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Understanding IBD & Post-Traumatic Stress Disorder

Dr. Nandi:
Did you know that at least 20 to 30% of IBD patients develop anxiety or depression just upon initial diagnosis? In fact, there is trauma that is incurred that is completely invisible to the eye. This trauma can sometimes be known as “post-traumatic stress disorder,” or PTSD, and it is an entity that requires and demands more management if we are to serve our IBD patients with utmost compassion.

Welcome to *GI Insights* on Reach MD. I’m Dr. Neil Nandi and joining me today to discuss IBD’s relationship with post-traumatic stress disorder is Dr. Tiffany Taft. Dr. Taft is the Director of Psychogastroenterology Research in the Division of Gastroenterology and Hepatology at Northwestern University. Dr. Taft’s research has focused on elucidating the relationship between gut health and psychosocial illness. Notably, Dr. Taft speaks not only as a clinician, but also from the perspective of a patient advocate. She, herself, draws upon her own journey with Crohn’s disease and eosinophilic esophagitis. Dr. Taft, welcome to the program.

Dr. Taft:
Thank you so much for having me today.

Dr. Nandi:
It’s a great pleasure indeed, and I think that you’re gonna provide some much-needed insight for our clinicians who listen. Can you tell us a little bit more about your professional journey into GI psychology and IBD, specifically?

Dr. Taft:
Sure. So, I entered the professional world of psychology a little bit later in life; I did study psychology as an undergraduate at the University of Illinois, but then I took a 7-year gap year and worked in the corporate sector and that is when I developed Crohn’s disease at the age of 26 and that propelled me to finally take that step to go to graduate school to get my doctorate in clinical psychology. I actually didn’t intend to do GI psychology, because it wasn’t really a thing in 2004. There was some research going on, but overall, integrated care in a GI practice, like we have in several places today, did not exist. So, by chance, at a visit with my then gastroenterologist at Northwestern, I met a different physician who was looking to hire a research coordinator working on irritable bowel syndrome research and we got to chatting and he offered me that position and I took it and 16 years later I’m still with Northwestern, obviously in a quite different capacity, but that’s how it started.

Dr. Nandi:
Now, let me, kind of, set the stage a little bit: it’s estimated in the U.S. general population that PTSD, about 1 million people are diagnosed annually, so 68% prevalence in the U.S. Do we have any data outside of your study, at least prior to that about the prevalence of PTSD in IBD in this country or around the world?

Dr. Taft:
Yeah, so, the way that this study came about, actually, was a conversation with Dr. Steve Hanauer, who was noticing symptoms of traumatic stress in his patients, and he sent an email to myself and some of the other psychologists in the behavioral medicine team at Northwestern and I assumed that there must’ve been at least a few studies on PTSD in IBD patients and I went and looked and I was pretty surprised to see the only study that existed, prior to our study, was done in Europe and so there’s nothing. And I read that study and they found 25 to 30% of patients in their population that they studied had enough symptoms to meet that, kind of, diagnostic criteria, but 90% of their population that they studied had symptoms. So symptoms of PTSD include hypervigilance, a sense of hyperarousal in the body, feeling on edge, nightmares, flashbacks, low mood, irritability. So, while we talk about the people who meet the criteria, so to speak, ‘cause there’s some levels of symptom severity that there needs to be to get a PTSD diagnosis, 90% had at least some of those symptoms, so that, to me, was really staggering. And so, we decided to replicate that study in the U.S. and then we’ve since done an

additional study that we're working on to make sure the numbers we got in our first study, which were pretty high, almost 30% in that study, had what we would call significant symptoms of PTSD and I thought, "Wow, that can't be right," because our veterans, you know, other populations that you think about having PTSD, they are more like 19% or so, depending on what combat they were in.

Dr. Nandi:
When I read your paper, you detailed what some of the risk factors were. You recognized that a Crohn's patient or having ileostomy were significant triggers to associate PTSD and then just having hospitalizations or preparing for surgery. Can you elaborate a little bit more for those listening why these are triggers for PTSD?

Dr. Taft:
Yeah. Some of the things that came up related to hospitalization was communication and information exchange from the team to the patients. And then, also, something regarding the supplementation of maybe poor information or not being very clear with what we would call in the psychology world and probably medicine, as well, "Dr. Google." So, patients would hear about maybe getting an ileostomy surgery, and they would go online, on their phone, and start looking up whatever the team had discussed, maybe not very clearly and they got very scared, because, as we know, the internet is full of wonderful information, some graphic pictures, you can go down some rabbit holes on the internet. One of the criteria to have PTSD is to experience a traumatic event that is underscored by serious or perceived threat to life or well-being and intense fear in reaction to that. And so, as these patients talked about that, it was very clear that the lack of communication, the lack of information triggered some anxiety, which then took them to a place that gave them some pretty graphic information.

Dr. Nandi:
Yeah. I guess at that bedside, I think what I would take away from our conversation so far is, be more present as a physician about the information you're relaying or asking of the patient going through surgery. Never underestimate how profound that surgery is on their body and their mental psyche and then offer or proactively engage the inpatient social worker, right, or case manager to employ mental health resources. You have written about post-discharge counseling before. And that might be something that could be planned inpatient, right, for them to continue that conversation afterwards, no?

Dr. Taft:
Yeah. So let's say the patient's in the hospital, they're talking about surgery, it's not an option, you're gonna have this and then they go on Dr. Google, then they have the surgery and they have really bad pain, like, it's just a really bad experience and so we have about a month after that to really intervene and try and make it so PTSD doesn't set in and become a chronic problem. So, in the first month, we call it "Acute Stress Reaction", and so if we get in there before that, I mean, obviously plus or minus a month, we can ward off a chronic PTSD diagnosis.

Dr. Nandi:
Thank you, Dr. Taft. For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Neil Nandi and today, I'm speaking with Dr. Tiffany Taft about the relationship between IBD and PTSD, post-traumatic stress disorder and how it influences our patients and our clinical practice. Now, Dr. Taft, where can clinicians for instance, inpatient, they may not have the resources at their institution, where can they direct their patients or who can they outreach to find a mental health caregiver for their patients?

Dr. Taft:
Yeah, I would recommend Psychology Today has a therapist finder database. I am listed in it; most people are listed in it. You can search by zip code, you can search by trauma specialization, you can search by insurance type, there's a lot of filters, that's why I direct people to this database above other ones, there are other therapist directories, but I like this one because of its filtering properties.

Dr. Nandi:
Dr. Taft, before we conclude, I wanna ask you, are there any other closing remarks or last thoughts that you wanna leave our gastroenterologists and healthcare workers about PTSD and how it effects our IBD patients and what they can do?

Dr. Taft:
Yeah, I think my take-away is don't be afraid to ask. I think sometimes people don't ask because they don't have an answer or they're, like you said, they're not trained in that area, but thinking about if there's a time when you were very afraid and what helped you feel better; was it a kind word or sense of support from somebody, was it just a hand on your hand saying 'it's gonna be ok'? Those simple gestures can diffuse that fear in patients pretty quickly. Letting them know that you've got their back, that you're listening, that doesn't mean you have to spend 45 minutes talking to them but these simple things that we all appreciate in our day-to-day lives to feel like, 'OK, I'm safe. I don't like this, I'm not excited about having surgery, but I feel safe', can diffuse some of that intensity that maybe make a difference in where that patient's trajectory might go. So, don't forget those simple things that don't take a lot of time.

Dr. Nandi:
So, it's OK to ask, it's OK to feel and really, when it comes down to it, what you're encouraging our clinicians to do is practice empathy, right? Be empathic. Dr. Taft, that's our time for today's episode, but I wanna sincerely thank Dr. Tiffany Taft for joining us today to discuss the psychological impacts of PTSD in our IBD patients. Dr. Taft, it has been my great pleasure to have you on our program. Thank you so much for doing what you do and being the patient champion that you are.

Dr. Taft:
Thank you very much for having me.

Dr. Nandi:
For ReachMD, I'm Dr. Neil Nandi. To access this episode and others from GI Insights, visit ReachMD.com/GIInsights where you can be part of the knowledge. Thanks for listening.