AN INTRODUCTION TO PSYCHOGASTROENTEROLOGY

Katie Simpson

Health Psychologist

ADHB and The MacMurray Centre

OVERVIEW

- Background and interest area
- What is psychogastroenterology?
- What it looks like in primary care
- Assessment
- Intervention
- Discussing psychogastroenterology with a patient
- Questions / case discussion

BACKGROUND

- Health psychologist
- Primary interest area is the gastrointestinal tract
- Internship in diabetes and renal at CMDHB
- Currently the psychologist for general surgery at ADHB covering: upper GI with an emphasis on bariatric surgery, colorectal, nutrition support/intestinal failure and physical trauma
- MacMurray every second Friday practicing GI psychology
- See surgical, organic and functional GI patients across my roles

BACKGROUND – INITIAL INTEREST

- 2016 – masters thesis
- Interested in psychosomatic processes and the gut
- Experiment on the stress-mediated effects of widespread hypersensitivity in people with irritable bowel syndrome
- Rudimentary findings that suggest people with IBS demonstrated a higher pain response than people without IBS after experiencing stress

PSYCHOGASTROENTEROLOGY

- The application of psychological science and practice to gastrointestinal health and illness
  - Essentially the brain-gut axis
- Includes organic and functional GI conditions
- Across the lifespan
  - Pediatric and adult divisions
- Emphasises the importance of a multidisciplinary team approach
  - Hard to achieve in primary care

PSYCHOGASTROENTEROLOGY

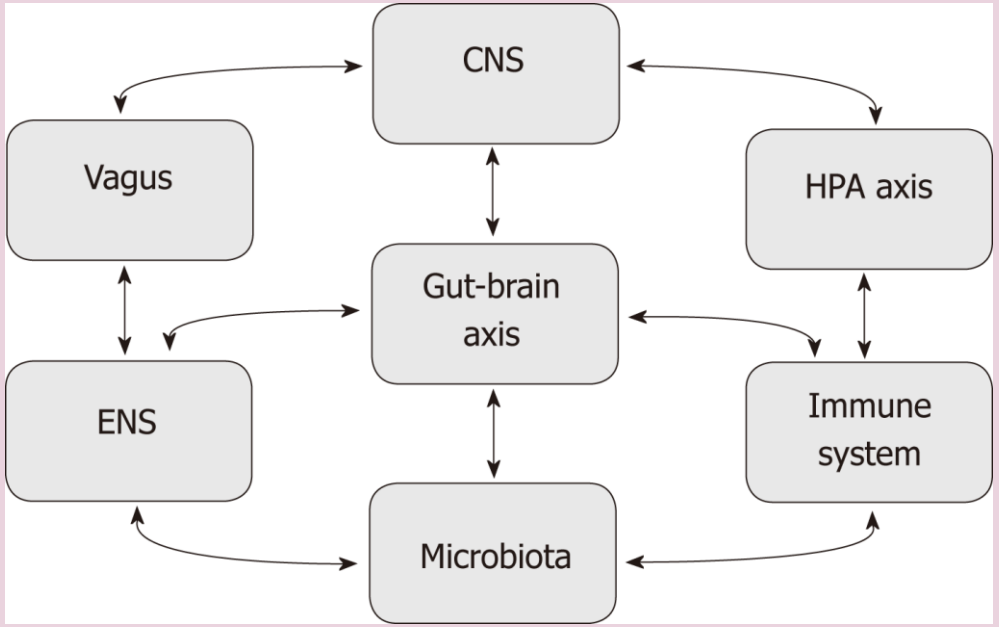
- The Rome Foundation, specifically the psychogastroenterology division
- More representation from functional GI population.
  - Previously known as functional gastrointestinal disorders (FGIDs) now conceptualised as disorders of gut-brain interaction (DGBIs)
  - Worldwide prevalence of 40% for any DGBI
- The development of sensitisation in patients who have had surgery on their GI tract and/or have an organic GI condition
  - Easy to overlook

PSYCHOGASTROENTEROLOGY

- Primary symptoms – pain, dysmotility, altered bowel habit, bloating, nausea, bowel dissatisfaction and distress
- Direct – dysregulation in central and visceral processing
- Indirect – unhelpful emotions, thoughts and behaviors
  - Avoidance is a common, problematic behavior that tends to make symptoms worse and further reduce quality of life

PATHWAYS OF DYSREGULATION

- Genetics
- Early adverse life events
- Microbiome structure and changes in microbiota
- Dietary
- Motility
- Visceral processing
- Central processing
- Immune
- Endocrine
- Psychology



GI CONDITIONS IN PRIMARY CARE

- Your reaction to ”unexplained abdominal” and other vague symptoms like nausea and change in bowel habit?
- How prevalent?
- IBS example
  - 6-10% prevalence worldwide
  - 19% in NZ (2002)
- Why do they keep coming back?

ASSESSMENT

- <u>What I do:</u>
- *Comprehensive, one-hour biopsychosocial assessment:*
- Motivation for seeking GI psych input
- Presenting GI complaint/s
- History of GI symptoms
- Current intervention and coping
- Impact on lifestyle
- Psychosocial history
- Trauma
- Mental health – historical and current
- Substance use
- Formulation and recommendation

- <u>What you can do:</u>
- Increase confidence in diagnosing DGBIs through a process of inclusion rather than exclusion. ROME IV
- Clinical history and criteria
- Physical exam
- Laboratory testing
- Gastroscopy, colonoscopy and biopsies where indicated

INTERVENTION

- <u>What I do:</u>
- Aim to reduce symptom experiences, reduce distress and improve functioning and quality of life
- Psychoeducation
- Achieved through primary therapeutic targets of physiological arousal reduction and increasing psychological flexibility

- <u>What you can do:</u>
- Introduce possibility from initial consultation that there may be no clear medical explanation for their symptoms
- Validate distress and impairment
- Be clear about what the intended effects of prescription medications are
- Consider prescribing neuromodulators e.g. tricyclic antidepressants
- Consider referrals for secondary care – gastroenterologist, dietetics and psychology
- Consider mental health

WHAT I DO - INTERVENTIONS

- Reducing physiological arousal
- Relaxation techniques
- Mindfulness
- Stress management
- Gut-directed hypnotherapy

- Increasing psychological flexibility
- Cognitive behavioural therapy
- Acceptance and commitment therapy
- Compassion focused therapy
- Problem solving/solution focused therapy
- Building resilience
- Healthy boundaries

DISCUSSING PSYCHOGASTROENTEROLOGY WITH A PATIENT

- Standard tests indicate no significant findings
  - For safety but also to reassure the patient
- Patient is experiencing distress and/or impairment
  - They probably are and you probably know about it!
- DO NOT SAY "it's *JUST* [insert DGBI label here]"
- DO acknowledge that their pain and symptoms are real, but the way these somatic experiences are generated and how we react to them is complex
- *There is a problem with the software, not the hardware*

DISCUSSING PSYCHOGASTROENTEROLOGY WITH A PATIENT

- "The brain and the gut are always talking to each other. A simplex example of this is you may have felt 'butterflies' in your stomach when you are nervous. You may have even noticed that you get unpleasant gut symptoms during times of stress"
- "We call this the highway of communication the 'brain-gut' axis. This highway is vulnerable to impacts from all kinds of things from life stress to illness to lack of sleep. These things can sensitise this highway such that messages between the brain and gut get distorted, resulting in increased pain, unpleasant symptoms and distress"
- "a psychologist trained in this area can help reduce this dysregulation which should help reduce your symptom experiences and/or reduce your distress and improve your coping so you can improve your quality of life"

QUESTIONS?