistic mindset into an optimistic one. The goal often is about mastering symptoms by coping instead of worrying.

One's capacity to alter perception can be illustrated by the effects of hypnotic suggestions, such as: “You don't have to perceive the pain as harmful” and then asking the patient to visualise the pain receptors in the colon, realising that those receptors are firing signals as a reaction to pressure, which is not really harmful, although it hurts. After such a suggestion I may encourage the IBS patient to proceed with a cognitive anaesthetic. There are as many hypnotic suggestions for this as our creativity and the patient's mindset allow us. We may use visual, auditory, kinaesthetic and sometimes olfactory imagery.

Various visualisation techniques for stimulating healing forces and the immune system have been investigated and described by Achterberg (1985) and Simonton et al (1978).

Hypnotic suggestions with IBS patients can also be formulated as metaphors in order to influence the sensitivity and motility of the colon. Dr Peter Whorwell in Manchester was one of the first to publish the metaphor of a serene river flowing calmly and smoothly. (Whorwell, et al. 1987).

I sometimes chose a mixture of concrete and metaphorical image: I ask the patient to visualise how the irritated areas receive calming and healing power from the mind through the immunological expertise on a cellular level. Inflammatory processes in the colon are visualised as traumatised soldiers from war, over-reacting to anything that reminds them of enemies (bacteria). The patient is instructed to help the soldiers calm down, relax and realise that most “enemies” turn out to be harmless on closer examination.

Patients sometimes are stuck in anger, frustration and helplessness, which maintain or exaggerate symptoms. Such cognitions are explored and constructive thoughts and images are suggested for improved symptom management.

It seems like most IBS patients and also other psychosomatic patients need to find ways to strengthen their boundaries towards other people, demands and stressors in the environment. The hypnotic suggestions aiming at strengthening self-esteem and ego boundaries are individually tailored to suit the personality of each patient. My guideline is to accept and use whatever material the patient presents and look for a way to reframe this as a resource. I suggest small changes and link them to something already obvious. I do this when the patient is open-minded, as in certain stages of hypnosis. Such hypnotic strategies are well described in the literature on Milton Erickson's work (Zeig, 1990), (Erickson, et al. 1976).

Post hypnotic suggestions and hypnosis on a cassette are used to prepare the patients for continuous future strengthening and coping.

I will conclude the part on cognitive aspects by repeating that the hypnotic techniques are therapeutic only if they are managed by sensitive communication, empathy and the optimal timing of interventions.

Psychodynamic aspects

If cognitive therapy is hardware, psychodynamic therapy seems to be a kind of software, dealing with matters not easily measured and never directly observed. Psychodynamic therapies often have the purpose of reaching insight, resolving defence mechanisms, making unconscious phenomena conscious and working through transference reactions.

In time limited hypnotherapy with IBS patients, psychodynamic goals are not in the contract, but nevertheless the psychodynamic perspectives provide additional data to the assessment and a more astute treatment approach. I will try to explain how.

As it is true that hypnosis, at least partly, sets aside the patient's habitual "defences", the patient needs to experience the therapeutic relationship as absolutely safe. Previous bad experiences from health care professionals, childhood experiences of maltreatments or traumas make it harder for some patient to trust a therapist, which may cause a negative transference, i.e. deeply rooted negative expectations. In the diagnostic imagery one of my IBS patient's head animal said "I feel afraid" and when asked for its secrets it said, "it's in the forest". From a psychodynamic point of view these answers can be understood as unconscious advice to me, to show respect for fear as protection in my hypnotic inductions and formulations.

Another patient showed to be extremely alone and had never having been attached to anybody as far as he could remember. In the diagnostic imagery, his head and abdomen animals were identical and had the same needs, namely care and love. A psychodynamic understanding of this patient's relational needs predicted a strong dependency on me and a separation anxiety could be foreseen. Most people have a favourite repertoire of defence mechanisms, influencing their whole personality. The psychodynamic perspective on this helps me adapt my hypnotic and therapeutic interventions to the patient's personality structure. Mattias Mende has published a very detailed article on how to adapt hypnotic strategies to the patient's psychodynamic personality structure (Mende, 1998) and Nancy Mc Williams has discussed diagnosis and transference in her book on psychoanalytical diagnosis (McWilliams, 1999).

I will present two illustrative examples from my work with IBS in the research project:

1) An IBS patient with an obsessive personality

Her days were ritualised by certain repetitive behaviours, magical thoughts and worries about losing control of the bowel habits. So I taught her a ritualised self-hypnosis and then gradually seeded the idea that the hypnosis would work even when irregularly practised and also in various contexts.

This strategy of accepting symptomatic behaviour or neurotic ideas and cautiously seeding options for change, became academically structured into theory 27 years ago (Watzlawick et al. 1974) and has also been presented by various of the "Ericksonian" disciples, e.g. by Zeig and Gilligan (1990).

According to psychodynamic theory and my own clinical experience, obsessive patients often repress anger. Hypnosis can threaten defences and evoke anger or anxiety. This patient presented to me the idea that her fear of anger made her fixate on her bowel symptoms and we decided that I should intersperse suggestions for coping with anger.

An example of a hypnotic suggestion was: *“each time you find yourself worrying about your bowels, you will feel more and more like a caring parent, realising that your bowels will transform your worries to a stable, calm strength..... In the near future, you will be surprised to realise that this calm strength will be as persistent as your worry used to be, so in the future your worry won't be needed... .. Your anger will move to your bosom, and it will give you the energy to set limits and to do that with a proud and calm sense of authority.”*

2) An IBS patient with a hypochondriac (histrionic) personality

A psychodynamic understanding of the histrionic personality means inability for self-soothing, immature language for feelings and that pain- or shameful emotions may be perceived as somatic suffering. Suffering offers a socially accepted reason for seeking care or sympathy. With such a patient I can use hypnotic suggestions such as *“All your sorrows and all your losses in life create feelings of sadness, anger, frustration etc. Your body has developed an extraordinary talent of telling you when you need support. Since you are thoroughly examined we know you don't suffer from any medical disease and still the pain is there and it is real, it is not just a fancy. It is real that your intestines are distressed by some reason. There may be a minor inflammation, or parts of your intestines are very narrow or there are cramps due to bad coordination of motility or the pain may be due to an overreaction on normal incoming sensations to the brain (accepting and mimicking the patient's habit of imagining various somatic reasons for the symptoms)..... .. It really doesn't matter, because in the hypnotic state of mind you will help your natural healing powers to work (seeding the idea that the patient has psychosomatic resources to care about herself constructively). Intestines are very sensitive to all kinds of emotions, they are like babies, who can't yet discriminate between various feelings, and all negative emotions become sensations of displeasure or pain. If your abdomen animal would say something about this to you now, what emotion would it express? And what does it need from you?”*

3) One IBS patient was a neurotic workaholic

Such persons are psychodynamically characterised by their too strong conscience and repression of personal needs or pleasure.

I accepted and used the fact that the patient had such a strong conscience. I suggested the conscience to act in a long perspective, instead of a short one. A hypnotic suggestion could be something like: *“Your tendency to please everybody without delay, will make you ill and not capable in the long run. It is your duty to take care of yourself now, in order to be there for those who really need you in the long perspective.”*

This patient hardly ever said “no” to other people and this inability was very persistent. I used a hypno-analytic regression to help her explore what would happen, according to her “unconscious mind” if she said “no” to somebody else's immediate needs. The answer gave her an emotionally important insight and thus resolved an obstacle for further progress.

Closing the paper

Although hypnosis through statistical research data has shown and will show a significant therapeutic efficacy in therapy with the IBS patients, I hope to have conveyed with my clinical perspective, that hypnosis is not a remedy with automatic inherent healing agents.

This means that the competence of a clinical hypnotherapist is not only technical, but due to the ability to manage the clinical challenges of communicating and empathising with unique personalities.

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