**COGNITIVE-BEHAVIOURAL THERAPY FOR IBD**

**Running head:** CBT in IBD

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To the Editors,

Despite a high burden of psychological comorbidity in IBD ([2](#_ENREF_2)) and recommendations that psychological care should be offered in IBD care ([3](#_ENREF_3)), we have thus far been unable to show psychological treatment to be effective in this population ([1](#_ENREF_1), [4](#_ENREF_4)).

 In the original 10-week intervention of cognitive-behavioural therapy (CBT) ([1](#_ENREF_1)), with CBT delivered online or face-to-face versus standard care (SC) (n=174, 90 CBT, 84 SC), we showed no effect of CBT on remission rates or mental health at 6 or 12 months. However, in a post-hoc analysis with participants classified as ‘in need’ (young, high IBD activity, recently diagnosed, poor mental health) (n=74, 34 CBT and 40 controls), CBT significantly improved mental QoL (p = .034) at 6 months, but not at 12 months. At 24 months, again, CBT did not significantly change disease activity or mental health (all p>.05). Unlike at 6 months, there was no impact of CBT on QoL or any other outcome variable in participants ‘in need’.

 In the recent trial ([4](#_ENREF_4)) of the 8-week online CBT intervention (n=199, 113 CBT, 86 SC) we showed that CBT improved QoL at 12 weeks (IBDQ p=.01, SF12 p=.03) but not at 6 months.

 We made important observations in these two trials. First, that attrition is a significant problem in online psychotherapy interventions. In the original trial ([1](#_ENREF_1)), we lost 65% of the CBT group and 46% of SC at 24-months, and in the latest trial ([4](#_ENREF_4)), 53% and 23%, respectively at 6 months. In the latter study, while nearly 90% accessed the program, only 25.7% completed all the sessions. For future trials, high attrition rates should be factored in in sample size calculations while adding some therapist-run sessions may improve retention. A more personalised approach rather than a program designed for ‘one-size fits all’ may be necessary to show effect. Second, that offering CBT to unselected IBD patients brings only minor improvements in QoL and none in disease activity. Focusing on patients with identified needs appears more appropriate, however, even in this group long-term effectiveness of online CBT is at present doubtful. More consideration needs to be given to how to design psychotherapy studies so that they bring lasting effect. Finally, intention-to-treat approach to analysis proves problematic ([4](#_ENREF_4)) as the participants who do not access CBT cannot be expected to gain any benefits, and so the per protocol approach may work better in future trials.

**References**

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