Foreword

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Many clinicians probably wonder how much of their patient's disease is psychological. It is well known that trauma and other events may manifest itself in gastrointestinal disorders. The converse is just as important; that being, how much of the psychosocial issues patients may experience is caused or triggered by their underlying disease. One might even wonder about how these issues affect the treating gastroenterologist! One might even wonder how the perception of what the patient thinks the doctor thinks of them may shape their own view of their disease and symptoms. The big question is, how do we as clinicians uncover these issues and address them appropriately?

Nowhere in medicine is there a stronger concern for the mind-body interaction than in gastroenterology. Even in individuals with no gastrointestinal issues, the thought of them evokes concern and fear. I once did a story on CNN on capsule endoscopy, and when we finished the full day of filming, I queried as to whether they'd want to do a story on intestinal failure and short bowel syndrome, which most people are completely unaware of. The response was one of disgust once the media folks found these patients had lots of diarrhea; their audience doesn't want to hear about that they told me. GI disease is a stigma. Nobody brags about their belly pain, their indigestion, their diarrhea, and even one of my kids, who was once so proud of himself as a youngster that he could pass wind on demand, found that was no longer socially acceptable and he began to abstain.

Behavioral medicine is an often overlooked and underutilized tool in the management of gastrointestinal disease; certainly, irritable bowel syndrome, but also inflammatory bowel disease, celiac disease and food intolerances, obesity management, pancreatitis (both acute and chronic), transplant, and others as described in this issue of *Gastroenterology Clinics of North America*. Many of the issues are rhetorical: how do stress and other behavioral issues cause, contribute to, or magnify gastrointestinal complaint; even cause or worsen inflammation, and how do the gastrointestinal issues themselves worsen stress, other behavioral issues, or even organic psychiatric disease? Perhaps the lack of consideration of the mind-gut axis explains some of the limits of even advanced biological therapies on remission rates in inflammatory bowel

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disease. Adherence and compliance also enter into the equation. These are all pieces of the psychogastroenterology puzzle.

The field of psychogastroenterology is complex. It is not well known; it even gets a red underline in Word as I type this Foreword, perhaps because it has not been in the running for "Word of the Year" in *Websters*. It is important that no space be left between psycho and gastroenterology; psychogastroenterologists are not "psycho." Dr Keefer and many of her esteemed colleagues have provided a terrific introduction to the understanding of the role of psychogastroenterology in the diagnosis, treatment, and ultimate prognosis of patients with gastrointestinal disorders as they seek to unravel a more exacting role in patient management. The future is wide open for exploration with regard to effects on medication effectiveness, pain control, inflammation, and a host of other issues; there may even be genetic predispositions and gene mutations that predispose to altered perceptions or symptoms of gastrointestinal disease. Perhaps at some point we'll need to have our psychogastroenterologist on speed dial.

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