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Editorial: Anxiety And Depression In Inflammatory Bowel Disease

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Anxiety and depression are common comorbidities in patients with inflammatory bowel disease (IBD), with 19% of patients reporting symptoms of anxiety and 21% of depression, as compared to 9% and 13%, respectively, in healthy controls [1]. Anxiety and depression have been associated with clinical recurrence in adults with IBD [2]. Bidirectionality of IBD and mood disorders has also been proposed in adults, with IBD activity at baseline associated with an almost six-fold increase in future risk for anxiety, and anxiety at baseline (in quiescent IBD) linked to future flares, steroid prescriptions and escalation of therapy [3]. Approximately 25% of IBD cases are diagnosed in paediatric populations [4], with 19% of incident cases occurring in the first decade of life [5], and poorer outcomes in those with early onset IBD [6]. While paediatric IBD is now becoming fairly common, much less systematic knowledge is available on anxiety and depression in children with IBD than in adults. The excellent systematic review with meta-analysis by Stapersma et al. is therefore timely [7].

Analysing 28 studies (n = 8107) published between 1994-2017, they7 showed the pooled prevalence of anxiety symptoms to be 16.4% (95% CI: 6.8%-27.3%), of anxiety disorders to be 4.2% (95%CI: 3.6%-4.8%), of depressive symptoms to be 15.0% (95% CI: 6.4%-24.8%), and of depressive disorders to be 3.4% (95% CI: 0%-9.3%). Except for anxiety disorders, significant heterogeneity was noted among the studies, and there were fewer studies reporting disorders as opposed to symptoms, which is consistent with previous systematic reviews [1, 8].

Reporting anxiety/depression symptoms and disorders separately is a strength of the present review. The differences between the two are frequently ignored both in practice and in academic papers. Symptoms are derived from screening measures such as the Child Depression Inventory, while disorders are typically established during a psychological or psychiatric interview, which is more costly and time-consuming, and thus less often used in research. Symptoms are common but, as shown [7], are not disorders in most cases. This is a reassuring finding for clinicians. Nevertheless, the symptoms of anxiety and depression are a sign that there is a need for psychological support and, if this can be provided, there is a good chance they will not escalate to a diagnosable psychological disorder.

As the rates of anxiety and depression are lower in children than in adults [1, 7, 8], pediatric IBD clinics may be ideally situated to provide biopsychosocial integrated care which could offer support not only for IBD symptoms and non-intestinal inflammatory issues but also, holistically, for overall wellbeing. Studies on psychological therapy,

while limited in number, show higher efficacy in children with IBD than adults [9], further supporting early psychological interventions in IBD. While the impact of anxiety/depression on disease course in pediatric IBD was outside the scope of the recent review [7], it sends an important message to clinicians and policymakers working in IBD: it is time to go beyond treating the bowel in our approaches to IBD care.

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Editorial: Anxiety And Depression In Inflammatory Bowel Disease - Authors' Reply

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We thank Mikocka-Walus & Knowles [1] for their editorial about our systematic review and meta-analysis on anxiety and depression in children and adolescents with inflammatory bowel disease (IBD) [2]. Indeed, anxiety and depression are common in IBD, and the bidirectional relationship between anxiety/depression and intestinal inflammation can be explained in terms of the “brain-gut-axis” [3, 4]. In adult (and less so in pediatric) IBD, the association between anxiety/depression and clinical recurrence of IBD has been confirmed [5, 6]. In almost 25% of the patients, IBD presents in childhood or adolescence with a disease course often more severe compared to adults [7, 8]. In addition, adolescence is a challenging life phase with many biological and psychosocial changes. IBD disrupts normal psychosocial development, and increases the vulnerability to developing anxiety/depression. Furthermore, it is known that anxiety/depression in adolescence is associated with anxiety/depression in adulthood [9, 10], affecting quality of life, work participation and socioeconomic status [11] with subsequently high societal costs [12].

There are several ways to integrate psychosocial support in the care for (pediatric) IBD patients. First, for early detection, patients should be regularly screened for anxiety/depressive symptoms. In our Dutch cohort we systematically screened 374 IBD patients, aged 10-25 years, and found that 47% suffered from symptoms of anxiety and/or depression, with the highest prevalence of anxiety [13], and females and patients with active disease having the highest risk. Ideally, mental health screening is done routinely in the outpatient clinic using a short and easy-to-use screening tool. Second, we fully agree with Mikocka-Walus and Knowles that in case of elevated symptoms, a psychiatric interview should check if symptoms are mild/subclinical or severe as in a clinical disorder. It is important to make this difference in order to determine the best treatment strategy. Third, mental health specialists should be part of the multidisciplinary IBD team for young IBD patients, to evaluate the outcome of screening and provide psychosocial care if necessary.

In pediatric IBD, Szigethy et al. found promising results of two psychological therapies in obtaining remission of clinical depression (cognitive behavioral therapy [CBT]: 67.8%, and supportive non-directive therapy: 63.2%) [14]. However, in our recently published multicenter trial we did not find an additional effect of CBT over care-as-

usual in improving subclinical anxiety and depressive symptoms in 10-25-year-old IBD patients directly post treatment [15], as patients in both groups improved. Whether psychosocial interventions also have an effect on inflammatory disease course remains questionable. In conclusion, future studies investigating anxiety and depression in paediatric IBD should use validated instruments cross-culturally, and, importantly, with similar cutoffs. For patients with subclinical anxiety/depression, screening and monitoring may be sufficient to prevent their development into disorders, but this group could also benefit from e-health (internet-CBT) interventions. Patients with clinical anxiety/depression should be referred for CBT. Future research will unravel the “dose” and modality of CBT that should be provided to patients with (sub)clinical anxiety/depression and the long-term effects of CBT on the course of disease.

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