Psychological Factors in Inflammatory Bowel Disease:

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Disclosure

- I have no financial relationships to disclose

Psychological Issues in IBD

- Overall negative impact on QOL: social isolation, stigma, impact on work, relationships
- Approximately one third IBD have anxiety and depression
- Chron's Disease higher (50%) compared to Ulcerative Colitis or other chronic GI disease
- Antidepressant use more frequent in IBD than general population and in patient's with Chron's compared to UC

Psychological Issues in IBD

- Impact of disease burden increased by psychological factors including poor coping
- 15% with IBD account for 50% health care cost which occurs with pain, depression and poor social support
- Depression in IBD increases risk for surgery, increased hospitalizations, and disability
- Symptom specific anxiety increases disease burden and results in higher health care utilization

What drives psychological symptoms?

- Disease impact
  - Being a burden on others, loss of energy, loss of bowel control
  - Associated with poorer perception of health, greater psychological distress
- Complications
  - Developing cancer, early death, having surgery
  - Associated with poorer daily function
- Sexual Intimacy
  - Associated with poorer psychological health
- Bodily stigma

Drossman et al. 1991

Best Practice Update: Incorporating Psychogastroenterology Into Management of Digestive Disorders

- Keefer L, Palsson OS, Pandolifino JE, Gastroenterology 2018 1-9 (article in press)

Best Practice Advice

- Routinely assess health-related QOL, symptom-specific anxieties, early life adversity, and functional impairment
- QOL: most impact on fatigue, pain, and limitations of life activities
- Assessment
  - Formal measures- IBS QOL and IBD Questionnaire
  - Informal measures "How do your bowel symptoms interfere with what you want to do in your life?

Best Practice Advice

- Provide patient friendly language on the following:
  - The brain-gut pathway and how this can become dysregulated by various factors
  - Psychosocial risk, and factors perpetuating and maintaining factors of GI diseases
  - Why referring to a mental health provider
    - Earlier referral better received

Best Practice Advice

- Know the structure and core features of the most effective brain-gut psychotherapies
- Brain-gut psychotherapies typically:
  - Short term
  - GI focused
  - Skills-based
  - Focus on down-regulation of bad GI sensations, decreasing avoidance behaviors, building coping and stress management

Brain-gut Psychotherapies

- Cognitive Behavioral Therapy (CBT): focus on changing maladaptive thoughts feelings and behaviors as they relate to symptoms
  - Targets catastrophizing, cognitive inflexibility, fear of symptoms, hypervigilance to benign sensations
- Gut-directed hypnotherapy: targets visceral hypersensitivity, motility disturbance, hypervigilance to benign sensations, somatization
  - North Carolina Protocol
  - Manchester Protocol

Evidenced-based behavioral interventions for IBD mental health concerns

- Disordered eating
  - CBT, CBT-E, intensive outpatient or intensive inpatient
- Insomnia
  - CBT-1, Medical hypnotherapy, Sleep healthy using internet (SHUTi)
- Fatigue
  - CBT, behavioral self management
- Posttraumatic Stress Disorder
  - CPT, PE, meds
- Treatment concerns
  - CBT, behavioral self management
- Intimacy concerns
  - CBT, medical hypnotherapy, pelvic floor physical therapy, psychoeducation
- Stigma
  - Individual or group CBT
  - Psychoeducation for family, friends, significant others

Taft et al. 2017

Best Practice Advice

- Establish a direct referral and ongoing communication pathway with 1-2 qualified psychologists or other mental health providers
  - Experience with medical populations
  - Collaborates with physicians
  - Has a cognitive-behavioral theoretical orientation
  - Practices evidenced-based brain-gut psychotherapies
- Brain-gut psychotherapies less effective when patient experiencing comorbid psychopathologies

Best Practice Advice

- Know 1 or 2 neuromodulators that can be used to augment behavioral therapies when necessary
  - SSRIs, SNRIs, TCA
  - Underlying depression or anxiety, lack of motivation for psychotherapy, chronic pain not responding to behavior therapy

Questions?

Selected References

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