THE PSYCHIATRIST'S TOOLBOX

Unraveling the Mind/Gut Puzzle

A few years ago, an accountant was referred to me by his internist. The accountant's chief complaint was that he had daily episodes of feeling bloated. When he wasn't bloated, he had an urge to defecate.

When I saw the patient, he was so possessed by the urge to move his bowels that, on certain days, he was afraid to leave the house. The referring internist had done a full gastrointestinal (GI) work-up, including a colonoscopy, and had found no significant pathology. He assured the patient that he was okay. The internist had, in fact, reassured the patient that he was okay many, many times.

BY ROBERT T. LONDON, M.D.

The internist even tried, according to the history, to elicit any stress the patient was under, but the patient had no previous psychiatric history. Aside from the normal stressors of work and family, the patient was not particularly troubled by life's events, as he and the internist saw it.

According to the history, the patient had been treated with several GI medications, none of which appeared to help. The internist and the gastroenterologist the patient saw for specific testing diagnosed him with irritable bowel syndrome (IBS).

In the United States, IBS is considered a chronic functional gastrointestinal disorder (FGID). This does not make it necessarily a psychiatric disorder per se, but it is a disorder that may be helped by psychiatric intervention. Data suggest that IBS may affect up to 15% of the U.S. population and cost the country billions of dollars, although many people have only mild symptoms of troubled bowel function or abdominal discomfort, such as bloating.

IBS is only a starting point. If all the functional syndromes affecting the GI tract are included under the umbrella of FGID from the top of the GI tract—including dyspepsia and esophageal spasm—all the way to the anorectal area, it becomes easy to understand the enormous cost to health care and society.

Because these disorders produce a substantial amount of psychological distress, including anxiety and depression, and have negative influences on daily life, people with an FGID are regularly referred to psychiatrists and psychotherapists for assessments and treatment.

In the case of this patient, I began the first visit after taking a good history of his diagnosed IBS. Then I explained the learning, philosophizing, and action (LPA) technique that I planned to use to help resolve his problems. I also introduced the concept of relaxation and guided imagery to help ameliorate any stressful issues that might be discovered during the learning or philosophizing parts of the treatment plan.

The last item on the first visit was a homework assignment: It would be his job, over the next 2 weeks, to keep a diary and note when he felt the desire to defecate and when he simply felt bloated. After the first week, I had the patient mail me his observations so I could develop an action-oriented approach for the second visit.

For me, this information proved critical in learning about the specific aspects of his disorder. With it, I was able to develop the appropriate aspects of my LPA technique.

After the first few weeks, it appeared that the patient had two main triggers for the urge to move his bowels: It was substantially more intense when he was about to go somewhere than when he was returning, and it occurred more often when he was in the process of working with a client from whom he had to ask for money. This feedback allowed me to develop a two-pronged treatment approach.

The first prong was a relaxation technique coupled to desensitization of his trigger points. The second prong was the learning aspect of the LPA, with a little of the philosophizing at times. On the second visit, I taught him a simple relaxation technique ("The How-To of Relaxation Techniques," The Psychiatrist's Toolbox, June 2006, p. 20) in which he visualized, on the left side of a split movie screen, leaving for work or a trip. It was important that he see the experience but *not* experience it.

I encouraged him to link this to any pleasant experience of his choosing on the right side of his movie screen. By using systematic desensitization—seeing the stress/anxiety situation on the left side of the screen and then linking it to the least anxiety/stress situation on the right side of the screen—the patient was on the road to inhibiting his possible stress-related disorder.

I spent about an hour and a half with him as he learned and practiced using this new tool. I encouraged him to use the strategy regularly so he would know how to work it when the triggers occurred.

The history of using relaxation techniques to control physiological functions goes back centuries and includes many cultures. I have used these techniques successfully over the years in patient care, so this approach is validated for me clinically as a way to relieve some pain and suffering of functional disorders.

After the action phase was taught and understood, the second tier of the approach was my learning aspect of the LPA. Because the accountant was educated and clear thinking—both in concrete areas as well as in abstract ones—I was able to introduce the ideas of many schools of thought in the area of psychosomatic disorders. We covered ground ranging from Walter B. Cannon's physiologically oriented concepts of stress affecting physiological responses (which most schoolchildren have heard about) to Dr. Harold G. Wolff's ideas about long-term stressors that may lead to physiologic changes.

Of course, Dr. Franz Alexander and Dr. Helen Flanders Dunbar are two of my favorites in the field of psychosomatic medicine. If one takes their theories of organ vulnerability and personality styles leading to certain types of dysfunctions and puts them into cognitive restructuring, many doors open for a person trying to cognitively reprocess a problem using his skills and imagination.

I further used the learning aspect of the LPA technique to give this gentleman an overview of some neurotransmitter concepts of the epinephrine/serotonin complex in the central nervous system, as well as the hypothalamic/limbic system, sympathetic, and parasympathetic relationships that interact with our emotions and the GI tract.

All this was very therapeutic in that the patient was circumscribing the problem and getting its resolution by action (the split screen technique) and by thinking through a variety of concepts and relearning how to process the triggers that had precipitated the disorder.

In our discussions, the patient revealed two interesting memories about his upbringing. One was that his mother, a family-oriented person, always emphasized the importance of being home. His father, also a successful accountant, did, at times, interrogate him before giving him money. Those interrogations led the patient to feel as if he was doing something wrong when he asked for money.

From a behavioral point of view, those family dynamics are not pathologic. However, the way in which a person processes information and how it is reinforced can have a bearing on perceptions and processing of life problems down the road. Those perceptions and processing may have contributed to the development of this patient's syndrome.

We met for 12 visits. I am pleased to report that, by thinking through the issues and using a learning/cognitive approach about perceptions, possibilities, and probabilities, this patient gained relief from his symptoms. Some years ago, when Katie Couric, former host of the "Today" show, showed her colonoscopy on live TV, she essentially made the learning part of the LPA technique relevant for millions of viewers by removing fear, worry, and anxiety about the procedure.

After seeing that segment, I'm sure that many followed her lead by getting a colonoscopy. Had the focus of the segment been on the symbolism and interpretation of the colonoscopic process, it would have gone on forever. The point about the importance of learning better health care would have been missed.

Let me know about your experiences and ideas for treating functional gastrointestinal disorders, and I'll try to pass them along to my readers. ■

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Post-MI Depression Severity Appears to Stabilize After 6 Months

DENVER — Depression that occurred in adults after acute myocardial infarction decreased in severity during the first 6 months after the cardiac event, but then stabilized over the next several years, Kenneth E. Freedland, Ph.D., reported in a poster presented at the annual meeting of the American Psychosomatic Society.

Dr. Freedland, a member of the psychiatry department at Washington University, St. Louis, and his colleagues reviewed data on 1,086 adults who were randomized to the usual care arm of the Enhancing Recovery in Coronary Heart Disease (ENRICHD) study, a multicenter trial sponsored by the National Institutes of Health that was designed to evaluate depression interventions in MI patients.

The patients' mean age was 43 years, 44% were female, and 35% were minorities. In addition, 55% were high school graduates, 19% were college graduates, and 26% had less than a high school education. About 60% of the patients had a history of major depression before the MI.

The patients completed a Beck Depression Inventory (BDI) at the start of the study, and again at 6-month intervals for an average follow-up period of 26 months. The average baseline BDI score was 15.3; baseline BDI scores were lowest among older patients, non-Hispanic white patients, and patients without a history of major depression, and highest among women and patients who were taking antidepressants.

Antidepressant use was associated with worse depression in the overall ENRICHD study, so its impact in this analysis must be interpreted with caution, the investigators noted.

Overall, the severity of depression decreased during the first 6 months after the MI, but depression scores then stabilized during the follow-up period, which lasted as long as 4 years for some patients. The average decrease in BDI score was –0.85 during months 0-6, compared with –0.07 during months 6-54.

Female gender, minority status, younger age, and lower levels of education were significantly associated with higher levels of depression immediately after MI, but younger female patients showed the fastest improvements in depressive symptoms over time. Additional analysis is needed to determine patterns among these subgroups, the researchers noted.

—Heidi Splete