Irritable Bowel Syndrome (IBS)

Problem specific competencies for Cognitive Behavioural Interventions (High Intensity)

(Rimes, Wingrove, Moss-Morris and Chalder, 2014)

These competences are designed to be used in conjunction with "basic" and "specific" CBT competences, and generic therapeutic competences and metacompetences (Roth and Pilling, 2007).

Knowledge

- Diagnostic process & criteria for IBS
- Basic knowledge of digestive system in relation to IBS symptoms
- Knowledge of "red flag" symptoms
- Research evidence about development and maintenance of IBS including role of infection, stress, cognitive and behavioural factors
- CBT / biopsychosocial model of IBS
- Basic knowledge of the other validated treatments, including anti-spasmodic medication
- Knowledge of prognosis for IBS and likely impact of CBT based interventions
- Ability to liaise and communicate effectively with medical professionals when needed
- Knowledge of comorbidity issues, e.g. with other medically unexplained symptoms

Establishing a working relationship

- Convey understanding of distress and impact associated with symptoms
- Ability to discuss potentially embarrassing symptoms, cognitive and behavioural factors sensitively using language preferred by client
- Elicit client beliefs and concerns about engaging in this form of treatment
- Discuss possible barriers to treatment
- Use multifactorial biopsychosocial model that avoids psychological / physical illness dichotomies
- Ability to work with clients who have a strong physical illness attribution or initial desire to focus on identifying cause or "cure"
- Awareness of potential beliefs about psychological weakness or expression of emotions that may impact on therapeutic relationship and process of addressing emotional issues in therapy

Assessment

Generic CBT assessment skills together with an ability to assess the following

- Whether diagnosis has been made by appropriate health professional
- Detailed verbal assessment of current physical symptoms, their development / onset, course, fluctuations, previous treatments, impact on daily functioning
- "Red flag" symptoms
- Typical day incl. sleep, activities, exercise, rest, routine (or lack of), eating habits
- Medications taken for bowel symptoms and other medications that may impact
- Assessment of other substances that may affect symptoms (e.g. food, caffeine, alcohol)
- Beliefs about development and maintenance of symptoms
- Beliefs about meaning of worsening / exacerbation of symptoms
- Shame, embarrassment, social evaluation concerns about symptoms
- Coping behaviours relating to symptoms that may be helping or hindering recovery (e.g. "boom or bust" activity patterns, too much / little activity or rest).
- Avoidance or other unhelpful behaviours relating to social evaluation concerns
- Impact of behaviour by other people on symptoms , disability or distress (e.g. over-solicitous behaviour, others doing too much or too little, relationship problems, bullying).
- Underlying beliefs (e.g. relating to high standards for performance, emotions, personal conduct)
- Ability to assert self, express emotions and access social support
- Current stressors e.g. work, financial or relationship difficulties
- Depression and relationship with physical symptoms

- Anxiety including components of this (e.g. perseverative thinking, heightened somatic arousal, avoidance behaviours) that may be contributing to symptom experience
- Childhood experiences relevant to IBS (e.g. trauma, illness experiences)
- Administer and interpret appropriate questionnaires including both outcome measures and appropriate process measures (e.g. Frost Multidimensional Perfectionism Scale or other perfectionism measure, Beliefs about Emotions Scale)

Case formulation

- Ability to construct an individualised multifactorial formulation incorporating and distinguishing predisposing, precipitating and maintaining factors, using client's own language
- Ability to use cognitive behavioural approach to IBS to guide treatment

Explaining the rationale for intervention

- Include in initial formulation client's own understanding of aetiology and maintenance; not challenging strongly held beliefs but increasing the range of factors included in understanding of symptoms / disability where possible and appropriate
- Discussion of possible role of stress, unhelpful thinking patterns and behavioural responses in maintenance of symptoms and /or disability and how addressing these may help

Intervention

IBS-symptom education and Socialisation to the model

- Convey information about IBS-related symptoms, the digestive system and stress, relating to client's own symptoms.
- Normalisation of signs and symptoms.
- Address common myths about bowel movements, diarrhoea, constipation
- Help the client understand how a multifactorial model of IBS that incorporates biological, cognitive and behavioural factors may apply to their symptoms / disability, using guided discovery

Treatment planning

- Ability to collaboratively establish specific, realistic, measurable end of treatment goals

Behavioural Strategies

Please note:

- Targets below should be set collaboratively with client and carefully graded where appropriate
- Many of the behavioural strategies below can be set up as behavioural experiments testing out specific beliefs if linked with the cognitive work

Generic behavioural competencies

To be used if appropriate:

- Problem-solving
- Relaxation training
- Sleep management
- Behavioural approaches to worry
- Assertiveness training

Self-monitoring diaries

- Help client learn to use self-monitoring sheet to monitor pain, stress, diarrhoea, constipation, size and regularity of meals and behaviour changes relating to symptoms
- Collaboratively identify patterns in diary
- Guided discovery regarding relations between symptoms and thoughts, feelings or behaviours
- Collaboratively set goals in relation to information gained from diaries

Diarrhoea

- Teach clients to strengthen anal muscles and practice control over them
- Explain rationale and set targets for stopping anti-diarrhoea medication
- Discuss optimal use and set targets regarding anti-spasmodic medication

- Explain rationale and set targets for reducing safety behaviours relating to diarrhoea including avoidance, checking, rushing to toilet or trying to empty bowels before urge

Constipation

- Explain rationale and setting targets for reducing straining
- Discuss use of medications relating to constipation and setting targets for stopping
- Ability to explain rationale and set targets for reducing safety-behaviours relating to constipation

Diet

- Provide rationale and set targets for healthy diet in line with current dietary advice
- Provide rationale and set targets for meal size, frequency, regularity, healthy eating as appropriate
- Provide rationale and help client to set targets for reintroducing avoided foods

Exercise

- Discuss relationship between exercise and IBS symptoms and collaboratively set graded exercise targets if appropriate

Activity patterns

- Collaboratively identify baseline level of activity and rest
- Collaboratively identify unhelpful activity pattern ("boom or bust", consistent over-activity, consistent under-activity), potential impact of this on physical symptoms and rationale for addressing
- Develop activity targets / programme to be tested as behavioural experiment
- Review activity diaries and modify targets if necessary to help towards goal for activity pattern

Sleep management

- Collaborative use of sleep diary to assess sleep onset, number of times waking, insomnia, getting up time, quality
- Help client understand rationale for behavioural sleep management methods
- Collaborative identification of specific sleep targets, e.g. set getting-up time, not sleeping in day
- Monitoring and adjustment to sleep-related homework tasks if needed

Behavioural stress management

- Ability to provide rationale for relaxation training in relation to IBS symptoms including fatigue / sleep-related symptoms
- (Generic competences: relaxation training, problem-solving, behavioural strategies for addressing worry e.g. worry periods; assertiveness training)

Cognitive strategies

Generic competences – identifying thoughts, moods, thinking biases, using thought records to address unhelpful thoughts. Behavioural experiments to investigate beliefs and assumptions (also see above Behavioural Strategies).

Addressing unhelpful cognitions about IBS, symptoms and activity

- Address unhelpful (negative) cognitions about IBS, symptoms, activity, sleep and rest through behavioural experiments (see behavioural strategies listed above for IBS-specific behaviours) and other methods (see generic cognitive competences)

Addressing symptom-focusing

- Address excessive attentional focus on bodily sensations / parts (e.g. behavioural experiments)

Addressing other unhelpful negative automatic thoughts

- Help client to identify and address other (non-symptom related) thoughts that may be contributing to general stress and hence indirectly to physical symptoms

Addressing underlying assumptions

- Help client identify through guided discovery unhelpful assumptions that may be related to their symptom experience either directly (e.g. by increasing stress or driving boom-or-bust activity pattern) or indirectly (beliefs about importance of not showing psychological vulnerability meaning that social support is not sought at times of stress)
- Apply generic CBT skills to address unhelpful underlying assumptions

Core belief work
• If appropriate / necessary, apply generic CBT skills to collaboratively identification of negative core beliefs that may be contributing to problems
Involvement of family / partner
• Help client identify whether appropriate family member / friend to act as a co-therapist and to have at least one joint session together to discuss and plan this role • Address unhelpful responses by partner / family
Future planning Relapse prevention
• Help client plan how to continue to work on goals in the future • Collaboratively develop set-back and relapse prevention plans including triggers or early warning signs
Metacompetences
Convey and deliver the programme in a flexible manner, responding to the issues raised by the client, while also ensuring that all relevant components are included.

Reference

Rimes, K.A., Wingrove, J., Moss-Morris, R. & Chalder, T. (2014). Competences required for the delivery of High and Low-Intensity Cognitive Behavioural Interventions for Chronic Fatigue, Chronic Fatigue Syndrome / ME and Irritable Bowel Syndrome. *Behavioural and Cognitive Psychotherapy*. [For full reference please see journal website: http://journals.cambridge.org/jid_BCP]