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Investigating IBS & IBD: An Exploration into Lifelong Management

Dr. Buch:
Diagnosing irritable bowel syndrome and inflammatory bowel disease is one step in helping our patients. However, treating these illnesses and also improving quality of life can occasionally be problematic.

This is your host, Dr Peter Buch. Welcome to ReachMD GI Insights here to help guide us is Dr Laurie Keefer. Dr. Keefer is professor of Medicine, Gastroenterology, and Psychiatry at Mount Sinai School of Medicine. She chairs the division of Psychogastroenterology within the Rome Foundation and is on the Council of the American Neurogastroenterology and Motility Society. Dr. Keefer, I'm so happy that you're joining us today.

Dr. Keefer:
Yeah, my pleasure. Thanks for inviting me.

Dr. Buch:
Pleasure having you. So let's get right into it. Who are good candidates and who are poor candidates for behavioral therapy?

Dr. Keefer:
Oh, great question. So I guess to begin, right, when we're talking about behavioral therapy for GI disorders, particularly disorders of brain-gut dysregulation. Right. It's really important that the patient understands and preferably has been told by their physician or GI provider the ideology of their symptoms. Right. Because these behavioral therapies that we're talking about, brain-gut psychotherapies, really are targeting brain-gut dysregulation. So, whether that is hypnosis or cognitive behavioral therapy or mindfulness-based stress reduction, it's really important that the patient buys into the idea that there are things that they themselves can do to actually influence their GI symptoms. So that's number one for in terms of who's a good candidate.

And, you know, patients who tend to experience a lot of isolation or engage in avoidance behavior or who have a lot of anxiety or distress around their symptoms or the settings in which they occur usually do pretty well in these types of interventions, because that's exactly what they target.

In terms of inappropriate candidates, certainly because we are offering brief, short-term skills-based interventions, you know, we're really not going to be able to move the needle on anyone that has any real severe psychological symptoms or severe depression or chronic anxiety, patients who tend to overly focus, for example on finding a cure, who don't really see the benefit of an intervention to improve quality of life, even if we can't take away their symptoms, would also not necessarily be the best candidate.

In the middle level. I kind of think of my red light, green light, yellow light, in that middle level, that yellow light level. It really depends on the therapist's comfort level with things such as disordered eating and post-traumatic stress and motivational deficiencies. Some of those patients can do really, really well with brain-gut psychotherapies. But a lot of that depends on the therapist’s experience and comfort and in preference for working with those patients.

Dr. Buch:
Thank you. Would you kindly discuss gut-directed hypnotherapy?

Dr. Keefer:
Sure. So gut-directed hypnotherapy is as it kind of sounds, that is, you know, hypnosis, medical hypnosis has been around for centuries and has been shown to have analgesic effects at the level of the brain, as well as a lot of other benefits from, you know, in terms of reducing autonomic arousal and improving immune function and that type of thing. So, hypnosis itself is a intervention much like, you

know, putting somebody into a hypnotic trance would be the equivalent of a physician, maybe an IBD doctor offering, you know, the needle into the arm before a patient gets an infusion. What makes hypnosis gut directed or cardiac directed or ego directed is really what happens after that I.V. is in. Once that hypnosis trance has been created, and that is what makes it gut-directed. So in gut-directed hypnotherapy, after the patient is in a hypnotic state, that dose of medicine that we push through that I.V., that suggestion that we make is very important to be related directly to their symptom profile. So, whether that's improving brain-gut dysregulation, improving motility and how easily things move through your system whether that is reducing pain and discomfort or extending periods of time in which you don't have pain or discomfort, all of those would make something gut-directed hypnotherapy. And there's certainly good evidence for irritable bowel syndrome but also for IBD for non-ulcer dyspepsia reflux all of those abdominal pain. So, it's a really helpful brain-gut psychotherapy that can be used across the spectrum of digestive diseases.

Dr. Buch:
Thank you. What differences have you noted when treating patients with IBS as opposed to patients with inflammatory bowel disease?

Dr. Keefer:
Hmm, that's a good question. So, you know, I think there's actually more similarities probably than differences. I mean, you have two disorders with very similar symptoms. Urgent diarrhea, abdominal pain, nausea, discomfort sensitivities to food, and stress. Right? And that's because the brain and the gut are really so interconnected regardless of the pathophysiology. So I think a lot of the concerns that patients have around being out and finding a restroom where one's not available or feeling embarrassed or stigmatized or ashamed of their symptoms, fearing bringing on their symptoms by getting too stressed out or by what they're eating are very similar.

But there are some, you know significant differences, too, in terms of the amount of brain-gut dysregulation you see in each of the conditions. And I think that's where some of the therapies are maybe need to be adapted based on that. So, for example, in an irritable bowel syndrome patient those symptoms that they're experiencing are just as real as the symptoms of an IBD patient. But their cause, their pathophysiology is much more directly tied to that gut-brain axis, gut-brain microbiome access. Right? So the interventions that we offer, like the hypnosis, like cognitive behavioral therapy, like mindfulness, are really likely to have a very clear impact on those symptoms directly. Right?

In IBD patients who also, 40 percent of whom also have brain-gut dysregulation, I think you're sort of dealing with that same pot of interventions. You can move the needle on the GI symptoms. But because there is an inflammatory and immune component in IBD other types of interventions are also sort of used. Things that are more related to positive improving positive affect, building social support, increasing optimism and hope. You know, those things that are tied to chronic disease, morbidity and mortality in a little bit of a different way than you would see with brain-gut dysregulation in the IBS space.

Dr. Buch:
For those just joining us, this is Dr. Peter Buch for ReachMD GI Insights. Joining us is Dr. Laurie Keefer, who is discussing improving quality of life for IBS and IBD patients with behavioral counseling and other techniques.

Dr. Keefer, would you discuss sleep disturbances in IBD and IBS?

Dr. Keefer:
Absolutely. I'm glad you asked that. Sleep disturbances are really common in both IBD and IBS probably for similar reasons and also for different reasons. So, we had done one of the earliest studies, just even assessing the prevalence of sleep disturbances in IBS and IBD patients back in the late the early 2000s. And you know, one of the things we noticed was that the IBS patients really perceived poor sleep, maybe even poor sleep than was evidenced by their polysomnography test. And that was for a lot of the same reasons that they experience amplified GI symptoms in the absence of sort of objective markers. And so really looking at the causes of insomnia in IBS are very much tied to things like muscle tension, difficulty modifying arousal, anxiety, chronic worry, you know, sort of difficulty shutting down the mind, ruminating about symptoms or the settings in which they occur can all be part of that amplification of GI signals, but also that difficulty resting and falling asleep.

In the IBD patients, we certainly saw that as well. But the sleep disturbances were a little more objectively marked in that patients were either having to get up to go to the bathroom and that disrupted their sleep. They had abdominal pain that made it difficult for them to stay asleep. Or There were also patients whose disease was maybe not quite in remission or who were anticipating a disease flare that also had some minor changes in sleep architecture, which is known in the field, that sleep disturbances can kind of come as a precursor to disease activity or disease flares. And a lot of my patients will say that they notice a change in their sleep in advance of disease activity.

Dr. Buch:
And thank you for the article that you wrote with Bill Chey, which pointed out to the importance of sleep in both of these conditions. So if you would kindly discuss the Mount Sinai Medical Home known as GRITT, G-R-I-T-T IBD, and how does it work?

Dr. Keefer:
So, GRITT stands for gaining resilience through transitions. And it is really based on the framework of positive psychology in which we sort of believe that patients with inflammatory bowel disease deserve to sort of thrive despite having a chronic condition. And as you know, these are disorders that are commonly appear in young people. They are not high prevalence, but they are very high cost. And my job at Mount Sinai which I started in 2016 there was to come in and create a multidisciplinary team-based care model that sort of wrapped their arms around these complex IBD patients, of which there are 12,000 in the Mount Sinai IBD Center, pediatric and adult and make sure that we're attending to not just their physiological needs, but also their nutrition support, their emotional well-being. And so the program really focuses on identifying stratifying patients early on that may need help, that may have trouble bouncing back from a diagnosis of IBD, or may have trouble bouncing back from another life transition. For example, transitioned into being well, transitioned into being laid off, transition into marriage. You know, we really see that transitions are a point in chronic disease in which we can sort of, you know push out to patients, added support and tools so that nothing like that really sets their disease back, given the sensitivity of IBD to, you know, changes in stress and environment and mood.

So my team has two social workers, a dietician, a pharmacist, several nurses, and nurse practitioners. We meet weekly to review cases to bring patients into the program. Most patients are in the program for about nine months before they graduate. But most of that work is done up front where they're receiving the comprehensive care program. And it's great because we've actually seen that the outcomes that the hospital wants to see, which is decreased ED visits, decreased hospitalizations, decreased opioid use. We've been able to demonstrate that when you take this resilience-based approach, you're really able to teach patients to thrive and not overuse resources that they frankly don't need with, you know, with a team around them supporting.

Dr. Buch:
What would you advise for patients with IBS or IBD who are poorly covered or not covered by insurance when they are seeking coping strategies?

Dr. Keefer:
Hmm, that, you know, that is such a hard question. You know, I think the COVID pandemic has really highlighted the gap in mental healthcare accessibility for patients, certainly even in the New York region where, you know, we have a therapist every block even those therapists are full or not taking health insurance or not able to accommodate chronic disease patients. So it's really a huge challenge. And, you know, one of the things that the gastro-psych community is really trying to work on is both increasing access by connecting patients and providers with the right type of care. Right? So going to the Rome GI psych directory and finding a GI psych person in your community is good. But again, you run into insurance issues. So the other focus is in really trying to train other types of health providers who are maybe less costly than a health psychologist. So, for example Helen Murray up in Boston is working on a study training nurse practitioners in how to perform cognitive behavioral therapy. A lot of our GI doctors and nurse practitioners have been trained in gut-directed hypnotherapy. It's a little easier to get in with those doctors with the health insurance than a psychologist or psychiatrist.

And then finally, there's been some new studies looking at some of these digital tools that might be substitutes or at least for milder conditions where patients can learn some of these skills. I think the other tried and true technique that directly affects the GI tract is diaphragmatic breathing. That's something that can be taught to you by your GI provider and you can implement it wherever you are, either for stress reduction or for in-the-moment symptoms, so urgent need to go to the bathroom, take a deep breath in four seconds, six seconds out exhale. Do that a few cycles. And that can actually affect the fight or flight response you have in anticipation of a GI symptom.

Dr. Buch:
So before we conclude, are there any other thoughts you would like to share with our audience today?

Dr. Keefer:
No, I just think that it's so great to work in a community of GI providers that embrace the psychological aspects of chronic digestive diseases. And, you know, I think it's important that we keep going with the discussion of, you know, you mentioned quality of life, but which is obviously really important. But it's even more than quality of life, in a way, it's well-being. It's subjective well-being. Its not just are you surviving your condition, but are you happy? Are you achieving the things in your life that you that are important to you? We may not ever be able to take away all of your GI symptoms for a patient but certainly we can strive for a patient to feel well. And I think that's a really great metric for all of us as GI providers to work on.

Dr. Buch:
That's all the time we have for today. I wanted to thank Dr. Keefer very much for sharing her insights.

Dr. Keefer:

Thank you. It was my pleasure to talk about these things.

Dr. Buch:
For ReachMD, this is Dr. Peter Buch. To access this recording and to listen to others, visit reachmd.com/giinsights where you can be part of that knowledge. Thanks for joining us today. See you next time.