RHEUMATOLOGY

Editorial

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The Odd Couple?—Hardly

The emerging overlap between rheumatology and psychiatry

At first look, the two authors of this opinion piece might appear to represent specialties that could be considered an odd couple. One is a rheumatologist, the other a psychiatrist. Don't they represent two completely different, non-overlapping specialties? Hardly. The last few years have clearly demonstrated a great overlap between rheumatological/inflammatory disorders and mental health impairments. Despite this, the fact remains that these two specialties rarely collaborate, which ends up being a disservice to the patients we treat. It is time to divide no more, and for both specialties to collaborate with each other to ensure better treatment outcomes for our patients.

But is this call to a more harmonious relationship between the two specialties an empty platitude, a feel-good statement, or is there evidence to demonstrate why rheumatology and psychiatry matter to each other? The emerging evidence has persuasively demonstrated unusually high rates of depression and anxiety disorders in patients with various rheumatological illnesses. This high association has been demonstrated in RA [1], AS [2] and PsA [3], among others. There is considerable evidence this overlap extracts a price from our patients in terms of disease activity [4] and impairment [5]. This overlap between rheumatological and psychiatric illnesses has now been widely documented in the literature and is not a trivial matter. In fact, a recent study revealed that of all the baseline prognostic indicators for disability at 1 year in a group of early inflammatory arthritis sufferers, depression ranked number 2 (odds ratio of 2.52) and anxiety ranked number three (odds ratio of 2.37) [6].

How is this overlap even possible, and why have the two specialties only recently become aware of this information? The simple fact is that both specialties trade in the same currency—pro-inflammatory cytokines such as TNF-α and IL-6 are not just important in rheumatology, but also in mental health disorders [7]. Additionally, chronic pain, a frequent co-morbidity of both rheumatological and psychiatric disorders, creates further ties that bind these two specialties. But how did we miss this link? Both authors strongly believe that the silo effect that afflicts both specialties is to blame. Both specialties saw the other as having distinct, non-overlapping pathophysiology. It is now clear we were mistaken.

We would like to recommend the following steps to expeditiously rectify matters. First, this opinion piece might serve as a model for how individuals from both specialties can collaborate at multiple levels. We think it is important for both specialties to be present at each other's continuing educational meetings, and active efforts to develop liaisons in the outpatient setting should be urgently undertaken. The training of junior staff of both specialties should include this emerging understanding of the overlap. Screening for depression and anxiety disorders should occur routinely in all patients afflicted with rheumatological disorders. There are multiple, reliable, patient friendly instruments available to serve both specialties well [8]. All of these steps matter as both anxiety and depressive disorders impede the primary goal of a rheumatologist—to control the inflammatory disease and to optimize functioning. And of course, if a psychiatric illness of significant concern is detected, obtaining a consultation from a psychiatrist is key.

We urge psychiatrists and other mental health professionals to be aware of the bidirectional overlap between mental health and rheumatological disorders, and to discard the outdated mind–body dichotomy that prevents interaction and consultation with each other. Rheumatology does need psychiatry's help to sharpen skills in the detection and screening for mental illnesses, and rheumatologists certainly need help from psychiatry with patients who are suffering from complex mood and anxiety disorders.

We do not believe this is going to be easy—either for rheumatologists or for psychiatrists. The legacy in both specialties has been to focus on just their areas of interest—just on the body in the case of rheumatologists, or just on the mind/brain in case of the psychiatrists. To be candid, there are numerous barriers in our path of reunification. Our decades of training and heritage often calcify our thinking. Clinics are typically not set up for ease of referrals to each other and of course, patients often resist being labelled as having a mental illness. Yes, we both see the challenges, but we also see that there is no real option other than to collaborate and partner for our patients' ultimate well-being.

We propose a unifying model for both specialties to consider—we call it the SEC model. SEC stands for sensory, emotional and cognitive. We propose that the sensory (pain, stiffness), emotional (stress, depression, anxiety) and cognitive (catastrophizing) domains negatively impact patients. There are strong neurobiological underpinnings to such an overlap in patients seen in both psychiatric and rheumatology clinics [9, 10] (see Fig. 1). If both specialties are persuaded to adopt this model, the odd coupling of these two will disappear and we will be more effective in helping our patients.

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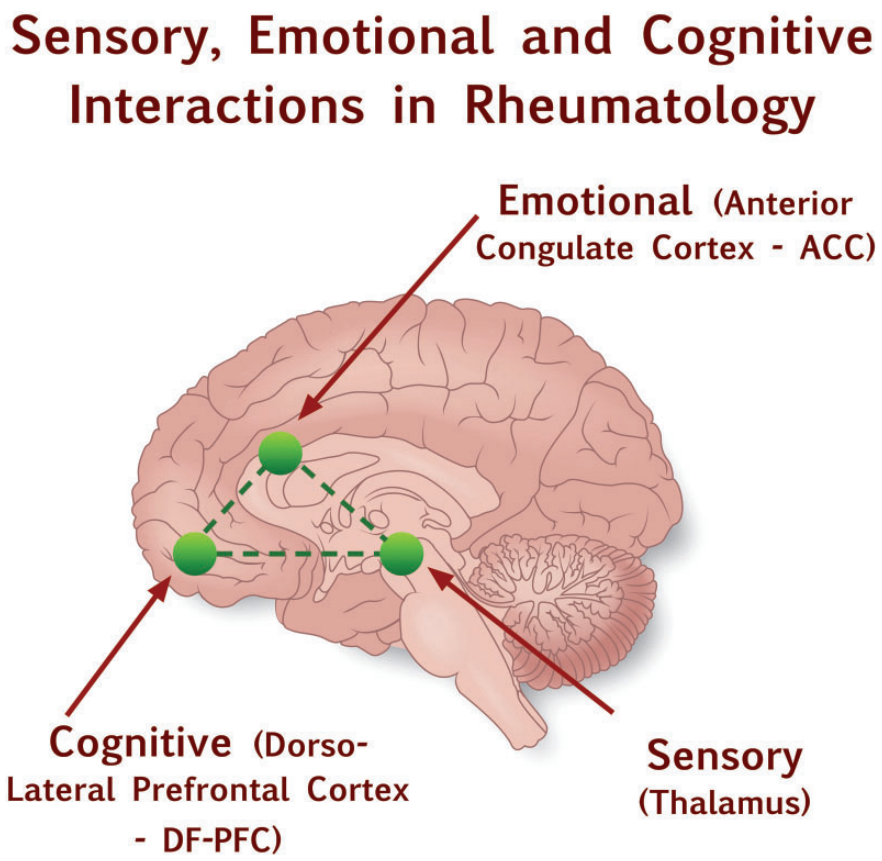
Fig. 1 An integrated model of sensory, emotional and cognitive issues in chronic inflammation



SEC: sensory, emotional and cognitive.

In conclusion, the authors—a rheumatologist and a psychiatrist—strongly urge both specialties to connect with each other, to collaborate with each other, to learn from each other and to use techniques from each of the specialties. It appears that to only partially address the needs of our rheumatologically ill patients is to guarantee suboptimum outcomes. And that, of course, is never our goal. We hope this is a call to action for both specialties, and we look forward to greater collaboration and partnership between the two.

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