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Editorial

Psychosocial aspects of rheumatic and musculoskeletal diseases[☆]

Aspectos psicosociales de las enfermedades reumáticas y musculoesqueléticas

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The majority of rheumatic and musculoskeletal diseases (R&MSD) affect the individual on a cognitive, emotional and behavioural level from the moment the patient receives their diagnosis. The patient begins with a series of clinical symptoms which may affect their mobility to different degrees and also lead to impairment or loss of some of daily life functions, such as personal care, work and other basic activities, thereby leading to direct or indirect alterations to the person's financial independence and social roles.

It is important to consider this disease from a biopsychosocial perspective, as a system where the modification of one dimension may lead to changes in others. In this sense, the severity over the course of the disease may lead to an increase in negative emotions (anxiety, rage or sadness), pain, disability and reduction of the ability to work, carry out everyday tasks and social activities. The currently recommended biopsychosocial model for an approach to any pathology, calls upon the detection and treatment of patients' psychological and social problems, not a mere focus on their physical problems, since it has been proven that control of psychological problems, offering information and correct adaptation improves the doctor-patient relationship and the course of the disease.¹

Cognitive assessment which is the patient's interpretation of the status of their disease has essential repercussions on their mood and how they are able to cope. Patients with a more negative view of their disease (catastrophist) or who have a low level of belief in their ability to function as a result of the disease are less susceptible to carrying out effective behavioural strategies such as adhering to medical recommendations or adopting active methods of coping such as, for example, performing the recommended physical activity.² In contrast, those people with greater resources in coping with their disease and who are able to seek alternatives or solutions for themselves usually have a more favourable evolution.³

Certain beliefs and attitudes towards disease prognosis, the need from treatment or fear of side effects of drugs may lead to poor treatment adherence.⁴

During the course of the disease attention must be paid to the patient's emotional sphere. With regard to symptoms of anxiety and/or depression, it appears that the first three months subsequent to diagnosis are those of the greatest risk in this sense, and from 3 years onwards the incidence largely decreases. Among the factors which are associated with a higher risk of psychological distress are: female gender; a primary educational level; being an active employee and having a lower income level. The clinical activity of the disease and the extent to which functional levels are affected are also determining factors with regard to the possibility of psychological distress.⁵

The novelty, unpredictability and uncontrollability of the disease and of the different situations accompanying it may be major factors of stress. From the minute a person begins to experience symptoms, when the diagnosis of the disease is received, when they are facing therapeutic failure, when they have to start a new treatment, etc. the patients are facing situations which meet all the typical traits that triggering off stress: new situations for them, about which there is little information, difficult to predict their appearance and their evolution and with major consequences for their life and their everyday existence that they sometimes regard as limited.

The clinical symptoms which are the major stressors for patients with R&MSD are the ones mainly affecting their quality of life.

Firstly pain, which is present to a greater or lesser extent during the course of these diseases and is one of its major stressors. Patients consider this to be key when assessments on their state of health and the state of their condition are made.⁶

In people with R&MSD disability presents as a consequence of disease and pain. It has a limiting effect on them for many of their

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activities, and is perceived by patients as one of the most frustrating aspects of their illness. Limitations and depending on others as a result, linked to the before-mentioned pain, are the most outstanding stressors associated with R&MSD in most studies. In many cases their ability to walk and do exercise is limited, occasionally affecting their ability to carry out domestic tasks. Patients who are sportspeople are particularly disadvantaged as the practice of these activities is drastically reduced.

Fatigue is a subjective sensation of tiredness or exhaustion which is not relieved by resting. Patients describe the fatigue as physical, cognitive and emotional, which is highly incapacitating for them and the percentages of severe fatigue vary between 35% and 80%, depending on the pathology.⁷

On many occasions these stressors are accompanied by complications with finances and employment. It has been noted that the support from colleagues, perception of the importance of work and self-sufficiency in the workplace are factors which help the patient to remain in an active situation of employment.⁸

Many patients with R&MSD refer to relevant changes in social and family relationships. Half of patients suffer from dysfunction in areas of social interaction, in communication with others and in emotional behaviour and two thirds state that they have experienced a drastic reduction in leisure or pleasurable activities. This is seriously damaging to their quality of life since apart from reducing social activities the patient loses the ability to enjoy him or herself, due to pain and the difficulty in performing some of these activities. Pastimes and hobbies of these patients are diminished, particularly in those cases where some kind of physical effort is required. The patient goes out less for leisure activities, such as going out to dinner, the cinema or shopping. Meeting friends is also affected, sometimes because the patient is not able to spend long hours in the same place or in the same posture. A similar thing occurs with inviting friends home, as this always requires extra effort for the host and if this is a patient, they prefer to avoid it.

Many patients with R&MSD perceive of not being understood in their environment.⁹ At present new treatment strategies and drugs result in external manifestations of the disease not being obvious in the majority of cases and experiences such as fatigue, stiffness or pain itself and its impact are not appropriately appreciated by other people. This situation may have an effect on the family and the social support the patient receives, which is of vital importance.^{10,11}

The appearance of the disease greatly affects the previously established family dynamics and requires a period of adaptation and restructuring of this dynamic or family functioning. The roles of the family usually change temporarily or permanently, since the patient often has to withdraw from their normal activities which are taken on by other family members. It is important that all members of the patient's family have the necessary resources to understand and be familiar with the disease, so as to make it into a source of positive social support for the patient and help them manage their disease appropriately.

Sexuality may also be affected in R&MSD, and is also usually accompanied by high levels of stress. Sexuality is part of the whole quality of life and therefore not being able to enjoy it is a type of disability. Approximately half of patients with R&MSD suffer from some type of problem in their relationships and problems with

several joints during their sexual activities.¹² However, this is rarely discussed at the surgery.¹³ If problems are detected in the sexual sphere, there are resources which may be of use to the patients,¹⁴ and in cases of doubt or serious dysfunction, the patient may be referred to the appropriate specialist.

Finally an area which is very highly affected in patients with R&MSD is the quality of sleep. It has been estimated that between 50% and 70% of patients with R&MSD present with some type of problem with sleep such as difficulty getting to sleep, or sleep not being reparative, or they have insomnia, wake up during the night or are overtired during the day.¹⁵

Our main conclusion is that R&MSD have a high impact on the psychosocial sphere of the patients, and therefore a biopsychosocial approach to them is needed, with treatment being carried out by a multidisciplinary team. Improvements in patients' education and information, together with the involvement of the family and social environment in the process of the disease are key factors, aimed at the patient acquiring the necessary support resources for appropriate adjustment to the disease.

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