

Clinical Case Report

Successful management of difficult-to-treat irritable bowel syndrome incorporating a psychological approach

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ABSTRACT

Irritable bowel syndrome is a common gastrointestinal condition with underlying psychological factors. Its management can be challenging, sometimes necessitating a multidisciplinary team of gastroenterologists, psychiatrists and clinical psychologists. Non-pharmacological interventions are gaining attention for the management of chronic irritable bowel syndrome. We present a difficult-to-treat case of chronic irritable bowel syndrome, which was managed successfully with psychological interventions.

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INTRODUCTION

Irritable bowel syndrome (IBS) is a common gastrointestinal disorder, characterized by abdominal pain, bloating and changes in bowel habits.¹ Its prevalence in the general population is between 5% and 20%,² and it puts a considerable financial burden on health services. In India, it is more common among young persons, men, and those from a poorer socioeconomic status.³ A major difference from IBS in western countries is its predominance of upper abdominal symptoms.⁴ IBS is a heterogeneous disorder with varying treatment options, and physicians sometimes struggle to find an optimal approach for its management. Recent reports suggest that non-pharmacological interventions are effective and safe.^{5–10} We discuss a patient with IBS who was successfully managed with psychological interventions.

THE CASE

A 52-year-old man presented to the psychiatry department of a tertiary care hospital with complaints of passage of frequent loose stools and feeling of incomplete evacuation and occasional constipation for 18 years. Initially, the patient passed stool once a day and spent 45 to 60 minutes in the toilet. Gradually, both the frequency and time required to pass stools increased; and, at the time of presentation, he went to the toilet 5–6 times per day and spent about 6–8 hours there every day. The consistency of stool was loose, mucoid with occasional passage of blood. However, the patient did not have any abdominal pain, loss of appetite or

weight loss. There was no history of significant life events or daily hassles (stressful events) before the onset of or during the course of the illness. However, because of the long-standing nature of the illness, the patient reported anxiety regarding the outcome of the disease and considerable psychosocial dysfunction. The pre-morbid personality of the patient revealed some anankastic (compulsive) traits, e.g. unattainable perfectionism; preoccupation with rules, details and orderliness.

The patient had been hospitalized on multiple occasions because of this problem lasting for 4–8 weeks at our (tertiary care) centre including some admissions under the psychiatric services. Though he was never convinced of a psychological causation, he agreed to behaviour therapy as an adjunct strategy. Time restriction measures, such as alarm and opening the toilet door after a certain period, helped reduce the time spent in the toilet to some extent. However, he would relapse to maximal functional impairment within weeks to months of discharge. During this period, he was also prescribed numerous laxatives and low-dose benzodiazepines for short periods; however, he refused selective serotonin reuptake inhibitors (SSRIs). Overall, the patient was not symptom-free for even 3–6 months during the past 18 years of his illness.

In the present admission, the patient was initially referred to the gastroenterology (GE) clinic of our centre, where the following investigations were done: ultrasonography, upper gastrointestinal (GI) endoscopy, colonoscopy, GI manometry, magnetic resonance imaging (MRI) of the abdomen and tests for *Helicobacter pylori* infection. All these investigations revealed no abnormality. His physical examination and routine investigations (including a stool examination) were within normal limits. Mental status examination revealed anxious preoccupation with somatic complaints (with distressing anxiety before and during visits to the toilet). In consultation with the GE services, a diagnosis of IBS (ICD-10 F 58.0) was made. The patient was initially prescribed 50 mg of sertraline daily, which was later increased to 100 mg daily. Cognitive behavioural intervention was considered due to the chronic, refractory nature of his illness, associated anxiety symptoms, anxious preoccupation with somatic complaints and maladaptive behaviours and cognitive distortions identified during the preliminary psychiatric assessment.

Psychological management

The patient was offered cognitive behaviour therapy (24 sessions spread over 9 months) beginning with an assessment (three sessions) of the patient's toilet routine and diet. The assessment included clinical interview by a therapist, self-monitoring by the patient¹¹ and behaviour sampling¹² by his wife. During assessment, some of the patient's statements were paraphrased to highlight the dysfunction caused by some of his maladaptive behaviours.

The case formulation based on the cognitive behaviour paradigm was developed and discussed with the patient and the informant (wife) in the fourth session. The goals of the intervention were (i) psycho-education, (ii) relaxation training to reduce and manage physiological anxiety, (iii) exposure and response prevention (ERP) to eliminate behaviours maintaining IBS (rubbing the abdomen, spitting, pressing head against the wall, etc.), (iv) exposure and safety behaviour (ESB), (v) identification and modification of anxious cognitions, and (vi) relapse prevention.

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In the fifth and sixth sessions, the patient was educated about the physiology of digestion and excretion; and the GI manifestations of anxiety to help him understand that such symptoms could be related to anxiety precipitated by thoughts of getting late for office or of not having attained complete evacuation. At this stage, however, the patient was not expected to fully acknowledge the interaction between his thoughts and physiological reactions.

The patient was then trained in the Jacobson progressive muscle relaxation method¹³ to manage physiological arousal (session 7–12). Subsequently, excessive ritualistic toilet-related behaviours were targeted through ERP¹⁴ based on a mutually agreed upon hierarchy of exposure (session 13–22). Then, anxious cognitions related to defaecation were addressed using Socratic questioning.¹⁵ Simultaneously, the patient was motivated to cut down on deliberate efforts to pass mucous. However, he did not comply with this suggestion, because he feared that incomplete evacuation could lead to soiling of his clothes at the workplace. Hence, exposure with safety behaviour (use of diaper) was attempted while simulating the office situation at our daycare centre. Over the next sessions, the cognitive distortions of perfectionism, prediction, all or none thinking and discounting the positives were observed, reflected back to the patient and modified. The cognitive restructuring techniques included challenging patient's cognition,¹⁶ and generating evidence against thoughts and reattribution.¹⁷ Over the course of therapy the patient gradually learnt to regulate the distress associated with his GI symptoms.

A few sessions were held with the wife to reduce critical comments, which had the potential to maintain the patient's symptoms. At the end of the therapeutic sessions, the patient had reduced the time spent on toilet-related behaviours to less than 50 minutes, he could reach his office on time and he subjectively reported an improved quality of life. Relapse prevention sessions are planned.

DISCUSSION

Our patient was suffering from IBS for the past 18 years with deteriorating symptoms despite multiple interventions. Gastroenterology consultations revealed no infective or malabsorptive state as a cause for his altered bowel habits. The long-standing illness imposed considerable financial and family burden. The patient reported considerable improvement after CBT sessions were added to his ongoing pharmacotherapy.

Psychosocial factors can play an important role in the course and prognosis of IBS as suggested by the biopsychosocial model.¹⁸ In clinical practice, a thorough evaluation of medical causes for altered bowel habits should be conducted for difficult-to-treat IBS, and adequate medical treatment should be instituted. The psychological component should be added to the management for patients who do not respond despite medical treatment, especially if symptoms are not adequately explained by medical causes. This case highlights the role of psychological factors in influencing digestion and excretion, symptom perception and maintenance of IBS.

This patient had multiple cognitive and behavioural symptoms which are important characteristics of IBS.¹⁹ CBT (usually 8–10 sessions) including stress management and coping skill training is

known to be effective in the management of IBS.^{6,20,21} However, for the present patient we needed more sessions, as the patient was initially unwilling for any psychological intervention due to a conviction that the symptoms signified serious physical illness. Also, the patient's deliberate efforts at expulsion of mucous were treated with the ESB technique, as he was unwilling for exposure with response prevention. These observations highlight the divergence between research and practice.

We recommend that psychological interventions should be frequently used for better management of IBS.

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