

## DEPRESSION IN IRRITABLE BOWEL SYNDROME (IBS)

- Dr.Ravi Abhyankar

Irritable bowel syndrome is perhaps the commonest gastrointestinal disorder. Irritable bowel syndrome is a motor disorder of the bowel consisting of altered bowel habits and abdominal pain, without any organic pathology, Symptoms as given in Table 1 are influenced by psychological & emotional factors and stressful life situations.

Table 1	
Symptoms in Irritable Bowel Syndrome	
Diarrhoea	Watery stools
Constipation	Hard, dry, pebbly stools
Abdominal distress	Mucous stools
Flatulence	String stools
Erratic bowel action	Lump in throat
Annoying discomfort	Giddiness
Excruciating pain	Palpitation
Abdominal cramps	Shortness of breath
Burning sensation	Frequency of urination
Twisting/Gripping	Weakness
Knotting in abdomen	Fatigue
Fullness/Heaviness	Lassitude
Pressure	Ennui
Belching	Cancerophobia

Although diagnosis requires the exclusion of organic diseases, it is confirmed by positive clinical, psychological, laboratory and motility finding. Irritable Bowel Syndrome or IBS is a syndrome, consisting of a number of conditions with similar manifestations. The symptoms which help to distinguish IBS from organic disease are given in Table 2.

Table 2
Symptoms which are diagnostic of IBS (Manning's Criteria)
<ol style="list-style-type: none"><li>1. Visible abdominal distention</li><li>2. Relief of abdominal pain by bowel movement</li><li>3. More frequent bowel movements with onset of pain</li><li>4. Looser stools with onset of pain</li><li>5. Passage of mucus</li><li>6. A sensation of incomplete evacuation</li></ol>

IBS has also been known as spastic colon, mucous colitis and nervous stomach. It is the prototypical functional gastrointestinal disorder. It is chronic, benign, non-inflammatory and non progressive and is regarded as psychosomatic or psychophysiological disorder.

### Epidemiology

IBS is present in about 50% patients seen in gastroenterology clinics, is commonly seen in general medical clinics and in family physicians clinics. Community surveys demonstrate that it is common in community and that more than 60% of patients who have symptoms of IBS have never taken any treatment at all.

It is two to three times more common in females, occurs in early childhood, adolescence and even in middle age. It is more prevalent in developed countries and in urban areas. Its incidence and prevalence is increasing over the past 50 years which may be related to increasing stress in daily life, changes in life style and in dietary patterns.

Irritable bowel syndrome exerts a large collective impact on the economy, the health care system and on the quality of life of the individual patient.

### **Pathophysiology & Etiology**

There is general agreement that irritable bowel syndrome is a disorder of intestinal motility. Most of the patients of IBS have an abnormal increase in 3 cycles per minutes contractility which is unrelated to diet or bowel habits and persists even during remission.

Recent discoveries have demonstrated histological and pharmacological similarities between the bowel and the brain e.g. presence of peptides like substance P, serotonin, dopamine, encephalins, prostaglandins and other neurotransmitters in the bowel tissue. These findings suggest the speculation that pharmacological agents that alter mental and neurological function may also prove effective in functional disturbances of the bowel.

Anxiety, fear and depression result in hypermotility. Aggressive feelings such as hostility and resentment also cause motility disturbances. Gastrointestinal complaints are frequently present in psychiatric disorders. Early attitudes, beliefs and family behaviors regarding functions of alimentary tract both at the upper and lower ends may be responsible for conditioning a learned response to bowel function.

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### **Psychiatric correlates of IBS**

Studies have consistently revealed the presence of psychiatric illness, mainly depression in the patients with IBS. Symptoms of Irritable Bowel Syndrome are often preceded by psychological distress or depression. Moreover effective treatment of depression relieves gastrointestinal symptoms. It has also been observed that the patients Irritable Bowel Syndrome are much more likely to have had a history of anxiety, somatization disorder or major depression than those with inflammatory bowel disease.

### **Personality Characteristics**

The personality traits of orderliness, punctuality cleanliness, rigidity and obsessive compulsiveness are present in the patients suffering from Irritable bowel syndrome. These traits correspond to the concept of anal personality according to Freudian psychoanalysis. Others have observed that conflicts regarding giving, receiving and aggression result into the symptoms of diarrhoea and constipation. Constipation was seen as withholding a manifestation of stubbornness, and diarrhoea suggested unconscious aggressive urges. However further work needs to be done before we come to any definitive conclusion.

### **Diagnosis**

Any patient complaining of abdominal pain and persistent alternating diarrhoea and constipation should undergo a thorough medical and psycho social evaluation including necessary investigations, laboratory tests and speciality consultations. When disorders such as carcinoma, tuberculosis peptic ulcer disease, inflammatory bowel disease, lactose intolerance, gall bladder and heart disease have been satisfactorily ruled out; the diagnosis of Irritable Bowel Syndrome should be considered. It must be remembered that patients are often reluctant to accept or identify psychosocial stresses in their lives and would rather prefer a physical diagnosis other than a psychogenic one. As such both the patients and treating physicians tend to avoid psychiatric consultations which result into palliative symptomatic physical approaches, inadequate psychiatric assessment and intervention that leads to chronicity and unnecessary suffering to the patient.

### **Management**

The patient should counseled that IBS is a biological vulnerability that worsens with psychosocial stress. A multimodal treatment plan consisting of medical psychopharmacological and psychotherapeutic modalities would be beneficial. All the contributing factors should be identified and should be taken care of. Customary medical treatments include antispasmodics and analgesics, anticholinergics, bulk forming agents, diet modifications etc. A patient suffering from IBS having an identifiable depressive disorder will benefit from treatment of his depression.

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### Management of depression in IBS

#### A) Doctor Patients relationship -

The physicians attitude should be caring , sympathetic and empathetic. There should be a genuine concern for the patient about his life and his sickness. The patient should be allowed and encouraged to talk freely about his complaint without any hindrance or expressing boredom. The patient should not feel that the doctor is not listening or is not interested in his problem. Simple unburdening of problems on a sympathetic listener gives some relief.

#### B) Aim and modalities of treatment

The aim of treatment is fourfold

1. treatment of presenting complaints,
2. treatment of psychosocial stressors
3. treatment of personality disorder if any and
4. prevention.

The therapeutic modalities which are commonly used are

1. Psychopharmacotherapy
2. Psychotherapy and
3. Behavior therapy.

#### 1) Psychopharmacotherapy

It is important to choose right drug in the dose to be administered at the right time in the right frequency of dose and which is available at the right price. It is good practice to be familiar with a few drugs than to use the latest available drug.

The traditional tricyclic antidepressants drugs include imipramine, amitriptyline, nortriptyline, dothiepin and doxepin. Most of these drugs are gold standard for antidepressant therapy and have proved their worth over a number of decades. One of these drugs (e.g. dothiepin) may be started in the dose 25mg daily and may be increased by 25mg every four days till the dose of 75mg per day is reached. Later on the increment of 25mg should be at the interval of one week till there is improvement or till side effects become unacceptable. These drugs can be safely given in the dose of up to 300mg per day but it would be prudent to seek a psychiatrist's consultation beyond a dose of 150mg per day. The dose may be given as a single night time dose or in 2 or 3 divided doses per day. The night dose should be taken about two hours before bedtime, to avoid hangover next day.

The common side effects include dryness of mouth postural hypotension and constipation. If the patient is informed of the side effects in advance and advised simple preventive and precautionary measures most of them do not find the side effects unacceptable. Usually the improvements starts within days but sometimes the onset may be delayed. Full improvement is seen within two to three months medication & it should be continued for about 6 to 9 months after full recovery. There after it may be gradually tapered off, some patient may require maintenance therapy to prevent relapse.

Fluoxetine is a prominent molecule from the category of newer antidepressants. It may be started in the dose of 10 mg per day, may be increased to 20 mg after a week. It may be further increased to 40 mg per day after 3 to 4 weeks if there is inadequate response. Fluoxetine should preferably be administered before noon, to avoid insomnia. Side effects are usually mild and minor.

## **2) Psychotherapy**

Initially the psychotherapy should aim at developing transference and at facilitating ventilation and catharsis. By transference we mean the positive approach, faith and confidence which the patient develops towards physician. It results from the transfer of patient's positive attitude towards the significant formative years of personality development. Ventilation is intellectual expression and discussion of patient's problems. Catharsis is expression or discharge of emotions and emotionally charged material often accompanied by crying, anger, resentment etc. At this stage, the physician should listen and make note of important material used in the later sessions. The patient should not be pressurized into doing anything and no false hope should be given. Abreaction is emotional recurring of past traumatic experience. It can give sudden relief at times. Depressed patients have a tendency of taking a negative view of life and magnifying the difficulties than what they actually are, minor obstacles appear insurmountable, patients feel helpless and worthless. They feel being used and exploited by other people. They feel they are not getting any credit or recognition for the good work done by them. Often their anxieties, ambitions, attitudes and priorities are vastly different from their family members. These attitudes need to be discussed with the patient. He should be encouraged to do a stock taking of his life, evaluate assets and liabilities; study strength weakness opportunities and threats and take rational and intellectual decisions to rectify things. He will have to re-examine his attitudes towards spouse, children, work and life in general. Quite often we mortgage our today for a better tomorrow, which unfortunately never arrives. While trying to please everybody else, we disappoint ourselves. We need to be happy here and now today.

Depressed patients have to be encouraged to look at themselves, their undesirable reaction and response to certain patients in situations. Psychotherapeutic process aims at substituting such undesirable behavior by desirable behavior.

## **3) Behavior Therapy**

Behavior therapy eliminates undesirable behavior and tries to inculcate desirable behavior by using the learning theories. Broadly speaking these are two types of learning processes. In the classical conditional learning also known as Pavlovian conditioning, conditioned behavior is elicited by coupling of unconditioned stimulus and conditioned stimulus e.g. Classical Pavlovian experiment in which dog starts salivating only when buzzer rings; when food and buzzer are coupled in the earlier trials.

On the other hand in operant learning desirable behavior is rewarded while undesirable behavior is punished.

A psychosomatic disorder like Irritable Bowel Syndrome (IBS) would have given better qualitative and quantitative response if both the medical as well as psychological namely cognitive, behavior and anti-depressant treatment are administered by the primary care physician.

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