Description of the Disorder:

Irritable Bowel Syndrome (IBS) is a disorder of the lower gastrointestinal (GI) tract. Symptoms are:
- cramping abdominal pain or severe abdominal tenderness,
- change in bowel habits (either diarrhea, constipation, or alternating diarrhea and constipation).
- Uncomfortable abdominal bloating is also often present.

The symptoms need to persist for at least 3 months. Care should be taken to rule out other GI disorders which share some of these symptoms such as problems with lactose absorption, inflammatory bowel disease (Crohn’s Disease or Ulcerative Colitis), and GI tract parasites.

About 10 to 20% of the adult American population suffers with IBS. Women outnumber men by 2 or 3 to 1. There is an even higher ratio of women to men among those who seek treatment. As many as half of those who meet criteria for IBS never seek medical care for it. Those who seek treatment tend to be more emotionally distressed than non-treatment seekers.

Treatment Comparison:

Three different kinds of treatments have been shown in well done studies to be helpful for reducing the symptoms of IBS:
- Hypnotherapy;
- brief psychodynamic psychotherapy;
- and combinations of different cognitive and behavioral techniques (known as cognitive behavioral therapy [CBT]).

At least 12 different well done studies from 7 different clinics in the USA, Canada, UK and the Netherlands, have been published. Most of these studies were small (under 20 patients per condition). CBT has consistently been shown to be better than GI symptom monitoring. Comparisons of CBT to psychoeducational support groups have shown mixed results, as have comparisons to attention-placebo control groups. The most consistent positive results have been shown for a purely cognitive therapy approach and a purely relaxation training approach. Benefits have been shown to hold up over follow-ups of one to 4 years.

There have not been any studies comparing the 3 broad types of psychological treatment. For cognitive therapy from 60 to 80% of patients have been shown to be improved when daily GI symptom diaries were considered. These improved cases also show reductions in symptoms of anxiety and depression.

Treatment Description:
The following treatment draws from cognitive therapy procedures described by Meichenbaum, Beck, and Persons. It borrows from their writings, and is an application of their methods to the problem of IBS. The length of treatment is for 10 to 12 individual sessions or 10 small group sessions of 90 to 100 minutes.

Treatment begins with a teaching session designed to help everyone understand that normal bowel functioning includes a range of bowel habits. The role of stress in disturbing normal bowel function is described. In addition, it is taught that much of the stress we feel is based on how we think about and interpret events. It concludes with the introduction of a diary for patients to keep track of stressful events and episodes of GI symptoms.

An initial goal of treatment is to teach members to be good, careful observers of their thoughts, especially in reaction to stressful events. Some members learn this observation and recording technique easily. Others can take a while, requiring several rounds of trial, error, and corrective feedback.

Next, positive and negative self-talk is discussed. These are the messages we give ourselves when dealing with stressful events and with GI symptoms. Once the individual understands how to recognize, examine and record self-statements (thoughts, things you say to yourself), we bring in the idea of substituting coping and positive self-statements for negative ones. Special attention is paid to:

- thoughts that come right before one approaches a stressful event,
- thoughts within the stressful situation,
- and thoughts following the stressful event.

When the person with IBS has coped well with or survived a stressor, the idea of using self-rewards is taught. These positive self-statements are meant to replace negative self-talk or self-blame. Special focus needs to be paid to possible catastrophic thoughts (e.g. “This is the most horrible thing I’ve ever dealt with!”) and countering them. Again, some persons grasp these ideas easily whereas others take a while. The use of the daily diary for thought listing, and efforts at substitution are important in order to provide the data for the therapy session.

Next, some of Beck’s ideas of thinking errors and distortions such as all-or-none thinking, overgeneralization, emotional reasoning, etc. are discussed. Using the sheets on which they record their thoughts, the client’s thinking in stressful situations is examined for these types of thinking errors. Some amount of time, 2 or 3 sessions, may be needed for clients to grasp these ideas and begin to see how they apply to their lives and life stressors.

Lastly, we introduce ideas of problem solving and Persons’ causal analysis to help clients understand underlying thought patterns that may be shaping their views of the world.

From Session 2 onward, patients keep diaries of their thoughts about stressful events and thoughts about changes or increases in GI symptoms. As they become better at this task and then at substituting coping self-statements and challenging problem thinking, the therapist role moves towards support for putting these principles into their lives.
In individual therapy, it is a relatively simple task to work with the client on the material he or she brings each week. In small group settings this is harder because clients understand what is wanted and needed at different rates. We believe there needs to be work with at least one situation per client per session. We count on clients' learning through each other. We also, in the group, count on group members helping each other to see connections.

Use of relaxation: As noted earlier, there have been studies that only taught different forms of relaxation (such as Jacobson’s progressive muscle relaxation or Benson’s meditative form of relaxation) and then its use with daily stressors as well as its routine practice. In several studies both cognitive approaches and relaxation strategies have been combined. The relaxation is then usually seen as another coping strategy for stressful situations.

We have used this multi-method approach and found it workable. Many of the well-done studies have used these two approaches in combination with other psychological techniques.

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