

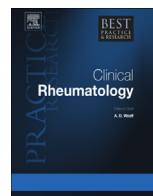


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## Best Practice & Research Clinical Rheumatology

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9

# The role of psychological factors in inflammatory rheumatic diseases: From burden to tailored treatment



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### A B S T R A C T

#### Keywords:

Psychology  
Cognitive-behavioral factors  
Stress  
Rheumatic disease  
Adjustment problems

Inflammatory rheumatic diseases have a long-lasting effect on patients' physical and psychological functioning, for instance, due to disabling symptoms and unpredictable disease course. Consequently, many patients show adjustment problems such as depressed mood, which in turn can negatively influence their disease outcome. Specific biopsychosocial factors have shown to affect this outcome. For example, daily stress, cognitive-behavioral risk factors such as pain catastrophizing and avoidance, and resilience factors such as optimism and social support influence the quality of life, physical symptoms of pain and fatigue, and inflammatory markers. Psychological interventions tackling these factors can have beneficial effects on physical and psychological functioning. Recent advances in screening for patients at risk, tailored treatment, and eHealth further broaden the efficiency and scope of these interventions while simultaneously optimizing patient empowerment. This chapter describes the biopsychosocial risk and resilience factors related to disease outcome and the possible benefits of psychological treatment strategies in inflammatory rheumatic diseases.

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Strong evidence has demonstrated the substantial negative impact of inflammatory rheumatic diseases such as rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis on everyday quality of life. Similarly, it has been well-documented that the manner in which patients deal with this chronic stressor affects their long-term physical and psychological functioning, indicating a number of biopsychosocial risk and resilience factors in these patient groups [1–7]. Tackling these biopsychosocial risk and resilience factors through psychological interventions has shown to have possible benefits for patients with inflammatory rheumatic diseases, with recent advances concerning screening, stepped care, tailoring, and eHealth providing new opportunities for optimizing patient care [2,3,8].

In this chapter, we describe the psychological burden reported by patients with inflammatory rheumatic diseases and the risk and resilience factors related to the quality of life (including physical and psychological functioning) and disease outcome according to prospective and experimental studies in inflammatory rheumatic diseases. In addition, we describe the effects of psychological interventions tackling these factors and outline implications for optimizing patient care in the future including recent advances of screening, stepped care, tailored treatment, and eHealth. Although this review aims to capture various inflammatory rheumatic diseases, it is relevant to mention that most of the studies have been performed in patients with rheumatoid arthritis. Therefore, although studies have shown that quality-of-life impairment and biopsychosocial risk and resilience factors are mostly comparable between diseases [9,10], generalizing the findings to all inflammatory rheumatic conditions should be performed with caution. In addition, we use evidence from healthy controls and patients with other chronic somatic conditions in the case of a lack of studies for inflammatory rheumatic diseases.

### **Psychological burden of inflammatory rheumatic diseases**

Inflammatory rheumatic diseases such as rheumatoid arthritis and ankylosing spondylitis have a major and long-lasting effect on the quality of life of patients. Their chronic and progressive nature, accompanied by disabling symptoms of pain, stiffness, and fatigue; their need for long-term medication use with potential serious side effects; and their unpredictable disease course lead to patients requiring to adjust to functional disability, to limitations on almost all areas of daily life (such as work, leisure activities, and social and family life), and to a changed and uncertain future perspective [1–7,11–13]. In addition to the effect of the disease on daily life, the pathophysiological disease process itself, with chronic inflammatory activity, may further influence psychological functioning, for example, due to a direct link between inflammatory processes and depressive symptoms [2,8,14–16].

The level of psychological burden, which can vary from a mild to moderate level of psychological distress to clinical depression and anxiety, differs between diagnostic groups and individual patients and can vary over time [8]. The past decades have shown large improvements in disease activity control of inflammatory rheumatic diseases, as shown by the large decreases in the levels of physical disability, anxiety, and depression [17]. However, the quality of life of patients with inflammatory rheumatic diseases remains considerably lower than that in the general population [13] and is comparable to that in other chronic somatic diseases including cardiovascular conditions and diabetes [1]. Thus, many patients show some level of heightened psychological distress, with a substantial percentage developing clinically relevant levels of distress, such as depression and anxiety, with prevalence rates varying between 10% and 40% depending on the criteria and instruments used (e.g., clinical interviews show lower percentages than screening questionnaires) [7,8,17–19].

A high psychological burden has been shown to significantly impair the health-related quality of life of patients with inflammatory rheumatic diseases. In addition, it negatively affects disease outcomes including physical disability, remission scores, pharmacological treatment adherence and response, healthcare costs, and mortality [2,8,15,20–23]. Thus, trying to minimize the level of psychological burden of patients with inflammatory rheumatic diseases is of high clinical relevance, and knowing the factors influencing this burden and their effects on the quality of life and disease outcome will aid in the development and refinement of interventions for these patient groups.

To conclude, the psychological burden of inflammatory rheumatic diseases is substantial, which corresponds to the percentages reported in other chronic somatic conditions, and demands serious

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