

PSYCHOLOGICAL ASPECTS OF RHEUMATIC DISEASES

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ABSTRACT

Psychological problems in rheumatic diseases are common and influence the maintenance of symptoms and management. The psychological and psychosocial aspect of rheumatoid arthritis and systemic lupus erythematosus are briefly described. An approach to psychological management and the role of the psychiatrist in rheumatology are considered. In addition to appropriate and adequate treatment of concomitant psychological disorders with drugs, psychosocial interventions and the use of other forms of therapy such as self-help groups are also invaluable.

Keywords: psychological, psychosocial, rheumatoid arthritis, systemic lupus erythematosus, depression, self-help groups

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INTRODUCTION

In medicine, there is currently a trend towards a bio-psycho-social approach in the treatment and management of diseases. This is especially true in the field of rheumatology which encompasses a wide range of disorders including rheumatoid arthritis (RA), systemic lupus erythematosus (SLE), fibrositis and osteoarthritis. Rheumatic diseases are often chronic, unpredictable and painful. Physical deformities and disabilities may occur and these affect social and occupational functioning. All these factors may lead to psychological sequelae which in turn affect the maintenance of symptoms and management⁽¹⁾.

Doctors treating rheumatic patients often find that a fair amount of time is spent dealing with psychosocial problems that often complicate management. The majority are treated by the primary physician and are not referred to the psychiatrist⁽²⁾. There is a need for physicians to be aware of the problems the patients face, to be willing to listen and help patients deal with them. Depression unless specifically sought is often missed and an apparent relapse of the disease or treatment failure may actually be the result of a depressive illness. Psychological symptoms add to the distress and suffering of the disease.

PSYCHOLOGICAL ASPECTS OF RHEUMATOID ARTHRITIS AND SYSTEMIC LUPUS ERYTHEMATOSUS

Rheumatoid arthritis

Rheumatoid arthritis has a tremendous impact on all aspects of a patient's life. At the time of diagnosis, the patient may react with shock, anger or denial. Resignation and later acceptance⁽³⁾ follow with adjustment to the illness. Psychological problems result from an interaction between the disease, the patient's personality and life experience and his environment.

RA is a disease that is unpredictable, painful and may lead to deformities and disabilities. Patients admit to a fear of becoming crippled and dependent and are uncertain about the future. There is loss of self-esteem and an altered self image. Sexual problems may arise and unless specifically asked,

patients often are too embarrassed to tell their physicians of their problems.

The prevalence of psychiatric disorders in RA in the literature ranges from 20% to 80%. However, many early studies had significant methodological flaws⁽⁴⁾. Recent studies using stringent criteria have been done and Murphy et al⁽⁵⁾ found a prevalence of depression or anxiety in RA of 21%, which is a figure that is similar to that of patients with other chronic diseases.

Earlier personality studies of RA patients have described them as being depressed, dependent or unable to express feelings of anger. These have been criticized and it is now accepted that these descriptions are the result of the illness rather than a "rheumatoid" personality⁽⁶⁾.

During exacerbations of RA, the pain and disability can be distressing and psychological symptoms are common. It was generally believed that the more disabling the disease the higher the prevalence of depression. However, recent studies have not confirmed this. Murphy et al⁽⁵⁾ found that the presence of a psychiatric disorder was not related to 10 measures of activity and duration of RA. Further research would be invaluable.

Occupational difficulties occur, especially if patients are manual workers and are unable to continue working. The decreased income and high medical bills can lead to severe financial strain. Financial difficulties and marital or family conflict are important factors in depression.

Non-compliance to treatment is a major problem and studies have shown that at least 50% of patients do not comply with their treatment⁽⁷⁾. Important considerations include the duration of the illness, the complexity of the treatment regimen and the patient's beliefs and attitudes towards the disease. Jette AM⁽⁸⁾ recommended that simplification of treatment regimens with clear instructions on drug dosages, individualised patient education and a good rapport between physician and patient may improve compliance.

Systemic Lupus Erythematosus

SLE is a chronic, unpredictable autoimmune disease that affects mostly females in the prime of their lives. The prevalence of psychiatric and neuropsychiatric manifestations of SLE ranges from 3- 52% depending on the study⁽⁹⁻¹¹⁾.

The common psychiatric disorders seen in SLE patients include organic mental disorders, depression, psychoses and adjustment disorders.

As SLE is a multisystemic disease the effects of SLE on the CNS may be due to immune-complex-mediated alterations in the choroid plexus⁽¹²⁾, antibodies to neural membranes or

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vasculitis. At times, it may be difficult to differentiate whether a particular psychological problem is purely organic, or is functional. If cognitive deficits are present then it is more likely to be organic. However, it must be remembered that mild or subtle cognitive deficits may be missed especially if the patient is uncooperative, aggressive or too disturbed during the psychiatric interview.

Other complications of SLE eg infections, electrolyte abnormalities, renal disease can also lead to psychological symptoms. The effect of drugs must be considered as patients often are on a variety of drugs. Anti-hypertensives and immunosuppressives are known to cause depression and mood changes and psychotic symptoms have been reported in steroid therapy⁽¹²⁾.

Acute confusional states (delirium) must be excluded and the underlying primary cause treated. Depression is common in SLE and may be reactive in nature. Alternatively, it may be due to drugs or the effect of SLE on the brain. Psychoses in SLE have been well documented and may present with affective or schizophrenia-like symptoms, or may have a mixed presentation. It may be difficult to distinguish SLE psychoses from steroid psychoses. Hall et al⁽¹³⁾ did not find a characteristic pattern of presentation of steroid psychoses, however those patients who received daily doses of 40 mg of prednisolone or its equivalent, were at greater risk of developing steroid psychoses.

The effect of SLE on a patient is tremendous. It can alter the patient's entire lifestyle. Arthritis, cardiac or renal complications all lead to restrictions and disability. A disfiguring facial rash or alopecia in a young girl can be stigmatising and make adjusting to this disease even more difficult. With repeated admissions, some lose their jobs or are unable to continue with their education. Ignorance about SLE is prevalent and misunderstandings occur when vague symptoms of malaise, fatigue and aches and pains are misinterpreted as laziness. Relationships are strained and families may react with criticism and intolerance or overprotectiveness.

APPROACH TO PSYCHOLOGICAL MANAGEMENT

Psychological problems in rheumatology are ideally managed jointly by the primary physician or rheumatologist and the psychiatrist. However, this may not be possible or feasible in all cases due to the stigma of mental illness and a shortage of psychiatrists. Consequently, the majority are treated by the primary physician or rheumatologist.

Nevertheless, the key in psychological management is to help patients cope with their illnesses. Patients need to be educated realistically about their illness on an individual basis, depending on their capacity to understand and cope with the information. Compliance should be emphasized and their families need to be involved at an early stage.

During routine assessments, an enquiry is made into the patient's emotional state. If a mood change is present, it should be decided whether it is a normal or abnormal mood change and whether it is appropriate for the physical condition and disability. If a pervasive low mood is present, other features of depression should be actively sought. Features such as early morning awakening, loss of appetite and weight, a diurnal variation in mood and suicidal ideation suggest a diagnosis of depression. However, other symptoms such as fatigue, lethargy, loss of energy and drive and insomnia may be due to a relapse of the rheumatic condition rather than a depressive illness. Where indicated, an assessment for cognitive deficits and psychotic symptoms should be done.

At times, it may be difficult to differentiate between depression and the disease itself. In such cases the skills of a psychiatrist may be needed. Psychiatric consultation is also necessary when there are associated psychotic symptoms or

when the depression does not respond to adequate treatment. In patients who are disturbed or suicidal, specialised inpatient treatment may be necessary and the patient is managed jointly by the physician and the psychiatrist.

In management, a holistic approach is required. When psychotropic drugs are used, caution is needed especially if for example, there is concomitant cardiac or renal involvement of SLE. In depression, an adequate course of anti-depressant treatment is indicated but psychosocial issues must also be addressed. Patients who do not respond to adequate anti-depressant treatment may respond to ECT⁽¹⁴⁾. Non-sedating anti-psychotic drugs such as haloperidol, are useful for psychotic symptoms.

It is important to be aware of the effect of the illness on the patient and his family and to identify any stresses or conflicts present as discussed previously. Management of the patient must involve the family as well as the patient. Often simple counselling and practical advice by an understanding doctor may be all that is necessary. Specific social problems may require referrals to appropriate agencies eg financial, employment and housing authorities. Other therapeutic approaches like relaxation, biofeedback and cognitive behavioural therapy⁽¹⁵⁾ have been described in RA and may be beneficial.

Organisation like the Lupus Aid Group are invaluable. In such organisations, educational talks and self-help groups are conducted. Working with patients who are dealing with a disease that may be potentially fatal requires skill and sensitivity as well as experience and training. Therefore, the self-help groups are run jointly by a psychiatrist and a group. Patients are given an opportunity to discuss their problems and express their anger and emotions openly and during such sessions. Patients often find that others have similar problems and that they are not alone in their suffering. Issues of family conflicts and losses are discussed and patients support and encourage each other and often share practical suggestions on how to cope with their disabilities and problems. This has considerable benefits as patients frequently contact each other outside the group meetings and thus extend their social support system.

In conclusion, there is much that can be done to alleviate the psychological suffering of patients with rheumatic disease. With a wider view of medicine, there is a need to forge closer links between the physicians and psychiatrists. Self-help groups are excellent opportunities for psychiatric training, where under supervision, trainees work as co-therapists and learn group therapy.

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