

encouragement, patience, availability, and perseverance from the patient, his/her physician, and his/her family and close friends. Naturally, any underlying medical factors that contribute to the depressive state must be identified and addressed.

Anti-depressant medications can have side effects and may intensify various symptoms associated with lupus (e.g., increase in the drying of mucous membranes in Sjogren's syndrome). When anti-depressant medications are effective, there is a welcome improvement in the individual's sense of well-being and overall attitude and ability to adjust.

Recovery from depression is usually a gradual process. Dramatic improvements do not usually occur in a few days; however, one begins to see some progress after a few weeks. Even when signs of clinical depression seem to clear quickly, it is not unusual for an individual to relapse when the medication is stopped. For this reason, medication should be continued for approximately six months or longer, and the dosage should be tapered slowly over a three to four week period when treatment is discontinued.

Psychotherapy, often in combination with anti-depressant and/or anti-anxiety medication, can be very helpful in assisting people with clinical depression to work through and understand their feelings, illness, and relationships, and to cope more effectively with stress and their life situation. The benefits to the individual are best attained when the primary care physician maintains a close working relationship with the individual's psychiatrist or psychologist. Such a relationship maximizes the quality of patient care and provides the most powerful approach to the management of depression.

Cognitive Changes in SLE, or "Lupus Fog"

In people with depressive illness, there is often a general slowing and clouding of mental functions (cognition). These troublesome and not infrequent disruptions in mental functioning tend to go underreported to their physicians and are rarely confirmed to be due to any specific structural change. Fortunately, these transient symptoms improve as the depressive condition improves.

Subtle changes in memory, concentration, and other cognitive functions (diminished attention, lapses in awareness, impairment in recall, problem-solving, calculations, planning and visual-spatial functioning), often occur in people with lupus. These are quite a nuisance and have profound impact upon the person's self-image, daily life, planning, and their relationships with friends, co-workers, and loved ones. Such changes often do not come to the physician's attention unless formal mental status testing is done. The true incidence of cognitive impairment is unknown other than that it is common.

There is no specific or characteristic cognitive deficit found in people with SLE; rather, there is a wide spectrum, variety, and combination. These deficits, though, do not appear to be related

to emotional stress or use of medication such as corticosteroids. Occasionally, in SLE with no overt central nervous system (CNS) pathology, cognitive functioning improves with antimalarial drugs or low doses of corticosteroids.

The Lupus Foundation of America

The Lupus Foundation of America (LFA) was established in 1977 to educate and support those affected by lupus and find the cure. The LFA supports research, education, awareness, patient services, and advocacy.

The Lupus Foundation of America is the only nationwide organization exclusively serving individuals, families and friends affected by lupus. The LFA has hundreds of local chapters and support groups throughout the United States, as well as international affiliates around the world.

The LFA is a grassroots, volunteer-driven organization. Contact the LFA or the chapter that serves your area to find out how you can become involved in our mission.

For information about lupus or to locate the chapter nearest you, visit our website at www.lupus.org or call toll-free 1-800-558-0121.

Become a Lupus E-Advocate and help pass federal legislation that will benefit people with lupus. Send an e-mail message to advocacy@lupus.org and enter SUBSCRIBE in the subject line. You'll receive periodic advocacy updates and other breaking lupus news and information.



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Depression in Lupus

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People with lupus often ask: "What amount of depression is normal?" and, "When should I seek professional help?" These questions reflect an awareness that depression occurs frequently in the course of lupus. However, there is also an uncertainty as to whether it is to be expected because of the stresses and sacrifices imposed by the illness. The person with lupus is often aware that states of depression may be induced by lupus, by the various medications used to treat lupus, or by the countless factors and forces in a person's life that are unrelated to lupus.

What Is Meant by the Term "Depression?"

The medical condition referred to as "clinical depression" is not to be confused with the everyday experience of a mild mood swing that everyone has from time to time. Just as we feel happy or fearful or jealous or angry, we all experience "depression" at some time in our life. On the other hand, clinical depressive illness is a very disabling, unpleasant, and prolonged condition. It is the most common psychiatric condition seen in the general population (20 percent of women and 10 percent of men), as well as in medical practice.

Clinical depression may bring on a variety of physical and psychological symptoms: sadness and gloom, spells of crying (often without cause), insomnia or restless sleep (or sleeping too much), loss of appetite (or eating too much), uneasiness or anxiety, irritability, feelings of guilt or remorse, lowered self-esteem, inability to concentrate, diminished memory and recall, indecisiveness, lack of interest in things formerly enjoyed, fatigue, headache, palpitations, diminished sexual interest and/or performance, other body aches and pains, indigestion, constipation or diarrhea, etc.

Not all people who suffer from clinical depression have all of the above symptoms. Individuals are considered to be clinically depressed when they have a depressed mood, disturbances in sleep and appetite, and at least one or two of the symptoms mentioned above which last for several weeks and are severe enough to disrupt daily life.

While there are many symptoms associated with clinical depression, there are seven which indicate the depth and degree of depression. These are: sense of failure, loss of social interest, sense of punishment, suicidal thoughts, dissatisfaction, indecision, and crying.

Two of the most common psychological signs of clinical depression are hopelessness and helplessness. People who feel hopeless believe that their distressing symptoms may never get better, whereas people who feel helpless think they are beyond help, that no one cares enough to help them or could succeed in helping, even if they tried.

How Common Is Depression in People with Lupus?

Some psychiatric and medical studies state that 15 percent of those with a chronic illness suffer from clinical depression; others place this figure as high as 60 percent. Although clinical depression is certainly more common in people with chronic medical illness (e.g., SLE) than in the general population, not everyone with a chronic illness suffers from clinical depression. Episodes of clinical depression usually last for only a few months in people with a chronic illness. A flare of the disease can also trigger depression because a person may feel he/she is never going to be free of the illness.

Depressive illness often goes unrecognized in those who have other medical illnesses because it presents symptoms so similar to those of the underlying medical condition. In SLE, symptoms of depressive illness such as lethargy, loss of energy and interest, insomnia, pain intensification, diminished sexual interest and/or performance, etc., can quite naturally be attributed to the lupus condition.

Even in those individuals without chronic medical conditions, most cases of depressive illness go unrecognized and untreated until the later stages of the illness, when the severity of the depression becomes unbearable to the person, and/or until the family or physician can no longer ignore it. In fact, several studies indicate that 30-50 percent of cases of major depressive illness go undiagnosed in medical settings. Perhaps more disturbing is that many studies indicate that even when recognized, major depressive disorders in the medically ill are undertreated and/or inadequately treated.

Many people refuse to acknowledge that they are in a depressive state and will actually deny that they are feeling unhappy, demoralized, or depressed. This group of individuals often experience what physicians called "masked" depression. These people resist the notion of emotional distress and will use various physical complaints to explain their feelings.

Physicians who are familiar with their patients' usual mood and personality, as well as their lifestyle and situation, are more likely to recognize changes associated with depressive illness. Similarly, people are more likely to open up about their feelings when they are encouraged to do so by a physician they trust and with whom they are familiar.

Unfortunately, all too common is a distorted notion that people with a chronic illness have "reason to feel depressed because they are sick." This misguided belief interferes with the early recognition, early treatment, and early relief of suffering from clinical depression. It also ignores the facts that clinical depression in people who are physically ill generally respond well to standard psychiatric treatments and that people treated only for their physical illness can suffer needlessly from clinical depression.

What Causes Depression in Lupus?

There is no one cause of clinical depression in lupus; rather, there are various and different factors that contribute to depression in chronic illnesses such as lupus. The most common cause is the emotional drain from the continuous series of stresses and strains associated with coping with the chronic illness and medical condition. Other causes may be the many sacrifices and losses required by the continuous life adjustments that a person with a chronic illness must make.

Various medications used to treat lupus, such as steroids (e.g., prednisone), may induce depression. Lupus involvement of certain organs (e.g., the brain, heart, or kidneys) can lead to clinical depression. There are also many unrecognized or unknown factors (which may or may not be related to lupus) which may cause depressive illness. Of course, there are people who would develop clinical depression whether or not they had lupus.

What Is the Treatment and Prognosis for Depression in Lupus?

Effective treatment requires early diagnosis and early intervention. Fortunately, most episodes of depressive illness in people with lupus subside on their own within a few months. Just as some people with lupus can tolerate a lot of pain, some seem to be able to accept and tolerate major symptoms of depressive illness without complaint.

Depression is very stressful and anxiety-producing, which may aggravate the lupus activity. Depressive reactions should be treated with the same aggressiveness and persistence that one would use to treat a lupus flare, or any other medical complaint. Naturally, any underlying medical condition that could contribute to the depression must be identified and controlled.

Today, effective treatment is available for depressive illness and usually consists of psychotropic medication or psychotherapy, and most often, a combination of both. Anti-depressant medications are the drugs that are most often used; the four main categories are: tricyclics, newer-generation non-tricyclic anti-depressants (called SSRIs—selective serotonin reuptake inhibitors known by the brand names Prozac, Zoloft, Paxil, etc.), MAO (monoamine oxidase) inhibitors, and lithium. Other types of anti-depressant medications are available such as Effexor, Serzone (nefazodone), Wellbutrin, Remeron, Desyrel, etc. Also, newer, potent anti-anxiety medications are now available and, when used in combination with the anti-depressant medications, offer significant and rapid mood stabilization and anxiety reduction. Occasionally a period of trial and error is necessary. Newer and safer hypnotics contribute to insomnia relief and offer uninterrupted and longer sleep.

Adequate and aggressive treatment involves blood tests to determine the appropriate dosages of medication, open communication between the patient and treatment team, and