Empirical Research

An implementation trial of ACT-based bibliotherapy for irritable bowel syndrome

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ABSTRACT

Keywords:
IBS
Acceptance & Commitment Therapy
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Background: Irritable Bowel Syndrome is a gastrointestinal disorder that is associated with pain, discomfort, constipation and diarrhea. It affects around 20% of adults in Western countries. Reports of distress and self-consciousness, as well as experiential and situational avoidance are common. Previous studies have shown that ACT may be effective for people with IBS.

Methods: An uncontrolled trial of ACT based bibliotherapy was undertaken in a specialist motility clinic. Outcomes were measured with standardised self-report questionnaires pre-treatment, and at two and six months. Missing data was handled using maximum likelihood imputation. Data was analysed using repeated measures ANOVA.

Results: 45 participants enrolled in the study, with 36 providing data at two months, and 24 at six months. Participants were predominantly female, with an average ten-year history of IBS, and 71% of the sample had moderate or severe symptoms. At six months, participants had improved on symptom severity (η² = 0.09, 90% CI = 0.01 – 0.18), GI specific anxiety (η² = 0.07, 90% CI = 0.01 – 0.16) and IBS willingness (η² = 0.14, 90% CI = 0.04 – 0.24), but had not shown behavioural changes towards greater activity, (η² = 0.01, 90% CI = 0.00 – 0.05) or to reduce IBS avoidance behaviours (η² = 0.05, 90% CI = 0.00 – 0.13). Contrary to hypothesis, intervention did not reduce the impact of IBS on quality of life (η² = 0.04, 90% CI = 0.00 – 0.09).

Discussion: Bibliotherapy interventions may be useful for people with refractory IBS, though greater contact and structured exposure may be necessary to change behaviour. The study was limited by problems with attrition, though these data suggest future research in this area would be worthwhile.

1. Introduction

IBS is a functional gastrointestinal disorder affecting around 10–20% of adults in Western countries, most of whom are female (Thompson, Irvine, Pare, Ferrazzi, & Rance, 2002; Wilson, Roberts, Roaf, Bridge, & Singh, 2004). It is characterized by abdominal pain, bloating, discomfort and changes in bowel habit (Longstreth et al., 2006; Tanaka, Kanazawa, Fukudo, & Drossman, 2011). When symptoms remain after 12 months of pharmacological treatment, IBS is considered ‘refractory’ (NICE, 2008). People with IBS often report embarrassment and shame, and stop socialising, withdrawing from intimacy, reduce working hours and reduce participation in normal community activities (Rønnevig, Vandvik, & Bergbom, 2009; Schneider & Fletcher, 2008).

IBS is associated with psychiatric disorder, with rates of 17% for major depression and 32% for generalised anxiety disorder (Lydiard, 2001). Several psychological therapies have been trialled for IBS. Hypnotherapy and cognitive behavioural therapy (CBT) have the strongest evidence (Lee, Choi, & Choi, 2014; Li, Xiong, Zhang, Yu, & Chen, 2014). The focus of hypnotherapy is upon reduction of stress via relaxation and suggestion, leading to better symptom control (Whorwell, 2005; Webb, Kukuruzovic, Catto-Smith, & Sawyer, 2007). Recent meta analyses show hypnotherapy to be effective at short term, but the pattern of results is not conclusive as to the effects at follow-up. In addition, mechanisms of action are unclear (Lee et al., 2014).

In CBT for IBS, patients are educated about the physiological, cognitive, behavioural and emotional influences on their condition, ...
and are taught self-control strategies to enhance coping behaviours, reduce stress and alter dysfunctional thinking about IBS. Meta-analyses have shown that CBT is effective for IBS, when compared to non-active controls, but not superior to standard medical care or basic support (Lackner et al., 2007; Li et al., 2014).

CBT has been used to design self-help interventions for IBS. Hunt, Ertel, Coello, and Rodriguez (2015) reported benefits as did Sanders, Blanchard, and Sykes (2007), though attrition was high in both studies. Everitt et al. (2010) found a web based self-help intervention to be comparable to medication, but neither outperformed a ‘no treatment’ control condition.

What is shared in both CBT and hypnotherapy for IBS is a focus on gaining control over IBS symptoms. For many patients, not only does this strategy not reliably lead to symptom control, it has the unintended consequence of further restricting normal functioning (Ferreira, Eugenicos, Morris, & Gillanders, 2011). Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 2012) challenges the need to use control-based strategies. Instead, client and therapist work together to construct overarching life goals, and behavioural strategies are used to move towards these goals. Mindfulness, acceptance and perspective taking skills are taught to facilitate goal oriented behaviour in the presence of difficult symptoms, thoughts and emotions; hence Acceptance and Commitment.

ACT is effective for other long-term health conditions, including chronic pain (Graham, Gouick, Krahe, & Gillanders, 2016; Hann & McCracken, 2014) and there is preliminary evidence that ACT may be applicable to IBS. Whilst not described as ACT, Ljótsson et al. (2010, 2011) reported benefits of an internet delivered exposure and mindfulness treatment. Treatment was highly structured, was supported by an online peer chat room and asynchronous weekly therapist support. It used mindfulness to facilitate patients’ exposure to avoided situations and sensations, whilst reducing control orientated behaviours. Large effect sizes were reported across measures of symptoms and quality of life, with gains maintained at 15–18 month follow up (Ljótsson et al., 2011). Ljótsson and colleagues’ study reflected a trend within other areas of CBT to use principles such as exposure and mindfulness, without naming the intervention as ‘ACT’ (e.g. Arch & Craske, 2008). Such a strategy has allowed studies to remain identified with the broader CBT tradition whilst incorporating elements of the ‘third wave’.

Finally, Ferreira, Gillanders, Morris, and Eugenicos (in press) reported a trial of ACT for IBS. Participants took part in a one-day group workshop, combined with a self-help book and audio CD to modify their approach to IBS (Ferreira & Gillanders, 2012). Ferreira and colleagues showed that participants’ acceptance of IBS increased, and that this mediated improvements in symptoms, stress, quality of life and avoidance behaviours.

The current study aimed to extend Ferreira et al. (in press) by testing the impact of bibliotherapy alone. The primary outcome was the impact of IBS on quality of life. The book explicitly targeted avoidance and acceptance and so it was predicted that the intervention would lead to improvements in both. If participants began to live more effectively with IBS, improvements in gastrointestinal specific anxiety and IBS symptom severity were also predicted. These improvements were expected to be seen at the two-month assessment and to have continued to improve at the six-month follow up.

2. Materials and methods

2.1. Design

An uncontrolled implementation trial of self-help was conducted in a specialist motility clinic. Participants were new or return attenders who were diagnosed with refractory IBS by a consultant gastroenterologist with expertise in IBS (author M.E.), using ROME III criteria (Longstreth et al., 2006). Participants completed standardised self-report measures prior to intervention, at two months and six months later. The study was designed and conducted in accordance with the Code of Human Research Ethics of the British Psychological Society (British Psychological Society, 2014) and approved by a UK National Health Service Local Research Ethics Committee (Approval reference #12/SS/0133).

2.2. Sample size

The study by Ferreira et al. (in press), using self-help and a group workshop showed an effect size of .55 for the primary outcome of IBS Quality of Life. The GLIMMPSE (http://glimmpse.samplesizeshop.org) software was used to calculate a sample size sufficient to detect equivalent effects (Guo, Logan, Glueck, & Muller, 2013). At an alpha of .05, 23 participants would be needed to have 80% power to detect such effects. More conservatively, 81 participants would have 80% power to detect effect sizes of .3 and above.

2.3. Recruitment

Recruitment took place between December 2014 and July 2015. Inclusion criteria were: Diagnosis of IBS, aged 18 years and older, and fluency in English. Exclusion criteria were: Women who were pregnant or breastfeeding, symptoms suggestive of inflammatory bowel disease (or similar), and inability to understand study consent procedure. These criteria were assessed by both the consultant gastroenterologist and the research assistant (author E.A.). Eligible patients met with the research assistant, who took written informed consent and administered pre-intervention measures. Some participants took the information sheets and questionnaires away to consider involvement and were given prepaid postal envelopes to return assessment measures. Follow up measures were posted to participants at two and six months, along with a pre-paid return envelope. Participants were prompted by telephone to return questionnaires, when necessary.

2.4. Intervention

The intervention consisted of giving participants the self-help book “Better Living with IBS” (Ferreira & Gillanders, 2012) and the accompanying audio exercises on CD. The book contained information about IBS, stress and symptoms, exercises to reflect on use of control strategies, values exercises, and exercises to develop skills in mindfulness, defusion and willingness. Participants were encouraged to engage in the book, by their consultant in gastroenterology and by the research assistant. No specific protocol was used for this encouragement, instead the benefits of regular practice with the intervention were outlined. Participants were asked to work through the book at their own pace and they would likely complete all sections within the first two months. Participants received two telephone calls from the research assistant during the first and second months following recruitment. They typically lasted between five and 20 minutes and covered practical problems of engagement, clarification of information in the book, and encouragement to use the intervention strategies. All participants reported using the book and exercises at least to some degree, though this was not formally measured.

2.5. Measures

2.5.1. Demographic variables

At pre-treatment, information was collected on age, sex, marital status, education and duration of IBS symptoms.

2.5.2. ROME III Questionnaire IBS Module (ROMEIII)

The IBS module of the ROME III questionnaire (Longstreth et al., 2006) contains 10 questions to aid diagnosis of IBS and determine subtype: Diarrhoea predominant, constipation predominant, mixed or...
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