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## Systematic review: the effectiveness of hypnotherapy in the management of irritable bowel syndrome

*Wilson S, Maddison T, Roberts L, Greenfield S, Singh S*

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### CRD summary

This was a generally well-conducted review that evaluated the efficacy of hypnotherapy in the management of irritable bowel syndrome. Most of the included studies showed an improvement in clinical symptoms, suggesting a significant benefit of hypnotherapy. The authors' cautious conclusions are appropriate given the small size and poor quality of the evidence presented.

### Authors' objectives

To review the available evidence on the use of hypnotherapy in the management of irritable bowel syndrome (IBS).

### Searching

AMED, CINAHL, CISCOP, the Cochrane Library, EMBASE, MEDLINE, PsycINFO, TRIP and the Social Sciences Citation Index were searched from inception to January 2006; the search terms were reported. The bibliographies of retrieved articles were cross-checked and the authors of all eligible papers were contacted for additional published, unpublished or ongoing studies. No restrictions on language, publication date, or country were applied.

### Study selection

#### Study designs of evaluations included in the review

Any type of study design, with the exception of single case and expert opinion, were eligible.

#### Specific interventions included in the review

Studies using single-component hypnotherapy were eligible; multiple component therapies were excluded. Gut-directed hypnotherapy (GDH) was performed via audiotape or as individual GDH in 4 to 12 sessions of 30 to 90 minutes each. Control therapies, where used, included supportive psychotherapy, symptom monitoring and usual general practice management.

#### Participants included in the review

Studies of adult patients with IBS, irrespective of diagnostic criteria, were eligible for inclusion. The included studies were of patients refractory to conventional treatment, classical or atypical IBS, IBS not otherwise specified, and long-term IBS sufferers known to the service.

#### Outcomes assessed in the review

Studies of any patient-related outcome were eligible for inclusion. The outcomes extracted included various types of symptom scores, overall improvement or well-being, consultation rate and medication use, physiological or emotional measures, and quality of life. Most of the studies used a symptom score outcome that included abdominal pain, distension and altered bowel habit. Follow-up beyond the treatment period ranged from 5 months to 6 years. One study carried on a 12 month follow-up for both the intervention and control groups, while the other studies followed up either the intervention group or the control group.

#### How were decisions on the relevance of primary studies made?

Two authors independently reviewed all citations, using predetermined criteria, to identify potentially relevant trials.

### Assessment of study quality

Two reviewers independently assessed study quality, with any disagreements resolved by a third person and consensus reached. Each randomised and controlled study was allocated a score from 0 (lowest) to 8 (highest) using a modified

version of the Jadad scale. The criteria evaluated were randomisation, drop-outs, method of analysis, the study groups' similarity at baseline and interventions received other than the study treatment. Uncontrolled trials were assessed according to a 4-point scoring system that took the availability of data before and after treatment, assessment of confounders, and drop-outs into account.

### **Data extraction**

Two reviewers independently extracted the data using predetermined pro-formas. Any disagreements were resolved through consensus or a third reviewer. Authors were contacted for additional information when necessary.

### **Methods of synthesis**

#### **How were the studies combined?**

The studies were described narratively and in a table, ranked by study design.

#### **How were differences between studies investigated?**

Differences in the study design, populations and outcomes were discussed in the text and presented in more detail in a table.

### **Results of the review**

Twenty studies (n=926) were included: 4 randomised controlled trials (RCTs; n=153), 2 non-randomised controlled trials (n=70), 12 non-controlled trials (n=693) and 2 case series (n=10).

Amongst the 6 controlled studies, only one scored more than 4 out of 8 on internal validity. Five of the 12 uncontrolled studies scored at least 2 out of 4. Comparability of the treatment groups at baseline was a particular problem, with no RCT providing evidence of adequate randomisation. Blinding was not used in any of the included studies. All 6 controlled trials reported some clinical benefit with GDH, and 5 studies showed a statistically significant advantage with GDH treatment compared with control. Overall, 56% of the included studies indicated a statistically significant benefit with GDH.

There was evidence of clinical heterogeneity between the studies, particularly in relation to the broad range of outcomes evaluated and the lack of standardised outcome measures used.

### **Authors' conclusions**

The available evidence suggested that GDH could be effective in the management of IBS. However, due to the lack of reliable evidence, the routine use of GDH cannot currently be recommended.

### **CRD commentary**

This review had clearly stated inclusion criteria with respect to the study design and intervention, whereas it appeared to adopt a broad definition for the participants. The authors searched nine relevant databases and made efforts to find further information by reviewing reference lists. They also attempted to identify unpublished or ongoing studies by direct contact with the authors of all eligible papers. No restrictions on language, publication date, or country were applied. The potential influence of publication bias was not considered in the report; the authors suggested the possibility of publication bias since their review did not include studies with negative results. The authors attempted to minimise bias and errors during the review process, by carrying out the study selection, data extraction and quality assessment in duplicate. The authors' decision not to pool the studies in a meta-analysis was justified given the apparent clinical and methodological differences between the studies. The authors' conclusions are consistent with the strength of the evidence shown and are likely to be reliable.

### **Implications of the review for practice and research**

Practice: Hypnotherapy should be restricted to specialist centres caring for the more severe forms of the disorder.

Research: A randomised placebo-controlled trial of high internal validity is necessary to assess the effectiveness of GDH in the management of IBS. Such a trial should stratify participants by duration and severity of disease

### **Bibliographic details**

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10.1111/j.1365-2036.2006.03028.x

### **Other publications of related interest**

1. Tan G, Hammon DC, Gurralla J. Hypnosis and irritable bowel syndrome: a review of efficacy and mechanisms of action. *Am J Clin Hypn* 2005;47:161.
2. Whitehead WE. Hypnosis for irritable bowel syndrome: the empirical evidence of therapeutic effects. *Int J Clin Exp Hypn* 2006;54:7-20.
3. Vickers AJ. Hypnotherapy for irritable bowel syndrome: A report commissioned by North East Thames Regional Health Authority. London: Research Council for Complementary Medicine; 1994.
4. Spanier JA, Howden CW, Jones MP. A systematic review of alternative therapies in the irritable bowel syndrome. *Arch Intern Med* 2003;163:265-74.

### **Indexing Status**

Subject indexing assigned by NLM

### **MeSH**

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This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.