Designing and delivering a hypnotherapy service for irritable bowel syndrome in primary care

Helen Bremner

Correspondence to

Helen Bremner, Community Clinical Nurse Hypnotherapist, Sandwell Primary Care Trust, Kingston House, 438 High Street, West Bromwich, B70 9LD, UK; helen.bremner1@nhs.net

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Abstract

Evidence-based guidelines recommend hypnotherapy as a treatment option for intractable irritable bowel syndrome (IBS). However, few National Health Service (NHS) hypnotherapy services are in place. We report the experiences and results from the only NHS-funded primary care service for IBS hypnotherapy in England (as identified by a telephone audit of 151 Primary Care Trusts (PCT) in England in February 2011). The service was delivered by a full-time nurse hypnotherapist, commissioned and funded by a PCT. In 18 months, 119 patients have been seen. Validated scoring tools showed improvement in quality of life and symptom severity scores, with improvement in all domains following therapy. This case study illustrates both the clinical effectiveness of hypnotherapy in the treatment of IBS delivered by a nurse hypnotherapist and some of the challenges faced when setting up this service. This paper summarises aspects of a model of care that could act as a template for service providers wishing to deliver hypnotherapy for IBS.

Introduction

Irritable bowel syndrome (IBS) is a chronic, relapsing and often lifelong disorder, characterised by the presence of abdominal pain, a change in bowel habit and a severe disturbance of quality of life.^{1,2} IBS is a commonly reported gastrointestinal problem, estimated to have between 10% and 20% prevalence.

There is no universally accepted definition of 'hypnosis' or 'hypnotherapy'. For the purposes of this paper and our clinical work, 'hypnosis' is defined as 'a natural state of altered consciousness, induced by a hypnotherapist, involving an increased willingness to respond to suggestions.' 'Hypnotherapy' is defined as 'using hypnosis to help the subject relax and focus their attention, to create positive change'.

Whorwell *et al* have published widely on IBS hypnotherapy since 1984. They observed that psychological distress is common in IBS and many patients with IBS experience an impaired quality of life.^{3,4} Clinical trials show that hypnotherapy for IBS is highly effective for a substantial proportion of patients at improving pain, distension, well-being and bowel habit, and that these improvements can be maintained for many years.^{2,5,6} Patients under the age of 50 years showed a 100% response to treatment.

Diagnosis and early management of patients with IBS mostly takes place in primary care. However, a large proportion of patients displaying symptoms of IBS are likely to be referred to secondary care specialists for diagnostic tests to exclude organic disease, or to confirm diagnosis of IBS. Patients can be referred to different specialities which may lead to a number of unnecessary tests and surgeries being conducted.^{7,8} Whorwell concluded that hypnotherapy for IBS may reduce patient-associated costs relating to outpatient appointments, investigations and medications.⁵

Refractory IBS is defined by the National Institute for Health and Clinical Excellence (NICE) as IBS symptoms which remain unresponsive to pharmacological treatments after 12 months.¹ The British Society of Gastroenterology guidelines on IBS and NICE guidelines on IBS in adults recommend psychological interventions for refractory IBS, including hypnotherapy.^{1,6} Hypnotherapy has proven successful in controlled trials in reducing, or even eliminating IBS symptoms, and improving quality of life.^{9,10} Prior to the community service, there was access to a part-time hypnotherapy service (3 days/18 patients per month,) in Sandwell, delivered by a secondary

care hypnotherapist, and funded by the gastroenterology department. Patients seen by this service are referred by the Trust's consultant gastroenterologists, with no direct access for primary care referrals.

NICE Clinical Guideline 61 recommends:

For patients with refractory IBS (12 months of unsuccessful pharmacological treatments, with continuing symptoms) consider cognitive behavioural therapy, hypnotherapy, psychological therapy.

Business case outline, engagement with the Primary Care Trust/General Practitioners/other stakeholders

The service was funded as a Primary Care Trust (PCT) 'Innovations Project', reviewed and approved by the Board of the local practice-based commissioning (PBC) cluster (one-third of the PCT). The application was supported by reference to evidence of efficacy, NICE IBS guidelines, and mapped to Step 2 of the stepped care closer to home model of mental health.¹¹ This provided funding for an evaluation period of 18 months. The aim was to develop a community hypnotherapy service for IBS. Local epidemiology showed the prevalence of IBS to be 18%.¹²

Personnel

One whole-time-equivalent band 7 (agenda for change scale) nurse hypnotherapist was recruited to design and set up the service, and was paid for through the innovations fund of the PBC cluster. The nurse was a general (adult) qualified nurse who was experienced in colorectal surgery and intensive care nursing. Her hypnotherapy training course was approved by The General Hypnotherapy Standards Council, and allowed to be registered with the General Hypnotherapy Register registration body. It included a number of methods for the induction of hypnosis, basic counselling skills and the use of various hypnotherapeutic techniques. A course in IBS Hypno-Psychotherapy by one of Whorwell's former colleagues was also undertaken. A nurse consultant was mentor, with peer support gained from other hypnotherapists, and the nurse had regular contact with a general practitioner (GP) who performs and teaches hypnotherapy. Clinical supervision was provided by a Consultant Clinical Psychologist. Our local IBS steering group includes members from general practice, dietitians, consultant gastroenterologists, a psychologist and the nurse hypnotherapist. The nurse hypnotherapist attended stakeholder (patient and public involvement) meetings, and has presented to them and the PBC cluster board her aims and results.

Hypnotherapeutic methods: clinical setting, use of hypnotic techniques and counselling, number of sessions

Clinic venues were carefully chosen to be as non-clinical as possible, yet accessible. Attention was paid to proximity to patients' homes (as per high-quality care

for all: National Health Service's (NHS) Next Stage Review final report), car parking availability, waiting room space, having a clean and well maintained toilet in close proximity to waiting and treatment rooms, welcoming reception (including staff) and a treatment room being in as quiet an area as possible.¹³

Whorwell's methods included teaching the patient basic anatomy and physiology, induction of hypnosis by arm levitation with suggestions for health, well-being and ego strengthening. The patient placed one hand on their abdomen and associated the warmth with control over their bowel. An audiotape was provided for patient use. One course of treatment was 12 sessions.⁹

Group therapy work can be effective,^{14 15} but Whorwell advocates treatment tailored to the individual.¹⁶ Many patients referred to the community hypnotherapy service reported that they would decline group therapy treatment.

Our practice differed from Whorwell's in several ways, as a community-based clinical service, rather than a research-based tertiary service. Techniques were more individualised, and were adapted to address the individual's specific concerns. Induction of hypnosis was typically by progressive muscle relaxation, coupled with suggestions for relaxation and well-being. As with all therapies, individuals responded differently. Deep hypnosis is not necessary to achieve successful results.¹⁷ Techniques used included guided imagery, such as a 'control room', where patients were able to increase or decrease a symptom, such as pain, by imagining turning a dial to where they wanted it to be. A garden metaphor shared indirect suggestions for bowel control using Whorwell's idea of the gut as a river, and patients were encouraged to adjust the flow of the river until it was right for them. The technique used in each session (eg, direct or indirect suggestion, ego strengthening), was dependant on the patient's experiences between appointments. Sometimes, a technique was repeated; for other patients, a new idea was introduced at each session. Patients were encouraged to use the techniques taught to them in sessions, and to listen to their CD regularly (ideally daily), using self-hypnosis to control their symptoms and appointments were offered less frequently after the mid-point of their course of appointments, so as to foster independence. The final session included a review of every technique used, with suggestions that the patient remain in control of their IBS in the future.

CDs were given to patients at two points: once during therapy, and once on discharge, which included techniques taught in sessions. Patients were encouraged to continue to use both CDs and to incorporate them into their routine, and in times of stress. This was an essential part of the therapeutic process: reinforcing work done during sessions. The aim was to encourage patients to practise self-management skills. The homework conveys positive messages and was designed to be

Table 1 Referral sources for irritable bowel syndrome hypnotherapy and disposal

Referral source	Number referred	No response to invitation	Declined therapy	Defaulted	Completed therapy	Continue therapy
General practitioner	87	19	2	26	26	14
Secondary care	39	14	2	7	13	3
Self-referral	26	0	0	9	11	6
Total	152	33	4	42	50	23

easy to fit into daily routine, rather than asking patients to focus on their problems or do written work.

A course of therapy was up to 10 sessions, each lasting 1 h. The first session included a background and disease assessment, goal setting and the option to experience hypnosis in the final 20 min. Follow-up sessions were a progress review including homework, counselling and use of a range of individualised hypnotherapeutic techniques, including gut-directed methods.⁹ Typically, the first 5 min of appointments were spent listening to the patient describing their challenges and achievements since the previous appointment. Counselling would take approximately 20 min, and included the patient stating how they would like to respond to triggers, and what they wanted to address in that particular appointment. Hypnotherapy would take about 30 min. The final 5 min were allocated to writing patient notes. The amount of time spent on each element varied, depending on patient need, but hypnotherapy was never administered for less than 20 min of an appointment.

Referrals

Referrals were received from primary care practitioners (including GPs and nurses) and from secondary care outpatient clinics from gastroenterologists, a dietitian and a colorectal functional specialist nurse. Self-referrals were accepted from patients with a history of IBS confirmed by a medical practitioner. Those who were most suitable for hypnotherapy were those who wanted it to work: those who believed it would help them, and who were prepared to work hard to achieve better health. Patients who were excluded were those with unaddressed or unmanaged mental health problems. Those with depression or managed conditions were accepted but with the consent of their mental health practitioner. Patients under 18 years of age were excluded because acceptance criteria were based on NICE guidelines; Child and Adolescent Mental Health Services are better equipped to help young people. Patients assessed to be at risk of suicide were referred back to their GP for more appropriate support, with a view to accepting them for IBS hypnotherapy at a later date. Translation was offered to those with extremely limited or no English-speaking ability, although this has not been taken up by any of the patients to date.

The service has received 155 referrals in 18 months. These came from GP practices, consultant

gastroenterologists, a secondary care colorectal specialist nurse, a multiple sclerosis specialist therapist, community psychiatric nurses, and a practice nurse (table 1). Three referrals from secondary care were rejected as they were out of the geographical area. Failure to respond to the invitation to book an appointment was common (22%), with more secondary care referrals failing to respond than GP referrals (36% vs 22%). Some of the secondary care referrals had waited for some time to be seen, having been redirected by the secondary care hypnotherapy service. Therapy was declined by four patients at the initial contact, with one non-fluent English speaker, one doubted their diagnosis of IBS and two were reluctant to experience hypnosis. Of the 115 cases enrolled, 50 (43%) had completed, 42 (37%) had defaulted and 23 (20%) continued their sessions.

Costs of set-up and delivery

The salary cost was the largest financial outlay. Using PCT venues ensured that no charges were made for reception support, room hire or car parking. A bespoke therapy chair was required for one venue: the other three venues provided examination couches. The nurse hypnotherapist recorded, burned and labelled her CDs with her own equipment at a yearly cost of around £200, avoiding studio costs of approximately £500.

Funding in the future could be released by following NICE guidelines: patients with IBS need not be referred to gastroenterology (at a cost of £268 for a first attendance) or to undergo invasive tests, such as colonoscopy (about £400). Local audit identified IBS-related costs (£160 000 per year) to three GP practice clusters, with the cost of IBS hypnotherapy being £37 000.

Outcome measures

Validated questionnaires were given to patients before therapy, at mid-point (to guide decision making and to review progress) and on discharge. A goal attainment tool is used to set priorities for, and to individualise therapy.

The IBSQOL measured quality of life for the patient specific to IBS symptoms, with higher percentage scores representing better quality of life.¹⁸

Francis and Whorwell's IBS Symptom Severity Score provided a Visual Analogue Score of five domains with numerical representation from 0 (best health) to 10 (worst health) of how bad patients' symptoms have

Table 2 Outcome data for scores of irritable bowel symptom severity (IBSS), irritable bowel syndrome quality of life (IBSQoL) and general health (Rand MOS36)

Score	Number of cases	Baseline median (IQR)	After therapy median (IQR)	Wilcoxon signed rank Z score (p value)
IBSS	50	30 (25–37)	18.5 (8–27.5)	–5.3 (p<0.0001)
IBS QoL	50	46 (27–57)	78 (59–86)	6.1 (p<0.0001)
Rand MOS36	50	41.5 (31–55)	63.5 (45–82)	5.1 (<0.0001)

Table 3 Impact on healthcare resources and employment

	Number of cases	Before therapy median (range)	At discharge median (range)	Wilcoxon signed rank Z s1 (p value)
Medications used	21	2 (0–6)	1 (0–5)	–2.8 (p<0.01)
Healthcare appointments	16	3 (0–20)	0 (0–5)	–2.7 (p<0.01)
Days absent from work	14	1 (0–182)	0 (0–35)	–2.4 (p<0.01)

been over the past 7 days, with a maximum severity score of 50.¹⁹

The SF-36 assessed patients' general quality of life, encompassing other emotional and physical conditions which may affect their well-being or their health, with higher percentage scores indicating better health.²⁰

The Clinical Outcomes for Routine Evaluation goal attainment form was given before therapy, and allowed patients to write four 'difficulties' which they wanted to be helped with.²¹ On discharge, they stated how much therapy helped with each difficulty, and gave free text on what was good and unresolved (ie, bad) about their therapy, whether they were happy with the service they received, whether they would recommend it to a friend, and free text for any additional comments. This helped the patients to focus on their progress, and provided excellent feedback to the nurse hypnotherapist to help her to improve the service in response to patient-reported outcomes.

Results

Symptom severity, quality of life and general health questionnaires were completed prior to commencement and at discharge from therapy. Wilcoxon signed rank test showed statistically significant difference in all scores at completion compared to baseline.

Symptom severity

Of those who completed a course of therapy, symptom severity scores improved in 42 (84%), quality of life scores in 49 (98%) and general health scores in 39 (78%) (table 2).

Impact on healthcare resources:

An audit questionnaire was completed by 21 patients at start and completion of therapy to assess the impact on healthcare resources (table 3). The median number of medications used per patient at the start of therapy was two (range 0–6). The number of patients taking no medication increased from two to four after therapy, with nine cases taking fewer or lower doses of

medication. The number of self-reported healthcare visits for IBS symptoms made in the 6 months prior to hypnotherapy was a median of three (range 0–20). Paired data at the end of therapy was available for 16 patients, with a median of zero (range 0–5). Time taken from work due to IBS-related symptoms was reported by seven of 14 patients in employment (50%), from 2 days to continuously for more than 6 months. At the completion of therapy, only three patients reported episodes of absence from work. Both patients on long-term sick leave returned to work.

Patient feedback

Patients reported on their Clinical Outcomes for Routine Evaluation Goal Achievement Forms²¹ that they were achieving much more than they imagined they could, in addition to symptom relief. Examples include reduced anxiety, greater confidence, returning to work after long-term unemployment, stopping smoking cannabis and cigarettes, and conquering a fear of flying. These testimonies were taken at face value.

Discussion

This report describes a unique PCT-funded community IBS hypnotherapy service. The initial pilot has twice been extended, and is now being commissioned permanently due to the success of the programme. The future of the service lies with the local Primary Care Medical Service following NHS reorganisation, allowing it to continue wholly within primary care. Although the management structures that approved the service funding have been reorganised, Clinical Commissioning Groups present the opportunity for an increase in IBS hypnotherapy provision across England. A checklist of recommendations is provided (box 1).

A systematic review of the literature which evaluated hypnotherapy for the treatment of IBS found that hypnotherapy is effective.¹⁴ Almost all the trials were in secondary care, and most studied only refractory IBS. The authors concluded that these results could not be generalised to all IBS patients, as the majority were

Box 1 Checklist for setting up an irritable bowel syndrome hypnotherapy service

- ▶ Staff: Consider the job description and personal specification. Do you need someone with healthcare qualifications and experience? Will it be a single-person service? How would sickness or maternity cover be arranged?
- ▶ Location: Easy parking and/or access to public transport. Reception staff prepared to welcome patients, and understand the importance of not disturbing sessions. Close proximity of clean toilet facilities.
- ▶ Facilities: Consider the therapeutic environment. Non-clinical, with as few reminders of traditional medicine and as few phobia triggers as possible (no needles, dressings etc). Comfortable chair or couch (reclining if possible). Consider mobility and other access issues. Consider posters with positive messages, which reinforce work done in sessions.
- ▶ Outcome measures: Use validated symptom, quality of life and health questionnaires. Which data are you collecting? What is most meaningful to your service?
- ▶ Stakeholder involvement: Who will this be? How will involvement be achieved? How will their input be acknowledged and incorporated into the service?
- ▶ Referrals: Have clear inclusion/exclusion criteria, advertise and network to raise profile, how will you manage self-referrals safely?
- ▶ How will you address equality of access issues, such as non-English speaking patients?
- ▶ Plan for treatment: How many sessions? How often?
- ▶ Homework: What follow-up work will patients do? Create your own CD or written work?
- ▶ Referring on and support: Who is required for back-up? Who can the hypnotherapist discuss concerns with? What review and appraisal is required?
- ▶ Growth: Be responsive and flexible to grow the service: consider widening your referral area, or develop new venues.

cared for in the community. The efficacy of our primary care service, however, is strikingly similar to published research data, with improved symptom severity, quality of life and general health scores. More importantly, patients have provided feedback with universal satisfaction with the service and many testimonials of personal benefit.

Facilitating factors

The service has benefited from consistent support from a core group of local primary care champions, including a GP with expertise in hypnotherapy and a PCT commissioning project manager. Secondary care provided support from a gastroenterology nurse consultant, as mentor and gastroenterologist, including observing hospital clinics. Referrals from secondary care gastroenterologists supported initial patient load, while primary care profile increased.

The service was advertised through PCT newsletters, the IBS Network (formerly the Gut Trust) website, NHS Choices website, national hypnotherapy service listings and with leaflets in GP surgeries. Venues were requisitioned from vacant medical centre rooms with the support of practice managers.

Difficulties encountered

A significant proportion of referrals received no response to invitation for an initial assessment from

both primary and secondary care (22% and 33%, respectively). Default during therapy was also common (35%). This was not unexpected, and was factored into the original business case for funding, as default rates for psychology services are commonly at this level. The service has a policy of discharging patients who failed to attend two appointments. This is because success of therapy relies on the patient being sufficiently motivated, both to attend therapy sessions and to practise techniques. Reluctance to experience hypnosis was rare in those who attended for assessment (1.7%). A small number of patients who had self-referred reported that the process of getting a GP referral was frustrating. This may reflect referrer doubts about the effectiveness of hypnotherapy. One patient reported their GP saying that hypnotherapy 'probably won't work'. After repeatedly presenting the service model and outcome data at GP meetings, referrals started coming in from an increasing number of practices.

The service was provided by a single-handed practitioner, with no local peer support, risking isolation.

Things that could have been done differently

If the service had a patient load that was too large for a single hypnotherapist, a team approach could offer both increased capacity and cost savings, as lower-band practitioners could deliver therapy under supervision.

A service from a secondary care practitioner offering outreach to community clinics would offer other potential advantages including support from the gastroenterology and nutrition multidisciplinary team, for both peer support and advice from other specialists. However, the contractual arrangements and access to primary care venues could be difficult to arrange.

Barriers to wider implementation

Hypnosis is often viewed sceptically, both by the public and medical professionals. This negativity is compounded by media portrayal of hypnotists as mind controlling or even evil, and further worsened by some hypnotherapists making unrealistic and unsubstantiated claims about what hypnotherapy can achieve. Even when a hypnotherapist can prove efficacy, and with evidence from randomised clinical trials, scepticism remains.

It is the nurse hypnotherapist's opinion that this job role lies between mental health, medical, nursing and complementary therapy. A mental health practitioner is less likely to have general health experience and training, and an adult health practitioner is less likely to have mental health experience and training.

Spending limited financial resources on a condition which is not life-threatening is difficult to justify in times of financial constraint. However, some individuals with severe symptoms seek healthcare, with associated costs. Moreover, effective hypnotherapy can allow a return to employment.

The initial limited geographical area for the community service became frustrating to supportive secondary

care colleagues, who needed to be aware of where patients lived, and whether their GP was included in the service's commissioning PBC cluster. This could well have reduced their inclination to refer. Initial referral rates were low, despite many attempts to gain the attention of GPs. After extending the service to cover the whole of the PCT, activity steadily increased.

Hypnotherapy is not subject to formal regulation or certification. Therefore, the quality of training, and the credibility of a qualification in hypnotherapy varies greatly. Voluntary self-regulation has recently been agreed upon between various hypnotherapy registration bodies and The Complementary and Natural Healthcare Council. Few healthcare professionals outside mental health settings undertake additional training in hypnotherapy. NHS services in IBS hypnotherapy may best be provided by someone who is a registered medical or allied health/mental health professional.

NICE guidelines suggest hypnotherapy be offered after a year of 'traditional' treatments (diet and lifestyle advice, first- and second-line medications). Experience in the community role has shown that most patients are not routinely offered dietary or lifestyle advice as described by the NICE guidelines. Instead, many report being told to increase their intake of 'fibre' in their diet. Only two of 79 patients (2.5%) audited in the hypnotherapy clinic recalled being told the difference between soluble and insoluble fibre. Thus, a specialised IBS service has a role in advocating all the available therapies.

IBS hypnotherapy delivered in primary care has proved viable, in line with NICE guidance and close to the patient's home, with high levels of patient satisfaction and reduced burden on other services. The service has developed and grown through persistent service promotion within primary care, and with support from both primary and secondary care colleagues. This unique NHS primary care IBS hypnotherapy service provides a model of care that could be adapted by both primary and secondary care providers.

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