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Review

A systematic review of minimal-contact psychological treatments for symptom management in Irritable Bowel Syndrome

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ABSTRACT

Objective: Psychological treatments are effective in alleviating symptoms of IBS but are not widely available. The need for wider dissemination of treatments has encouraged the development of 'minimal-contact' therapies requiring fewer resources than existing psychological treatments which rely on face-to-face contact.
Method: Using comprehensive search terms, the Embase, Medline and PsychInfo databases (all years) were searched.
Results: Twelve studies – nine RCTs and three non-controlled preliminary studies – meeting inclusion criteria were reviewed and assessed for quality using objective criteria. Apart from one study of expressive writing, all interventions were based on cognitive (and/or) behavioural principles or hypnosis and tended to be adaptations of existing therapist-led interventions. Compared to control conditions, minimal-contact interventions were efficacious, the majority of studies showing statistically significant improvements by the end of treatment. For cognitive-behaviour-therapy-based interventions effects sizes were large. The two studies that compared minimal-contact with therapist-delivered interventions broadly suggest comparable outcomes between these modalities.
Conclusions: Minimal-contact cognitive–behavioural interventions show promise in the treatment of IBS. Because of the lower quality of studies of hypnosis and those involving interventions delivered entirely remotely, further support is needed before such approaches can be recommended for widespread use. More generally, future research should use representative samples, active control conditions, and intention to treat analysis. Nonetheless, existing high quality studies suggest that minimal-contact therapies may be a safe, effective means of achieving scaleability of psychological treatments for IBS.

Introduction

Irritable Bowel Syndrome (IBS) is a chronic functional gastrointestinal disorder characterised by recurrent episodes of abdominal pain or discomfort, bloating and altered bowel habits in the absence of detectible organic disease [1]. Psychiatric comorbidity is common [2].

Up to 11% of the populations of most countries are affected by IBS symptoms [3]. Of these at least 30% seek medical advice [4]. Since IBS is a chronic condition for which there is no 'cure' [1], this level of healthcare-need represents a substantial burden on services [5,6] which is unlikely to be met with existing models of service delivery.

Recent treatment guidance emphasises the need for clinically- and cost-effective management in primary care through lifestyle/dietary advice and pharmacotherapy and/or psychological interventions where appropriate [7]. At primary care level such interventions need to be acceptable to patients and ideally, easily implemented and highly scalable.

Psychological approaches to IBS symptom management

In line with the aim of reducing impairment caused by a chronic condition, self-management approaches are recommended for IBS patients [7]. While some of these emphasize the provision of supportive counselling or encourage life-style changes, others are more formally grounded in psychological theories of behaviour change [8]. Given the high levels of mood and anxiety disorder in IBS [2], treatments that target psychological distress as well as IBS-specific symptoms of pain and gut dysfunction may be especially appropriate for achieving positive outcomes in the range of symptoms present in IBS.

Psychological treatments emphasise active coping through systematic changes in behaviour and thoughts which are believed to exert a top-down influence on gastrointestinal functioning [8]. The aims of treatment include refocusing of, testing IBS-related beliefs and changing the *meaning* of symptoms and related sources of distress that contribute to symptom expression [1,7]. The predominant mode of delivery of psychological treatments for IBS is the traditional 'face-to-face' encounter involving a variety of therapeutic modalities, including cognitive and/or behavioural, interpersonal therapy or hypnosis [7,8]. Such approaches

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have considerable advantages over purely self-guided treatments (encouraging, for example, ongoing symptom monitoring and careful shaping of between-session self-help behaviour) and may remain the most desirable for those with the most severe symptoms and co-morbidities. However, as Wilson and Zandberg [9] note, such a resource-intensive model of service delivery is, by a considerable margin, incapable of providing sufficient access to evidence-based treatments to all those who need them.

Alternative treatment models: minimal-contact psychological treatments for IBS

Minimal-contact psychological treatments [10–12] place a significant emphasis on self-management of symptoms. Contact with health care professionals varies but is generally limited to a small number of face-to-face sessions (or possibly, none at all), supplemented or replaced by computer-assisted therapy, telephone and/or online support. When optimised, these modes of treatment delivery are likely to produce considerable efficiency savings and allow for wider dissemination, especially to under-served communities.

The distinction between non-psychologically guided self-management approaches and those based on formal psychological models is an important one. For example, while self-guided approaches lacking a psychological basis – for example stress management and/or dietary advice – may be efficacious, psychological-based interventions can 'add value' (e.g. [13]). Minimal-contact therapies often form the first rung within 'stepped care' models of psychological service delivery [14] which predominate in the UK and Australia [15]. Stepped care involves tailoring the 'intensity' of the treatment to the presenting disorder and its severity, with the aim that milder presentations (those causing relatively mild levels of distress and impairment) with limited co-morbidity are treated with fewer face-to-face sessions, guided by an associate-level practitioner (i.e. one who is not fully accredited in Clinical Psychology or allied professions). Other important considerations include choice and convenience for the client: the flexibility engendered by these approaches mean that clients can often engage in treatment without significant disruption of their work or other daily activities. Even 50–60 minute long telephone-based therapy sessions intended to closely mimic/match face-to-face sessions in content and interaction with a therapist potentially entail very significant opportunity cost savings for the client (e.g. in time spent travelling to the therapist's office/absence from work).

Recent reviews outlining evidence for minimal-contact psychological treatments [16–18] conclude that for milder anxiety disorders and depression such treatments can be as effective as face-to-face treatments. Other reviews [19,20] and meta-analyses [21,22] suggest that even purely self-administered psychological treatments are effective, particularly for anxiety problems.

Minimal-contact psychological interventions may also be efficacious for a variety of physical symptoms and their psychological concomitants including tinnitus, [23]; headaches [24]; insomnia [25]; chronic pain [26] and obesity [27]. Cuijpers et al. [28] reviewed the literature on internet-delivered treatments for health problems and concluded that on a variety of outcomes for headaches and chronic pain the effects for internet-based cognitive behavioural therapy (CBT) were comparable to face-to-face treatments. Even substance use disorders, which have traditionally relied on case-management or multimodal treatments (e.g. pharmacological, and individual/group psychotherapy) are amenable to minimal-contact interventions, which show some promising outcomes [12].

Given these findings and the fact that existing empirically-supported face-to-face psychological treatments for IBS already tend to emphasise self-management strategies [29], it is unsurprising that minimal-contact treatments have also recently been developed for IBS. A description of these recent developments will form the remainder of this paper. In particular, we will systematically review studies of minimal-contact therapies (published up until 2011) which are linked by the relatively limited number of direct therapist contacts compared to predominantly therapist-administered psychological treatments.

Influenced by Glasgow and Rosen [30] and Newman et al. [12], in our definition of 'minimal-contact' we included studies involving: (1) *pure* or *predominant self help* (with therapist contact for assessment at most), (2) *guided self help*, in which limited and/or brief therapist contact occurred for the purposes of clarification of self-management strategies/homework assignments, and (3) *reduced/remote contact treatments*, in which the 'dose' of face-to-face contact is *substantially* reduced compared to predominantly therapist-administered treatments (reviewed in Lackner et al. [8]). The latter category includes studies whose purpose was to determine whether efficacy is retained through substitution of direct (face-to-face) contact with remote contact [11,31]. In addition to service-level efficiency savings, this latter category of minimal-contact intervention may have high acceptability for clients for the reasons outlined above.

This is the first review of its kind to specifically focus on minimal-contact psychological interventions (as defined above) for IBS. A comprehensive review of psychological treatments by Lackner et al. [8] concluded that psychological treatments as a whole were more effective in reducing symptom severity than a pooled group of control conditions. A more recent review examining antidepressants and psychological therapies similarly concluded that psychological treatments are efficacious compared to control treatments, although concerns were raised about the quality of studies [32]. Because these reviews predominantly focused purely on therapist-guided face-to-face interventions, and taking into account the recent therapeutic and technological advances, it is timely to examine the efficacy of minimal-contact therapies involving a range of psychological therapy modalities in IBS sufferers. At this relatively early stage of evaluation of these therapies, it is appropriate to examine both randomised controlled trials (RCTs) and non-RCT designs.

Method

Search methods for identification of studies

A systematic computer-assisted search of Embase, Medline and PsychInfo databases (all years) was performed using the search terms below. The fields "title" and "abstract" were used as limits. No other limits or filters were used.

Title/abstract search

(IBS OR irritable bowel syndrome OR irritable bowel OR gastrointestinal OR bowel disorder OR abdominal OR gastric OR functional gastrointestinal disorders OR functional digestive disorders OR functional GI OR somatisation disorder) AND (CBT OR cognitive behavio(u)ral therapy OR psychological OR psychology OR psychologic OR mindfulness OR psychosocial OR cognitive therapy OR behavio(u)r therapy OR psychotherapy OR psychoeducational OR psychological treatment OR counselling OR acceptance OR psychological intervention OR mental health intervention OR expressive writing OR intervention) AND (internet self help OR self OR self-help OR self-management OR psychoeducational OR website OR online OR telephone OR support group OR psychoeducational OR group cognitive therapy OR internet delivered OR stepped care OR group cognitive behavio(u)ral therapy OR internet-therapy).

Titles and/or abstracts of all studies identified by the search strategy ($n = 2334$) were screened for relevance. After screening out on the basis of relevance and removing duplicates, full text articles were obtained for all potentially eligible studies. Hand searching was conducted on eligible studies for additional potential papers, and corresponding authors of key research groups were contacted regarding studies that were *in press*.