A few years ago, an accountant was referred to me by his internist. The accountant’s chief complaint was that he had daily episodes of feeling bloated. When he wasn’t bloated, he had an urge to defecate. While lying on the examining table, the patient was so pos- sessed by the urge to move his bowels that, on certain days, he was afraid to leave the house. The referring internist had done a full gastrointestinal (GI) work-up, including a colonoscopy, and had found no significant pathology. He assured the patient that he was okay. The internist had, in fact, reassured the patient that he was okay many, many times.

The internist even tried, according to the history, to elicit any stress the patient was under, but the patient had no previous psychiatric history. Aside from the normal stresses of work and family, the pa- tient was not particularly troubled by life’s events, as he and the internist saw it.

According to the history, the patient had been treated with several GI medications, none of which appeared to help. The in- ternist and the gastroenterologist the patient selected to treat him diagnosed the patient with irritable bowel syndrome (IBS).

In the United States, IBS is considered a chronic functional gastrointestinal disor- der (FGID). This does not make it necessarily a psychiatric disorder per se, but it is a disorder that may be helped by psychi- atric intervention. Data suggest that IBS may affect up to 15% of the U.S. popula- tion, and cost the country billions of dol- lars, although many people only have mild symptoms of troubled bowel function or abdominal discomfort, such as bloating.

IBS is only a starting point. If all the functional syndromes affecting the GI system are included under the umbrella of FGID from the top of the GI tract—in- cluding dyspepsia and esophageal spasm—all the way to the anorectal area, it be- comes easy to understand the enormous cost to health care and society.

Because these disorders produce a sub- stantial amount of psychological distress, including anxiety and depression, and have negative influences on daily life, people with an FGID are regularly referred to psy- chiatrists and psychotherapists for assess- ments and treatment.

In the case of this patient, I began the first visit after taking a good history of his diagnosed IBS. Then I explained the learn- ing, philosophizing, and action (LPA) tech- nique that I planned to use to help resolve his problems. I also intro- duced the concept of relaxation and guided imagery to help ameliorate any stressful issues that might be discov- ered during the learning or philosophizing parts of the treatment plan.

The last item on the first visit was a homework as- signment: It would be his job, over the next 2 weeks, to keep a diary and note when he felt the desire to defecate and when he simply felt bloated. After the first week, I had the pa- tient mail me his observations so I could develop an action-oriented approach for the second visit.

For me, this information proved critical in learning about the specific aspects of his disorder. With it, I was able to develop the appropriate aspects of stress assessment unique.

After the first few weeks, it appeared that the patient had two main triggers for the urge to move his bowels: It was sub- stantially more intense when he was about to go somewhere than when he was re- turning, and it occurred more often when he was in the process of working with a client from whom he had to ask for mon- ey. This feedback allowed me to develop a two-pronged treatment approach.

The first prong was a relaxation tech- nique coupled to desensitization of his trigger processes. The second prong was the learning aspect of the LPA, with a little of the philosophizing at times. On the second visit, I taught him a simple relaxation tech- nique (“The How-To of Relaxation Tech- niques,” The Psychiatrist’s Toolbox, June 2006, p. 20) in which he visualized, on the left side of a split movie screen, leaving for work or a trip. It was important that he see the experience but not experience it.

I encouraged him to link this to any pleasant experience of his choosing on the right side of the split screen (technique of systematic desensitization—seeing the stress/anxiety situation on the left side of the screen and then linking it to the least anxiety/stress situation on the right side of the screen—the patient was on the road to inhibiting his possible stress-related disorder.

I spent about an hour and a half with him as he learned and practiced using this tool. I encouraged him to use the strategy regularly so he would know how to use it when the triggers occurred.

The history of using relaxation tech- niques to control physiological functions goes back centuries and includes many cultures. I have used these techniques suc- cessfully over the years in patient care, so this approach is validated for me as a way to relieve some pain and suf- fering of functional disorders.

After the action phase was taught and understood, the second tier of the ap- proach was my learning aspect of the LPA. Because the accountant was educated and clear-thinking—both in concrete areas as well as in abstract ones—I was able to in- troduce the ideas of many schools of thought in the area of psychosomatic dis- orders. We covered ground ranging from Walter B. Cannon’s physiologically ori- ented vulnerability and personality styles leading to certain types of dysfunctions and puts them into cognitive restructuring, many doors open for a person trying to cogni- tively reprocess a problem using his skills and imagination.

I further used the learning aspect of the LPA technique to give this gentleman an overview of some neurotransmitter con- cepts of the epinephrine-serotonin complex in the central nervous system, as well as the hypothalamic/limbic system, sympathetic, and parasympathetic relationships that in- teract with our emotions and the GI tract.

All this was very therapeutic in that the patient was circumscribing the problem and getting its resolution by action (the split screen technique) and by thinking through a variety of concepts and re- learning how to process the triggers that had precipitated the disorder.

In our discussions, the patient revealed two interesting memories about his up- bringing. One was that his mother, a fami- ly-oriented person, always emphasized the importance of being home. His father, also a successful accountant, did, at times, interrogate him before giving him money. Those interrogations led the patient to feel as if he was doing something wrong when he asked for money.

From a behavioral point of view, those family dynamics are not pathologic. How- ever, the way in which a person processes information and how it is reinforced can have a bearing on perceptions and pro- cessing of life problems down the road. Those perceptions and processing may have contributed to the development of this patient’s syndrome.

We met for 12 visits. I am pleased to re- port that, by thinking through the issues and using a learning/cognitive approach about perceptions, possibilities, and prob- abilities, this patient gained relief from his symptoms. Some years ago, when Kate Couric, former host of the “Today” show, showed her colonoscopy on live TV, she essentially made the learning part of the LPA technique relevant for millions of viewers by removing fear, worry, and anx- iety about the procedure.

After seeing that segment, I’m sure that many followed her lead by getting a colonoscopy. Had the focus of the seg- ment been on the symptoms and inter- pretation of the colonoscopic process, it would have gone on forever. The point about the importance of learning better health care would have been missed.

Let me know about your experiences and ideas for treating functional gastroin- testinal disorders, and I’ll try to pass them along to my readers.

Dr. LONDON is a psychiatrist with the New York University Medical Center and Lutheran Medical Center, New York. He can be reached at cpnews@elsevier.com.