

Irritable Bowel Syndrome (Part One)

by Lindsay Fovargue

In April I attended a presentation by Alison Prior, Consultant Gastroenterologist at the Norfolk & Norwich Hospital, who specialises in the diagnosis and treatment of Irritable Bowel Syndrome (IBS). Her thesis, written twenty five years ago, looks at links between IBS and gynaecological problems. Others present were complementary therapy practitioners at the Humbleyard Centre in Norfolk. Prior's presentation prompted me to look at some of the studies which she made reference to and to begin reflecting on their relevance to biodynamic massage and body psychotherapy. Below is a summary of Prior's presentation with further details from these studies, as an overview of a medical approach to IBS. In Part Two I hope to look at IBS more from a body psychotherapy perspective. I would welcome case vignettes or other comments and contributions with this in mind.

Fifteen percent of the population in the United Kingdom suffer from Irritable Bowel Syndrome (IBS) during their lifetime. Not all of these individuals will present to a GP. A high proportion present to complementary therapy practitioners.

In the UK the majority of those suffering IBS, or certainly of those presenting for treatment, are women. Male sufferers in the UK tend to be in the 16-25 age group and highly anxious. In India, the majority of IBS sufferers who identify as such are men. Prior found a high incidence of IBS amongst men in India when she worked as a mission hospital doctor. Already this tells us something about the socio-cultural context of IBS. Obviously it may tell us both about gender differences in presenting for medical care and about the types of physical difficulties which are culturally open to discussion, as well as indicating the strong social-psychological components of the syndrome. In the UK women are generally more likely to seek health and medical advice than are men. Prior believes patients with most severe symptoms or highest anxiety are those who present at their GP.

IBS is characterised by three main symptoms, the severity of which varies greatly:

- 1) *Pain* - in the gut, but also often in legs, chest and arms;
- 2) *Bloating* - often increasing throughout the day, so women may have two wardrobes: normal and 'maternity';

- 3) *Constipation or diarrhoea* - most typically alternating between the two, often rapidly.

The social cost

The social implications of IBS for women and men who are severely afflicted are massive. Often the structure of a day revolves around ease of access to toilets: patients and clients with severe IBS know where all the public toilets are located and their hours of opening. Eating or not eating is planned around whether they must leave the house or not. IBS patients and clients carry and use plastic bags in the car in which to defecate if they get stuck in traffic. The anxiety surrounding these arrangements is intense, not least because of the absolute taboo in our culture around faecal incontinence. Places become 'no-go areas', for example following an 'accident' in Tesco's. IBS sufferers often present socially as if nothing is wrong, may dress immaculately, hold down a job and be thought of by others as 'vivacious and friendly'. In severe cases of diarrhoea sufferers may be chronically thin, although within our society this is often overlooked in women.

On first meeting, Prior wants to establish what has prompted a patient to seek advice now and what she is seeking. For many women the main concern is confirmation of the diagnosis and reassurance that they do not have cancer, coeliac disease or Crohn's disease. The vast majority of patients presenting with

IBS type symptoms have negative results to tests for these. Many women present with a fearfulness that they 'must be going mad' and seek reassurance that the symptoms are 'not in my head'. Often women are capable of managing the pain and other symptoms once they know what is happening and 'require no further medical intervention'. Luckily so, as there appears to be little on offer.

IBS and sex

IBS in women is often accompanied by dysmenorrhoea (painful periods) and pain on having sex, although this is little discussed. Female sex hormones affect bowel function so that for many women the bowels are looser before each menstruation. Prior's thesis explored links between hysterectomy and bowel function. Such major surgery, be it hysterectomy of the womb or vagina, has obvious impact on the innervation of this area of the body. From the perspective of biodynamic and body psychotherapy it has energetic implications, as well as the potential for trauma. The medical profession recognises a connection between IBS and history of sexual abuse, but having IBS does not mean a person has been sexually abused.

What causes IBS symptoms?

Medical studies into the causes of IBS are inconclusive. Primarily, studies show that IBS is a disturbance of gut motility. The gut pushes too hard, or for too long, or

over too great a section of its length. Hence the use of a wide selection of antispasmodics to relieve symptoms. Drug companies are very keen to find an effective treatment for IBS; the variety of antispasmodics on offer indicates that they have not done so yet. Prior feels drug trials to be particularly deceptive in IBS treatment because of the unmeasured benefits to participants, such as being listened to and receiving attention.

Studies also indicate differences in the mucus membrane lining the gut of IBS sufferers. Suggestions that IBS patients have a lower pain threshold have been contradicted by research testing the electrical resistance of participants' skin. Conversely these tests showed the IBS patients to be 'tougher'. Further extraordinary experiments carried out on medical students have involved the insertion and inflation of balloons in different areas of the gut and measurement of how discomfort was registered. This has given some insight into how sensations in the gut are interpreted by the brain.

Most interestingly, PET (Positron Emission Tomography) scans of the brain have indicated different responses in the brains of subjects with IBS. In non-IBS sufferers the area of the brain which was activated by such discomfort was the anterior cingulate gyrus, an area of the brain which dampens down sensation/stimulation. In IBS sufferers it was the prefrontal cortex which was activated, an area of the brain associated with anxiety, hyper vigilance and trauma. This research suggests that the brain of an IBS sufferer interprets sensation and stimulation in a way which is out of the ordinary. Hardly surprisingly, anxiety symptoms were triggered in IBS sufferers by being told of the balloon experiment. In some medical quarters however, this has been interpreted as suggesting that some 'normal' sensations are experienced as abnormal, just stopping short of the implication that

it is 'all in the mind'.

Of most interest to me was Prior's cursory mention of the Enteric Nervous System, the nerves which serve the gut, being 'a separate brain'. The gut is not under Central Nervous System control. She stated how little is understood by the medical profession about the ENS and that understanding it would be fundamental in the treatment of IBS.

I am curious if others more familiar with the functions and development of the vagal nerve, which 'controls' the gut, might make any further observations.

Psycho-social factors

Psycho-social issues are recognised within the medical profession as highly significant to IBS onset. Certain issues are understood to predispose individuals to, precipitate or prolong IBS. A high proportion of women with IBS have a history of sexual and/or emotional abuse. Severe cases of constipation, perhaps defecating once every three or four weeks, is recognised as a 'cutting off' of the perineum from the brain. Major life stresses, in particular losses such as bereavement, divorce or the death of a childhood pet, are often triggers for IBS onset.

Hearing the examples given by Prior, I would say often there are multiple traumas in the patient's history. For some, IBS is triggered by gastroenteritis. Anxiety is the key factor to increase the likelihood of IBS onset.

Prior's experience is that patients who expect a medical cure or who are regular users of medical services, described as 'will go to the GP for anything' and those who 'catastrophise' or make gains from being unwell, through receiving attention or care, have a poor recovery rate. Those who take responsibility for their healing have a significantly better recovery rate. Those whose recovery rate is most poor are those patients with chronic trauma histories and/or experiences of extreme conflict. Maybe it is

these individuals that we see most often in body psychotherapy.

Medical and dietary treatment of IBS

Much of the treatment offered following diagnosis is information-giving about symptoms, reassurance and 'normalising' of the condition. Prior admitted that none of the medical interventions usually on offer are particularly helpful. Diet and food allergies are often suggested as linked with IBS, however blood tests instigated by Prior's clinic have found allergies to be very rare. Some patients do have particular sensitivities to wheat, green leafy vegetables, dairy foods or citrus fruits and can reduce intake of these. Usually Prior suggests patients eat less fibre.

Occasionally anorexic behaviour is masked by the presentation of IBS symptoms. Because of the desperation often felt by sufferers, extreme forms of restrictive eating often occur. Prior described a patient arriving on the ward with three large suitcases 'one filled with potatoes grown by a family member, the only thing she could eat and another with her own pans in which to cook them'.

Some 'remedies' are sometimes found to be helpful. Artichoke extract can be experienced as helpful for constipation and its effectiveness has been replicated in trials. Small doses of liquorice can be effective for constipation. Aloe Vera can be helpful for pain in the gut, bloating and particularly for diarrhoea. Cutting out caffeine can reduce gut irritation.

The reintroduction of 'good flora' to the gut is hard to achieve, although a laboratory in Cambridge led by Cummings et al have had some positive results with use of probiotics. Some patients feel a benefit from taking live yoghurt or new drinks which are currently marketed for this purpose such as Kombucha, or from eating Jerusalem artichokes or green, unripe bananas.

Gut directed hypnotherapy

The most effective means of treatment found is 'gut directed hypnosis'. This was pioneered by Peter Whorwell, an apparently charismatic doctor, working at Withington Hospital in Manchester. The results of his trials were published in the Lancet in 1984 and for those interested are widely quoted on the internet. IBS symptoms were significantly reduced in the 30 patients who took part in the initial trial, including at follow up three months and three years after treatment. Gut-directed hypnosis has been successfully replicated in various further trials, including a comparative study between group and individual

treatment by Richard Harvey in Bristol. Happily for the funders, this study found group hypnotherapy to be as effective. The treatment is widely accepted by the medical establishment and I learnt from the internet that it was approved by the American Medical Association as a valid medical treatment in 1958! Whorwell and others after him developed the technique as follows: He used 'progressive muscular relaxation to induce a trance-like state' followed by directed imagery to modify gut function. It was suggested to subjects that they visualise the gut as a river. For the patient with a constipated gut, the image of stagnancy and blockage is suggested and then modified to an

image such as the river gently flowing through meadows towards the sea. For the patient with an explosive gut, an image of turbulent waters would be slowed down. Treatment in the Whorwell study included the use of auto-hypnosis using tapes at home and seven sessions of 'supportive psychotherapy, which included a discussion of symptoms and an exploration of any contributory emotional problems and life events'. Psychotherapy and CBT (Cognitive Behavioural Therapy) are both considered helpful to the treatment of IBS. However, despite this and the clear links between IBS and psycho-social factors, the majority of IBS clinics have neither psychotherapeutic nor psychiatric support. St Marks Hospital in London is one exception to this.

Prior was asked if SSRIs (Selective Serotonin Reuptake Inhibitors) such as Prozac were prescribed to treat the depressive symptoms. She has only prescribed amitriptyline (Elavil: a muscle relaxant also used in the treatment of depression) at a tiny dose, to relieve pain. Prior clearly felt that the prescription of psychiatric drugs to treat IBS contradicts the message to patients that their experiences are being taken seriously and she rarely comes across patients who want this intervention.

There ensued an open discussion about the various potential benefits of acupuncture, osteopathy and other complimentary therapies to IBS. Babies with colic have been treated successfully by osteopaths at the Humbleyard Centre. There is anecdotal evidence that babies who experienced long, traumatic births are more prone to colic and to explosive nappy filling than average, perhaps because of vagal irritation caused by compression of the head and neck. Without treatment these babies go on to have a tendency to childhood tummy upsets.



Photograph by Vicki Martin

Emotion, expression and the Autonomic Nervous System (ANS)

In my practice I have often worked with IBS sufferers to mobilise expression, specifically aggressive feelings, in relationship. Client histories which spring to mind include intrusions by family members or emotional abuse in childhood in response to a child's expression of feeling. I wanted to know if Prior perceived sufferers as having such inter-relational struggles. Prior confirmed that in her experience sufferers tend to 'weep not shout' and often have difficulty expressing anger. We discussed how the social norm is still that both expression of anger and release of flatulence (farting) is less acceptable in women than in men. As biodynamic practitioners and body psychotherapists we know it is no coincidence these two ways to 'make a stink' appear in the same sentence. Excess wind can alert us to what is unexpressed.

The high anxiety levels and hyper vigilance characteristic of IBS suggest high Sympathetic Nervous System (SNS) arousal. The accepted theory of IBS for biodynamic/body

psychotherapy is that the SNS arousal needs to be mobilised, rather than directly inviting parasympathetic relaxation. In terms of the vasomotoric cycle the client's energy needs to move towards expression, for the charge to be 'followed through', before relaxation occurs.

Clearly gut-directed hypno-therapy is working with ANS arousal. I am interested in the energetic-expressive and biofeedback potential of image work. I was curious to know how, when image invites energetic change in the gut, this affects behavioural and relational functioning of the individual, but I have found no reference to this in the studies mentioned.

Research

Prior admitted that 'innervation [of the gut] is much more complex than we thought'.

Some of you will be better informed than I about how much neuroscience has arrived at underpinning Boyesen's work and the work of all of us who work with psychoperistalsis. I would welcome your comments.

Aside from 'evidencing' our work as biodynamic massage practitioners and body psycho-

therapists with neuro-scientific findings, I want to underline that IBS is one example of somatisation which the medical profession admits it is ill-equipped to treat. I am interested to know how much success, or otherwise, colleagues have had in relieving symptoms in their work with IBS sufferers and I wonder how we might gather up, mobilise and voice the wealth of experience in 'working with the gut' within our profession? I realise this is not a new thought. Dr. Helen Payne is currently overseeing a research project at Hertfordshire into the treatment of somatic disorders in primary care with dance movement therapy. Perhaps biodynamic massage and/or body psychotherapy might yet do something similar?

Acknowledgements

I would like to thank Gill Westland for her comments.

Massage volunteers in London

The Cancer Resource Centre in London is looking for massage volunteers to visit people with advanced cancer in their own homes across South, West, and Central London. Recruitment drives are taking place in August and September, but the centre will continue to be on the lookout for suitable therapists. For more information contact Heather or Eleanor on 020 79243924, or visit the centre's website address on: www.cancer-resource-centre.org.uk

Peer supervision

Sue Armstrong would like to hear from you if you are interested in joining a peer supervision group. Sue is hoping to start one in the Fleet area. Contact her on sue@tactilis.co.uk

Referrals

Jenny Whiting, our secretary, answers queries from the public about practitioners. If you have clients who have come through the referral system she would like to hear from you. This is an opportunity to see how successful the system is; which areas tend to attract most clients; and could directly influence ideas around publicising AHBMT. Contact Jenny on ja.whiting@ntlworld.com