Model of Psychological Approach to the Treatment of Irritable Bowel Syndrome:

It is necessary to talk about this

SILVIA BERNSTEIN

Lic. - MP 2221 - MN 4642

Author Note

The psychologist Silvia Bernstein was born in Buenos Aires, Argentina. She has been a clinical psychologist since 1979. She studied psychoanalysis and completed various postgraduate trainings within the Jungian, PNL, gestalt, bioenergetics, transpersonal, cognitive behavioral, PNEI (psycho-neuro-endocrine-immunology), and the third wave therapies schools as well as training in EMDR, dialectical behavior therapy (DBT), and acceptance and commitment therapy (ACT).

She served in the Ministry of Education and Justice as a psychologist in the area of online Teaching Improvement. She worked with adolescent and adult patients in the Mariano Castex Hospital and Mental Health Center No. 1. In recent years, she has improved in the area of functional digestive pathology and has synthesized a model of brief, strategic psychotherapy for addressing these disorders. She is the author of the book "You Can Stop Suffering" (3 editions, published by Editorial Planeta) and co-author of a handbook for therapists, "Psychological Approach to Patients with Irritable Bowel Syndrome." Currently, in addition to her practice, she delivers national and international conferences on this subject.

Abstract

Irritable bowel syndrome (IBS) is considered a biopsychosocial disorder, whose appearance and precipitation are the result of the multifactorial interaction between different variables, including motility disorders, disorders of gastrointestinal sensitivity, intestinal inflammation and infection, altered processing information in the brain-gut axis, altered microbiota, psychological disorders, and psychiatric disorders.

This paper is a synthesis of what the author has produced so far in her psychological clinic, while catering, for three decades, to patients suffering from functional gastrointestinal diseases, especially those afflicted by the irritable bowel syndrome, a prevalent disease in gastroenterology consultations.

The main focus of psychological treatment lies in helping patients to increase their mastery and symptomatic control to improve their quality of life. The model is comprised of four base pillars:

1. hypoactivation training techniques for stress management

2. reassuring and effective psychoeducation about the symptoms

3. cognitive restructuring so that the patient can better cope with their illness

4. desensitization and reprocessing techniques model based on EMDR (eye movement desensitization and reprocessing), adapted to assist underlying traumas.

These traumas could trigger digestive symptoms or be the cause of the continuity of the symptoms, just as the symptomatic history needs to be desensitized and reprocessed so as not to constitute in itself another trauma that prevents the patient from functionally developing his or her life.

Keywords: psychological treatment, irritable bowel syndrome, mood disorders, mood syndrome

Why do we need a psychological treatment for these conditions?

People may experience chronic and recurrent diseases, and they can view them as either an ordeal or an opportunity to change and grow in personal values. As a psychologist and enthusiast of my profession and service, after receiving many functional digestive patients who could not manage their symptoms solely with medical treatment, I decided, after the 80s, to synthesize a model of psychological approach to deal with the burdensome symptoms of an irritable bowel.

In the last decade, I named this branch of health psychology, *psicogastro*, or psychogastro, in order to specifically address the patients suffering from the vast range of functional gastrointestinal disorders (FGD), which include primarily irritable bowel syndrome (IBS) and functional dyspepsia (FD).

Given the close relationship between the central nervous system (CNS) and the so-called "second brain," or enteric nervous system (ENS), the discipline of psychogastroenterology was born, designed to complement medical treatment and address the existing psychological and psychiatric comorbidities in these patients.

Studies show [1] that in the range of patients who consult for their refractoriness to medical treatment, almost 50% have a high rate of affective and mood disorders (anxiety and depression in all its variants). As with the specialties of psychocardiology and psycho-oncology, psychogastroenterology offers an interesting contribution when working on "emotional digestion," deepening the psychosocial commitment with functional digestive patients.

Epistemological Base

My synthesis is an integrative approach centered on model cognitive behavioral therapy, including psychodynamic techniques, bioenergetics, gestalt, NLP (PNL), transpersonal therapy, Ericksonian hypnosis, psycho-neuro-endocrine-immunology (PNEI), and third wave therapies [2].

Introduction

One of the functional gastrointestinal disorders most common and difficult to address in the medical-psychological clinic is irritable bowel syndrome (IBS), broadly defined as a variable combination of chronic gastrointestinal (GI) symptoms that include abdominal pain, change in shape and stool, and frequent evacuation. Such changes are not explained by structural or biochemical abnormalities and present themselves at least three days a month for three months [3].

Additional characteristics include a high female predominance, heterogeneity of symptoms in relation to the prevailing bowel habits (constipation or diarrhea or alternating between the two evacuatorias modalities), and additional common intestinal symptoms (digestive, urinary, sexual, emotional, etc.) as well as psychiatric and psychological comorbidity.

Brain-Gut Axis

A functional gastrointestinal disorder is currently conceptualized as a dysregulation of brain-gut axis. The enteric nervous system (ENS), also called "second brain," is a complex system of neurons and supporting cells capable of generating and integrating information and producing a response. However, it is connected to the central nervous system, which creates afferent and efferent responses that allow the exchange of information between the two systems. In the case of the digestive system, it is essential to consider a psychoneuroimmunoendocrinological reading (the nervous system, endocrine system, immune system, and the world of emotions operating on a network).

A central factor is that the intestinal nerve endings hold 95% of the body's serotonin, which would explain why bowel activity affects the brain's pain perception, mood, and secondary behaviors, just as emotional activity affects gastrointestinal sensitivity, motility, and intestinal secretions and activity. It follows that serotonin dysregulation brings about both functional gastrointestinal disorders and mood and affective disorders.

Stress and IBS

Around three-quarters of patients with IBS report that stress causes pain and changes in bowel motility. According to a history of early adverse experiences, IBS patients report a significantly higher number of stressful life events [4]. They perceive stressful events with greater severity than those patients afflicted with inflammatory digestive diseases, i.e., ulcerative colitis

(UC) or Crohn disease (CD). Both groups of patients have similarly low levels of health-related quality of life (HRQOL), indicating similar levels of psychological stress [5].

IBS can be conceptualized within the so-called somatic sensory disorders, or somatic symptom disorders (SSD), also called central sensitivity syndromes, multiple neurochemicals, and functional somatic syndrome, because its inception, evolution, and response to treatment has been linked to stress and psychosocial factors [6]. Included in this entity are myofascial pain, restless leg syndrome, headaches, interstitial cystitis, irritable bladder, fibromyalgia (high comorbidity with IBS), and temporomandibular joint dysfunction (TMJD).

Cognitive Profile of Patients—The Role of Emotions

To understand which psychological techniques are affordable to help these "megapatients," it is first necessary to describe the cognitive profile. Research shows that patients with IBS have higher levels of anxiety and depression than healthy people. In turn, the condition of chronic disease enhances anxiety and depression. An interesting reflection that fits perfectly with the population that we see is: It’s always more important to know what kind of patient has the disease than to know what kind of disease the patient has.

Intestinal Anxiety

The predominant feature in these patients is the GI-specific anxiety, which is a heightened sensitivity signifying fears and anxiety-related sensations such as palpitations or "butterflies in the stomach. It is an important predictor of anxiety reactions in the line of panic attacks and/or panic disorder.

Anticipation and Generalized Anxiety Disorder

It is common to hear patients suffering from these disorders assert verbalizations such as the following: "I cannot go to a restaurant," "I cannot go on a trip," "I cannot go to a breakfast," "I

cannot get married, " "I cannot because I'll surely feel bad." There is prior anticipation and catastrophizing and assertions regarding something that limits them, and it's related to the fear they feel about their own bowels or sphincters and how they respond to them.

Generalized Anxiety Disorder (GAD) and Functional Gastrointestinal Disorder (FGD)

In these patients, there is a high comorbidity with functional gastrointestinal disorder and generalized anxiety disorder, whose central feature is constant excessive worry. It's as if the patient has an alarm on all the time. Thus, the vulnerability can be extremely burdensome. We observe these concerns as dysfunctional cognitions, hypervigilance, and pain catastrophism.

Undoubtedly, this psychopathological entity is the most prevalent in my patients next to panic disorder (PD) and depression [7]. Thus, the therapeutic approach is to teach the patient that they can decode their visceral sensations (painful, dysfunctional) without increasing a vicious circle of catastrophic and anticipatory thoughts and feelings. They will work out their increased concerns regarding the symptoms, desensitize them, and reformulate their beliefs about symptomology and life.

Irritable Bowel Syndrome (IBS) And Panic Disorder (PD), Agoraphobia-type Irritable Bowel

More than a third of my patients show association between functional gastrointestinal disorders and panic disorder. They experience a catastrophic and anticipated fear of again generating gastrointestinal symptoms such as spasms, pain, being unable to escape from places where they are, or being locked up and unable to access a nearby bathroom. The latter is called "irritable bowel agoraphobia," which is one of the most frequent causes of consultations.

Transfers. They fear traveling in cars, buses, trains, and especially on subways and planes.

Prohibited zone. Patients often fear and avoid beaches, pools, sporting events, stadiums, concerts, recitals, transit and highway traffic jams; young people often leave their schools due to this issue.

The circuit of fear in IBS is the same that exists in panic disorder—one of a biological vulnerability and a stressful event. There is an alert reaction, triggering catastrophic thoughts such as, "I will not make it to the bathroom," or, "I cannot go to such a place." And that is precisely where we must work on this avoidance behavior, so that the patient overcomes and faces their fear adaptively.

Excessive Control

IBS and Obsessive Compulsive Disorder (OCD)

I have noticed in patients that, because of their suffering, they are permanently watching their intestines, which become the focus of their attention. This means they constantly ask how their gut is, if symptoms subside, etc., and they develop a mechanism of excessive control when feeling insecure about their sphincters. They are patients with controlling and perfectionist characteristics.

It is useful, therefore, to address and work on the issue of control as it relates to anxiety. The patient at this table, dependant on the autonomic nervous system, feels impotent in their inability to control it and loses self-efficacy in their daily functions.

Shame

IBS and Social Anxiety Disorer (SAD)

Shame, as a characteristic element of social anxiety, in which one is afraid of being misjudged by others, is a feature of paramount importance in sufferers. We know that these issues generate intestinal shame and are not easily treated socially. They do not enjoy the prestige of the heart or brain. People feel uncomfortable referring to feces and defecation, not only in common

social situations but also with the doctor. One feels shame when perceived to have no control over their own bodily functions. Therefore, they feel inadequate.

It can be humiliating having to share bathrooms at work, being very aware of the odor that is produced and of the presence of others. Often, they take precautions like going to farther-away bathrooms and avoiding other people's bathrooms or public toilets.

Many patients are embarrassed to share the bed and bathroom with their partners, let alone in new relationships. There's a whole ritual and costumes around the subject. Helping them in these areas is also very rewarding. Weight and solemnity should be removed from this factor.

It is useful to ask the patient what the difference is between having IBS and many other diseases such as asthma, diabetes, or arthrosis. It is important to humanize the disease and work toward acceptance and adaptation. In my experience, this is often achieved in therapeutic groups with patients suffering from the same ailment. Due to shame in practice, it is difficult to form these groups even though they are extremely functional. Most patients require individual treatment without permitting themselves to go through this group modality.

The issue of excessive flatulence and how to live with it, considering that one has to perform in social settings, is one of the most frequent reasons for consultation and generates a special shame.

Anger

Central and Intestinal Irritability

Anger is another main symptom. Although we allude to it when referring to the colon or irritable bowel, we must emphasize that it extends to an "irritative personality." Many of our patients feel helpless in their bodies, unable to manage them, and this generates great anger and irritability. In

turn, if we work on those other sources of anger in their lives, we can teach them how to better channel this untapped emotion without worsening their symptoms.

IBS and Depression

Due to the limitations of the symptoms and the chronicity of the condition that affects daily digestive functions, it is not surprising, in IBS patients, to find high comorbidity with significant levels of depression. In fact, a person suffering from IBS is five times more likely to have a depressive episode than a control individual [8].

With these patients, we will work on raising their self-esteem and personal security. We will aim to work on the core values of their life so they can realize their life goals beyond gastrointestinal symptoms and the difficulties that accompany them.

IBS and Post Traumatic Stress Disorder (PTSD)

Sexual Abuse

It is observed that among the large population suffering from IBS consultation a large percentage have been victims of childhood sexual, emotional, or physical abuse, which may be remembered traumatically by the patients. EMDR methodology (eye movement desensitization and reprocessing) [9] is precisely a treatment of choice, highly effective and recommended for acute stress, especially in posttraumatic stress disorder (PTSD).

According to studies in subjects with PTSD (children, teenagers, or adults), the best results are observed when treated with EMDR. By applying this integrated model, the intention is to help patients rewrite their life traumas, and it can be extremely beneficial in relieving the functional digestive symptomology (diarrhea, spasmodic pain, dysregulation of the brain-gut axis). Thus the

patients may be, in a short period of time, resuming functions and activities that have long been delayed, depending on their symptoms and limitations.

Pain and Suffering

Severe pain is one of the reasons we call on doctors and psychologists. It is interesting to see how the patients would prefer a surgical solution rather than having to endure this chronic condition. Also very common are consultations for abdominal distention (bloating), which disables the person from developing a good quality of life. The psychological pain is treated with behavioral techniques to decrease the emotional pain associated with the symptoms and to prevent the vicious cycle of increasing physical pain.

Pyschological Schools

Among the guidelines that bring a model approach for treatment are the following:

- cognitive therapy—behavioral
- dynamic therapy—interpersonal
- hypnotherapy
- relaxation training
- multi-component treatment
- EMDR

Cognitive behavioral therapy focuses on changing cognition and behavior by changing the distorted thoughts and feelings pointing to its contents.

Interpersonal dynamics incorporates elements of psychoanalysis in regard to historical reading and the systematic approach in regard to reading interpersonal relationships.

Hypnotherapy has shown great benefits and the ability to help soothe pain and diarrhea. There is research that supports the achievements from long-term monitoring, in which the changes are preserved.

The relaxation training mode and multi-component packages correspond to CBT.

Pillars of Treatment

The model lies in working on personal meanings, emotions, and training in techniques of self-mastery as well as overcoming the underlying traumas in order to increase management power and coping skills for symptoms and obviously for life.

1. **Psychoeducation**. This modality is continued with the one already given by the doctor. Good psychoeducation plays an informative function as it reassures and allows one to bring down myths and ghosts (cancerophobia).
2. **Self-control techniques and hypoactivation**. They include a wealth of resources to teach the patient how to reduce their anxiety when it comes to symptomatology and emotional growth.
3. **Relaxation training**. It is one of the major pillars of the model and consists of training in conscious breathing (diaphragmatic, abdominal, alternating, autogenous training, progressive muscle relaxation, and others) and learning different meditations and healing visualizations—techniques designed to clear the mind and appeal to inner calm.

Relaxation and breathing training aims to teach the control of peripheral anxiety and to promote and develop pleasant feelings to counteract the negative and catastrophic bodily anchors.

A posteriori, it will be essential for patients to apply these techniques regularly under resting conditions. To start, I recommend that they practice them at that time when they are asymptomatic, so that they get used to the resources in order to use them more easily in situations of high anxiety and pain.

4. **Cognitive restructuring**. In applying this model to IBS patients, we want to detect the beliefs that enhance catastrophic anxiety and increase their painful visceral sensations. By working with them, we will seek to diminish or cut the vicious circle in which the patient is enclosed (symptom → increased hyperalgesia → catastrophic belief → increased symptoms). From implementing cognitive restructuring, will seek to review and challenge maladaptive beliefs to reprocess and modify them by other more functional ones.

To do this, we will use the Daily Record of Dysfunctional Thoughts (RDPD) which is a requested self-monitoring of the patient as homework in which they must record the correlation between symptoms, thoughts, feelings and behaviors. The ultimate goal is to transform them into more adaptive ones in order to arrive at a change in behavior.

5. **EMDR**. This model, synthesized by Francine Shapiro in the 90s, is an alternative to effective psychotherapy with lasting results in patients with "psychological trauma" (posttraumatic stress disorder) and related disorders on the trauma spectrum—products of wars, assaults, natural disasters, and traumatic events in childhood.

EMDR is one of the treatment models with a greater number of scientific validations, a fact that has earned him the recognition of the ISTSS (International Society for Traumatic Studies, 2002) and the APA (American Psychological Association, 2004) for its use in trauma. However, more than 60,000 clinicians trained in EMDR recommend it in dealing with anxiety disorders, depression, addiction, etc.

Underlying Development of Trauma and/or Perpetuating Symptomatology

In applying this integrative model, I found a way to help patients to rework their life traumas, reflecting their results in a reduction or alleviation of functional digestive symptomatologies

(diarrhea, spasmodic pain, dysregulation of the brain-gut axis) and in anxiety and depression associated with these ailments.

They were able to register as traumatic to the patient, both past vital events (abandonment, abuse, parental separation, illness of loved ones, deaths) and digestive symptomatology in itself, unmanageable and chronic (pain, voiding urgency, diarrhea, debilitating, fecal boluses, etc.) with the impossibility to attend social and work gatherings due to the limitation and shame associated with IBS sufferers or functional dyspepsia.

In summary, the implementation of this technique can reduce gastrointestinal symptoms by overcoming the traumatic events throughout its neuron chain.

Thus, faced with new episodes, they will not automatically trigger the feelings of panic and doom and gloom that had accompanied the symptom in the past, nor will they enhance this event, bringing a rapid decrease in somatic complaints.

6. **Hypnotherapy**

In my clinic, when I observed no changes in symptom improvement after working on trauma and cognitive restructuring, I usually incorporate hypnotherapy as a resource, especially in refractory patients. Hypnotherapy has been shown in published research [10] for its implementation in IBS; with fully standardized protocols, you can experience sustained improvements for years after treatment ends. Our patients manage to improve their psychological well-being, reducing the amount of medication and doctor visits.

Third Wave Therapies

While cognitive behavioral approaches are clearly beneficial in treating IBS and FGD, today we have new therapies that, like the aforementioned EMDR model, are useful to understand how the mind works and are greatly beneficial when implemented.

In my clinic, I include mindfulness (MFN) or full consciousness, dialectical behavior therapy (DBT), given the high percentage of patients with borderline personality structure as well as gastrointestinal symptoms, and acceptance and commitment therapy (ACT), given the values and metaphors that this guidance brings us, it provides us with useful resources to allow the patient to assess their total condition as a person and not as a "walking intestine."

These new approaches can be implemented with high benefits for chronic medical syndromes as they focus on changing awareness and increasing acceptance of their personal status.

Psychometric Instruments

In the evaluation of these patients, it is useful to apply two questionnaires:

- The SCL (or checklist 90)
- IBS-QOL Questionnaire

1. The SCL is a subjective evaluation based on psychological symptoms and measures nine dimensions: somatization, interpersonal relationships, depression, anxiety, obsessive compulsive disorder, hostility, phobias, paranoia, and psychosis.

It is remarkable the difference that there usually is between test and post-test after applying the treatment, which relates to an improvement in all dimensions.

2. IBS-QOL questionnaire (Irritable Bowel Syndrome Quality of Life) [11] consists of 34 constructs about how the patient perceives IBS's disturbance in their life. This test

is translated into Spanish, being validated and adapted linguistically in Argentina, Mexico, and other Latin American countries.

Suggested Tests for Taking Gastroenterological Admission

We propose to gastroenterologists taking two scales in order to assess anxiety and depression as well as somatization in patients to know when to refer them to our psychological clinics. These two tests are:

- ADH: anxiety and depression scale.
- PHQ15: somatization scale.

Scientific Evidence

The conclusions reached by various research on the effectiveness of psychological treatment for this condition are:

1. Psychotherapy decreased the amount of unexplained somatic symptoms and the conviction of having a serious disease, such as fear of cancer. In addition, lower somatic attribution, less catastrophic cognitions, and lower usage of health services were obtained [12].
2. Brain studies have shown that antidepressants work in subcortical areas, including the anterior cingulate cortex and the insula, to improve connectivity to the prefrontal cortex and other cortical areas (bottom-up effect). Meanwhile, psychotherapeutic treatment works on prefrontal cognitive areas (top-down effect) [13].
3. Combined medical-psychological treatment can increase benefits 50% or more than the use of a single treatment modality [13].

When Do Gastroenterologists Need to Refer to a Psychologist?

When gastroenterologists question whether to refer to a psychologist, the best answer is that those severe or refractory cases can benefit from treatment—patients with diarrheal mode and severe pain and basically those who feel that the symptoms bring a great alteration in their quality of life, and they fail to cope and live effectively.

Conclusion

The impact of irritable bowel syndrome (IBS) and other functional gastrointestinal disorders (FGD, TFGI) on the patient's quality of life is often underestimated by doctors and researchers because people with these disorders do not face a direct threat to their lives.

For the same reason, friends and relatives of people with functional gastrointestinal disorders may underestimate the impact these disorders often have on a person who suffers from them. But, in fact, research has now shown that these disorders often have a very substantial impact on the quality of life of patients.

Treating this "difficult" patient, challenging for the doctor and the psychologist, turns out to be highly rewarding once they are able to help them improve their quality of life. Psychological treatment, in my experience, coinciding with the above scientific evidence, can be very effective but needs, without exception, interdisciplinary work (together with the doctor, nutritionist, and psychiatrist).

The focus of our treatment is to teach the patient the tools needed to increase their internal locus of power in relation to their condition and connect it to the high values of their life, getting out of the obsession they have over their intestines.

In these functional disorders, the clinician demonstrates that, by working on affective states and comorbid moods (anxiety and depression), symptoms decrease in intensity and/or become less frequent in their attacks.

Similarly, working on the underlying traumas (whether vital or engraved in their neural networks) regarding digestive symptoms, makes it easier for these traumas not to perpetuate the symptoms, allowing the patient to improve.

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