



Diabetes and mental health; the problem of co-morbidity

Journal:	<i>Diabetic Medicine</i>
Manuscript ID:	DME-2010-00462
Manuscript Type:	Editorial
Date Submitted by the Author:	17-Jun-2010
Complete List of Authors:	Lloyd, Cathy E; The Open University, Faculty of Health & Social Care
Keywords:	diabetes, mental health



view

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

1
2
3 this means that further research studies need to be conducted in order to find out
4 whether new ways of working are appropriate. In biomedical terms this usually
5 involves setting up randomized controlled trials, however when it comes to issues of a
6 psychological or psychosocial nature this is often problematic. Indeed most studies
7 which have attempted to measure the prevalence of depression or other mental health
8 problems have been naturalistic or observational. So far few studies have been
9 conducted on the efficacy of psychological treatments. A further challenge is to
10 understand the specific health needs of minority ethnic groups, in particular those of
11 South Asians living in the U.K. whose risk of developing diabetes is much greater
12 than the white indigenous population [11]. Research indicates for example, that there
13 may be particular difficulties with regard the take up of insulin therapy [12]. Research
14 studies to improve both health services delivery and self-care within minority ethnic
15 populations may be compromised because established ways of collecting data have
16 frequently been found to be inappropriate for these groups [13, 14]. Although more
17 innovative methods are becoming available, more needs to be done in order to ensure
18 that service users can be involved in research regardless of cultural background or
19 literacy level [15].
20
21
22
23
24
25
26
27
28
29
30
31
32
33

34
35 Bringing research and clinical practice together so that one informs the other has
36 always been a challenge. However psychosocial research that helps practitioners
37 understand why individuals decline treatment or experience difficulties in self-
38 managing their condition can only help improve the services that are offered and
39 could impact on long-term prognosis as well as quality of life [16]. This research may
40 well take the form of large-scale surveys, but equally important are the smaller-scale
41 studies, usually of a qualitative design, where an in-depth understanding of the
42 experiences and emotional status of individuals with diabetes can be gained. The
43 Diabetes UK State of the Nations report (2005) stated that 'All people with diabetes
44 need access to psychological and emotional support... so that they can manage their
45 condition effectively and reduce the risk of complications' (Diabetes UK 2005, p.31).
46 A recent survey, however, showed that psychological support remained unavailable in
47 most diabetes centres [17]. Furthermore where it was available the service was
48 patchy with variable skill levels found within diabetes teams. It seems that researchers
49 and clinicians alike are faced with a lack of evidence of the type of psychological
50 services required as well as the most beneficial ways of treating those with
51
52
53
54
55
56
57
58
59
60

1
2
3 psychological problems. Further research clearly needs to be conducted which can
4 inform the clinical practice of those working with the individual with diabetes and
5 maintain appropriate levels of self-care.
6
7
8
9

10 One step towards this goal was made in December 2007, when a group of individuals
11 from diverse global professional organizations came together in Geneva to commit to
12 working to improve outcomes for patients with co-morbid diabetes and depression. At
13 this meeting the Dialogue on Diabetes and Depression (DDD)
14 (<http://www.diabetesanddepression.org/>) was formed, with a whole range of
15 specialists and stakeholders agreeing to work together as a collaborative community
16 of research and care in order to understand the current state of knowledge about
17 diabetes and depression, and to set the agenda for future research and care in diabetes
18 and depression. Subsequently, the World Health Organisation, the US National
19 Institutes of Health and several other institutions and organizations have all expressed
20 interest in the work of this group. Notwithstanding the challenges of working together
21 across continents as well as sometimes competing professional perspectives, the DDD
22 continues to develop its agenda and push for greater recognition of this important and
23 costly problem.
24
25
26
27
28
29
30
31
32
33
34
35

36
37 Given the available evidence, it is clear that the mental health and wellbeing of people
38 with diabetes needs to be taken seriously, not just at the wider national/international
39 level but locally, where individuals receive care [18]. Research still needs to be
40 conducted; we are far from fully understanding the nature of the relationship between
41 diabetes and mental health. Despite an increased awareness in some parts of the
42 world, there remain few integrated approaches to the problem in practice, few
43 resources directed towards improving care and quality of life for people with co-
44 morbid diabetes and depression and even fewer resources directed towards research
45 focused on the causes and consequences. I look forward to a future time when
46 research into this serious issue receives the funding it clearly deserves and emotional
47 and psychological care is universally integrated into diabetes services.
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3
4 Declaration of competing interests: Nothing to declare.
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For Peer Review

References:

- [1] Holt RIG, Phillips DIW, Jameson KA, Cooper C, Dennison E, Peveler RC. The relationship between depression and diabetes mellitus; findings from the Hertfordshire Cohort Study. *Diabetic Med* 2009; 26: 641–648
- [2] Ali S, Stone M, Peters J, Davies M, Khunti K. The prevalence of co-morbid depression in adults with Type 2 diabetes: a systematic review and meta-analysis. *Diabetic Med* 2006; 23:1165-1173.
- [3] F. Pouwer, P.H.L.M. Geelhoed-Duijvestijn, C. Tack, E. Bazelmans, A.T.F. Beekman, R.J. Heine and F.J. Snoek. Prevalence of co-morbid depression is high in outpatients with type 1 or type 2 diabetes mellitus. Results from three outpatient clinics in The Netherlands. *Diabetic Med* 2010; 27: 217–224
- [4] Simon G, Katon W, Lin E, Ludman E, VonKorff M, Ciechanowski P, Young B. Diabetes complications and depression as predictors of health service costs. *Gen Hosp Psychiatry* 2005; 27: 344-351.
- [5] Egede L E, Nietert PJ, Zheng D. Depression and all-cause and coronary mortality among adults with and without diabetes. *Diabetes Care* 2005; 28: 1339-1345.
- [6] Katon W, Lin EH, Kroenke K. The association of depression and anxiety with medical symptom burden in patients with chronic medical illness. *Gen Hosp Psychiatry* 2007;29:147-155.
- [7] Lloyd CE, Pambianco G, Orchard TJ. Does diabetes-related distress explain the presence of depressive symptoms and/or poor self-care in individuals with Type 1 diabetes? *Diabetic Med* 2010; 27: 234–237.
- [8] L. Fisher, J.T. Mullan, M.M. Skaff, R. Glasgow, P. Arean and D. Hessler. Predicting Diabetes Distress Among Patients With Type 2 Diabetes: A Longitudinal Study. *Diabetic Med* 2008; 25: 1096–1101.
- [9] L.B. Williams, L.M.B. Laffel and K. Hood. Diabetes-Specific Family Conflict and Psychological Distress in Paediatric Type 1 Diabetes. *Diabetic Med* 2009; 26: 908–914.
- [10] M. J. Bair, E. J. Brizendine, R. T. Ackermann, C. Shen, K. Kroenke and D. G. Marrero. Prevalence of Pain and Association with Quality of Life, Depression, and Glycemic Control in Patients with Diabetes. *Diabetic Med* 2010; 27: 578–584.
- [11] Erens P, Primatesta P, Prior G: Health Survey for England: The health of minority ethnic groups. London, Department of Health, 2001.
- [12] U.M. Ahmed, B. Junaidi, A. W. Ali, J. Akhter, M. Salahuddin and O. Akhter

1
2
3 Barriers in initiating Insulin therapy in a South Asian Muslim Community. *Diabetic*
4 *Med* 2010; 27: 169–174.

5
6
7 [13] Lloyd CE, Sturt J, Johnson MRD, Mughal S, Collins G and Barnett AH.
8
9 Development of alternative modes of data collection in South Asians with Type
10
11 2 diabetes. *Diabetic Medicine* 2008; 25: 455–46.

12
13 [14] A. Navneet, T.C. Skinner, K. Khunti and M. Davies. The prevalence of elevated
14
15 depressive symptoms in a White-European and South-Asian population with impaired
16
17 glucose regulation and screen-detected Type 2 diabetes mellitus. *Diabetic Med* 2010
18
19 (Accepted for publication)

20
21 [15] Lloyd CE, Johnson MRD, Mughal S, Sturt JA, Collins GS, Roy T, Bibi R, and
22
23 Barnett AH. Securing recruitment and obtaining informed consent in minority ethnic
24
25 groups in the UK. *BMC Health Services Research* 2008; 8:68.

26
27 [16] D. Casey, M. De Civita and K. Dasgupta. Understanding physical activity
28
29 facilitators and barriers during and following a supervised exercise programme in type
30
31 2 diabetes: A qualitative study. *Diabetic Med* 2010; 27: 79–84.

32
33 [17] T. R. J. Nicholson, J.-P. Taylor, C. Gosden, P. Trigwell and K. Ismail.
34
35 National guidelines for psychological care in diabetes: how mindful have we been?
36
37 *Diabetic Med* 2009; 26: 447–450.

38
39 [18] Report from the emotional and psychological support working group of
40
41 NHS Diabetes and Diabetes UK. Emotional and Psychological
42
43 Support and Care in Diabetes.
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60