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IBD's Impacts Beyond the Gut: Managing Mental Health in Pediatric Patients

Maureen Kelly:

Hi, my name is Maureen Kelly. I'm a pediatric nurse practitioner at the University of North Carolina at Chapel Hill. I'm going to be talking to you today about psychosocial and mental health in pediatric IBD, specifically depression and anxiety. I will talk about the risk, the signs and symptoms, what are the screening recommendations, some basic screening tools and a little bit about a treatment plan.

We know that children and adolescents with IBD may be at risk for development of mental health and psychosocial difficulties. These risks may be due to genetic predisposition, environmental stressors, situational stressors or IBD-associated stressors. My focus will be on disease-related stressors. Disease-associated stressors include adjustment to the diagnosis of a chronic and lifelong illness, the need to develop and maintain self-management skills, learning about the disease, taking medications and/or enteral therapy, keeping appointments, undergoing lab tests and procedures, as well as the uncertainty and unpredictability of the disease and risk for complications of the disease and medications used for management. We know that there are adjustment issues with self-image and self-esteem, difficulties with school and social adjustments due to disease activity and quality of life issues.

We know that youth with IBD have higher rates of depression than not only healthy children but also those with other chronic diseases, such as cystic fibrosis, diabetes or cancer. Up to 25% of pediatric patients with IBD have shown evidence of depression. Those with more severe disease have a higher incidence of depression. They have also found that IBD patients with depression also have higher rates of anxiety.

Children and adolescents with IBD who are at risk for the development of depression or anxiety often report feeling different, not fitting in, feeling embarrassed; they may feel guilty, as in "nobody wants to be around me when I'm ill," loss of control, or fear. Depression is often expressed as feeling moody or sad or feeling isolated. There may be changes in appetite such as eating too much or not eating enough. Anxiety may be expressed as excessive worrying, separation anxiety, obsessive-compulsive behaviors or phobias. Other more subtle behaviors may include school or work absences, school difficulties, smoking, alcohol or substance abuse, other risk-taking behaviors, relationship problems, nonadherence with the prescribed plan, withdrawal from usual activities such as school functions, sports or activities, and frequent hospitalizations and ED visits with somatic complaints not thought to be related to IBD.

It is really important to understand that IBD, depression and anxiety have a bidirectional relationship. Depression and anxiety can worsen flares of IBD, impact nutritional and growth status and decrease adherence with medication management which impacts disease. On the other hand, IBD flares can worsen depression and anxiety, increase social isolation, worsening depression and anxiety and adjustment. It is recommended that routine assessment of depression and anxiety in IBD patients be performed annually and as needed. Those found to be affected should be referred for mental health counseling.

There are several, quick screening tools available The primary purpose of the PCDAI and PUCAI are to assess disease activity, but they also contain a quality of life component inquiring about patient functioning. For example, general wellbeing—if a patient is well, that means no limitation of activities. If the patient is below par, that means occasional difficulty in maintaining appropriate activities. And if the patient response is very poor, that means frequent limitation of activity.

Another screening tool is called MESSAGE, and MESSAGE is an acronym for depression screening including mood, energy—Are they fatigued? What is their activity level like?—sleep, such as changes in sleeping pattern, sleeping all of the time or not sleeping enough, suicidal ideation and self-esteem, anhedonia, losing pleasure in things previously felt to be pleasurable or interesting, guilt and eating. Eating refers to either loss of appetite or binging.

The Patient Health Questionnaire 2, or PHQ-2, is a simple assessment using 2 questions. Any results raising concern for depression or anxiety demonstrated on these screening formats, including the PCDAI, the PUCAI, MESSAGE and PHQ-2, require consideration for more detailed evaluation and referral to a mental health provider.

There are many tools that can be used to assess depression and quality of life. With the exception of the quality of life questionnaires, these screening tools are not specific to IBD. They are widely used, most often by trained therapists and personnel, for the assessment of mental health and adjustment of children and adolescents. It is important to know that some of these tools may not be available for use in general practices as they require permission and often payment for their use. In our practice, we use the modified PHQ-9 with our patients because it is quick for the adolescent to take, it is easy for the provider to score, and it doesn't require permission to use, and it is free.

Our job is to perform effective screening at least yearly or as needed. Following screening that is positive for depression or anxiety, we need to help our patients find someone to treat them. Many of us have psychologists in our center, but we also have families that come from long distances. Finding a treatment center can be a challenge. What we try to do at our center is match our patients up with a psychologist. They come from all over the state, so we have a running list of psychologists and what insurance plans they will take, and we actually help our patients do this once we've done the depression screening and found it to be positive.

Treatment for depression and anxiety in pediatric IBD often includes cognitive behavioral therapy, hypnotherapy, social support and pharmacotherapy. Cognitive behavioral therapy has been shown to be effective in the treatment of depression and anxiety in IBD. It is based on a theory that our thoughts, feelings and behaviors are interrelated. Making positive changes in feelings changes thoughts and behaviors. In IBD, changes in illness perception has been found to have an impact on depression and anxiety. Emerging evidence suggests that hypnotherapy may be useful among youth with IBD. Although the use of pediatric hypnosis for pain, anxiety and coping with a chronic illness is increasing, further empirical validation for efficacy is needed. Social support is very important, including family and friends support, support groups, and Camp Oasis, which is a camp throughout the United States for children with IBD to attend in the summertime. Pharmacotherapy has been used for treatment of depression, anxiety, and functional pain. Its use in IBD in conjunction with cognitive behavioral therapy has not been widely studied. Currently, there are no large-scale randomized trials to support their efficacy and use. Although psychotropic drugs are available to treat anxiety, depression, and abdominal pain in children, their use in pediatric IBD requires further study.

Thank you for joining me for this important topic today. You can find more information on psychosocial resources for providers and patients on the Crohn's and Colitis Foundation's website at www.crohnscolitisfoundation.org. Thank you.