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2020 Crohn's & Colitis Congress: Pain, Fatigue, & Nutrition in IBD

Announcer:
You're listening to ReachMD. The following episode was produced in collaboration with the Crohn's & Colitis Foundation & the American Gastroenterological Association.

Here's your host, Dr. Matt Birnholz.

Dr. Birnholz:
Coming to you from the Third Annual Crohn's & Colitis Congress in Austin, Texas, this is ReachMD. I'm Dr. Matt Birnholz. With me today is Dr. Tiffany Taft, Director of Psychogastroenterology Research in the Division of Gastroenterology and Hepatology at Northwestern University to discuss key takeaways from a recent session titled IBD Patient Quality of Life: Pain, Fatigue, and Nutrition.

Dr. Taft, welcome to you.

Dr. Taft:
Thank you for having me. I'm thrilled to be here. I'm thrilled to be at the congress this year and just really having this nice session dedicated to those important topics, especially to IBD patients.

Dr. Birnholz:
Absolutely. Before we even get started, I have to ask, your credential of being a Director of Psycho gastroenterology Research is going be novel to many of our audience. It's a really unique combination of fields, which is probably, from your perspective, long overdo but I'd love to know more about the work that you do in that role.

Dr. Taft:
Sure. Dr. Laurie Keefer and I started the first integrated behavioral medicine or psychology practice in gastroenterology at Northwestern about 15 years ago, so this has been a long process. And we are clinical psychologists by training, so we all have doctorates in clinical psychology or master's level in social work, and then we go on to subspecialize in something called health psychology. So it's kind of like medicine, right? You have internal medicine and then you go into the more granular specialties, and we health psychologists deal with chronic medical illness, and then within that is psychogastroenterology where we dedicate our research and our clinical work to patients with chronic digestive disease like IBD, and so that's what I do. I do research on those topics at Northwestern.

Dr. Birnholz:
Fascinating. And you really carved a unique niche within the university, especially as you're devoting a lot of your time and energy to IBD research

Dr. Taft:
Yeah, we focus on all digestive diseases in psycho gastroenterology, but IBD has a special place in Dr. Keefer's heart and mine in terms of, you know, just the mental health aspects and the impacts of IBD on these patients, so we really want to get that message out, and we're thrilled that the congress has such a dedicated lineup of people looking into these issues.

Dr. Birnholz:
Well, that's a perfect segue. Why don't we jump right into the congress then, because I'd love to hear about how the session looking at pain, fatigue and nutrition—very ambitious subject, taking on many critical factors for quality of life. What stood out to you regarding this session?

Dr. Taft:
It was a lot of really great information. Sometimes our sessions kind of get crammed together because there's just so much information to get out, right? And so we wanted to put together topics that are often of concern and are difficult to deal with. So, like, fatigue, for example, is one of the most difficult secondary effects of IBD, if you will, to treat, so things that should fix it like maybe rectifying nutritional deficiencies or getting the disease under control do not equal the fatigue being resolved, and patients report fatigue being their number one concern beyond bowel symptoms, so it's a big problem. And so the session really highlighted how do we try to help patients with fatigue because it's so multidimensional. You know, there's so many things that can cause someone to be tired and it's more than being tired. It's fatigue, you know, in your bones where you just can't function. And so that presentation really got into the importance of movement and physical activity but also balancing not burning all your gas in your tank and then trying to recover. So patients often struggle with, "I feel good today, so I'm gonna go out and do all the things that I haven't been able to do," and then they do too much and they overexert, and then the fatigue comes back, and they get in this vicious cycle, so the talk really got into that and how we as clinicians can try and help guide patients to break that vicious cycle.

Dr. Birnholz:

So, from your vantage point as a clinical psychologist, how do you address that with patients, both adolescent and adult patients?

Dr. Taft:
It's tricky, so it will be different. Adolescents have their own developmental place, and sometimes people diagnosed with illness in childhood or adolescent years developmentally have different courses than we would put in our textbooks, so we have to meet the patient where they are developmentally. So with adolescents we're going be doing a lot of working with the family, the parents or the caregivers that are present to get them to help us, so we leverage the family as much as we can to get them to the adolescents who already don't sleep. You know, they're up on their phones. It's already a problem outside of IBD, so we try to get them to get good sleep habits.

And then in adults we work with them on a variety of things that might contribute to their fatigue, so physical activity—if they're not moving, getting them moving, but in a way that won't maybe overexert them too quickly. People get excited and they want do things—or encouraging them if they don't think they can. So small, achievable goals is the heart of behavior change. We also look at nutrition, so we do help people if they're having trouble, we'll refer them to dietitians or other people with that expertise. We look at their sleep habits. There's something we call sleep hygiene, if they've got poor sleep, that will obviously contribute to their fatigue. There's something called cognitive behavioral therapy for insomnia. So cognitive behavioral therapy is a broad treatment approach used outside of psychogastroenterology. It's for anxiety and depression. It's been around since the 1960s, so we apply that to insomnia, and there's like a protocol that we follow to help people not have bad sleep habits.

We just kind of bring all of it as we can together from a behavioral perspective, like what might people be doing that they think is helping them adjust and do well that actually might be hindering them, and we try to show them, like, "Hey, why don't we try it this way?" and through a series of almost behavioral experiments have people go out and try it and find what works best for them.

Dr. Birnholz:
Why don't we shift then to another huge factor affecting quality of life, that being pain. Obviously, there are many sessions and entire career tracks that are devoted to that one subject alone for pain management. In IBD it's particularly difficult in the sense that you will have patients reporting of pain whether they are in active flares or not. Even when they're in remission there is pain. How do you as a clinical psychologist work with these patients around processing and managing their pain alongside the clinicians who are trying to help manage it for them?

Dr. Taft:
Yeah, so pain is a tricky topic these days especially with the opioid crisis and the attention to those medications. We hear stories of underprescribing now or patients being taken off of those medications maybe prematurely, so that's a whole other topic, but in terms of what we can do in psychology is there are pain psychologists, and so there's a whole body of literature on pain that we draw from, and we can come at pain from 2 different ways. We can do exercises to reduce the nervous system arousal or autonomic nervous system arousal which can amplify pain, so if you feel more stressed, more amped up in your body, your pain is gonna be amplified, so we try and go through the nervous system, through things like diaphragmatic breathing. Things that are actually quite simple on paper can be quite powerful in terms of their effects on pain. It's not gonna cure it, it's got gonna get rid of it, but it might bring it down a couple pegs that it feels more manageable. So we'll teach patients basic relaxation strategies and we also use something called gut-directed hypnotherapy, which is hypnosis but not in the context of, like, movies or stage hypnosis, but it is an effective treatment for pain, abdominal pain, and so we can use that with patients, which patients really like hypnosis even if it isn't that effective. It does work about 60 or 70% of the time on pain symptoms, but not everybody will get benefit, so we do that.

And then we come at it from a cognitive approach, so how do people think about their pain, how much attention are they paying to the pain, and can we get them to engage in other activities, meaningful activities that divert that attention, so doing in spite of pain versus the sometimes the draw to withdraw and not move and not do anything because that feels safer, so some of those safety behaviors that might not really be doing them much good. We encourage people to get outside of that comfort zone that has become problematic.

Dr. Birnholz:
In the area of diet and exercise counseling, there are now many technologies, many apps that people are being referred to help them better manage their own nutrition habits, but before one just sends them off to X or Y app that will tell them, “Hey, these are your macros,” “This is what you need to focus on,” “Oh, you have IBD,” and it will plug in some algorithm, what are some counseling tips that you provide for these patients to really help them get ahead of their own disease course, maybe even be able to mitigate some of the flares through nutritional education?

Dr. Taft:
Yeah, so we are very fortunate at Northwestern to have talented dietitians that really understand IBD, and I wish I could clone them and put them all over the place so that everybody had access to qualified registered dietitians that are knowledgeable of IBD, and we know that’s not kind of a pie in the sky thing. So we do try to guide people to the best resources and are educated enough that we can help people read through some of the stuff online that maybe isn’t as helpful, some of the quick-fix cures. For me, I see diet as critical. Patients are very interested in diet, and I think with the microbiome research coming out, that’s really advancing diet as a topic in IBD. I can remember not that long ago when IBD researchers were saying diet wasn’t really that important, and now there’s been a big change, which is great.

One of the things I want to highlight for clinicians is when I hear an IBD patient is either being prescribed a diet or is just considering it on their own, is to be mindful of that patient’s resources and predisposition to certain things. Patients that are very anxious may not be well-suited for a dietary approach that requires a lot of elimination of foods. So some of these diets are very exclusionary and they’re supposed to have a period of exclusion, then reintroduction depending on the diet, and I see patients that become food-phobic and are afraid to eat and will not reintroduce foods. We see really kind of maladaptive attitudes towards food that result from unmonitored diet interventions, so we try to help with that. And I spend a lot of time getting patients to eat food again after they have become so afraid that... “Well, I can’t eat that, and it’s on the diet.” You know, “I ate that twice, and I didn’t feel well.” So diet is exciting, but it’s also a risky area for some patients who are more anxious and maybe prone to disordered eating already. When we throw a diet at them, they can have a hard time.

Dr. Birnholz:
Do you also have to account for their access to certain food types, whether they live in food deserts, for instance, or what their means are to be able to account for certain dietary habits versus others?

Dr. Taft:
Yeah, so some of the diets, if you read them, they’re just not feasible. I’m in Chicago, so food deserts are definitely a thing, and we can’t ask patients with lower incomes to implement diets that require foods that they just don’t have access to. So you can’t get healthy fresh fruits and vegetables everywhere in Chicago. You have to travel 10 miles sometimes to get access to that. And if it costs 5 times as much as the cheeseburger or the fast food, it’s really hard to convince patients, so we try to at sources of B-grade produce, and you don’t have to go to Whole Foods and get the organic stuff. So we will sit with patients in sessions and say, “Where can you implement 80% of this diet?” “Maybe you can’t do a hundred percent, but let’s see if you can get even,” you know, “halfway there,” and, “What do you feel comfortable with?” And so I think an all-or-nothing approach to diet isn’t probably a good idea for most people, and allowing flexibility is what we try to instill in patients versus hardcore rigidity because that’s when people get in trouble.

Dr. Birnholz:
Well, Dr. Taft, we could design a yearlong elective for each of the quality of life factors that we are trying to just touch upon today from fatigue to pain to nutritional and diet considerations. But before we go, any additional pieces of advice that you want to impart to clinicians to help them consider these quality of life factors for IBD patients and maybe take positive steps forward in their care?

Dr. Taft:
At Northwestern I know the doctors spend maybe 15, 30 minutes with your patients. I think that’s kind of the norm. And so we as psychologists know and appreciate that clinicians don’t have a lot of time and you guys have a lot of stuff to talk about, but please don’t shy away from the questions about fatigue and, “How are you eating?” “How are you sleeping?” “How are you doing?” “How are you coping?” Patients will appreciate that. And if you ask regularly, they’ll open up to you, they’ll feel more comfortable, versus waiting until it’s like a crisis. So we often get people referred to us once they’ve cried in their gastroenterologist’s office versus if that question was being brought up regularly and it felt like a normal conversation with their gastroenterologist or nurse practitioner, what have you, it

might not get to that crisis point. So we want early intervention, so ask. Don't be afraid to talk about these topics. Weave them into your talks about treatment. Whatever you can do to make it kind of flow naturally as part of this is just part of your care, I think will normalize these topics and get them the attention that they're not really getting on a regular basis.

Dr. Birnholz:
I very much want to thank Dr. Tiffany Taft from Northwestern University for joining us to talk about these various quality of life factors and the important role that psycho gastroenterology is starting to play and has always played but now is in a definitive way, starting to play in both research and treatment for these patients.

Thanks so much, Dr. Taft.

Dr. Taft:
Thank you for having me.

Dr. Birnholz:
For ReachMD, I'm Dr. Matt Birnholz. Thanks again for listening.

Announcer:
This program was brought to you in collaboration with the Crohn's & Colitis Foundation & the American Gastroenterological Association. If you missed any part of this discussion, or to find others in this series, visit ReachMD.com/foundation, where you can be part of the knowledge.