GUEST EDITORIAL

INTEGRATED HEALTH CARE MUST CONSIDER MENTAL HEALTH TO REDUCE RATES OF CARDIOVASCULAR DISEASE

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Why, readers may be asking, would a psychiatrist write an editorial for a journal dedicated to cardiovascular health? Where is the interface between psychiatry and cardiovascular disease and how does this pertain to ISHIB's readers? I am going to answer these questions with the hopes of not only satisfying general curiosity but of stimulating the development of an enhanced consulting relationship between the specialties of psychiatry and cardiology and internal medicine.

To begin, let's look at some well-documented clinical experiences and published scientific data. Depression is an independent risk factor for increased morbidity and mortality in cardiac disease and post myocardial infarction (*JAMA,* October 20, 1993). Depression creates a heightened long-term risk in coronary artery disease (CAD) through its association with CAD progression and/or the triggering of acute events (*Am J of Cardiol,* 1996;78). Other studies have demonstrated that "rates of stroke were 2.3 to 2.7 times higher in most [older adults] with high depressive symptomatology . . . rates of cardiovascular disease-related death were also elevated in most subgroups . . . [the study] presents evidence that high depressive symptoms in older adults with diagnosed hypertension may place them at increased risk of stroke and possibly cardiovascular related death relative to (similar adults without depression) . . . (*Psychosom Med,* 1995:57) Finally, a CDC paper (*Epidemiol,* 1993;4) reported that ". . . depressed affect and hopelessness may play a causal role in the occurrence of both fatal and nonfatal ischemic heart disease . . ."

As can be seen with the articles cited above, the data are not new. By the mid 1990s, the medical community in general, and cardiologists in particular, had sufficient data to accept the need to understand, screen for, and treat depression in cardiac patients. Unfortunately, even now in 2003, the degree to which this disease is either missed, dismissed or, on occasion, minimized in severity by physicians who treat cardiovascular disease continues to place these patients at a high degree of risk for premature death.

Taking this a step further, this research and most studies conducted before 2000 consisted of only Caucasian males and females. African-American patients have not, until recently, been included in broad-based clinical trials. In addition, the results of these findings are often not applied to minority populations for a variety of reasons.

When it comes to seeking and receiving state of the art health care, it is well known that ethnic minorities are often the victims of less-than-adequate care. The primary reason given is economic. There are limited resources in the public healthcare system and private insurance carries limitations, which may further limit or discourage care. In addition, patients' attitudes toward health care and acceptance of recommended treatments are influenced by personal fears, biases, cultural taboos and past experiences (actual or historical), as well as the attitude of the treating physician.

Unfortunately, based on my own experience of 16 years in private practice, African Americans and other ethnic minorities often find it difficult to receive psychiatric care, even when they openly acknowledge their concerns and request assistance from their physicians. Sadly, some of my colleagues still have biases, prejudices, and a limited clinical perspective as to the degree of co-morbidity between psychiatric illnesses, such as depression and chronic diseases. It is this failure, for whatever reason, to recognize and treat this co-morbidity that can ultimately place patients at risk of increased morbidity and mortality during the course of their illness.

In a recent article written for the *Journal of Health Studies* (2002), I addressed the reasons why African-American women ". . . do not get help for depression . . ." The reasons are multiple and, as stated herein, often the result of cultural and community attitudes, which trivialize the impact and personal misery experienced by depressed people. Also noted in this article was the fact that women were often already in treatment for other medical conditions, including cardiovascular disease; their expression of depression was characterized as a "normal part" of being sick.

For the record, depression is never normal, at any age, for any reason. Being depressed and meeting the criteria for depression are 2 very separate and distinct clinical conditions. On the other hand, patients suffering from various chronic and/or acute medical conditions can and do develop a severe depression, which must be treated in order to avoid further deterioration and a less than favorable outcome.

Therefore, it is my hope that ISHIB, an international organization of considerable quality and reputation, would take the lead in the establishment/identification of a philosophy supporting treatment that is comprehensive, integrated, and representative of the most current of clinical data. Of necessity, this would include consultation with psychiatry for those patients at risk of depression and related diseases. The result, I hope, would be that all physician members of ISHIB would function as part of a healthcare team, devoted to reducing morbidity and mortality from cardiovascular diseases and its complications, regardless of specialty, etiology, or personal prejudices of African Americans and other members of the Diaspora.