ADVANCES IN IBD

Current Developments in the Treatment of Inflammatory Bowel Disease

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Screening for Depression in Patients With Inflammatory Bowel Disease

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G&H How prevalent is depression in patients with inflammatory bowel disease?

LK A recent analysis by Barberio and colleagues estimated that 25% of patients with inflammatory bowel disease (IBD) met the criteria for depression according to a clinical cutoff on the Hospital Anxiety and Depression Scale (HADS). Other studies have reported that up to 40% of patients with IBD will show depressive symptoms over their lifetime (eg, low mood, loss of interest in activities, fatigue, poor concentration, reduced appetite, thoughts of feeling worthless or like a burden). Rates of depression increase when patients have active disease.

G&H What is the current understanding of the pathways between IBD and depression?

LK IBD and depression have some elements of shared genetic susceptibility as well as shared immunologic processes. For example, depression is thought to be part of the tumor necrosis factor–alpha pathway, similar to certain forms of IBD. A growing number of studies in the psychiatry literature suggest that depression should be viewed as an inflammatory condition in the brain, another similarity with IBD, which has an inflammatory nature. The increase in depressive symptoms when patients have active IBD shows the overlap in symptoms that come with inflammation. Whether inflammation is experienced as low mood or not depends on the patient. The aforementioned depressive symptoms can be the result of not feeling well because of IBD as much as the result of being depressed. Therefore, it is difficult to disentangle IBD and depression, which is why doctors should think about these conditions as being bidirectional and influencing each other, and not separate out that the patient has depression or the patient has inflammation.

Thus, inflammation in the gut is driving depression in the brain, but, in the other direction, depression in the brain may lead to worse self-management behaviors. When patients are depressed, they are less likely to take care of themselves. For example, they may not go to see their doctor or undergo routine laboratory work, or they may be tired of being sick and give up on their treatment plan.

The microbiome may play a role as well. It is known that the microbiome is related to both mental health and gastrointestinal health, and both diet and microbiome level disruptions can influence the gastrointestinal tract as well as the brain.

G&H Should all patients with IBD undergo screening for depression?

LK This is a controversial issue. Depression is prevalent enough that IBD providers should keep in the back of their minds that patients may have a mental health condition. Screening should occur. The dilemma is whether screening should happen routinely (eg, handing out a questionnaire at the front desk to every patient) or whether providers should include a question or two about the patient's mental health during their review of systems. I have often seen the systems review on a patient's chart state that he or she is not depressed or anxious, but the referral sheet says the opposite. I am reluctant to say that all patients should be screened; I think that emotional

well-being needs to be a discussion that occurs in the context of a doctor-patient relationship.

Another dilemma is what to do with the information obtained during screening. If a patient is screened at the front desk and says that he or she is depressed, there has to be a pathway for care going forward. If there is not a pathway, screening will not change outcomes. If the patient screens positive for depression and there is a referral and potential pathway for the patient to obtain help, then I think that screening is very reasonable. Unfortunately, there often is not a pathway. If the provider is just collecting data on depression, I do not know if that is helpful to the patient.

If a provider is interested in screening patients, it is important to screen them not only when they are crying in the office, but as part of routine care and overall patient health assessment.

G&H If an IBD provider wants to screen patients for depression, when do you recommend that screening occur?

LK Annual screening for depression and probably anxiety is very reasonable. If patients are in remission, they usually see their IBD provider twice a year, so one or preferably both of those visits could also be a general wellness check-in with the doctor. Screening does not take long; most of the questionnaires are only 4 or 5 questions. If a provider is interested in screening patients, it is important to screen them not only when they are crying in the office, but as part of routine care and overall patient health assessment.

G&H Which screening questionnaires are most commonly used in patients with IBD?

LK The current data are largely based on HADS, which provides an anxiety score and a depression score. One of the advantages of this scale is that it has a clinical cutoff. If a patient has a score greater than 11, it is likely that he or she meets the criteria for clinical depression. Another advantage is that HADS was based on hospitalized patients, which means that it does not ask about some of the symptoms of depression that could also be symptoms of IBD, removing some of the overlap between the conditions. However, there is a level of scoring and interpretation to HADS that most practices are not able to manage, making it somewhat impractical. I recommend using the National Institutes of Health's Patient-Reported Outcome Measurement Information System. It is free and easy to score, and it can be integrated into an electronic health record. The items are well validated and usually only 2 or 3 questions. They give a sense of how the patient fits with the rest of the population (eg, in comparison with people without health problems, people with cancer, people with diabetes).

The other questionnaire that I see many practices use is the Patient Health Questionnaire (PHQ)-2. The 2 items focus on whether the patient has a depressed mood and whether the patient has a loss of interest in activities (anhedonia). There is also the PHQ-9, which is a much more robust measure that consists of 9 questions. However, the last question asks whether the patient has thought about suicide. Most practices do not want the liability of asking that and may not know what to do if a patient says yes because they do not have a mental health clinician who is prepared to see the patient. Therefore, many practices will instead use the PHQ-8, which eliminates the suicide question, although that may underestimate the patient's depression.

G&H Are there any other challenges with these screening questionnaires or with screening in general?

LK Depression is clearly prevalent enough in patients with IBD that it is worth talking about. However, there are many precursors to depression that I think could be more easily addressed before a patient becomes depressed. Screening for depression often occurs too late in the process. If a practice wants to have mental health or psychosocial integration, there are other ways of learning about a patient's burden, how the patient is feeling and coping, and any emotional issues that have not manifested yet as depression. Not everyone becomes depressed, but they can certainly feel overwhelmed, burned out, isolated, and lonely, especially during the COVID-19 pandemic. These symptoms might not be captured by screening questionnaires, which is why it is important to ask about general mental health as part of the patient's clinical examination and not just rely on a screening metric of depression.

G&H Is there a gap between screening recommendations and the screening actually received by the average patient with IBD?

LK Yes. The American Gastroenterological Association Care Pathway recommends screening for depression in patients with IBD, but not all patients are being screened. However, in all fairness, I think that this gap highlights the difficulty and impracticality of blanket screening. I do not necessarily blame practices that are not screening because they may not be prepared to manage a patient who screens positive for depression. I think it is worth revisiting the conversation around what providers are screening for, why they are doing it, and what the pathway is if a patient screens positive. It is easy to say screen, but a lot of thought needs to go into it, and I can see why there is a gap in the implementation of screening in clinical practice.

> … asking a simple question such as "How have you been coping/managing lately?" will open the door to what the patient is feeling.

It should also be mentioned that there has been some pushback around whether gastroenterologists need to be concerned with their patient's mental health in the first place. Some gastroenterologists want to focus only on treating IBD and inflammation, whereas others are trying to promote a mind-body treatment approach in IBD. However, I do not think that it is possible to disentangle the mind and body in a disease that has such a strong gut-brain-microbiome component. Although depression is a mental health condition, it is also an inflammatory condition as well as a physiologic condition that directly affects the gut; therefore, not addressing depression in the context of IBD is a mistake.

G&H Are there any strategies that gastroenterologists can use to improve or increase screening for depression?

LK As part of the general review of systems, asking a simple question such as "How have you been coping/managing lately?" will open the door to what the patient is feeling. That is likely a more robust strategy for the gastroenterologist than directly asking "Are you depressed?"

Some gastroenterologists may be hesitant to ask how a patient is coping for fear that the answer will take up a lot of valuable time, but it usually takes only a minute or so and makes a large difference in patient satisfaction with the visit. Asking how the patient is coping also allows the gastroenterologist to place the patient in the context of the rest of his or her life. The patient sees the gastroenterologist only a few times a year but has to live with his or her disease every day.

G&H Do you have any other tips to help gastroenterologists question patients with IBD about their mental health?

LK If gastroenterologists are hesitant to ask directly about mental health, asking patients about their positive well-being is a way to open up the conversation—for example, "What is going well with your disease management? Tell me about a success you have had managing your disease." Another possibility is asking about the patient's happiness: "On a scale from 0 to 100, how well is your life going?" This gives gastroenterologists a sense of how well the patient is doing in general, not just in terms of his or her IBD. It is important to treat not just the patient's inflammation but to make sure the patient is living his or her best life despite having Crohn's disease or ulcerative colitis. If the patient's disease is being controlled fairly well but he or she is below 50 on the happiness scale, there is clearly a disconnect that needs to be addressed. Asking about the happiness scale is easy, and patients are often familiar with visual analogue scales (eg, pain scales from 0-10).

G&H If depression or its symptoms are identified during screening, what should be the pathway forward?

LK Depression is very treatable. If IBD providers do not have an integrated mental health professional in their practice, they should have a list of several mental health professionals in the community who treat depression and/or psychiatrists who can prescribe psychotropics. Treatment becomes more difficult when there is overlap between the patient's disease state and his or her depression, and it may be unclear which is driving which. That is when it is valuable to know a mental health practitioner in the community who is familiar with IBD to whom the patient can be referred. It is important to make sure that the mental health practitioner understands the patient's IBD; otherwise, although the depression may be treated,

it may not translate into disease outcomes and positive self-management behavior.

At my institution, I also recommend that gastroenterologists familiarize themselves with 1 antidepressant medication, if not 2, that they feel comfortable prescribing in the context of IBD (eg, they know the dose, time line, and side effects) because access to mental health care, particularly psychiatric care, can be limited. This is something that gastroenterologists can do to make a difference in most cases of noncomplicated depression. If the patient does not respond, he or she can be referred to a psychiatrist or psychiatric nurse practitioner.

G&H What are the priorities of research in terms of depression in patients with IBD?

LK Over the past 10 years, the focus has been on the prevalence of depression and how depression influences outcomes in IBD. In my opinion, the next research agenda should focus on how to prevent depression and on determining the risk factors for developing depression in the context of IBD. More research is also needed on effective early interventions to make sure that patients do not become depressed or disabled. Most depression occurs in the first year after diagnosis of IBD, so we need to learn what should be done at the point of diagnosis to stratify patients who are at risk of developing mental health issues and disability.

Disclosures

Dr Keefer is a consultant to Eli Lilly and AbbVie. In addition, she is a cofounder and equity owner in Trellus Health and is on the Rome Foundation's Board of Directors.

Suggested Reading

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