ANXIETY AND DEPRESSIVE DISORDERS IN RHEUMATOID ARTHRITIS: A CLINICAL PSYCHIATRIC STUDY

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Abstract. *Studies show that patients with rheumatic disease usually have the following anxiety-depressive spectrum disorders: depressive episodes (single and recurrent) of varying severity with concomitant anxiety; dysthymia (chronic depression of moderate severity); generalized anxiety disorder, as well as adjustment disorders with anxiety and depressive symptoms.*

Keywords: *anxiety-depressive disorders, rheumatoid arthritis, psychosomatics, emotional disorders.*

Introduction. Rheumatoid arthritis (RA) is a chronic autoimmune inflammatory disease of connective tissue, primarily affecting small joints, leading to pronounced physical disability, reduced quality of life, and social maladjustment. [1,6,7,8,11,12,13,15] In recent decades, increasing attention has been paid not only to somatic but also to psychiatric manifestations of RA. Among the most common mental disorders accompanying RA are anxiety-depressive disorders (ADD), which, according to various authors, are observed in 30–80% of patients. [1,2,4,14]

This study emphasizes that anxiety and depressive disorders are found in patients with chronic somatic diseases 4–7 times more often than in the general population. The prevalence of depressive symptoms in RA ranges from 30% to 65%, while anxiety disorders are noted in 25–70% of cases.

Based on these data, the aim of our study was to assess the frequency and clinical features of ADD in RA patients and to investigate their impact on the course of the disease. [1,2,9,10,12] Furthermore, we aimed to determine the relationship between the severity of ADD and clinical characteristics of RA.

Material and methods of research. The study included 217 patients with a confirmed diagnosis of rheumatoid arthritis undergoing treatment in a rheumatology hospital in Tashkent. The patients' ages ranged from 25 to 65 years, with a mean age of 48.3±8.7 years. Women comprised 79% of the sample, and men 21%. Patients were divided into two groups: Group I (n=108): patients with signs of anxiety-depressive disorders; Group II (n=109): patients without significant ADD symptoms.

The following methods were used: socio-anamnestic methodology (Z.R. Ibadullaev's 2018 medical psychological questionnaire, patent №001031), SF-36 Health Status Survey, Hospital Anxiety and Depression Scale (HADS), Patient Health Questionnaire-9 (PHQ-9), and statistical methods including descriptive statistics, Student's t-test, and correlation analysis.

Results and discussion. The socio-anamnestic survey revealed that ADD were more common among women (78%), unmarried individuals (64%), and unemployed patients (59%).

Table 1.

Research results on the social status of patients with MDD before treatment with antidepressants

Indicator	Group 1 (ADD), %	Group 2 (No ADD), %
Women	78.0	57.0
Not married	64.0	29.0
Unemployed	59.0	24.0

Socio-anamnestic data showed that MDD was more common among women, individuals living alone, and the unemployed.

The data obtained from the HADS scale showed that 65% of patients exhibited varying degrees of anxiety and depressive symptoms. Severe anxiety was identified in 42%, severe depression in 33%, and a combination of anxiety and depressive symptoms in 25% of patients.

Table 2.

Results of the obtained HADS scale data in patients with major depressive disorder (MDD) before treatment with antidepressants

HADS Indicator	Group I (ADD), %	Group II (no ADD), %
Severe anxiety	42.0	8.0
Severe depression	33.0	6.0

According to the PHQ-9 results, 38% of patients showed signs of moderate to severe depression.

Table 3.

Results of the obtained PHQ-9 questionnaire data in patients with major depressive disorder (MDD) before treatment with antidepressants

PHQ-9 Indicator	Group I (ADD), %	Group II (no ADD), %
Moderate and severe depression	38.0	7.0

According to the SF-36 questionnaire data, patients with anxiety-depressive disorders had a low quality of life, and their physical and social activity scores were significantly reduced ($p<0.01$).

Table 4.

Baseline SF-36 questionnaire results in patients with major depressive disorder (MDD) prior to initiation of antidepressant therapy

SF-36 Indicator	Group I (ADD), %	Group II (no ADD), %
Physical Functioning	45.2	61.4
Psychological Well-being	72.0	28.0
Social Functioning	68.0	32.0

The calculations confirmed that the presence of major depressive disorder (MDD) is associated with a more severe course of rheumatoid arthritis, higher levels of pain, and reduced treatment adherence.

A comparative analysis conducted at the first stage of the study showed that patients with anxiety-depressive disorders (Group I) demonstrated significantly higher levels of anxiety and depression on the HADS and PHQ-9 scales compared to patients without MDD (Group II). These patients also exhibited reduced psychological and social functioning, as well as lower quality of life according to the SF-36 scale.

Additionally, in the MDD group, there was a higher prevalence of women, unmarried individuals, and patients without stable employment. This indicates the significant impact of psychoemotional and social status on the course of rheumatoid arthritis and emphasizes the need for an interdisciplinary approach in the treatment of such patients.

Conclusion. Based on the obtained data, it was considered appropriate to incorporate psychopharmacotherapy into the standard treatment strategy. Accordingly, patients in Group I were additionally prescribed antidepressants from the SSRI group. The treatment duration was 4 to 6

weeks. After the SSRI therapy, the patients were reassessed, and the results were compared with the baseline indicators.

Scientific and statistical evidence demonstrates that: 1. anxiety-depressive disorders represent a frequent and underappreciated psychopathological component of rheumatoid arthritis. 2. ADD negatively impacts RA progression by increasing pain sensitivity, reducing treatment adherence, and worsening disability.3. Early diagnosis and adequate treatment of ADD improve both mental and physical health outcomes in RA patients.4. An interdisciplinary approach (rheumatologist + psychiatrist) is recommended to enhance patient quality of life.

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