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AGA CLINICAL PRACTICE UPDATE: EXPERT REVIEW

Best Practice Update: Incorporating Psychogastroenterology Into Management of Digestive Disorders

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Chronic digestive diseases, including irritable bowel syndrome, gastroesophageal reflux disease, and inflammatory bowel diseases, cannot be disentangled from their psychological context—the substantial burden of these diseases is co-determined by symptom and disease severity and the ability of patients to cope with their symptoms without significant interruption to daily life. The growing field of psychogastroenterology focuses on the application of scientifically based psychological principles and techniques to the alleviation of digestive symptoms. In this Clinical Practice Update, we describe the structure and efficacy of 2 major classes of psychotherapy—cognitive behavior therapy and gut-directed hypnotherapy. We focus on the impact of these brain–gut psychotherapies on gastrointestinal symptoms, as well as their ability to facilitate improved coping, resilience, and self-regulation. The importance of the gastroenterologist in the promotion of integrated psychological care cannot be overstated, and recommendations are provided on how to address psychological issues and make an effective referral for brain–gut psychotherapy in routine practice.

Keywords: Brain-gut Psychotherapy; GI Psychologist; Gut-directed hypnotherapy; Cognitive Behavior Therapy.

Chronic digestive disorders cost the health care system billions of dollars and are associated with substantial disease burden.[1] The burden of these diseases is co-determined by symptom/disease severity and the ability of patients to cope with their symptoms without significant interruption to daily life. In other words, chronic digestive diseases cannot be disentangled from their psychosocial context. The most common chronic digestive disorders are the functional gastrointestinal (GI) and motility disorders, the burdens of which are amplified when symptoms are severe or refractory, psychiatric comorbidity is present, and/or coping skills are impaired.[2] Patients with reflux hypersensitivity and functional heartburn acquire risk from the unnecessary long-term use of PPIs when esophageal hypervigilance overshadows symptom-reflux correlation.[3,4] Irritable bowel syndrome (IBS) can progress into severely disabling centrally mediated abdominal pain syndrome[5]; and psychosocial factors, when coupled with opiate use, increase risk of narcotic bowel syndrome.[6,7] The burden of "organic" conditions, such as Crohn's disease and ulcerative colitis, is similarly amplified by psychosocial factors and poor coping. Indeed, 15% of patients with inflammatory bowel disease (IBD) account for approximately 50% of health care expenditures, which appears to be driven by concomitant chronic pain, depression, and poor social support.[8,9] Depression, when present in IBD, has been shown to increase risk for surgery, hospitalizations, and disability, and may contribute to disease flare.[10]

Brain–gut psychotherapies, including cognitive-behavior therapy (CBT) and gut-directed hypnotherapy, are optimally delivered by mental health professionals specializing in psychogastroenterology, a field dedicated to applying effective psychological techniques to GI problems. These therapies have the capacity to reduce health care utilization and symptom burden,[2,11,12] especially when they are integrated directly into GI practice settings.[9,13,14] Specifically, brain–gut psychotherapies work on 2 related pathways—they target abdominal pain, visceral hypersensitivity, and GI motility; and/or facilitate improved coping, resilience, and self-regulation skills.[11] Without a gastroenterologist's strong, compelling recommendation for these effective therapies and his/her knowledge about how to successfully facilitate referrals for such treatments, many patients do not receive care at all,[13] or do so too late in the process, when self-management has failed and refractory psychopathology and/or inflammatory disease have developed.[2] There is also mounting evidence that stress has important and commonly deleterious effects on gut function through neural-, immune-, and microbiome-related interactions.[15] Table 1 summarizes the best practices for promoting the use of brain–gut psychotherapies in routine GI care for best clinical outcomes.

Best Practice Advice 1: Gastroenterologists should routinely assess health-related quality of life, symptom-specific anxiety, early life adversity, and functional impairment as these relate to a patient's digestive symptoms.

Individuals with GI disorders tend to have significantly impaired quality of life (QOL) compared to the general population,[16–18] with IBS patients in particular demonstrating lower QOL than patients with end-stage renal disease and diabetes.[19] Across functional and organic diseases alike, the most pronounced impact of GI symptoms

Abbreviations used in this paper: CBT, cognitive-behavior therapy; GI, gastrointestinal; IBD, inflammatory bowel disease; IBS, irritable bowel syndrome; QOL, quality of life.

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Table 1. Best Practice Update: Incorporating Psychogastroenterology Into Management of Digestive Disorders

Description	The current review provides the reader with a framework to understand the scientific rationale and best practices associated with incorporating brain–gut psychotherapies into routine GI care. We discuss how gastroenterologists can employ state-of-the-art assessment and referral techniques that ensure a tailored, precision-medicine behavioral care pathway into their unique practice settings, across the full spectrum of digestive disease.
Methods	These practice updates come from review of the literature, including existing systematic reviews and expert opinion.
Best Practice Advice	
1	Gastroenterologists should routinely assess health-related QOL, symptom-specific anxieties, early life adversity, and functional impairment related to a patient's digestive symptoms.
2	Gastroenterologists should master patient-friendly language on the following topics: the brain–gut pathway and how this pathway can become dysregulated by any number of factors; the psychosocial risk, perpetuating, and maintaining factors of GI diseases; and why the gastroenterologist is referring a patient to a mental health provider.
3	Gastroenterologists should know the structure and core features of the most effective brain–gut psychotherapies.
4	Gastroenterologists should establish a direct referral and ongoing communication pathway with 1–2 qualified mental health providers and assure patients that he or she will remain part of their care team.
5	Gastroenterologists should familiarize themselves with 1 or 2 neuromodulators that can be used to augment behavioral therapies when necessary.

on QOL include fatigue, limitation of life activities, and pain.[19] The impact of GI disorders on QOL, including which domains of QOL are affected, varies greatly among patients with the same diagnosis, even when disease history, location, severity, or medical therapies are similar. QOL is largely dependent on individual differences in coping and resilience, as well as the experience of GI-specific anxiety, need for lifestyle adaptations, and stress. Patients with substantial GI-related life impact may need more, or differently targeted, medical interventions than other patients with the same diagnoses, and routine assessment of life impact and distress associated with GI symptoms could identify patients in need of extra support early on in care.

Assessment of health-related QOL can be informal and brief, using 1–2 open-ended questions that invite the patient to provide the most relevant information about the life impact of the physical symptoms, for example, "How do your bowel symptoms interfere with your ability to do what you want to do in your daily life?" and "What areas of your life are affected most?" These simple questions often elicit valuable information about the particular domains of the patient's life that are most affected by GI problems. There are multiple benefits to this approach:

1. Without an open-ended option, the physician may remain unaware of key areas where targeted medical intervention can be of greatest help for restoring satisfactory life functioning.
2. These questions about life impact build rapport by indicating to patients that their doctor is aware of, and interested in, the burden of their illness.
3. The patients' responses to open-ended queries about life impact of symptoms can also provide useful comparison data points for rechecking later to assess the effectiveness of interventions in improving the domains that are most important to his/her life and well-being (eg, "Did you make it out on the boat this summer?"). This gives a more complete picture of true progress in managing the patient's health problem than does information about changes in frequency or type of digestive tract symptoms alone.
4. Impact questions can identify patients who clearly need help from a behavioral health professionals to cope more effectively with their illness—when a referral to a GI psychologist is proposed specifically to help improve QOL, it is more likely to be well received.

Asking about early life adversity to understand whether the patient had a personal history of physical, emotional, or sexual abuse; witnessed domestic violence in their household growing up; was raised by a caregiver with a substance abuse problem or mental illness; or had a family member who was incarcerated, could identify critical factors affecting the onset and expression of functional GI disorder symptoms[20] and point out which patients would benefit from psychological intervention earlier on in care. One commonly used screening questionnaire for early life adversity is the Adverse Childhood Experience Questionnaire.[21]

Symptom-specific anxiety can also amplify disease burden and lead to higher health care utilization.[22,23] A survey of 1242 IBS patients[24] found, for example, that a substantial minority of the patients thought that their disorders could develop into colitis (43%) or cancer (21%). In IBD, patients are worried about the effect of biologic therapies or surgery; that pain indicates flare, obstruction, or perforation; or about their risk of infertility.[25,26] These concerns or fears can be uncovered by asking a simple and direct open-ended question: "What worries or concerns do you have about your symptoms?," which can yield an important opportunity for education and reassurance. Eliciting and discussing whatever worries and concerns the patient has about his or her condition can also help identify instances where excessive anxiety, catastrophizing, or depressive symptoms weigh so heavily in the patient's disease experience that a referral to a behavioral health care provider is needed.