

SKYPE HYPNOTHERAPY FOR IRRITABLE BOWEL SYNDROME: *Effectiveness and Comparison with Face-to-Face Treatment*

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Abstract: Gut-focused hypnotherapy is an effective treatment for irritable bowel syndrome but is not widely available. This study assessed whether providing hypnotherapy by Skype might partially overcome this problem. Using a 50-point or more reduction in the IBS Symptom Severity Score as the primary outcome measure, 65% of subjects responded to Skype hypnotherapy with all other outcomes significantly improving. The primary outcome figure for face-to-face hypnotherapy was 76%. When other outcome scores for Skype and face-to-face treatment were compared, the mean changes were these: symptom severity (−94.1 vs. −129.2), noncolonic score (−52.3 vs. −64.8), quality of life (+56.4 vs. +66.2), anxiety (−3.3 vs. −3.0), depression (−1.7 vs. −2.5), and a 30% or more pain reduction (44% vs. 62%). Skype hypnotherapy is effective but slightly less so than face-to-face treatment. However, many patients would have been unable to access treatment without the Skype option.

Functional gastrointestinal disorders, particularly irritable bowel syndrome (IBS), affect between 10% and 15% of the population (Canavan, West, & Card, 2014). Many patients are managed satisfactorily in the primary care setting, where they are usually treated with dietary manipulation, antispasmodics, antidiarrheals, or laxatives, and sometimes antidepressants, often of the tricyclic variety (Spiller et al., 2007). Those who fail to respond to these measures are often referred to secondary care, where these approaches are frequently repeated, although some more recently developed medications are now available. In a small minority of patients, symptoms continue to be a problem or even deteriorate further, and it is these patients who

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are referred to tertiary care centers such as ours. It is in this setting that we have found gut-focused hypnotherapy to be particularly effective and have consistently reported response rates in the order of 70% (Miller et al., 2015; Miller & Whorwell, 2009). Furthermore, the beneficial effects have been shown to be sustained over many years (Gonsalkorale, Miller, Afzal, & Whorwell, 2003; Lindfors et al., 2012).

Despite the impressive effects of treatment and its' endorsement by the National Institute of Health and Care Excellence (NICE), hypnotherapy has not been widely adopted and is still of limited availability in the United Kingdom. Our center is funded by the National Health Service (NHS) and, consequently, we receive referrals from all over the United Kingdom, which means that some patients have to travel long distances for treatment. Not only is this costly and inconvenient for patients but traveling might be impossible because of symptoms such as severe diarrhea and fecal incontinence (Atarodi, Rafieian, & Whorwell, 2014).

To try and overcome these problems, we have started to offer Skype hypnotherapy to patients with a range of severe functional gastrointestinal disorders who would find it almost impossible to travel. This article reports the results of the first 20 IBS patients treated via Skype and compares the results to those achieved face-to-face in the clinic, as detailed in our recently published audit of 1,000 patients (Miller et al., 2015).

SUBJECTS AND METHODS

Subjects

Following a consultation in the outpatient department, subjects with IBS considered suitable for hypnotherapy are referred to the hypnotherapy unit. Twenty consecutive subjects fulfilling the Rome III criteria for a diagnosis of IBS (Drossman, 2006), who felt that it would be difficult to attend the department for hypnotherapy or had to travel particularly long distances, were offered the opportunity of having their hypnotherapy provided by Skype rather than having to attend the department for treatment.

Hypnotherapy

Traditionally, hypnotherapy provided by our unit consists of 12 weekly sessions, lasting up to an hour, on a face-to-face basis with a therapist. Those subjects expressing a preference for having Skype hypnotherapy were asked to attend the unit for a first visit, to meet the therapist face-to-face. Thereafter, all sessions were provided via Skype. The conduct and content of the hypnotherapy sessions

provided by Skype were no different than the traditional approach, which has been described elsewhere (Miller & Whorwell, 2009). The subjects were at liberty to record the Skype session, but they were also provided with CDs with which to practice.

Questionnaires

Before and after their course of Skype hypnotherapy, all subjects completed the same questionnaires that were used in our 1,000-subject audit. These were the IBS symptom severity score (IBS-SSS), the IBS noncolonic symptom score, the IBS quality of life score, and the hospital anxiety and depression score (HAD). Subjects were also invited to comment on their experience with the process as well as the quality of the Skype connection.

The IBS-SSS scores pain severity, pain frequency, abdominal bloating, bowel satisfaction, and interference with life on a 0-to-100 scale, giving a maximum possible score of 500 (Francis, Morris, & Whorwell, 1997). A 50-point or more reduction in this score is regarded as clinically meaningful and was used as the primary outcome measure in this study and the previous audit. The IBS-SSS can also be used to classify severity into severe (great than 300), moderate (175–300), mild (75–175), and remission (less than 75; see Francis et al., 1997).

The U.S. Food Drug Administration (FDA) has recommended that a responder to the treatment in subjects with IBS should be defined as an individual experiencing at least a 30% reduction in pain score following treatment (Food and Drug Administration, 2012). Consequently, this endpoint was derived from the IBS-SSS and the percentage of subjects fulfilling this criterion calculated.

The IBS noncolonic symptom score (Gonsalkorale, Houghton, & Whorwell, 2002) evaluates extraintestinal symptomatology by asking participants to rate the severity of the following on a visual analog scale of 0 to 100: nausea, early satiety, headaches, backaches, lethargy, excess flatulence, heartburn, urinary symptoms, thigh pain, and bodily aches. This generates a score out of 500, with higher scores being indicative of more severe symptoms. The illness-impact score evaluates subjects' quality of life (Gonsalkorale et al., 2002). There are 15 components to the questionnaire, scored out of 500, with higher scores representing a worse quality of life.

The HAD questionnaire is a frequently used screener for anxiety and depression (Zigmond & Snaith, 1983). Respondents answer each of seven anxiety and seven depression questions, which are scored from 0 to 3, giving a maximum possible score of 21 for anxiety or depression or both. Scores from 0 to 7 were classified as normal, 8 to 10 borderline or mild, 11 to 14 moderate, and 15 to 21 severe.

The subjects were requested to complete a "Skype questionnaire" to record their experience of having the hypnotherapy sessions via

Skype. In this questionnaire, they were asked about the quality of connection with regard to the video and audio reception during their sessions on a scale of good to unsatisfactory (good, fairly good, poor, and unsatisfactory). They were also asked how effective they thought the therapy was in comparison to their first face-to-face sessions. In addition, subjects were asked whether they would have been able to have treatment if Skype had not been available.

Power Calculation

With 20 subjects, the study would be able to estimate the change in IBS-SSS with reasonable accuracy. For an observed 50-point reduction in IBS-SSS, the associated 95% confidence interval is -97 to -3 and, therefore, an observed reduction of 50 points or more would be evidence of a statistically significant reduction in IBS-SSS (as the upper limit of the 95% confidence interval would be below 0). This calculation is based on an estimated standard deviation (*SD*) of a change of 100 points in the IBS-SSS. The estimated *SD* is taken from a previous audit (Miller et al., 2015), which found a 130-point change in IBS-SSS after hypnotherapy.

Statistical Analysis

The effect of Skype on symptom severity, noncolonic symptoms, quality of life, anxiety, and depression was assessed using paired *t*-tests. Analyses of covariance and logistic regression analyses were used to compare the Skype and audit outcomes adjusting for age.

The statistical package SPSS 22 (SPSS Inc., Chicago, IL, USA) was used to analyse the data. The conventional 5% significance level was used.

RESULTS

Twenty subjects completed the questionnaires as outlined previously; they had a mean age of 38.4 years, and 75% were female. According to the IBS-SSS, 65% of subjects had severe IBS pretreatment, with the remaining 35% having moderate IBS. All subjects received 12 hypnotherapy sessions in total. The first hypnotherapy consultation was face-to-face, with the remaining 12 sessions delivered via Skype for all subjects.

A total of 65% of subjects exhibited a 50-point or more reduction in their total IBS-SSS score following gut-focused hypnotherapy via Skype, which is regarded as being clinically significant (Francis et al., 1997). Furthermore, 30% of the subjects exhibited a 150-point or more improvement in their scores. Postintervention, 25% of subjects were classified as having severe IBS, 40% moderate IBS, and the remaining 35% mild IBS. Table 1 summarizes the remaining results, which showed a significant improvement in all outcomes. The mean total IBS-SSS score fell

Table 1
IBS Symptom Scores Pre- and Post- Gut-Focused Skype Hypnotherapy

| | Mean (<i>sd</i>) | | Mean (95% CI) | Paired <i>t</i> -test |
|-----------------------|--------------------|---------------|---------------------|-----------------------|
| | Pre- | Post- | Change | |
| Severity score | 336.3 (95.4) | 228.2 (108.1) | 108.0 (65.5, 150.5) | $p < .001$ |
| Noncolonic score | 212.7(103.0) | 161.2 (104.5) | 51.6 (18.5, 84.6) | $p = .004$ |
| Quality of life score | 257.3 (85.9) | 318.1 (72.2) | 60.8 (21.8, 99.8) | $p = .004$ |
| HAD anxiety | 12.2 (3.2) | 8.5 (3.3) | 3.8 (2.0, 5.5) | $p < .001$ |
| HAD depression | 7.4 (4.0) | 5.4 (3.8) | 2.0 (0.4, 3.7) | $p = .015$ |

significantly from 336.3 to 228.2 ($p < .001$), mean (95% CI), change 108 (65.5, 150.5). The IBS noncolonic symptom score fell from 212.7 to 161.2 ($p < .004$), mean (95% CI), change 51.6 (18.5, 84.6). The quality of life score improved from 257.3 to 318.1 ($p < .004$), mean (95% CI), change 60.8 (21.8, 99.8). The anxiety score showed a significant improvement, falling from 12.2 to 8.5 ($p < .001$), mean (95% CI), change 3.8 (2.0, 5.5). The depression score fell from 7.4 to 5.4 and tended toward significance ($p = .015$), mean (95% CI), change 2.0 (0.4, 3.7).

The individual components of the IBS-SSS also improved. Abdominal pain decreased significantly, from 62.2 to 40.3 points. Bloating and distension reduced significantly, from 61.0 to 38.2. Subjects also reported a significant reduction in their dissatisfaction with their bowel habit, which decreased from 71.6 to 47.2. Furthermore, interference with life by IBS decreased from 78.9 to 54.6.

Quality of the Skype Connection

With regard to quality of the Skype connection, 76.5% of the subjects found the picture quality during Skype sessions to be good most of the time, whereas 23.5% found it to be good on all connections. Similarly, 64.7% of the subjects found the sound quality during Skype sessions to be good most of the time, whereas 23.5% found it to be good on all connections. However, 11.8% found the audio quality to be good in half of the sessions due to disturbance in the network connection, which could either have been from the subjects' side or the hospital.

When subjects were asked whether they would have been able to receive hypnotherapy if the Skype service was not available, 70.6% reported that they would not have been able to receive the treatment without Skype. The main reasons were distance from the department coupled with the stress of having to travel with issues such as urgency and incontinence. The remaining 29.4% said they would have been able to travel to receive the treatment, but it would have been difficult

due to issues such as symptom severity, work commitments, childcare issues, and the cost of travel. Two subjects stated that they would have had to take a whole day off work for each session to accommodate traveling time.

Round-trip mileage for one session of treatment would have varied from 60 to 520 miles, with the estimated cost, including an overnight stay in some instances, ranging from £20 to £600. When subjects were asked to judge how they found the communication via Skype compared to their initial face-to-face consultation, 62.5% said that it was just as good and 37.5% rated it as nearly as good.

Comparison of the Skype Cohort with Our Previously Conducted Audit of IBS Subjects

The results of the current study were compared with the results of a previously reported 1,000-subject audit (Miller et al., 2015) from our department using the same outcome measures and hypnotherapy techniques. The Skype cohort was significantly younger (mean age 38.4 years) than the audit cohort of 1,000 subjects (mean age 51.6 years) and, therefore, an adjustment for age difference was performed, as described above.

A 50-point or more reduction in IBS symptom severity score was compared between the Skype and audit group; 65% of the Skype subjects showed a 50-point or more reduction, as compared with 76% in the audit group. Using logistic regression and adjusting for age, there was no significant difference between the Skype and audit subjects.

Similarly, a 30% or more reduction in the pain score was compared between the Skype and audit group; 44% of the Skype subjects showed a 30% or more reduction, as compared with 62% in the audit group. Using logistic regression and adjusting for age, there was no significant difference between the Skype and audit subjects.

Tables 2 and 3 give more details of the comparison between Skype hypnotherapy and face-to-face treatment. As can be seen, although there appears to be a difference in favor of face-to-face treatment, this did not reach significance.

DISCUSSION

This study shows that Skype hypnotherapy is highly effective in refractory IBS. It therefore seems reasonable to recommend this form of treatment to patients who live long distances from centers that provide such treatment or who find it difficult to travel. When Skype and traditionally delivered hypnotherapy were compared, there was no significant difference in outcomes, although it did appear that Skype hypnotherapy might be marginally less effective than face-

Table 2

Response to Hypnotherapy Delivered by Skype Compared to Face-to-Face Treatment Reported in Our Previous Audit

| | Mean change in score adjusted for age | | Mean difference (95% CI) | |
|-----------------------|---------------------------------------|--------|--------------------------|--------------|
| | Skype | Audit | Difference | Significance |
| Severity score | -94.1 | -129.2 | 35.0 (-7.4, 77.5) | $p = .11$ |
| Non-colonic score | -52.3 | -64.8 | 12.5 (-17.4, 2.4) | $p = .41$ |
| Quality of life score | +56.4 | +66.2* | 9.8 (-19.3, 38.9) | $p = .51$ |
| HAD anxiety | -3.3 | -3.0 | -0.2 (-1.7, 1.2) | $p = .75$ |
| HAD depression | -1.7 | -2.5 | 0.8 (-0.5, 2.1) | $p = .22$ |

Note: A minus change in score indicates a reduction in symptoms except for quality of life in which a positive change reflects improvement.

Table 3

Response to Hypnotherapy Delivered by Skype Compared to Face-to-Face Treatment in Terms of 50 Point or More Reduction in Symptom Severity Score and 30% or More Greater Reduction in Pain Score

| | Skype | Audit | Mean difference (95% CI) * | |
|---|-------|-------|----------------------------|--------------|
| | | | Difference | Significance |
| 50 point or more reduction in IBS-SSS. | 65% | 76% | 13% (-9% to 34%) | $p = .25$ |
| 30% or more reduction in pain score component of IBS-SSS. | 44% | 62% | 19% (-4% to 42%) | $p = .10$ |

* Using logistic regression, adjusting for age.

to-face treatment. To fully answer this question, a large randomized, controlled, noninferiority trial involving more than 100 patients in each group would be required. However, it would be inappropriate to await the outcome of such a trial, which would be challenging to fund, before introducing Skype treatment, as it is so effective in this desperate group of patients.

Skype is starting to be used in a variety of clinical situations (Armfield, Bradford, & Bradford, 2015), especially in relation to chronic illness; but to our knowledge, there have, so far, been no reports of its' use in hypnosis, particularly in relation to IBS. The encouraging results reported here suggest that this is a feasible way of treating subjects who, for a number of different reasons, may find it difficult to travel to the unit. It is especially

noteworthy that if Skype treatment had not been available, 71% of subjects claimed they would not have been able to have this form of treatment. Even in those individuals who might have been able to attend the unit, the stress involved in making the journey would be likely to degrade the efficacy of treatment. Consequently, we are now intending to offer Skype hypnotherapy to local residents if we feel that attending the unit would compromise treatment, especially in individuals with the diarrheal form of the condition. Similarly, subjects have reported that they can avoid taking time off work and even have a session at work if a quiet area is available.

It is interesting to note that, in a similar way to traditional hypnotherapy, Skype hypnotherapy had an impact on all the individual symptoms associated with IBS as well as improving noncolonic symptoms, quality of life, anxiety, and depression scores. This contrasts with many medications, which only target one or two symptoms such as pain or bowel dysfunction. Abdominal pain is frequently considered to be the most important symptom for targeting in the treatment of IBS and, using the FDA criteria for successful pain reduction in IBS, 44% met this endpoint (Food and Drug Administration, 2012).

Many subjects with IBS suffer from a variety of noncolonic symptoms such as low backache, constant lethargy, chest pain, nausea, and even bladder symptoms (Whorwell, McCallum, Creed, & Roberts, 1986). These symptoms are often ranked as a subject's most intrusive problem (Maxton, Morris, & Whorwell, 1989) and they are notoriously difficult to treat. Consequently, it is an added bonus of Skype hypnotherapy that these noncolonic symptoms often respond to treatment. It is still unclear why hypnotherapy can help with these noncolonic symptoms; however, we have previously hypothesized that if a subject generally feels better, then he or she is more readily able to cope with these other symptoms. Another potential theory is that certain noncolonic symptoms can be attributed to visceral hypersensitivity, and we have previously shown that hypnotherapy may normalize visceral sensitivity (Houghton, Calvert, Jackson, Cooper, & Whorwell, 2002; Prior, Colgan, & Whorwell, 1990). Furthermore, the quality of life scores showed significant improvement, with treatment having an impact on all domains of the score.

Over the years, we have found that the majority of subjects with severe IBS exhibit some degree of anxiety, but depression is not particularly prominent, and this trend was confirmed in our recent audit (Miller et al., 2015). Similarly, in our Skype group, scores for anxiety were initially elevated, and fell to within the normal range following treatment. The mean depression scores were not above the normal range, as seen previously in our large-scale audit (Miller et al., 2015), but it was interesting to note that the post-Skype hypnotherapy depression scores were lower when compared to baseline.

We have previously shown that other functional gastrointestinal disorders, such as functional dyspepsia and noncardiac chest pain, also improve with hypnotherapy (Calvert, Houghton, Morris, & Whorwell, 2002; Miller, Jones, & Whorwell, 2007). A consistent finding in all of our studies has been that the beneficial effects of hypnotherapy are long lasting, although some subjects need the occasional “top up” from time to time (Gonsalkorale et al., 2003). Consequently, there is no reason to believe that the benefits of hypnotherapy delivered by Skype should not also be sustained.

It is important to point out that hypnotherapy for IBS should not be considered as a stand-alone treatment. Therefore, other measures—such as dietary manipulation, antispasmodics, and antidepressants—should also be considered to form part of the treatment package. Bowel function, in subjects with the diarrhea form of IBS, frequently improves considerably with hypnotherapy, but we have found that constipation-type subjects do often need to continue to use laxatives, although often at a somewhat lower dose.

In conclusion, Skype hypnotherapy appears to be a good alternative to face-to-face treatment in subjects when the availability of hypnotherapy locally is limited or under circumstances in which subjects find traveling difficult.

AUTHOR CONTRIBUTIONS

SSH and PJW conceived the idea and SSH and JSP conducted the study. JM conducted the statistical analysis. SSH, JSP, and PJW reviewed the literature and drafted the manuscript, and all authors approved the final version of the article.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the authors.

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Skype-Hypnotherapie bei Reizdarm: Effizienz und Vergleich mit der Angesicht zu Angesicht-Behandlung

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Abstract: Darm-fokussierte Hypnotherapie ist eine effektive Behandlung des Reizdarmsyndroms, aber nicht überall verfügbar. Diese Studie beurteilte, ob das Angebot einer Hypnotherapie mittels Skype dieses Problem teilweise beheben könnte. Von einer Reduktion um 50-Punkte oder mehr im IBS Symptom Severity Score als primäre Ausgangs-Skala, berichteten 65% der Teilnehmer bezüglich Hypnotherapie mittels Skype und auch bezüglich anderweitiger Verbesserungen. Die Zahl für die Angesicht zu Angesicht-Hypnotherapie lag bei 76%. Als andere Ergebnisskalen für Skype und Angesicht zu Angesicht-Behandlung verglichen wurden, waren die beabsichtigten Veränderungen: Symptomausprägung (-94,1 vs. -129,2), noncolonic score (-52,3 vs. -64,8), Lebensqualität (+56,4 vs. +66,2), Angst (-3,3 vs. -3,0), Depression (-1,7 vs. -2,5) und eine Reduktion des Schmerzes um 30% und mehr (44% vs. 62%). Hypnotherapie via Skype ist effektiv, aber etwas weniger als die Behandlung von Angesicht zu Angesicht. Dennoch hätten viele Patienten ohne Skype gar keinen Zugang zu einer Behandlung.

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L'hypnothérapie par Skype pour traiter le syndrome du côlon irritable: efficacité et comparaison avec le traitement en face à face

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Résumé: L'hypnothérapie axée sur l'intestin est un traitement efficace contre le syndrome du côlon irritable (SCI), mais il n'est pas universellement accessible. Cette étude a évalué la possibilité de surmonter partiellement ce problème à l'aide de l'hypnothérapie par Skype. En utilisant une réduction du score de gravité des symptômes du SCI de 50 points ou plus comme principale mesure des résultats, l'étude a démontré que 65% des sujets ont bien réagi à l'hypnothérapie par Skype, avec une amélioration sensible de l'ensemble de leurs autres symptômes. Le résultat de la mesure principale de l'hypnothérapie en face à face était de 76%. Lorsqu'on a comparé d'autres scores de résultats obtenus à l'aide de Skype avec ceux du traitement en face à face, on a observé les changements moyens suivants: intensité des symptômes (-94,1 vs -129,2), score non colique (-52,3 vs -64,8), qualité de vie (+56,4 vs +66,2), anxiété (-3,3 vs -3,0), dépression (-1,7 vs -2,5), et 30% ou plus de réduction de la douleur (44% vs 62%). L'hypnothérapie par Skype est efficace, mais un peu moins que le traitement en face à face. Cependant, de nombreux patients n'auraient pu accéder à un traitement sans cette option.

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Hipnoterapia por Skype para el Síndrome del Intestino Irritable: Eficacia y comparación con tratamiento presencial

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Resumen: La hipnoterapia enfocada en los intestinos es un tratamiento eficaz para el síndrome del intestino irritable pero no es ampliamente accesible. Este estudio evaluó si el ofrecer la hipnoterapia a través de Skype pudiera solucionar parcialmente este problema. Utilizando una reducción mínima de 50 puntos en la Calificación de Severidad de Síntomas del SII como medida principal de resultados, el 65% de los sujetos respondieron a la hipnoterapia por Skype mientras que el resto mostró mejoras significativas. El resultado principal para la hipnoterapia presencial fue del 76%. Al comparar otras puntuaciones de otros resultados en hipnoterapia y terapia presencial, los cambios promedio observados fueron: severidad de síntomas (-94.1 vs -129.2), puntuación acolonica (-52.3 vs -64.8), calidad de vida (+56.4 vs +66.2), ansiedad (-3.3 vs -3.0), depresión (-1.7 vs -2.5), y una reducción mínima del 30% de dolor (44% vs 62%). La hipnoterapia por Skype es eficaz pero un poco menos que la terapia presencial. Sin embargo, muchos pacientes no hubiesen podido tener acceso a la hipnoterapia sin la opción de Skype.

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