EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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Treatment of Irritable Bowel Syndrome: Changing the Paradigm

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Irritable bowel syndrome (IBS) is one of many functional illnesses treated by primary care physicians (PCPs). Functional illnesses can be characterized as multisystem, symptom-based disorders for which no single physiologic source can be isolated. Treating patients with functional disorders is often complicated by the psychosocial aspects of the illness. For example, there is often a correlation between the symptoms patients experience and the meaning and behaviors ascribed to their difficulties. Interplay between patients' physiologic problems and their patterns of thoughts, feelings, and behaviors prompts either helpful coping strategies or dysfunctional strategies that exacerbate and perpetuate the illness. Moreover, this complex interplay can be further complicated by the PCP's choice of evaluation and treatment strategies. In fact, diagnostic and treatment decision-making based on reported distress symptoms may, in effect, create a pattern of perpetuating factors that act as vicious cycles for both the clinician and the patient. For example, addressing patient complaints of continued symptoms by ordering additional medical tests or by providing additional referrals to medical specialists even after an exhaustive workup may actually create anxiety for the patient. Aggressive evaluation and treatment strategies may inadvertently reinforce patients' worry that something very dangerous is causing their symptoms. Furthermore, the costs of ordering unnecessary tests and performing unnecessary procedures are a burden for patients and their families and often, indirectly, for society.

Addressing the complex interplay of biology, thoughts, feelings, and behaviors associated with functional illnesses requires a reassuring and supportive environment. Unfortunately, many PCPs find their practices overloaded with appointments, and they may have little time to build the substantial doctor-patient relationship necessary for the successful management of these complicated patients. Patients with chronic functional illness often seek reassurance by requesting frequent or extended office visits, by making frequent office calls, and by contacting the physician after hours. These patient behaviors can be viewed as entitled and demanding, and they often result in physician and staff exasperation with the patient's persistent requests for reassurance. This frustration may lead to combative and dysfunctional doctor-patient-staff relationships that reinforce the patient's preoccupation with the illness, thus maintaining a vicious cycle of negative interaction.

Conversely, reassurance that the illness is not life-threatening (after careful initial workup) along with a referral for a brief course of cognitive-behavioral therapy (CBT) may help the patient develop the coping skills necessary to deal with the symptoms of functional disorders. The following case demonstrates the usefulness of a PCP's referral for psychotherapy for a young woman struggling to cope with her IBS.

CASE PRESENTATION

Betsy presented for psychotherapy asserting that this consultation was not her idea. She expressed anger and worry that her family and her PCP believed

that her illness was all in her head. She reported that although her doctors had performed numerous tests, including exploratory abdominal surgery, no organic disease had been found. She had long exhausted her budget for health care and her husband's patience and at one point had made a trip to Mayo Clinic for a complete workup that she could not afford. She stated that she could not be reassured that her illness was something benign such as IBS because she felt so bad. The various specialists she saw could not dissuade her worry that something was dreadfully wrong or allay her concerns that doctors were missing the culprit that was causing her "bowel attacks." Her PCP suggested that she seek psychotherapy because the treatment-as-usual strategies for her IBS, such as supportive reassurance, patient education, increased-fiber dietary changes, and medications, were not effective. Betsy's chronic IBS symptoms led to numerous visits to the emergency room (ER) and frequent calls to her PCP's office.

PSYCHOTHERAPY

The first order of therapy was to reassure Betsy that her symptoms were valid and that therapy would not focus on convincing her otherwise. Her therapy began with an explanation of the biopsychosocial model of illness and the protective and destructive aspects of thoughts, feelings, behaviors, and relationships. She was provided with the basic tenets of CBT, defined as a structured therapy using a problem-solving focus and collaborative work toward well-defined goals. Betsy set goals of decreasing her visits to the ER and doctor's offices and learning how to cope with her IBS symptoms. I advised her that additional goals for therapy would include increasing her ability to self-soothe and calm her worried thoughts. She agreed to come weekly for a short course of therapy to increase her problem-solving skills and coping strategies.

CBT often begins with addressing dysfunctional behaviors, and, in Betsy's case, this was the initial plan for treatment. Betsy demonstrated few skills for managing her stress and worry, which clearly exacerbated her symptoms. Fortunately, she was willing to learn and implement daily deep breathing and relaxation strategies. She found these simple strategies empowering for stress and worry management and used them frequently to calm herself before making the decision to call the doctor or go to the ER. Within the first 2 weeks of therapy, Betsy was able to decrease her visits and calls to a fraction of her previous levels of reassurance-seeking.

The next phase of therapy focused on identifying triggers for her worries and fears about her illness. Using the dysfunctional thought record, we were able to identify that anger toward her husband and mother frequently precipitated an increase in her IBS symptoms. Exploration of her thoughts about these important relationships revealed that she rarely felt heard by significant people in her life. She felt ill equipped to communicate her needs without feeling overwhelmed by her husband's and mother's strong personalities. She also noted that expressions of illness were better received by them than expressions of her needs and that she felt that the sick role generated genuine concern. Once Betsy was armed with this new insight, therapy then focused on assertive communication skills practice and the benefits of using words to express her emotions rather than physical symptoms. Home practice enhanced therapy through reading assignments about emotionally manipulative relationships and strategies for managing them. This home study information helped Betsy become aware of the effects of strained interpersonal relationships on her IBS symptoms.

After 7 sessions, Betsy was able to analyze the thoughts, feelings, and behaviors that contributed to her illness both positively and negatively, and she terminated therapy. Later follow-up with her PCP revealed that through this increase in coping skills and insight, Betsy's calls to her PCP and her trips to the ER decreased substantially, and her minor IBS symptoms were now controlled with treatment as usual. ◆