Symposium: 2014 Knee Society Proceedings

CORR Insights®: What Is the Role of Mental Health in Primary Total Knee Arthroplasty?

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Where Are We Now?

The evidence is compelling: Psychosocial factors (circumstances, mood, mindset, coping strategies) are the major determinants of symptom intensity and magnitude of disability, with objective

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physical impairment having a more limited influence [1]. Poor emotional health is prevalent among recipients of TKA [2], and is associated not only with greater postoperative pain, disability, and dissatisfaction, but also with greater impairment (less knee motion) [3, 5–7]. In spite of this knowledge, the cognitive and emotional aspects of recovery are still the “elephant in the room” [1]. The false assumption that illness is either all physical or all mental and the stigma associated with symptoms of depression and ineffective coping strategies have limited the adoption of evidence-based screening and treatment.

Where Do We Need To Go?

The study by Lavernia and colleagues confirms the association of psychological distress not only with greater pain intensity and magnitude of disability, but also with less knee motion after TKA [2, 3]. The authors’ choice to dichotomize psychological distress (distress or not) rather than measuring distress on the continuum that it occurs in humans, risks reinforcing our unhelpful tendency to categorize the

emotional aspects of recovery. When distress and effective coping are evaluated on the continuum on which they are experienced, the conclusion amounts to common sense: the more confidence, adaptiveness, and resiliency, the better one’s health.

How do we translate common sense into better care? No less than culture change. Imagine a world where patients and caregivers are aware of how mindset and circumstances affect health and recovery — where coaches for optimal mindset are as desired as physical fitness trainers in the gym or yoga studio. Imagine patients choosing their surgical team based on the team’s skill in caring for their thoughts and emotions, not just their technical skill in addressing pathological anatomy.

How Do We Get There?

We have effective ways to screen for psychological distress and ineffective coping strategies and effective ways to improve mood and mindset (cognitive behavioral therapy and variations [8, 9]). The next step is to make these a standard part of orthopaedic practice in a way that is appealing to patients and

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caregivers. The stories of people that experienced enhanced recovery by attending to their emotional needs might breathe life into the compelling scientific data. Those stories should be shared.

The addition of psychologists and social workers to medical teams can improve treatment compliance and reduce disability [4]. We can expect the same for musculoskeletal health where being able to rely on one's body often depends on more than physical treatments.

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