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EDITORIAL

The Problem of Detecting and Managing Depression in the Rheumatology Clinic

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Psychiatric comorbidity in arthritis can be surprisingly high. For example, Wells et al (1) reported a lifetime psychiatric prevalence rate of 64% and a recent prevalence rate of 42% (last 6 months) in persons with arthritis drawn from a community sample. Depression is one of the most common psychiatric conditions found in patients with arthritis. Frank et al (2) reported that as many as one-third of patients with rheumatoid arthritis (RA) have been found to experience major depression or dysthymia, according to objective diagnostic criteria. In contrast, the prevalence of depression in nonmedical populations is estimated to be between 5% and 8%. Thus, while depression is one of the most common psychiatric conditions in the general population, it is clear that arthritis increases the risk for depression. Patients are very likely to have difficulty with depression while managing their arthritis and, therefore, to experience symptoms of depression during rheumatology visits.

Depression includes a spectrum of disorders that vary in severity and associated impairments. Patients with a history of major depression typically have a chronic course that requires effective monitoring and management. Chronic depression may exist independently of, but can also be exacerbated by, disease flares and other illness-related obstacles. Patients with minor depression, or who have an adjustment disorder with depressed mood, experience fewer symptoms and generally have less social, occupational, and functional impairment from their condition than patients with major depressive disorder. In contrast, moderate to severe depression can adversely affect health outcomes and quality of life in a manner similar to that of other chronic medical conditions. In addition, depression may contribute to inflammation, interfere with medical adherence, and thus compromise medical treatment and management. In this regard, a longitudinal study by Ang et al (3) found that clinical depression resulted in a 2-fold increase in the likelihood of early mortality in a cohort of patients with RA followed over a 12-year period. In addition to negative health consequences, depression may contribute to unemployment, loss of work productivity, and increased health care costs in persons with arthritis (4). All of these factors heighten the importance of detecting and managing depression in patients with arthritis. When rheumatologists do not recognize depression, the risks to patients, their families, and the health care system can be severe.

In light of the above findings, the article by Sleath et al (5) in this issue of *Arthritis Care & Research* provides evidence of a significant clinical problem in the care of patients with RA. Three important findings stand out in this research. First, the authors found that patients who were rated by their rheumatologists as having worse functional status were more than twice as likely to have moderately severe to severe depression. Second, only 4 (19%) of the 21 depressed patients had the opportunity to discuss their depression during medical visits. Third, when depression was addressed, the patient initiated the discussion each time. Not once during 200 office visits did a rheumatologist bring up the topic of depression to the patient. Because the study focused only on moderately severe to severe depression, the prevalence of minor depression was not assessed. Many more patients could have been afflicted with less severe forms of depression in the sample.

Potential Issues Involved in the Recognition and Management of Depression

A combination of factors may prevent depression from being identified, evaluated, and managed within the rheumatology clinic. Presently, the lack of research on this issue causes analysis of the problem of managing depression in rheumatology to be speculative and without definitive answers. The dearth of research is a problem itself and begs the question of why investigators also have ignored this issue. Nevertheless, future studies directed at the following areas may help shape the agenda of health services researchers.

The disconnect between research and practice. Although psychosocial research has had a rich history in

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rheumatic disease and several leading rheumatology journals have published studies on depression, empirical findings on depression, as the article by Sleath et al (5) suggests, may not affect the practice of rheumatology in a meaningful way. Findings on depression may not be penetrating clinical practice. The problem of dissemination may be compounded in instances in which scientific information crosses interdisciplinary boundaries, and practicing clinicians may lack familiarity with the relevance of the information to the everyday functioning of patients and their own clinical activities. Research is needed on the barriers that prevent the dissemination and incorporation of scientific knowledge on depression into rheumatology practice settings. A variety of psychosocial factors such as stress, negative health beliefs, passive coping, and poor social support have been shown to contribute to depression in RA (6), but greater efforts may be needed to demonstrate the clinical relevance of such factors to patient treatment. Currently, there is little evidence that such information affects how rheumatologists manage their practices, and how they evaluate and treat patients who have mood disturbances. Studies on the dissemination of psychosocial factors into rheumatology care are essential to address this problem.

Systems constraints. Even if dissemination of research occurs, rheumatologists may not be able to identify or manage depression because time limitations, reimbursement and insurance coverage problems, and lack of personnel resources may prevent them from doing so in the clinic setting. The main priority of rheumatology care is to evaluate disease activity and make necessary adjustments to medications and biomedical management. Clinical transactions commonly take place within a window of 15–20 minutes, leaving little opportunity for rheumatologists to explore psychosocial aspects of the patient's adjustment. The high degree of specialization involved in rheumatology could make it impractical to address psychosocial issues in patient functioning such as those that may be involved in depressed patients. Whereas primary care practitioners commonly detect and manage depression (7), rheumatologists may not be able to assume this responsibility despite acknowledging the importance of depression as a clinical problem.

RA can mimic the symptoms of depression. In the absence of systems constraints, rheumatologists may still find it difficult to recognize depression in patients with RA because the symptoms of these conditions can overlap and create diagnostic confusion. Fatigue, insomnia, and loss of motivation are symptoms that can potentially reflect either RA or depression. The inflammatory process itself may lead to depression and sleep disturbance (8). When patients report these symptoms during a rheumatology visit, the medical context of the clinical encounter may cause rheumatologists to attribute the symptoms to RA instead of to depression. Furthermore, in instances in which patients somatize their psychological distress by focusing on their physical discomfort and symptoms, the probability of not detecting depression is compounded because, by definition, these patients avoid communication about emotional issues. Thus, rheumatologists and patients may embrace a similar attitude about the medical nature and significance of the clinical transaction, with the result that depression goes undetected.

Reticence to deal with psychological issues. Rheumatologists may be reluctant to evaluate depression for several reasons. They may feel uncomfortable about asking personal questions that could create clinical ambiguity and uncertain outcomes for which they will be responsible. Attempts to acquire personal information may lead to a "mental health slippery slope" that rheumatologists do not have the time, resources, or expertise to manage. Rheumatologists may not feel adequately prepared to deal with depression, particularly in instances in which they are addressing difficult medical challenges and problems and may feel overwhelmed by the prospect of detecting a psychiatric disorder. Alternatively, some rheumatologists may lack personal communication skills that are necessary to understand the mental health needs of their patients. Insufficient education and training on the psychosocial adjustment process in rheumatic disease may be a contributing factor to this dilemma. In this regard, rheumatologists may not be sufficiently aware of the efficacy of psychological treatments and the availability of adjunctive clinical resources that could provide support for depressed patients.

How to Improve the Detection and Management of Depression in RA

Embracing an integrated model of care. With its emphasis on pathophysiology, physical symptoms, and pharmacologic interventions, the biomedical approach in rheumatology has obvious limitations for the detection and management of depression. This approach is narrow and highly specialized and, consequently, does not lend itself to evaluating the psychosocial functioning of patients. Optimally, the paradigm of care for patients with RA should encompass all relevant dimensions of the condition, including psychological, cultural, and social factors, and match the nature and complexity of the problem. For example, if many different factors affect the adjustment to RA, health care providers should take this information into account in designing management approaches and intervention strategies that are likely to ameliorate depression. Narrow paradigms of care that do not address important elements of the adjustment process are likely to contribute to incomplete management approaches that have marginal clinical benefits. This is particularly a problem in the management of depressed patients. In contrast, the adoption of an integrative framework facilitates the recognition of depression as a clinical problem that is seen within the context of the disease process and as a factor that can both influence and be influenced by RA. The promotion of this framework in research has highlighted several factors that are related to depression in RA and has created an awareness of the need for behavioral treatment and psychoeducational approaches. Clinical care for depression in patients with RA should have a parallel em-

phasis to ensure correspondence between science and practice and a best practices approach to treatment.

The need for screening and evaluation in the clinic setting. Identifying symptoms of depression in rheumatology practice is not difficult. It is possible to assess the severity of depressive symptoms and the likelihood of depressive disorder through appropriate screening and evaluation methods. Rheumatology has a long and successful history of using self-report inventories to assess health status and troublesome symptoms. Accordingly, several self-report measures of depression are available that can be incorporated into routine clinical evaluation procedures. Instruments such as the Beck Depression Inventory (9), the Center for Epidemiologic Studies Depression Scale (10), and the Patient Health Questionnaire (11) have been used in studies of patients with chronic illness and have cutoff scores for detecting depressive disorder. Other self-report measures that have been validated through extensive research, such as the Arthritis Helplessness Index (12) and the Arthritis Self-Efficacy Scale (13), may also signal the presence of functional problems and depressive disturbances and may have a useful role in the rheumatology clinic as well. The integration of these measures into rheumatology practice is simple and straightforward. While time may be a limiting factor, the health care team should review the data and briefly discuss the meaning and significance of depression as a clinical problem with the patient, emphasizing the need for active management.

Establishment of a management plan. In addition to establishing a screening process, the rheumatology health care team must have a management plan to provide effective followup to depressed patients. An important element of such a plan is to establish a liaison with a behavioral medicine specialist. Behavioral medicine specialists are typically clinical psychologists who have expertise in evaluating psychosocial functioning in medical patients and in providing behavioral interventions to enhance their quality of life. These professionals can work closely with the health care team in developing and implementing interventions for depressed patients. They can play an important educational role by explaining to RA patients how depression may result from the stress of the illness and functional limitations. They can also point out that depression may influence the disease process by influencing adherence, activity level changes, and sleep. Behavioral medicine clinicians can carefully assess the need for psychological interventions and implement psychotherapeutic and cognitive-behavioral treatments that have established efficacy for depressed patients. Although it is advantageous to provide this form of clinical care in the rheumatology clinic to facilitate coordination of care and patient compliance, it is not common for behavioral medicine specialists to practice in a rheumatology setting. Extra care may be required to establish effective collaborative relationships with behavioral medicine specialists who practice in other settings. An effective framework for communicating between rheumatology health care providers and behavioral medicine professionals may offset some of the logistical difficulties that result from rheumatologists and behavioral medicine specialists practicing at separate sites.

Absence of disease versus the need for positive health functioning. Reducing inflammatory disease activity and controlling difficult symptoms will continue to be the major objectives of rheumatology care. However, the biomedical approach for managing chronic illness places inordinate emphasis on preventing or eradicating negative health consequences in patients and much less importance on enhancing the positive psychosocial adaptation in patients. Rheumatology care for RA should embrace the challenge of helping patients achieve optimal psychosocial functioning in the face of their medical condition. The existence of depression reflects a definite threat to the adjustment of patients with RA and a significant deficit in their emotional functioning. However, the absence of depressive symptoms does not mean that patients are functioning optimally in the face of their medical condition. Patients may continue to have difficulty in accepting their condition and finding opportunities to pursue meaningful, productive lives in the face of RA. Ideally, the health care system should have the capacity to address such needs in patients. Behavioral interventions can lead to the achievement of these goals by helping patients cope with disease-related burdens and negative emotional states that interfere with quality of life (14).

Conclusion

In summary, the article by Sleath et al (5) illustrates a need for improvement in the paradigm of care of patients with RA. In addition to managing disease, rheumatology care should address the challenge of addressing and responding to the psychosocial needs of patients more directly and thoroughly. Further education and training for rheumatologists and the use of effective strategies to cope with practice barriers and constraints may be necessary to effect this change. Doing so may yield important benefits to patients and the health care system. Through the adoption of effective screening and management strategies for depression, the practice of rheumatology can have an important and lasting impact on the emotional well-being of patients with RA.

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