The IBS Toolbox: Diet, Lifestyle, and Gut Health with Kate Scarlata, MPH, RDN (ep – 40)

[00:00:00] **Kate Scarlata:** There was one survey study that was done with IBS patients, and they asked how much of their remaining life would they give up for a treatment that would offer symptom relief. And they were willing to give up 25 percent of their remaining life. For that treatment might not be life threatening, but it's completely life debilitating.

[00:00:29] **Ginger Hultin:** Welcome to the Good Clean Nutrition Podcast. I'm your host, Ginger Hultin. I'm an integrative registered dietician nutritionist. In the last episode, we talked with Kate Scarlata. Host of the Gut Health Podcast. She is a registered dietitian nutritionist with a master's in public health and she's a gut health nutrition expert.

If you missed it, I highly recommend taking a listen. We went deep on gut health and how your microbiome affects your overall health. And she gave some really incredible tips about diet and fermented foods, and we talked about probiotics, too. Today, we're talking with Kate about IBS. And I have to say, whether or not you personally have this condition, I imagine someone that you know does.

It's a lot more prevalent than you might know. So we're going to explain what it is, symptoms, and treatments, and how we can get past the stigma that people that have IBS often have to navigate. But first, as I was thinking about this topic and IBS and all the patients that come to me affected by it, it reminded me of a client that I had that I just can't get out of my mind because she developed this very disordered relationship to food because she had undiagnosed SIBO, which is small intestinal bacteria overgrowth, and we talk about it in the episode, and she had these really severe IBS GI issues, but nobody was taking her seriously.

She got to the point when she came to me where she could hardly eat anything. And she still was having this belly bloat. And she said every day, when I wake up, I feel normal and throughout the day I end up looking like I'm pregnant because my belly is so big and I'm so uncomfortable and in pain. And I'm telling you, she went to everyone.

She saw specialists. She went to doctors and naturopaths and Gastroenterologist. And when I met her, she was telling me a little bit about her history and how she had had all these symptoms develop after she had a very severe bout of gastrointestinal food poisoning. So I said, go to your team and ask them about SIBO testing.

She tested positive and then finally she had a path forward to treatment. So what I see a lot is people really suffering with severe symptoms and some of my patients are getting passed around from place to place and the whole time they're suffering. So I just want to acknowledge that this is so real.

It affects people so profoundly and a lot of times patients have to advocate fiercely for themselves and I really like to help them do that as part of my nutrition practice. So Kate, IBS, which is Irritable Bowel Syndrome, is the most common GI issue.

[00:03:09] **Kate Scarlata:** It is. It's the most common reason that patients seek guidance from a gastroenterologist.

[00:03:16] **Ginger Hultin:** The people that choose to speak up, like we've been encouraging.

[00:03:19] **Kate Scarlata:** Correct. A lot of people live in silence, that's very true.

[00:03:24] **Ginger Hultin:** I am getting flooded with more and more people coming to me. I specialize in health mysteries and in the confusing aspects of autoimmune and gut health and IBS affects a lot more people than I think folks realize. 40 million Americans.

[00:03:42] **Kate Scarlata:** 40 to 45 million. It's a little variable because IBS is diagnosed using the Rome Foundation criteria, which changes, and so they're working on right now the fifth iteration of the Rome Foundation criteria. And so, depending on that criteria, the prevalence can go up a little or down a little bit.

[00:04:05] **Ginger Hultin:** Yes, so you go to the doctor, you're having issues, pain, bloating, diarrhea, constipation. Can you talk us through how you're going to get diagnosed, like what is the Rome criteria all about?

[00:04:16] **Kate Scarlata:** So it just really defines the diagnostic criteria, which is presence of abdominal pain and alteration in bowel habits.

Shape and form and frequency. And then we classify different types of IBS based on what the majority of the stool consistency looks like. So if it's more deer like pebbles, Infrequent bowel movements, that's going to be IBS C, constipation predominant, versus someone that would have very watery, loose stools, which would be diagnosed with IBS D.

And then there's a mixed subtype and also an unsubtyped if they really can't fit them into a box. And then there's also post infectious IBS, which we're learning when people have episodes of gastroenteritis, even norovirus, foodborne illness. Parasitic infections. About 13 percent of people that have those types of infections will go on to having what we call post infectious IBS.

And it affects more women for some reason. The more severe the illness. Some people will have foodborne illness and maybe be sick for a short time. Those that are really sick and down and out might need IV fluids, for instance, they're more likely to go on to that post infectious IBS diagnosis.

[00:05:37] **Ginger Hultin:** So it can happen for a lot of different reasons. Is there a hereditary component? Can this run in families?

[00:05:43] **Kate Scarlata:** Yes, there is a hereditary component. So particularly between the mother and child, so there is an increased risk if you have a, particularly your mom, a genetic link there. They're not sure fully if it's genetics or that the fact that we all are living in that same environment, but for now they've classified it as genetically.

[00:06:06] **Ginger Hultin:** So interesting. Can you explain the science of IBS? Because for so long, I feel like people say, oh, IBS is just a catch all, or they're telling me I have IBS because they don't know what else is wrong. But I don't think that's true.

[00:06:22] **Kate Scarlata:** I don't think that's true either. Although I do think we are going to find a number of other conditions that mimic IBS that we just haven't fully explored.

The truth's in the middle, I think. But IBS is a motility disorder. Some people will have a fast moving intestine, others will have a slow moving intestine. It's associated with what's called visceral hypersensitivity, and this is when the gut is particularly sensitive to stimuli in the gut. So what they've learned with IBS patients, this is a terrible experiment, but they put like rectal balloons in the colon and IBS patients experienced greater amounts of pain quicker than people that didn't have IBS.

And then now we're really understanding that there appears to be this altered gut microbiome piece of it as well, especially associated with that post infectious IBS scenario.

[00:07:20] **Ginger Hultin:** I'm getting so many folks that are suffering from small intestinal bacterial overgrowth, commonly called SIBO. Can you explain how that overlaps with IBS?

[00:07:30] **Kate Scarlata:** Absolutely. So there appears to be in the post infectious IBS model, some work with Dr. Pimentel's group at Cedars Sinai, that when they've looked at those patients, It appears that the motility in the small intestine is impaired. So I always liken this to if you're looking at a bubbling brook, it's clear, everything's looking beautiful.

If you look at a stagnant brook that's not moving like the way it should, there's a lot of algae growth, right? So seeing that movement and motility is protective against SIBO and this post infectious model appears to really. Change that movement. We also, in the data, have seen that people that live with Irritable Bowel Syndrome have less of the Phase 3, all right, bear with me, I'm getting science y, Migrating Motor Complex, and this Phase 3 A migrating motor complex is what we call the housekeeper of the small intestine and it will initiate this not peristalsis like movement through the gut that we all know about.

This is really like a wave that clears out bacteria, clears out excess food in the small intestine and individuals with IBS have less of those. Again, this may contribute to that overgrowth of microbes. Because the food isn't being moved out, the microbes aren't being moved out and they have this opportunity to feed and fester and grow and take over that small intestine.

The symptoms of SIBO mimic that of IBS, and we know that there is some overlap. SIBO? Remains to be seen, but definitely people with IBS are at greater risk for having small intestinal bacterial overgrowth.

[00:09:28] **Ginger Hultin:** It is really challenging. And when I'm hearing things like quote unquote, pregnancy blow, you know, I'm very bloated, but I don't have any other symptoms or these symptoms happened all of a sudden, I will refer out and say, Hey, like, can you talk to your gastroenterologist?

Can you talk to your doctor about SIBO testing? And some of them, my doctors are really open to it and say, yeah, great. And some are like, nah, I'm not going to do that. What are you seeing out there in the environment right now? Okay.

[00:09:54] **Kate Scarlata:** There's definitely that non-believers in SIBO and then believers in SIBO, and it drives me a little bit crazy because it's a true condition.

It's in the medical literature, and I feel it's gatekeeping and not really providing patients with the opportunity to go assess for something that really is a challenge to live with. When they've looked at the role of rifaximin, which is a non absorbable antibiotic that's commonly used. to treat SIBO, 40 percent of people get better on this antibiotic.

That's better than most IBS treatments. So you can't really look the other way if you're really looking at the science. So I'm concerned for those patients that are out there that I'd say, find another provider that's a little bit more open.

[00:10:46] **Ginger Hultin:** Yeah, I, I'm advocating for the same thing. There's so much misinformation and confusion, I think, because we're in this bit of a nebulous world where some people quote unquote believe in it and some people don't.

Though, like you said, it's in the literature. This is real. It affects people hugely, especially quality of life. But what I tell my patients, SIBO is treated with antibiotics, and they often, like, don't believe me or don't want to hear that because they're like, well, antibiotics can cause SIBO. How come we're using them to treat it?

These are non-absorbable. They're active in certain places in the body. Can you talk a bit more about the rifaximin, xifaxin?

[00:11:24] **Kate Scarlata:** Yeah, absolutely. So rifaximin works really most effectively when bile acid is present and so that's in the small intestine primarily because most of the excess bile acid will get absorbed out into the liver and the enterohepatic circulation through the ileum.

So, in the small intestine, that's where the bile is, and rifaximin works very well in that bile enriched environment. So, in the colon, there's less bile, it'll work less effectively. It appears to be fairly safe in the colon. colonic microbiome seems to really bounce back pretty well. So I feel of all the antibiotics, it's not this broad spectrum.

It's not really targeting the colonic microbiome. That's not to say that they're not affected because some of it will affect them. It's not absorbed into the system, so that's an additional benefit. It's not getting into your bloodstream, for instance. Would I throw it out like candy? No, I think it needs to be used appropriately.

And I think to your point of some providers not treating, there's the other providers that are giving out rifaximin like jelly beans. So the truth's in the middle somewhere with how we should be treating this, but antibiotic therapy is the most evidence based treatment at this time.

[00:12:40] **Ginger Hultin:** That's what I have been telling folks to, and I think there's a lot of confusion about it, but the fact that it is active with bile acids is fascinating.

There is a high rate of stigma that can be associated with GI issues, with IBS, like you and I have talked about, it's important to speak up and to talk more about it. And you've done a lot of work in that space with your hashtag, I believe in your story campaign. And I see that all over your Instagram and your social.

Can you tell me more about why you started that?

[00:13:09] **Kate Scarlata:** Yes, because you know, I've been working with IBS patients for 30 years, and many of them are not believed. Not taken seriously. Gas lit. And it's just such an unfortunate place to be when you feel really miserable. And I wanted to start the I Believe in Your Story campaign to really raise awareness of IBS.

Make people feel that they could share their story in a safe place, and I shared a lot of stories on my blog. We use the I believe in your story hashtag a lot during April, IBS Awareness Month, but to your point, a lot of people were living in silence. It's very difficult when you go in and say I have all these symptoms and the doctor says you're stressed.

Just cut down on your stress. See you later. And a lot of patients have gotten that. So that was sort of the impetus of that. It is highly stigmatized. Patients feel stigmatized. Providers are stigmatizing. So that's been documented and hopefully it's being taken a little bit more seriously as we really understand the complexities of this condition.

I believe that we're seeing changes. I always say the poop emoji was a huge breakthrough because we're just using the poop emoji more and people are talking about poop and poop habits like whatever. It's so different than just 10 years ago. So it's looking up but it is a very highly stigmatized condition and we just want to make patients feel heard and get what they need.

[00:14:48] **Ginger Hultin:** I'm really glad that you are empowering people in that way, and part of that campaign is also to raise some money for IBS

research, and like you said, we need more research so that people are more believed and we understand it better. Why is there a limit in research if it affects so many people? Good question.

[00:15:07] **Kate Scarlata:** I wonder about, and I hate to say this out loud, but just pharmaceuticals and lobbying because bigger money is an inflammatory bowel disease than IBS. And I don't know if this is the money thing. This might be a little controversial discussion. But when we look at NIH funding for IBS, it's about 11 cents per person is the amount of money that goes into the research funding.

There's a lot of people affected by this condition, but for whatever reason, it is always been underfunded. And I think possibly also because IBS is not life threatening, where IBD and other conditions that maybe get a little more funding do have a higher risk of impacting mortality, but I will say that when you look at IBS and living with IBS, there was one survey study that was done with IBS patients, and they asked how much of their remaining life would they give up for a treatment that would offer symptom relief.

And they were willing to give up 25 percent of their remaining life for that treatment. Might not be life threatening, but it's completely life debilitating. And I think that's really important for people to realize and I would hope that more funding would be put in this very difficult condition to understand it better.

[00:16:38] **Ginger Hultin:** I can definitely say the people that come to me that are struggling, they, they tell me they can't live a normal life. They're very stressed by this. It creates more stress and then that can make the symptoms worse. They don't know what to do or who to turn to.

[00:16:50] **Kate Scarlata:** Yeah, exactly. And we're learning in IBS research that just a gastroenterologist Treating an individual versus a team, a registered dietitian, a GI psychologist, and the gastroenterologist.

The multidisciplinary team has much greater efficacy. So it's a complicated disease that really does require a team approach, not a single provider approach.

[00:17:18] **Ginger Hultin:** And you talk about that in your new book, which came out this year, Mind Your Gut, and that's an incredible resource. And you highlight in that book, multidisciplinary approach and putting together your dream team.

Can you talk me through again who that is, where you could talk in dietitian, physician who knows a lot about GI. And tell me about the Mind Gut Connection.

[00:17:39] **Kate Scarlata:** Yeah, so now there's a new sort of area of psychology called a GI psychologist expert. And so when Dr. Megan Real, who's a GI psychologist at Michigan Medicine came to me with, let's partner.

And I thought, you know what, we should, because there's no book that really looks at the role of the GI psychologist. as well as the nutritionist, as well as the GI provider. But to your question, other really key component in your dream team, I would say is a pelvic floor physical therapist, particularly when, in my experience, in those constipated patients, Because they can have a condition, about 50 percent of them have a condition called dysnergic defecation.

And I call that opposite day. It's when your nerves and your muscles work against you to have a normal bowel movement. They get tight instead of relaxed. And it's a learned kind of behavior. that really can benefit from pelvic floor physical therapy. Huge, like I can't even tell you how helpful for so many of my patients.

We also might have a social worker or other pieces of the team, but primarily the psychology, the dietician, the GI provider, and I would say the fourth key one is the pelvic floor physical therapist.

[00:19:05] **Ginger Hultin:** That is a dream team. And I wanted to hear from you how you define the role of a dietitian and the importance of our work.

[00:19:13] **Kate Scarlata:** It depends on the patient because IBS is so heterogeneous. So for some people the dietitian is going to be the leading role provider. So those are the patients that are really food sensitive and that's many of them. And then there's some that are very stress oriented IBS patients, and that's where maybe the leading role would be more the GI psychologist.

So I would really describe myself in my role and the role of the dietitian is one to help the patient have a really healthy relationship with food, expand the diet to their personal tolerance, understand the art and science that goes into looking at their diet, looking at their food records.

understanding when they do get symptomatic and try to tease out what you anticipate as potential problematic foods for them and carefully create a specific dietary plan to help determine which those, you know, intolerances are. People definitely have intolerances. It's not everyone, but we need to kind of work with

the patient to really figure out what's going to work for them so that they can have the most liberal diet possible.

That's well balanced, that allows for a healthy relationship with food. That also manages their symptoms.

[00:20:38] **Ginger Hultin:** It's no surprise that Orgain is America's number one plant-based protein powder brand because their products are really delicious and made with clean ingredients. I love their organic plant-based protein powder for my clients because it tastes amazing and it's also packed with nutrients.

It comes in a large variety of flavors and offers. To 21 grams of high quality plant protein. It has a complete amino acid profile. There's no added sugar and no artificial sweeteners. Visit orain.com to learn more. What I find is my patients come to me and they've met with a doctor that said, Hey, you have IBS go on a low FODMAP diet and here's a handout.

Have a nice day. And what I say as a dietician, I'm the how to person I help take that. Very complicated diet to follow and help you make a meal plan and help you strategize. Like you said, figure out what are your low FODMAP issues and what's okay. And how are you going to spread it out throughout the day and just really bring in that personalization and education.

And it just takes so much stress and worry off. I want to talk about the low FODMAP diet because it's commonly prescribed for SIBO and for IBS. And I just want to like break it down and, and just hear from you how you overlay that and what you think about it.

[00:21:57] **Kate Scarlata:** Yeah, so I have to say, you know, I was one of the first people to really learn about the low FODMAP diet.

I went down to Australia, learned from Monash University researchers. It made a lot of sense to me and I said, Oh, these foods are always common triggers. How can we apply this science? So the low FODMAP diet, FODMAPs are a group of commonly malabsorbed carbohydrates and fibers and the diet itself has been shown to be effective in 50 to 80 percent of people with IBS.

It's not for everyone. If there's a history of an eating disorder or food fear is really a big, glaring problem for an individual. I want to move away from diet therapies because I don't want to trigger or re trigger eating disorder or restrictive eating. So we have to be careful. It's not one size fits all.

But for the right patients, I would embark. on two approaches. One of them is science based and one of them is clinically based. So no science, but we're learning and it's getting researched. So the first is the three phase low FODMAP elimination diet. And this is where we remove all high FODMAP foods in the sort of elimination phase, which lasts about two to six weeks if they're feeling better.

Then we would transition them to the reintroduction phase. This is where we systematically add back certain FODMAP subtypes like lactose, for instance, is an example of a commonly malabsorbed sugar. It's a disaccharide, the D in FODMAP. We would add some lactose back, see if the individual tolerated it or not.

And we go through all the different types of FODMAPs. So excess fructose is another example. We'd go through foods that have only excess fructose to assess whether the patient got triggered with symptoms or not. I always tell patients too, when they're going through this reintroduction phase, it's normal to get a little bloating.

It's normal to get a little gas. When you're reintroducing foods, that have fermentable carbohydrates, that's what's going to happen. But if those symptoms are problematic, they resemble an IBS flare, then, hmm, this might not be the food for you. We might take it out for a little while. And then the last phase of the diet, once we've kind of gone through all the different types of FODMAPs, We would do the personalization phase and that's when we add those foods back on to their more liberal diet and off the patient goes.

We can re challenge and re test FODMAP tolerance again in three to six months if they want to because tolerance to FODMAPs can change over time. The microbiome can change even through menopause it can change. So It's always good to kind of retest. Stay curious. I always tell patients stay curious with food and don't keep feeling like everything's off the plate forever.

Yeah. That's how I approach the low FODMAP diet. So that's the more restrictive. In clinical practice, what I'm using more and more is what's called a FODMAP gentle diet. And this is a very art and science approach where the dietician will really look at their 24 hour recall, get a sense of what the patient's eating, get an understanding of when the patient is getting symptoms, get an understanding of what the patient thinks is problematic for them, and then cherry pick out common high FODMAP foods.

Just to give you a quick scenario, I had an elderly woman came in, she was having IBSD, so diarrhea predominance, and had some breakthrough fecal incontinence. It was not a good way to live. She was having a rush to the

bathroom, not always making it. And when I looked at her diet, she had a ton of apples.

apple juice, applesauce, just it was a regular show in her diet. And apples have a number of FODMAPs. They have sorbitol, which is pulls water into the gut. They have excess fructose, which pulls water into the gut. And so I thought, you know what, let's just make some substitutions. Well, she was taking applesauce with medications, we switched out to yogurt, we found a different beverage for her to drink instead of apple juice, and voila.

She was fine. She still had diarrhea occasionally, but she wasn't having these urgent episodes. She could get out again, and that was good enough for her, and that was good enough for me, and I didn't have to do a major overhaul. I do the FODMAP Gentle in kids, when they're just developing eating habits where we think and suspect that FODMAPs are a player.

It's just a much more liberal diet. It is being studied now, so we'll see the actual evidence, but in clinical practice, it can work, and it's a less restrictive approach, which, you know, dieticians want less restrictive, and it works better for food quality of life and a number of other measures.

[00:26:45] **Ginger Hultin:** That's a really powerful story, and that actually is the approach that I take, and I didn't know that it was an actual approach, but it is more inclusive and less stringent and can work for a lot of people.

Yes. I have a lot of folks that ask me, what is this FODMAP anyway? And you defined it, it's fermentable carbohydrates, but for anyone that's interested, it's fermentable oligo, di, monosaccharides, and polyols. And after I say that tongue twister, that's when I say And that's why we call it FODMAP. Beata.

[00:27:14] **Kate Scarlata:** Exactly. And don't worry about those crazy words. I always say too that, you know, many of the FODMAPs are osmotically active, so they pull water into the gut and that can cause diarrhea or cramping. And they're also, because they're small, they're fast food for our gut microbes. So they can create gas really quickly with it, which a lot of IBS patients can relate to because they're gassy and bloated.

And so, So that's just another, like, quick way to describe them. I did want to comment to one thing you said, though, because I think sometimes doctors will give the one page sheet and then they send them to you, and then you might look at it and say, geez, this patient has an eating disorder. They're not appropriate.

And now the doctor has said this. So I'm really encouraging physicians that are listening. Or just dietitians that work with physicians. Try to encourage them to let you make the diet choice and not provide that diet recommendation because it might not be appropriate and then it's really hard to dial it back once the diet's been mentioned.

[00:28:16] **Ginger Hultin:** When people get given the low FODMAP, it's not usually one page, actually. It's usually a packet because this is a very complex diet because there's different foods in different categories that fall into all the different words within FODMAP. And my patients just get so frustrated because they're like, well, why can't I have 10 pecan halves, but not 15.

You know, you can have maple syrup, but not honey. Like that's so confusing and the portions are so important. You did mention your work at Monash and I recommend them in general and their app specifically almost every day. Could you just define Monash and what they do and who they are?

[00:28:53] **Kate Scarlata:** Yeah, so Monash University is in Melbourne, Australia, and they're the first group that kind of collectively looked at these short chain carbohydrates.

and their impact on IBS. So we knew like lactose was a problem. We knew that if you ate a ton of sugar free gum and mints, you might have diarrhea. But they took all of them and put them into a dietary approach. And they've done the bulk of the research in this area, and they do have the app, which can be very helpful, especially for clinicians, really kind of seeing the updates and things that are happening there.

But they've really came up with this concept, they're the pioneers, and I think we're going to see the low fermentable diet being part of IBS management, but I do see that we're going to see some changes, and that maybe we were a little too restrictive. of. at the get go. And I'm hopeful that we'll still be modifying FODMAPs, but more into this gentle approach, which I think will just be better altogether for dieticians that are educating, as well as patients that are embarking on this.

[00:29:58] **Ginger Hultin:** It is really hard because, like you and I have both highlighted, the quality of life can be hugely disruptive. It's so confusing. A lot of people don't believe you. You're having all these symptoms. And we know that about a quarter of people with GI issues display some signs of disordered eating, some people moving into full on eating disorders.

I do fear for people that have had eating disorders, and then they get put on this restrictive diet, I think that can be so damaging and we need to be really careful about that. But then I also think I'm seeing people that don't have disordered eating start to develop fear of food and food avoidance.

I'll hear people with IBS or SIBO say, I just don't want to eat anything because I don't know what to eat and I'm scared. So then I feel like they're getting pushed into disordered eating.

[00:30:42] **Kate Scarlata:** I don't know if it's the diet that's causing that. Is it social media that's recommending certain crazy things? Is it the fact that eating hurts and it's an adaptive response?

I'm actually working on a paper with a bunch of experts in this area because it is complicated and I, I am worried about patients not being provided a low FODMAP diet when that might really be life changing for them because of this fear of disordered eating. But on the flip side, I don't want to encourage or be part of the story of encouraging eating disorder.

Thank you. There's a number of factors that are bringing our patients to what you just described. For instance, you have someone with SIBO, everything's fermenting in their small bowel, there's no stretch to that small bowel, you know, there's stretch, but it's small, right? And so the gas and the cramping and the upper GI symptoms, and then they go to a provider that says, Oh, I don't believe in SIBO.

And so then they go to an alternative provider and say my doctor doesn't believe in this and that doctor says oh you need to go on a keto diet and I think you also have candida and you have histamine intolerance and then they give them six foods that they can eat and so is that the patient's problem or is it more of an upstream problem where we're just not really caring for these patients in a comprehensive way?

Patients are getting to that point of food fear, but I think there's a number of factors that are leading them there. And part of that might be some of this gatekeeping, where they're not really getting what they need. So this needs to be teased out, but what we are seeing is there is a risk, there's a risk of disordered eating, there's a risk of food fear in this patient population, and we need to walk carefully. And we're, we're learning and figuring out the best way to manage these patients.

[00:32:45] **Ginger Hultin:** Dietitians are sensitive to relationship to food, and I also talk a lot about relationship to body. You're very good at that, I believe,

across the board, and I love that you pointed out People that don't have dietary training, like doctors, they're a critical part of the team, and they probably shouldn't be prescribing the dietary changes, like that's a great referral out to us, and then if people do have disordered eating or eating disorders or fear of food or problems with relationship to food with the low FODMAP diet, that psychological aspect to the multidisciplinary team becomes even more important, I would say.

[00:33:19] **Kate Scarlata:** Absolutely. Yeah. And same with the GI psychologist. You know, sometimes doctors will say, Oh, go see a GI psychologist. You'd be great for gut directed hypnosis, which is an evidence based therapy for IBS. But if you have a history of trauma, it's often not indicated. So the trains left the station and then the GI psychologist is like, Sorry.

Yeah, you can't have that treatment. So again, I think just trusting in the team members to make the right decisions. in their reign of expertise, right? So we're moving in that direction. We really are. And I think that'll be better for the patient.

[00:33:56] **Ginger Hultin:** Yeah, it really does take a team. I'm seeing that more and more.So you have IBS, you're suffering with the symptoms, you're getting treatment and moving through it, maybe struggling with relationship to food or not. IBS and Have them care for themselves during the treatment time.

[00:34:18] **Kate Scarlata:** Identifying what that individual needs for self care. It might be that they're sitting at a desk 24 seven and you get them to get out and do a little forest bathing.

It might be that they're saying yes to everyone in their life and there's no time for themselves and figuring out some time that they can meditate or do something that fills their cup with joy. I have some patients, for instance, that are just so stress overloaded that you need a GI psychologist to really dial this in and give you the tools that you need.

So in IBS, a lot of those types of behavioral therapies, it might be An app, you can get an app to do gut directed hypnosis. So if the provider says, no, you're cleared, you should do gut directed hypnosis, Nerva is an app that a patient can download. There's cognitive behavioral therapy apps that are evidence based for IBS.

So even without the providers, there are things that individuals can tap into. And just, this is a little aside, but very interesting, there's data shown to improve

IBS symptoms with the virtual reality. So there's a virtual reality IBS program that you can get a virtual reality set from Apple and upload software and it brings you into a whole outer stratosphere.

I did it and I thought I was going to last 10 minutes. I was in there for 45 minutes going, this is the coolest thing ever. So. I think the toolbox for patients is becoming so big, and it's exciting to see that really expand.

[00:36:03] **Ginger Hultin:** It is. Logistical, time consuming, and a labor of emotion also when managing IBS.

It is really, can be all encompassing. So I love that you're focused on the tools that are available, the evidence based options, putting a team together, believing people's stories, and also focusing on self care. And food while you're navigating IBS, I think sometimes that's for a short period of time, maybe you're getting SIBO treatment or what have you, and sometimes it's for a longer period of time.

I feel really empowered and I hope that anyone listening that struggles with IBS and is feeling really challenged and hopeless that they see a path forward and understand that there might be more options than they previously thought.

[00:36:51] **Kate Scarlata:** Absolutely. Like I said earlier, 30 years in this business where we were giving high fiber diets to everyone with IBS and wishing on a prayer that they'd get better and none of them did, of course.

We have come so far and there is such an interest in this space because the microbiome is involved and the research is just expanding daily. So there is a good reason to feel hopeful. Find your dream team. They're out there. You can put them together yourself or maybe your gastroenterologist can get you aligned with the right team as well.

And just know that the treatments are so much better than ever. And many people are living and thriving despite their IBS diagnosis. And I always say to my patients, you know, when they're making a decision, I'm not going to go to the movies. I'm not going to go on that trip. I'm not going to do that, that, you know, don't let IBS win.

It doesn't have to win. So sometimes making those decisions, you go on the trip and maybe you modify the trip a little bit. It That's okay. Maybe you bring all your food. That's okay. But don't fully let IBS win. Don't make your life smaller. The goal of all the therapies for IBS is to make your life bigger and funner and more fulfilling.

And that is very possible in 2024 with all the multidisciplinary treatments that we have right now. There's a lot to be hopeful for.

[00:38:27] **Ginger Hultin:** And we have your gut health book, Mind Your Gut. We'll put that link in the show notes for sure. And then I will be listening to your podcast because we need it so badly.

Thank you for launching it.

[00:38:38] **Kate Scarlata:** Yes. Thank you for mentioning it. I appreciate it.

[00:38:44] **Ginger Hultin:** Our show is sponsored by Orgain and produced in collaboration with Larj Media. That's L A R J media. Thanks for listening to this episode of The Good Clean Nutrition Podcast. To stay up to date on the latest podcast episodes, be sure to subscribe.

And if you want to submit a voice message with a question or comment about the show, please visit healthcare.orgain.com/podcast to record your message. And if you like this podcast, I'd love for you to let us know. You can rate and review this show on Spotify and Apple Podcasts, or you can give us a thumbs up on YouTube if you're watching right now. I'm your host, Ginger Houlton. You can find me online at gingerhultinnutrition.com. Thanks so much for listening.