If Food Heals, Why Are We Taking It Away?

A gut–brain first approach to care without restrictive eating

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Patient A

01

IBS diagnosis

Initial presentation with classic symptoms: abdominal pain, bloating, altered bowel patterns

02

Early gut–brain intervention

Started with app-based gut-directed hypnotherapy GI conditions within the first visit

03

Diet used strategically later

Once nervous system regulation improved, introduced gentle dietary modifications as needed + general nutrition counselling

Patient A Outcomes

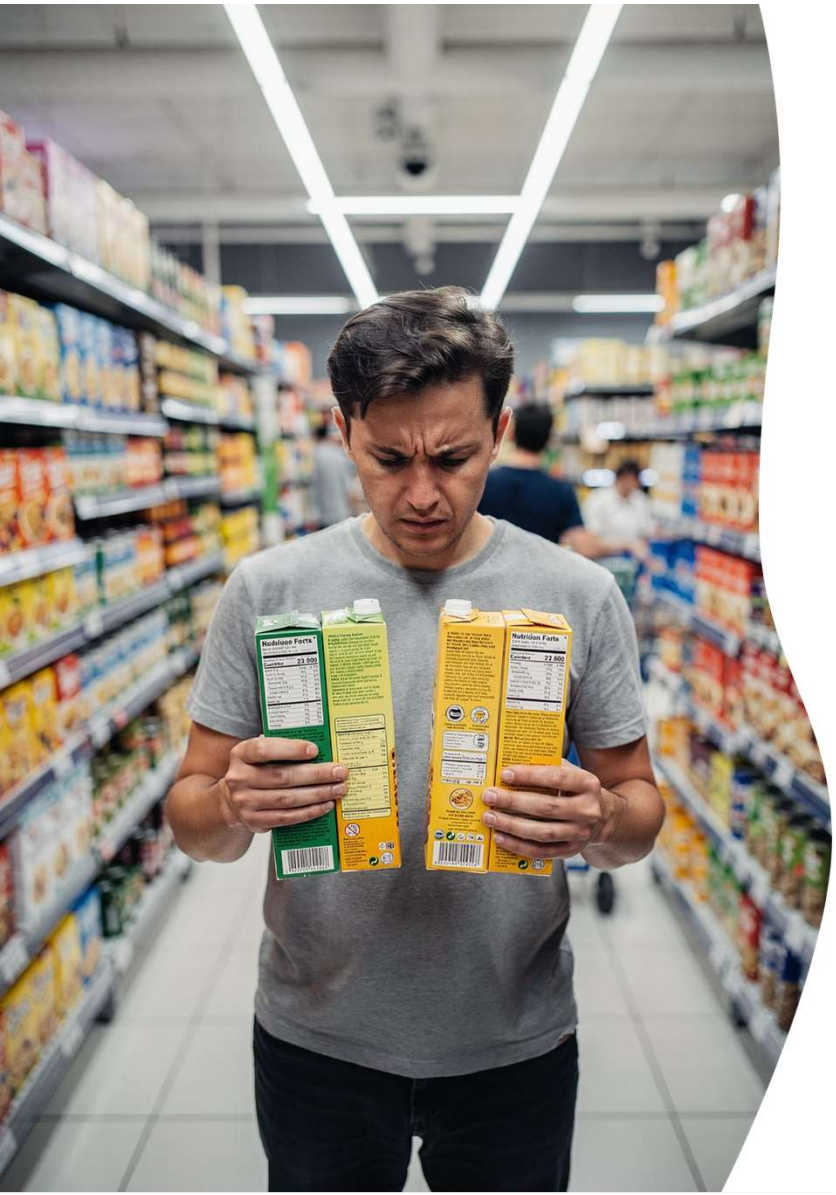
Improved Outcomes

- Symptoms improved significantly on validated measures
- Confidence increased in managing symptom flares
- Food variety preserved—still enjoying diverse meals
- Reduced hypervigilance to bodily sensations

Preserved Lifestyle

- Still eating socially without fear or restriction
- Still travelling comfortably, including internationally
- Still trusting their body's signals
- Quality of life maintained or improved across all domains

Patient A achieved both symptom control *and* freedom. Their life expanded rather than contracted during treatment.



Patient B

01

IBS diagnosis

Initial presentation with classic symptoms: abdominal pain, bloating, altered bowel patterns

02

First-line elimination (FODMAP) diet

Started restrictive diet within the first clinic visit, before addressing gut-brain factors

03

Prolonged restriction

Reintroduction delayed or incomplete due to fear of symptom return

Patient B Outcomes

Symptoms improved — the diet worked in that sense

But Patient B also developed:

Food fear

Anxiety around "trigger foods" became generalized and rigid

Travel anxiety

Worried about accessing "safe" foods away from home

Narrowed diet

Food variety decreased over time, not increased

Social restriction

Declining invitations to eat out or attend gatherings

Both Patients Improved

- Both patients experienced significant symptom reduction
- Both would be counted as treatment successes in many clinical trials

When we measure success solely by symptom scores, we miss the outcomes that matter most to patients:
freedom, participation, and quality of life.

What This Talk Is (and Isn't)

This is about:

- **Sequencing** — When we introduce restriction and why timing matters
- **Defaults** — Examining reflexive clinical patterns that may not serve patients best
- **Long-term outcomes** — Looking beyond symptom reduction to quality of life, food freedom, and psychological health

This is *not*:

- **Anti-diet** — Dietary interventions have a valuable role in IBS care
- **Anti-nutrition** — Nutrition therapy is essential; this is about when and how we deploy it
- **Anti-guidelines** — This is about applying evidence more thoughtfully, not rejecting it

This presentation advocates for a shift in our starting point—not the elimination of dietary interventions. The goal is smarter sequencing that maximizes both symptom control and long-term patient flourishing.

The Core Question

If gut–brain therapies work as well as restrictive diets
— *without* taking away food — **why do we still lead with restriction?**

It's time to ask whether our clinical habits align with both the evidence and our patients' long-term quality of life.

The question isn't whether diet works—it's whether restriction *first* serves patients best.

The Problem Isn't Food

Let's be clear: food matters profoundly in IBS.

- Certain foods can trigger symptoms.
- Understanding personal tolerance can be empowering.
- Dietary modifications can provide meaningful relief.

The question isn’t: "Does diet work?"

The question is: "What happens when we lead with restriction before addressing the gut-brain axis? What do we gain—and what do we risk?"

Many Patients Didn’t Get Here by Choice

Reassured without being supported

Patients often report being told "everything is fine" without receiving concrete support or strategies to alleviate their persistent symptoms.

Told tests are “normal” without explanation

When diagnostic tests come back negative, patients are frequently left without a clear understanding of their symptoms or next steps for care.

Left without tools to manage ongoing symptoms

Many individuals struggle with chronic DGBI symptoms, yet feel unequipped with practical, evidence-based methods for self-management.

When Care Gaps Exist, Information Fills the Void

When symptoms persist and professional support is limited, patients often embark on a digital quest for answers

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What they often find online is:

- **Confident**, even if unfounded
- **Simplified**, often to a fault
- **Inaccurate**, promoting misinformation
- **Fear-based**, heightening anxiety

Information Overload Changes Behavior

In the absence of clear, trusted guidance, patients naturally gravitate towards what feels most tangible and controllable:

- Rules feel safer than flexibility
- Restriction feels like control
- Certainty feels safer than nuance

Food becomes the immediate solution—
not because it's always correct,
but because it's readily available and seems to offer agency

Gut Symptom–Specific Anxiety

Not all anxiety is the same. Gut symptom–specific anxiety is distinct from generalized anxiety disorder. It is the fear of:

- Symptoms occurring unpredictably
- Losing control in public or social situations
- Being far from help, bathrooms, or perceived safety

It drives hypervigilance, catastrophic thinking, and avoidance behaviors.

Here's the paradox: symptoms may improve with dietary restriction, but **fear often does not**. In fact, restriction can reinforce the belief that food is dangerous and that avoidance is the only path to safety.

Why This Matters in Dietary Restriction

Restriction can temporarily reduce symptoms—
but it can simultaneously reinforce the fear that drove the symptoms in the first place.

For patients with high gut symptom–specific anxiety:

- Restriction strengthens the avoidance loop
- Each avoided food becomes more threatening
- The "safe food" list shrinks over time
- Reintroduction becomes psychologically harder, not easier

Psychological Mechanisms of Change

Real-world data shows that gut–brain therapy drives significant psychological shifts that predict symptom improvement:

Reduced Visceral Anxiety

Patients experience a tangible decrease in gut-specific fear and apprehension, allowing for greater emotional stability and less hypervigilance.

Less Catastrophic Thinking

Individuals learn to reframe bodily sensations, shifting from worst-case scenarios to more balanced and rational interpretations of their symptoms.

Increased Self-Efficacy

A strengthened belief in one's own ability to manage and cope effectively with symptoms, fostering greater independence and resilience in daily life.

Reference: Petrik & Arizmendi, Mayo Clinic — ongoing evaluation

What If We Started With the Evidence?

What if we set aside habit, training, and expectation—and looked only at outcomes?

What if we asked: *What does the research actually tell us about gut-brain interventions compared to dietary restriction?*

Peters et al., 2016

A landmark randomized controlled trial with 74 patients diagnosed with IBS

1

Gut-directed hypnotherapy

Six sessions over 12 weeks

2

Low-FODMAP diet education

Four dietitian consultations over 12 weeks

3

Combination therapy

Both interventions delivered together

All groups received standardized, evidence-based interventions delivered by trained professionals. Outcomes were measured using validated tools including the IBS-SSS and IBS-QOL.

What the Results Showed

~70%

Response rate in both groups

Defined as clinically significant reduction in IBS-SSS scores

Equal

Quality of life improvement

No significant difference between groups on IBS-QOL measures

Gut-directed hypnotherapy maintained benefit longer at follow-up, suggesting more durable outcomes without ongoing dietary restriction.

The combination group did not show additional benefit over either intervention alone—suggesting that adding restriction to gut-brain therapy may not enhance outcomes.

Anderson et al., 2025

A more recent and larger randomized controlled trial with 241 patients diagnosed with IBS

Comparing **app-based gut-directed hypnotherapy** versus a digital education control group

This study is significant because it demonstrates that gut-brain interventions can be delivered at scale through digital platforms - addressing one of the major barriers to implementation: access to trained therapists.

Key Outcomes

1

Achieved ≥50-point IBS-SSS improvement

81% in hypnotherapy group vs 63% in control

2

Achieved ≥30% pain reduction

71% in hypnotherapy group vs 35% in control

The hypnotherapy group showed significantly greater gains in quality of life across multiple domains—including vitality, social functioning, and mental health.

Evidence Isn't the Barrier

The barrier isn't data. We have robust evidence that gut-brain interventions work.

The barrier is **decision-making**—the ingrained clinical reflexes, training patterns, and institutional defaults that lead us to reach for dietary restriction first.

Why Diet Feels Like the Right First Step

It's tangible

Concrete instructions patients can follow immediately

It's structured

Clear phases, measurable adherence, visible tracking

Patients Expect It

"Just tell me what to eat" is a common request

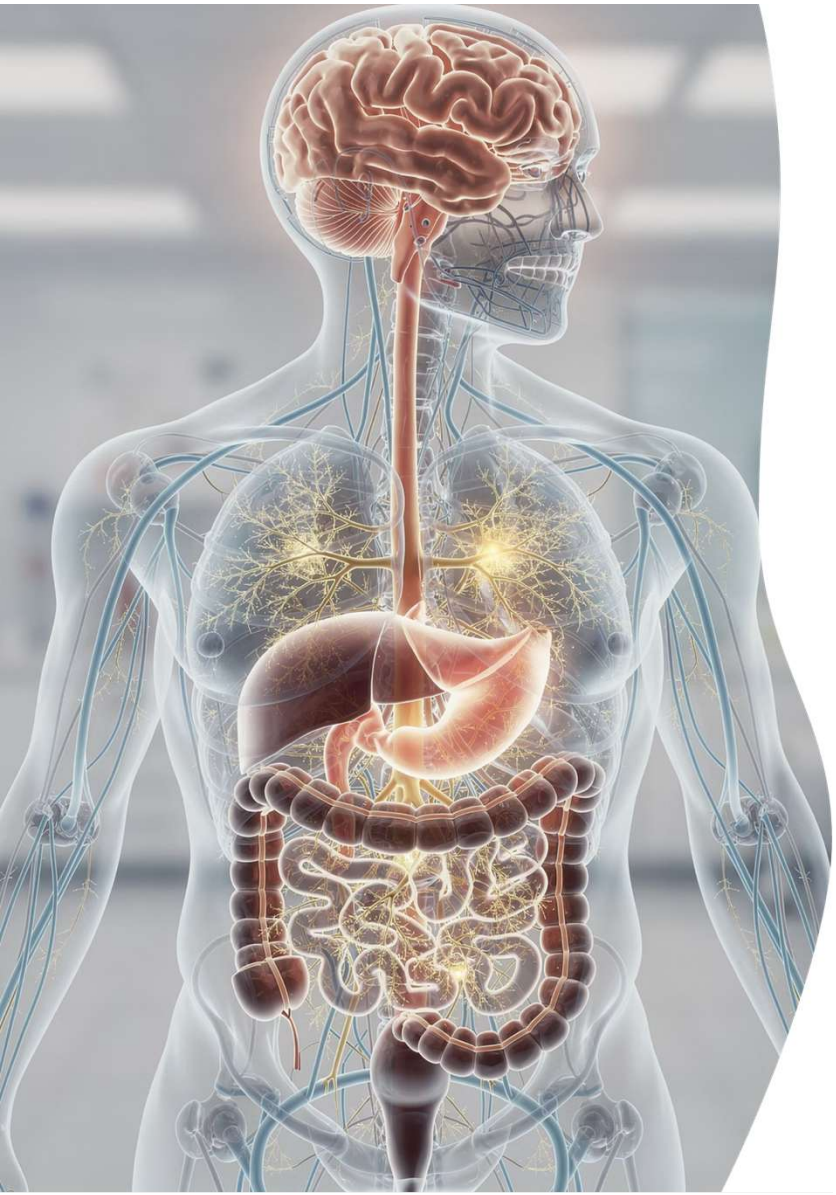
It feels active

Patients do something concrete rather than "just thinking differently"

Clinicians are trained in it

Diet is emphasized in GI training; gut-brain therapy often is not

These are understandable reasons. They reflect real pressures in clinical practice.
But they are not evidence-based reasons.



A Gut–Brain First Approach

This is not about removing diet from the treatment plan.

It's about **sequence**. It's about asking:
What do we do first, and why?

A gut-brain first approach means building nervous system capacity, reducing symptom-specific anxiety, and strengthening resilience *before* introducing dietary restriction—if restriction is needed at all.

Changing Our Minds — and Our Patients'

How do I approach this?
– an *accusation audit*

A *negotiation technique adapted for gut–brain care*

- Name the objection before the patient does
- Normalize skepticism and discomfort
- Align first – explain evidence second
- Preserve curiosity and engagement

Changing Our Minds — and Our Patients'

For patients already deep into restriction, changing course is not failure.
It's clinical recalibration based on evolving understanding.

It sounds like:

> "This approach helped short term - now we need a different tool to build long-term resilience."

> "Your symptoms are calmer, but your nervous system isn't yet. Let's work on that."

> "Let's shift focus from control to capacity - building your ability to tolerate a wider range of foods and situations."

Not Just Hypnotherapy

Gut-brain interventions encompass a range of evidence-based approaches:

Cognitive Behavioral Therapy for GI conditions

Targets unhelpful thought patterns and avoidance behaviors specific to GI symptoms

Biofeedback

Uses real-time physiological signals to help patients recognize and regulate gut-related stress and autonomic responses.

Nervous system regulation approaches

Includes somatic therapies, breathwork, and vagal tone exercises

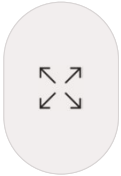
The common thread:

All aim to modulate the gut-brain axis, reduce threat perception, and build resilience without restricting food.

When Fear Drops, Diet Works Better

Lower anxiety

Patients approach dietary changes with curiosity, not fear



Greater tolerance

Reduced visceral hypersensitivity means foods are better tolerated

More flexibility

Patients can adapt diet without rigid adherence or catastrophic thinking

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When gut-brain work precedes dietary intervention, diet becomes a tool—not a threat. Patients can experiment with modifications from a place of safety rather than fear. Reintroduction becomes exploration rather than exposure therapy.

This Is About Long-Term Outcomes

We cannot measure success solely by symptom scores at 12 weeks.

We must also measure:

- **Quality of life** — Are patients living fully, or living smaller?
- **Food confidence** — Can they eat flexibly, or are they trapped by rules?
- **Participation in life** — Are they travelling, socializing, thriving?
- **Psychological flexibility** — Can they adapt to challenges without catastrophizing?

Thank you for listening today!

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