“Editorial: Depression in the setting of IBD means we have failed to provide early, effective psychosocial care - are we ready to shift towards a resilience-based psychosocial care model? - authors' reply“

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Dr Keefer describes a Resilience-based approach to inflammatory bowel disease (IBD) care in the accompanying editorial to our recent systematic review and meta-analysis on the impact of a depressive state on outcomes in IBD,1 and discusses the potential implications of this research on the broader field of managing psychiatric disorders in patients with IBD. This helpful editorial highlights the paucity of research in this field. Our research identified 5 of eleven relevant studies that reported an association between depression and subsequent deterioration in disease course. However a quantitative analysis, restricted to studies with patients in clinical remission at baseline, indicated no association.

Further research into the relationship between psychosocial stressors such as depression, and outcomes in IBD is warranted. It is clear that the relationship between depression and disease course is bi-directional.2,3 That is, worse disease may lead to higher risk of depression, but also that depression itself may lead to poorer disease course. Whereas disease severity has been shown to be a risk factor for developing depression,4 proving the reverse is much harder.

We agree that a more pro-active approach is required in the diagnosis and management of co-existent depression amongst patients with IBD. Early screening for symptoms of depression and anxiety are paramount and are underscored in European consensus guidelines.5 Yet Gastroenterologists are poor at recognising the presence and severity of psychiatric disorders in their patients.6

Screening patients for resilience is a novel approach to identifying those that may be vulnerable. It is an appealing idea to go down the route of primary prevention of depression in IBD. However we still do not yet fully understand who is and who isn't vulnerable, and as yet, there is limited evidence that resilience training works in this population. Resilience may be associated with a readiness for transition to adult care in younger IBD populations,7 but further work is needed to establish its role in older patients. Furthermore it may be challenging to intervene in this way at disease onset given that patients may be unwell at this time. Gastroenterologists and allied health care professionals ideally need training to screen for signs of psychiatric disorders and traits like resilience. To enable the optimum management of such patients, stronger links between gastroenterology and liaison psychiatry need to be forged against a background of what are very often hard pressed services. Integrated care models between physicians and liaison psychiatry are already operating successfully in several London trusts.8

It is likely, even with approaches like resilience-building, depression will remain a major outcome. Certainly more work is needed to identify appropriate interventions for the treatment of depression and related potential improvements in physical disease outcomes in IBD. Given the burden of depression in these patients, we keenly support evidenced-based approaches to the identification and treatment of IBD patients with concurrent depressive illnesses, such as those described by Dr Keefer. We also emphasise the need to explore the efficacy of other interventions, such as the impact of anti-depressant medications, on short and long-term outcomes in IBD.

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