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Review Article

IBS – Irritable Bowel Syndrome – Management through Comprehensive Non Pharmacological Approach Need of Hour

Mayank Chugh[1], Satender Tanwar[2]

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ABSTRACT

Irritable bowel syndrome (IBS) is one of the most commonly diagnosed gastrointestinal conditions. It represents a significant healthcare burden and remains a clinical challenge. Over the years IBS has been described from a variety of different perspectives; from a strict illness of the gastrointestinal tract (medical model) to a more complex multi-symptomatic disorder of the brain-gut axis (biopsychosocial/ psychosomatic model).[1] In this article we present aspects of the pathophysiology and the non-pharmacological treatment of IBS based on current knowledge. Effects of conditioned stress and/or traumatic influences on the emotional system (top-down) as well as effects on the intestine through stressors, infection, inflammation, food and dysbiosis (bottom-up) can affect brain-gut communication and result in dysregulation of the autonomic nervous system (ANS), playing an important role in the pathophysiology of IBS. Conditioned stress together with dysregulation of the autonomic nervous system and the emotional system may involve reactions in which the distress inside the body is not recognized due to low body awareness.[2] This may explain why patients have difficulty identifying their symptoms despite dysfunction in muscle tension, movement patterns, and posture and biochemical functions in addition to gastrointestinal symptoms. IBS shares many features with other idiopathic conditions, such as fibromyalgia, chronic fatigue syndrome and somatoform disorders. The key to effective treatment is a thorough examination, including a gastroenterological examination to exclude other diseases along with an assessment of body awareness by a body-mind therapist. The literature suggests that early interdisciplinary diagnostic co-operation between gastroenterologists and body-mind therapists is necessary.[3] Re-establishing balance in the ANS is an important component of IBS treatment. This article discusses the current knowledge of body-mind treatment, addressing the topic from a practical point of view.

Author's Affiliation:

[1] Consultant, Gastroenterologist, Chugh Multispecialty Hospital, Bhiwani, Haryana, India.

[2] Associate Consultant, Department of Medical Gastroenterology, Chugh Multispeciality Hospital, Bhiwani, Haryana, India.

Corresponding Author:

Satender Tanwar, Associate Consultant, Department of Medical Gastroenterology, Chugh Multispeciality Hospital, Bhiwani, Haryana, India.

E-mail: drsatendertanwar@gmail.com

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INTRODUCTION

Irritable bowel syndrome (IBS) is one of the most commonly diagnosed gastrointestinal conditions, characterized by symptoms such as abdominal pain, cramping or abdominal bloating, faecal urgency, and alteration of bowel habits with the relief of pain or discomfort upon defecation. Women are more frequently diagnosed with IBS than men. IBS patients are generally subdivided into diarrhoea predominant (D-IBS), constipation predominant (C-IBS) or an alternating type (A-IBS), which stool fluctuates between diarrhoea and constipation.[4]

IBS generates a significant healthcare burden with huge economic costs Increased economic consequences are also incurred as a result of unnecessary surgery. A threefold higher rate of cholecystectomy, a twofold higher rate of appendectomy and hysterectomy and an approximately 50% higher rate of back surgery have been recorded in IBS patients compared to those without IBS. The severity of symptoms varies widely, from very mild to incapacitating. The prevalence of moderate and severe cases may be underestimated. Previous studies have highlighted how IBS impairs health-related quality of life, possibly even increasing the risk for suicidal behaviours.[5] An IBS diagnosis is based on clinical symptoms and the exclusion of somatic diseases. Clinical symptoms have often been defined through questionnaires including the Manning, Kruis Score, Rome Criteria, Abdominal Symptom Questionnaire and the Gastro Intestinal Scale. These questionnaires differ in how the questions are formulated. To be classified as IBS according to Rome II, patients answer, "yes or no" to the question; "in the last 3 mo, did you often have discomfort or pain in your abdomen?" If they answer "no" they do not have IBS.[6] While in the Gastro Intestinal Scale, the questions consist of a seven-point scale from no discomfort to the worst conceivable symptoms. In the Rome III questionnaire more alternatives in most of the questions are provided. In our experience, individuals rate their pain in different ways depending on their earlier life experiences, body awareness, gender, *etc*.[7]

In addition to gastrointestinal symptoms, IBS patients often experience a wide range of other problems, such as non-abdominal pain, psychological symptoms, low quality of life, as well as difficulties in carrying out activities of daily life. They also exhibit complicated body tensions, bodily stress patterns, low body awareness and abnormal stress parameters. Many IBS patients have been exposed to traumatic events and may also have low self-esteem, difficulties setting limits and hypersensitivity. Therefore IBS patients may show many signs of being in a state of chronic distress.[8]

Within the past decade there has been increasing evidence supporting the concept of IBS as a multi-symptomatic disorder of brain-gut function. The brain and the enteric nervous system communicate through the autonomic nervous system (ANS) and the hypothalamic-pituitary-gut axis. This communication allows stressors in the brain to influence gut function (top-down) and stressors in the gut to influence the brain (bottom-up). This bidirectional signalling can result in the dysregulation of the autonomic nervous system, which may play an important role in the pathophysiology of IBS.[9]

Gut directed hypnotherapy: Relies on inducing a state of relaxation or trance (altered attention in the subject) in response to verbal or other stimuli, with suggestions for improvement made based on whatever condition is being treated The patient is taught relaxation, ego strengthening and coping skills. Tailoring the therapy to the patient's symptomatology is very important. The importance of practice cannot be over-emphasized and should ideally take place on a daily basis. It is often necessary to provide 12 sessions of treatment to gain maximum benefit. According to the author, this is a technique that is exceptionally operator-dependent.[10]

The key aspects of mindfulness are to observe without reacting to internal sensations and to pay emotionally neutral attention to all experiences, impressions, thoughts and feelings. It is also important to be fully present in all activities and have a non-judgmental

approach to life experiences. Adaption of this practice to an IBS population was done by emphasizing the relevance of mindfulness in coping with IBS-related symptoms and perceptions.[11] Participants are instructed to notice any sensations in the abdominal area and to distinguish those sensations from thoughts about the sensations. Instruction and homework assignments are related to body scan, sitting and walking meditation, and mindful yoga.

Body awareness therapy: Body awareness therapy (BAT™) consists of simple structured movement exercises based on human anatomical and physiological prerequisites to achieve optimal movement dynamics. The BAT™ exercises aim to help the body find its natural posture, thus facilitating the circulatory, muscular, nervous and breathing systems to recover their natural function. By doing so, unconscious physical and psychological experiences will be brought into awareness and can be dealt with both physically, mentally and verbally.[12]

Hypnotherapy has been used in IBS patients with good results since Whorwell *et al* introduced it in 1984. Hypnotherapy has been used mostly with gut-directed therapy and mostly on an individual basis; patients are given an audio-tape for homework. However, according to Whorwell *et al* 2006, it is a labour-intensive modality with a finite success rate and is not suitable for everyone. He suggests that it is best incorporated into a program of graduated care that has a contingency plan for dealing with individuals who do not respond to this particular form of treatment. Improvement in symptoms with hypnotherapy is largely sustained, although some patients may require occasional "top-up" sessions to maintain their improvement. Carolusson and her team also used individually tailored techniques but included both gut-oriented hypnotherapy and hypnoanalysis either separately or in combination. The author conclude that the hypnosis treatment has to be designed depending on the patients' personality and possible mental defence-functions in relation to the symptoms as well as the patients' mental and social resources.[13]

When treating patients with body awareness therapy in a group, one has to emphasize that each person concentrate on and listen to her own body and not to carry out any movement that does not apply to her. In allowing the body, and not the mind, to do what it wants, one can find a way out of pain. The ability to listen to the body might be severely impaired in patients at the beginning of treatment. By suggesting that patients try different ways of performing an exercise, the therapist(s) can help the patients find what is comfortable for them. A good working alliance and safety in the treatment situation are important for change to take place.

When treating IBS patients with a tendency to dissociate, the therapist must be careful not to re-victimise the patient and thus risk the patient dropping out. By noticing early warning signs for dissociation and with careful guidance, the patients will learn how to build a trusting relationship with themselves and others, to maintain a psychological as well as a physical integrity (maintaining boundaries) and to gradually find words to describe the body's signals and sensations. Thus, with increasing body awareness, the patients learn how to stabilize themselves when emotional systems are aroused. To first perceive the body and then to connect the sensations in the body with a certain sense or emotion is crucial for the treatment to be effective The patient may express after several treatments: "Before I just had a stomach ache, but now it is like that just before I get pain, I feel angry".

DISCUSSION

Many authors, including Collins *et al* in 1948, Bargen *et al* in 1956 and Enck *et al* in 2008, stressed that IBS is a complicated condition with both physiologic and psychological factors involved in the pathogenesis.[14] According to Gonsalkorale *et al* in 2002, IBS has gained the reputation of being somewhat unrewarding to treat. As a consequence, physicians are inclined to adopt the approach of ensuring that there is nothing "seriously wrong" by a process of thorough investigation but not necessarily offering help in terms of how to cope with the condition. Many of the patients, especially the severe cases, have lost their confidence and feel like "failures" with no hope when they come to an assessment. Because IBS patients also exhibit a variety of symptoms, they find it difficult to "fit in" within the normal health care system with its high degree of specialization. For example, within the field of gastroenterology, hospitals may have different departments for

the upper and lower gastrointestinal tract. This involves a great risk that patients with multiple symptoms and multiple diagnoses may fall in between categories, and that their treatment will be inadequate. However, by adopting a graduated treatment program with a team approach to management, extremely high levels of satisfaction in patients and fulfilment in staff can be achieved.

The key to effective treatment strategies for these multi-symptomatic IBS patients is to understand the heterogeneity of the disorder. A pathophysiological explanation may be that ANS dysregulation occurs due to conditioned chronic stress or emotional stress (traumas) experienced early in life or later on. The emergence of ANS dysregulation may also be caused by a straightforward effect on the gut. Thus, a question may arise as to whether we can give these different types of IBS patients the same non-pharmacological treatment, or if we should differentiate the treatment for different types of IBS. One study has shown that approximately 25 percent of patients repressed somatised psychological problems and needed insight oriented hypnotherapy in addition to gut-directed treatment.

A comprehensive body examination can give us a hint about the non-pharmacological treatment duration needed for a patient to improve. When IBS patients are either treated too briefly or with a treatment that is not optimal, the patient may experience relief from some symptoms, but the underlying distress present in quite a few of these patients will remain untreated and can be replaced by other symptoms (known as symptom shift). The risk is that their underlying problems will be expressed in new ways, and that the patients will therefore seek treatment elsewhere without ever understanding their internal body-mind communication. It is the opinion of many authors that treatment should be carefully chosen after a thorough examination of each patient and that treatment should tar*get all* of the symptoms.

Those patients who need longer treatment durations may be patients defined as non-responders, males with D-IBS or those who have severe social stress; these factors are likely to detract from the efficacy of the treatment. One suggestion for the lack of improvement in males with diarrhoea was that they had somewhat lower hypnotic or imaginative abilities compared to females. Another possible cause for the lack of improvement could be that these males with D-IBS had lower body awareness from the beginning. We know that D-IBS patients with lower body awareness have prolonged recovery times. However, the results in that study did not separate men and women because of the low number of men enrolled.

Some patients will experience relief from some symptoms but not always the gastrointestinal symptoms first. Hypnotherapy, body awareness therapy and mindfulness treatment will almost certainly improve their coping skills in life situations. It is unclear whether these body-mind therapies such as hypnotherapy (guided imagery), mindfulness and body awareness therapy have something in common or are separate entities. These methods involve the body by relaxing the muscles or by normalizing muscle tension, and they also emphasize the importance of being present in the moment. Only in the present one can access and influence the experience and behaviour patterns of the body/mind, which are established in the nervous system. A plausible consequence of this is that consciousness of the "here and now" is essential for changing processes and should be the focus of therapy from the beginning. The patients must first become aware of the present moment and the elements of their experiences of both the body and the emotional sphere in its entirety. Then, they understand that they need to learn to react differently to alarming situations that otherwise can be made worse by their response to it. This educational process is one part of the therapeutic package together with body awareness. The technique can thus be used to control symptoms and to reduce psychological distress and improve coping skills.

There is a general consensus that the health problems that will dominate in the future are psychosomatic or psychosocial disorders or diseases. It has also been suggested that in the public medical service one cannot make use of the same diagnosis and treatment that is used for welfare diseases. This should cause us great concern, and we need a new approach for these patients. Good teamwork is important during this new approach to treat multi-symptom patients. Therapists should be encouraged to discuss IBS cases with each other and also with

the physicians included in the team to ensure that any real or potential medical problem that may arise can be promptly resolved.[15]

CONCLUSION

The pathophysiology of IBS syndrome likely depends on autonomic dysfunctions that can affect the patient both "top-down" (from the brain to the gut) and "bottom-up" (from the gut to the brain), leading to multiple symptoms such as increased intestinal sensitivity and motility dysfunction. In addition, psychological distress enhances these symptoms. The key to planning effective management strategies is to understand the heterogeneity of this disorder. Thus, treatment should be focused on a body-mind intervention directed by a good assessment survey of the individual patient both by a gastroenterologist and a body-mind therapist. The duration of the treatment should be adjusted according the needs of the individual patient.

REFERENCES

1. Ford A.C., Talley N.J. Irritable bowel syndrome. BMJ. 2012; 345: e5836. doi: 10.1136/bmj.e5836.
2. Vol U., Lewerenz A., Nieber K. Treatment of irritable bowel syndrome: Sex and gender specific aspects. Handb Exp Pharmacol. 2012; (214): 473–497. doi: 10.1007/978-3-642-30726-3_21.
3. Liu J., Hou X. A review of the irritable bowel syndrome investigation on epidemiology, pathogenesis and pathophysiology in China. J Gastroenterol Hepatol. 2011; 26 Suppl 3: 88–93. doi: 10.1111/j.1440-1746.2011.06641.x.
4. Boeckxstaens G., Corazziari E.S., Mearin F., Tack J. IBS and the role of otilonium bromide. Int J Colorectal Dis. 2013;28:295–304. doi: 10.1007/s00384-012-1598-0.
5. Spiller R., Aziz Q., Creed F., Emmanuel A., Houghton L., Hungin P., Jones R., Kumar D., Rubin G., Trudgill N., *et al*. Guidelines on the irritable bowel syndrome: mechanisms and practical management. Gut. 2007; 56: 1770–1798. doi: 10.1136/gut.2007.119446.
6. Sandler R.S., Everhart J.E., Donowitz M., Adams E., Cronin K., Goodman C., Gemmen E., Shah S., Avdic A., Rubin R. The burden of selected digestive diseases in the United States. Gastroenterology. 2002; 122: 1500–1511. doi: 10.1053/gast.2002.32978.
7. Inadomi J.M., Fennerty M.B., Bjorkman D. Systematic review: the economic impact of irritable bowel syndrome. Aliment Pharmacol Ther. 2003; 18: 671–682. doi: 10.1046/j.1365-2036.2003.t01-1-01736.x.
8. Hillilä M.T., Färkkilä N.J., Färkkilä M.A. Societal costs for irritable bowel syndrome--a population based study. Scand J Gastroenterol. 2010; 45: 582–591. doi: 10.3109/00365521003637211.
9. Heitkemper M., Jarrett M., Jun S.E. Update on irritable bowel syndrome program of research. J Korean Acad Nurs. 2013; 43: 579–586. doi: 10.4040/jkan.2013.43.5.579.
10. Longstreth G.F., Yao J.F. Irritable bowel syndrome and surgery: a multivariable analysis. Gastroenterology. 2004; 126: 1665–1673. doi: 10.1053/j.gastro.2004.02.020.
11. Lembo A., Ameen V.Z., Drossman D.A. Irritable bowel syndrome: toward an understanding of severity. Clin Gastroenterol Hepatol. 2005; 3: 717–725. doi: 10.1016/s1542-3565(05)00157-6.
12. Spiegel B., Schoenfeld P., Naliboff B. Systematic review: The prevalence of suicidal behaviour in patients with chronic abdominal pain and irritable bowel syndrome. Aliment Pharmacol Ther. 2007; 26: 183–193. doi: 10.1111/j.1365-2036.2007.03357.x.
13. Mönnikes H. Quality of life in patients with irritable bowel syndrome. J Clin Gastroenterol. 2011; 45 Suppl: S98–101. doi: 10.1097/MCG.0b013e31821fbf44.
14. Chang J.Y., Talley N.J. An update on irritable bowel syndrome: from diagnosis to emerging therapies. Curr Opin Gastroenterol. 2011; 27: 72–78. doi: 10.1097/MOG.0b013e3283414065.
15. Henderson P.K., DiPalma J.A. Diagnosing irritable bowel syndrome: a changing clinical paradigm. South Med J. 2011; 104: 195–199. doi: 10.1097/SMJ.0b013e31820*bfb6c*.