Diabetes and mental health; the problem of co-morbidity

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Version: Accepted Manuscript

Link(s) to article on publisher’s website:
http://dx.doi.org/doi:10.1111/j.1464-5491.2010.03067.x

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Diabetes and mental health; the problem of co-morbidity

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<th>Journal:</th>
<th>Diabetic Medicine</th>
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<tr>
<td>Manuscript ID:</td>
<td>DME-2010-00462</td>
</tr>
<tr>
<td>Manuscript Type:</td>
<td>Editorial</td>
</tr>
<tr>
<td>Date Submitted by the Author:</td>
<td>17-Jun-2010</td>
</tr>
<tr>
<td>Complete List of Authors:</td>
<td>Lloyd, Cathy E; The Open University, Faculty of Health &amp; Social Care</td>
</tr>
<tr>
<td>Keywords:</td>
<td>diabetes, mental health</td>
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Diabetes and mental health; the problem of co-morbidity.

Cathy E. Lloyd, Ph.D.

Faculty of Health & Social Care
The Open University
Walton Hall
Milton Keynes
MK7 6AA

Tel: 01908 654283
Email: C.E.Lloyd@open.ac.uk

Until quite recently the psychological well-being of people with diabetes remained firmly on the periphery of diabetes care. In many ways it continues to do so, with biomedical targets for improving glycaemic control and reducing the risk of the physical complications of diabetes taking priority over the emotional state of the person attending the diabetes clinic. However there is now increasing evidence of the importance of good mental health in relation to diabetes care, both from the perspective of the individual managing their condition as well as in terms of the implications for service provision. Recent research has shown that at least one third of people with diabetes suffer from clinically relevant depressive disorders [1-3]. Indeed, the prognosis of both diabetes and depression – in terms of disease severity, complications and mortality – as well as the costs to both the individual and society [4] have been found to be worse for either disease when they are co-morbid than when they occur separately [5, 6]. Not only is depression more prevalent in people with diabetes, there are a whole range of other mental and emotional wellbeing issues of concern.

Recently research has shown that individuals might experience feelings of depression or anxiety, but they may also find themselves overwhelmed with the demands of self-management, sometimes referred to as diabetes-related distress or ‘burn out’ [7,8]. There is also evidence of psychological distress in families coping with a child with type 1 diabetes [9], as well as the impact of chronic pain on mental health and quality of life [10]. As new diabetes technologies appear and guidelines for treatment change
this means that further research studies need to be conducted in order to find out whether new ways of working are appropriate. In biomedical terms this usually involves setting up randomized controlled trials, however when it comes to issues of a psychological or psychosocial nature this is often problematic. Indeed most studies which have attempted to measure the prevalence of depression or other mental health problems have been naturalistic or observational. So far few studies have been conducted on the efficacy of psychological treatments. A further challenge is to understand the specific health needs of minority ethnic groups, in particular those of South Asians living in the U.K. whose risk of developing diabetes is much greater than the white indigenous population [11]. Research indicates for example, that there may be particular difficulties with regard the take up of insulin therapy [12]. Research studies to improve both health services delivery and self-care within minority ethnic populations may be compromised because established ways of collecting data have frequently been found to be inappropriate for these groups [13, 14]. Although more innovative methods are becoming available, more needs to be done in order to ensure that service users can be involved in research regardless of cultural background or literacy level [15].

Bringing research and clinical practice together so that one informs the other has always been a challenge. However psychosocial research that helps practitioners understand why individuals decline treatment or experience difficulties in self-managing their condition can only help improve the services that are offered and could impact on long-term prognosis as well as quality of life [16]. This research may well take the form of large-scale surveys, but equally important are the smaller-scale studies, usually of a qualitative design, where an in-depth understanding of the experiences and emotional status of individuals with diabetes can be gained. The Diabetes UK State of the Nations report (2005) stated that ‘All people with diabetes need access to psychological and emotional support… so that they can manage their condition effectively and reduce the risk of complications' (Diabetes UK 2005, p.31). A recent survey, however, showed that psychological support remained unavailable in most diabetes centres [17]. Furthermore where it was available the service was patchy with variable skill levels found within diabetes teams. It seems that researchers and clinicians alike are faced with a lack of evidence of the type of psychological services required as well as the most beneficial ways of treating those with
psychological problems. Further research clearly needs to be conducted which can inform the clinical practice of those working with the individual with diabetes and maintain appropriate levels of self-care.

One step towards this goal was made in December 2007, when a group of individuals from diverse global professional organizations came together in Geneva to commit to working to improve outcomes for patients with co-morbid diabetes and depression. At this meeting the Dialogue on Diabetes and Depression (DDD) (http://www.diabetesanddepression.org/) was formed, with a whole range of specialists and stakeholders agreeing to work together as a collaborative community of research and care in order to understand the current state of knowledge about diabetes and depression, and to set the agenda for future research and care in diabetes and depression. Subsequently, the World Health Organisation, the US National Institutes of Health and several other institutions and organizations have all expressed interest in the work of this group. Notwithstanding the challenges of working together across continents as well as sometimes competing professional perspectives, the DDD continues to develop its agenda and push for greater recognition of this important and costly problem.

Given the available evidence, it is clear that the mental health and wellbeing of people with diabetes needs to be taken seriously, not just at the wider national/international level but locally, where individuals receive care [18]. Research still needs to be conducted; we are far from fully understanding the nature of the relationship between diabetes and mental health. Despite an increased awareness in some parts of the world, there remain few integrated approaches to the problem in practice, few resources directed towards improving care and quality of life for people with co-morbid diabetes and depression and even fewer resources directed towards research focused on the causes and consequences. I look forward to a future time when research into this serious issue receives the funding it clearly deserves and emotional and psychological care is universally integrated into diabetes services.
Declaration of competing interests: Nothing to declare.
References:


[18] Report from the emotional and psychological support working group of NHS Diabetes and Diabetes UK. Emotional and Psychological Support and Care in Diabetes.