Psychological Wellbeing and Diabetes

Diagnosis:

At the time of diagnosis many patients will experience a variety of powerful emotions such as denial, shock, confusion, fear, anger, guilt, blame and loss. Some people go through a process very similar to mourning – it is as though they are grieving for lost health. Although it is normal for people to experience these feelings, the diabetes team and/or the primary care team should acknowledge these feelings and provide appropriate support if it is requested.

Psychological Problems:

There is, however, a need to be vigilant to the possibility that patients with diabetes may experience psychological disorders. Research has found that people with diabetes are more likely to experience anxiety and depression than people in the general population.

It is estimated that one in three patients with diabetes will experience clinical depression.

Depression is associated with poor glycaemic control whilst remission of depression is associated with improved control. Patients with complications associated with diabetes have a higher prevalence of depression.

Screening procedure:

All people with diabetes should be screened for depression and anxiety. The Scottish Diabetes Group (SDG) Psychology Working Group has recommended the use of the Hospital Anxiety and Depression Scale (HADS) for this purpose. Other common tools include the PHQ-9 for depression and the GAD-7 for anxiety. A screening system using the HADS has been developed in the diabetes clinic at St John’s Hospital, and if this pilot is successful it may be possible to roll this out to other secondary sites.

In primary care, patients with diabetes should be screened for depression according to local mental health protocols.

Recognition of Depression

Diagnosis of depression may be made when a patient describes

• Low or sad mood
• Loss of interest or pleasure

and FOUR of the following associated symptoms:

• Disturbed sleep (insomnia/hypersomnia)
• Worthlessness or guilt
• Poor concentration
• Loss of energy or fatigue
• Disturbed appetite (loss or increase of appetite/weight)
• Suicidal thoughts or acts
• Retardation or agitation
• Symptoms of anxiety or nervousness

These symptoms must persist for at least two weeks

How does mood affect diabetes?

The exact pathways are not yet known for certain. However, many people with low mood feel unmotivated and can’t be bothered. This may affect how often they check their blood sugar or insulin levels, or they may not take prescribed medications. Feeling low can also affect appetite, and make it less likely that someone
will engage in regular exercise. Feeling stressed or anxious can also increase blood sugar levels. This may lead to feeling unwell, which increases feelings of low mood, stress and anxiety, setting up a vicious cycle.

**Interventions:**

There is evidence that providing treatment and support for depression and other emotional health problems can bring a range of physical and psychological benefits for this patient group.

Where the local diabetes team has direct access to clinical psychology sessions, local referral criteria should be developed, not only for the treatment of psychological disorders but also to assist with behaviour change and lifestyle modification relating directly to their diabetes.

For the majority of cases, the normal protocol operating for the General Practice at which the patient is registered should be followed i.e. social prescribing, exercise programmes, prescription of an appropriate antidepressant or referral on to local mental health services or psychological therapy services.

**Children and Young People:**

The psychological and social changes that occur during the course of normal child development have important implications for the child's or young person's ability to manage his/her diabetes.

In addition, any chronic disease can place children at increased risk for the development of psychological problems and can also place numerous demands on the family's ability to cope. Risk factors to be aware of might include: using maladaptive coping strategies such as avoidance to cope with diabetes; too much responsibility being placed on the child for his/her diabetes care; family conflict; poor communication within the child's family and between the family and the diabetes team; poor parental mental health; psychological problems that existed pre-diabetes.

As with adults, referral should be as normal. At the time of publication Lothian has received funding from the Scottish Diabetes Group for a 3 year project to address paediatric psychological needs in diabetes.

**Living Better**

Living Better is a new initiative which aims to improve the mental health and wellbeing of people with diabetes and chronic heart disease. Five primary care pilot sites are exploring different treatment models for these populations. The project will run from January 2008 to March 2011.

Living Better is led by Royal College of General Practitioners Scotland, in partnership with the Scottish Development Centre for Mental Health and the University of Stirling. Other partners in the project include Diabetes UK Scotland, British Heart Foundation (Scotland), Chest Heart and Stroke Scotland, and Depression Alliance Scotland. The project is funded by the Scottish Government.

Further information is available on the Living Better website.