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Review

Are self-administered or minimal therapist contact psychotherapies an effective treatment for irritable bowel syndrome (IBS): A systematic review ☆

Alyce Ahl [a], Antonina Mikocka-Walus [b,c,*], Andrea Gordon [b], Jane M. Andrews [d,e]

[a] School of Psychology, University of South Australia, Adelaide, Australia
[b] School of Nursing and Midwifery, University of South Australia, Adelaide, Australia
[c] Department of Health Sciences, University of York, Heslington, York, United Kingdom
[d] Department of Gastroenterology and Hepatology, Royal Adelaide Hospital, Adelaide, Australia
[e] School of Medicine, University of Adelaide, Adelaide, Australia

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ABSTRACT

Objective: Irritable bowel syndrome is a highly prevalent gastrointestinal condition that is known to be associated with maladaptive psychological coping and is extremely costly to the health-care system. Psychotherapy has been found to improve both physical and psychological symptoms in IBS. However, it is unknown whether 'no therapist' or 'minimal therapist' contact self-help psychotherapy programs are effective treatments for IBS. Thus, this paper aims to determine whether 'no therapist' or 'minimal therapist' contact self-help psychotherapy programs are effective treatments for IBS.
Methods: A search of PubMed, SCOPUS, Cochrane Library, and Ebscohost research databases was conducted without language or date restriction in July 2012.
Results: Nine relevant publications were included in the final review, all of which were randomized controlled trials (RCTs) and included an intervention that was primarily self-administered. It was found that 'no therapist' contact self-help programs are likely to have poor results due to lack of engagement in the program, whilst 'minimal therapist' contact programs appear to produce positive results in terms of symptom relief. Trends towards 'minimal therapist' contact self-help programs having a positive impact on quality of life (QOL) and psychological outcomes were evident.
Conclusion: 'Minimal therapist' contact psychotherapy programs have the potential to reduce healthcare seeking behaviour and potentially reduce healthcare costs. However, further studies need to be conducted to confirm this effect as there is poor standardisation in the measurements of the available studies.

Introduction

Functional gastrointestinal disorders (FGiDs) are highly prevalent gastrointestinal conditions, which are defined by their symptoms, as no entirely satisfactory or uniform biologic cause has yet been established. In some studies, FGiDs are associated with altered autonomic activity and thus sufferers experience heightened sensation in the gastrointestinal tract [1]. Whilst it is commonly accepted that there is a bidirectional pathway between the central nervous system and the enteric nervous system known as the brain-gut axis [2], currently no pathological cause can be found to explain FGiDs. As such, whilst FGiDs are positively diagnosed based on the presence of typical symptoms, other possible organic diseases also need to be considered and ruled out [3]. FGiDs are a significant public health concern, as no single treatment can fully resolve FGiD symptoms and health-related costs are high, due to repeated medical consultations and procedures, time lost from work, psychological distress and poor quality of life (QOL) [4].

Irritable bowel syndrome (IBS) is one type of FGiDs, estimated to be present in approximately 10% of the world population [5] and is a common reason for health care visits to physicians and gastroenterology outpatient clinics [4–6]. IBS patients are more likely to suffer from mood disorders, anxiety and neuroticism compared to healthy controls [6]. Whilst mild cases of IBS have been shown to improve with education, changes to lifestyle and diet, moderate to severe cases can benefit from psychological or pharmacological treatment, or a combination of both [7]. Research suggests that neither form of treatment is superior and instead the most important factors in successfully reducing IBS symptoms are that the patient accepts the need for treatment and is motivated to engage in it [8]. Antidepressants are commonly prescribed in IBS to target pain perception, as well as subsequent mood disturbances, and associated sleep problems [6]. However, since this line of treatment has been associated with side-effects, many patients are more open to try psychotherapy than

☆ This work was conducted at the Schools of Psychology and Nursing and Midwifery, University of South Australia and Department of Gastroenterology and Hepatology, Royal Adelaide Hospital.

* Corresponding author at: Department of Health Sciences, University of York, Heslington York YO10 5DD, United Kingdom. Tel.: +44 1904 321521; fax: +44 1904 321383.
E-mail address: antonina.mikocka-walus@york.ac.uk (A. Mikocka-Walus).

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commence a drug treatment [9]. Relaxation training, mindfulness meditation, hypnotherapy, and psychodynamic psychotherapy have all been found to be useful in treating IBS [7,10]. However, cognitive behavioural therapy (CBT) has the most evidence of a treatment effect for symptom alleviation [6]. CBT helps patients to alter their beliefs about their symptoms, and experience of pain or discomfort so they are able to cope more effectively. CBT has been shown to primarily improve bowel symptoms which in turn decreases distress and increases quality of life [11].

Despite the benefits of psychotherapy as a treatment option, it can be costly, time consuming and not easily available, as it is usually conducted face-to-face over multiple sessions. One solution to this problem are 'self-administered' or 'minimal therapist' contact psychotherapy programs. Only one study on 'self-administered' CBT [12] was included in a recent comprehensive systematic review of IBS treatments, but it was decided that there was insufficient evidence from this study alone to determine a treatment effect [6]. To date, no review of the literature has been conducted on the efficacy of 'self-administered' and 'minimal therapist' contact psychotherapy and therefore this paper aims to address this question.

'Self-administered' programs were defined as referring to the use of a previously developed resource by a psychological practitioner such as a book without any assistance from the psychological practitioner throughout the program. 'Minimal therapist' contact programs referred to the use of a resource in conjunction with small amounts of support or feedback from, or contact with a psychological practitioner throughout the program.

Method

Data source

Search locations

Electronic searches of PubMed, SCOPUS, Cochrane Library, and Ebscohost research databases were conducted in July 2012. These databases were chosen due to perceived relevance to the topic and were expected to provide coverage of the majority of relevant papers in the public domain.

Process

The key search phrases that were used in each of the databases were: "self-administered cognitive behavioural therapy AND functional gastrointestinal disorders", "self-administered short therapy AND functional gastrointestinal disorders" and "self-administered psychotherapy AND functional gastrointestinal disorders". Although the search strategy was directed at finding studies in FGiD, all studies retrieved by the strategy and fulfilling criteria for inclusion concerned treatment of IBS patients. Each of these key search phrases was entered into a particular database individually one after the other so that there was a total of three searches in each database. The results of each search were screened manually and studies were included or excluded based on their relevance after reading the title and abstract. AA conducted the searches which were later reviewed by AMW. Study eligibility was confirmed by AA, AMW and AG, with no disagreement recorded. Data were extracted from papers independently by AA and checked by AMW.

Hand searching

Reference lists from included articles were searched to identify any additional relevant studies. Automatic database suggestions of similar articles were also considered and included if they met the inclusion criteria.

Study selection

Study characteristics

Data on the design, sample size, sample characteristics, intervention, comparison group(s), types of measures, outcomes, amount of therapist interaction and follow-up period was extracted for each study.

Primary outcome measures

The primary outcome measures of this literature review were physical symptoms related directly to IBS, psychological coping in terms of anxiety and stress, and QOL. These outcome measures are all related to the physical and psychological health of the person with IBS and therefore were perceived as most relevant.

Inclusion criteria

Only randomized controlled trials were included in this review. Studies were required to focus on participants who met the criteria for IBS. Studies needed to include a psychotherapeutic intervention that was primarily self-administered with 'minimal or no therapist' contact as opposed to individual or group therapy.

Exclusion criteria

No date or language restrictions were applied. Studies which only presented economical/cost-benefit analysis of the interventions were not included in the review as the main outcome measures of interest were clinical and psychological improvements.

Risk of bias

Studies were critically appraised. The method of randomisation, blinding and selection of an adequate control group were looked at by scrutinising method sections of the published papers (see Table 1).

Results

Description of studies

The electronic database searches produced a total of 98 articles. After screening the articles to determine whether they met the inclusion criteria and were relevant, eight articles were included in this review and one was added from the hand search of reference lists (see Table 2 for a detailed description of the studies; see Fig. 1 for exclusion process). The nine articles included eight studies, as one study published its 18-month follow-up separately [13,14]. All studies that met the inclusion criteria were RCTs. The studies differed in the number of participants included in the trials, from 28 participants in the smallest to 420 participants in the largest. A total of 862 participants were recruited, excluding the overlap from the follow-up study. All participants were described as having IBS; however, studies defined this variably, using Rome I, Rome II, and Rome III criteria [15], and another using diagnosis from a specialist or GP without necessarily meeting Rome criteria [16,17].

Treatment conditions

Of the eight studies, seven identified the intervention as CBT based. The other study ($n = 420$) was described as a self-help guidebook with no further information provided regarding content [17]. Studies differed in the form of treatment with three being delivered via the internet, one through personal digital assistants, two in a booklet form, and two described as using 'study material'. The duration of therapy varied from four to ten weeks. One study ($n = 420$) provided the booklet and then proceeded to follow-up at 12 months using questionnaires and data from primary care records with no specified program duration to allow for control over therapist/researcher influence [17]. Two studies specified 'no therapist' contact [12,17], whilst in the other studies, 'minimal therapist' contact differed in terms of frequency and method (see Table 2). Control conditions varied and included waitlist (3), standard care (3) and access to a closed online discussion forum (2). Two studies incorporated a third comparison group that was exposed to the same procedure as the treatment condition but with full-therapist contact, for example, standard face-to-face CBT was used instead of 'self-administered' CBT [17,18].

Critical appraisal

The process of randomisation was discussed in all eight studies, with varied but typically simple methods of randomisation used (see Table 1). The description of the randomisation process was minimal in some studies [12,16] and more extensive in others [17,19]. It was not possible to disguise the contents of psychosocial treatment and thus double blinding was not present, with blinding generally not discussed. Four studies matched the control condition closely to the treatment condition, for example by giving participants access to an online discussion forum. Two studies labelled as waitlist controls crossed their control group over to treatment at the conclusion of the study [13,18].