

Epidemiological depression and diabetes

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Description

Depression is a serious condition, not merely a bad mood. Depression makes it difficult for people to carry out routine tasks and function on a daily basis. Depression has major physical and mental health consequences.

Managing type 1 or type 2 diabetes, as well as chronic autoimmune disorders, can be extremely difficult owing to setbacks and numerous hurdles. The continual vigilance required maintaining blood sugar, navigating health-care systems, drug side effects, and other connected health issues can lead to despair. Depression, if left untreated, can lead to bad lifestyle choices, which can wreak havoc on one's physical health.

If person experience one or more of these symptoms for longer than two weeks, then speak to healthcare professional. Depression can affect diabetes. A few symptoms of depression can have a direct impact on patient diabetes management, such as: not wanting to do anything or see anyone. Person might not manage diabetes properly. This may mean not taking medication or testing blood sugars, missing doctor appointments or ignoring other health problems. All of these could lead to complications. Feeling down often and for long periods of time. Waking up a lot at night, or not being able to get out of bed. Feeling tired more often than not. Significant depressive symptoms impact about one out of every four adults with type 1 and type 2 diabetes, while formal diagnoses of depressive disorders are made in about 10%–15% of diabetics. Because of methodological discrepancies in the definition of depression, prevalence estimates vary substantially. In some research, the term “depression” refers to self-reported high depressive symptom scores, while in others, it

refers to a formal psychiatric interview diagnosis. Furthermore, ‘diabetic-related distress’ is a construct that captures the emotional suffering linked with diabetes self-management, social support, and health treatment. This concept was shown to be weakly connected with depressive symptoms, with roughly 30% overlapping variance, but it was determined to be separate from depression in terms of its relationship with adherence and glycemic control.

According to a recent meta-analysis of 11 studies involving over 50,000 persons with type 2 diabetes who did not have depression at baseline, the rate of depression is also 24 percent greater in those with diabetes. The symptoms of depression appear to remain persistent once depressed symptoms arise or a diagnosis of depression is obtained. Self-reported depressed symptoms persisted in 73 percent of patients 12 months following a diabetic education programme, according to Peyrot and Rubin. Furthermore, over a 5-year period, Lustman and colleagues discovered a relapse rate of 79 percent for identified severe depressive illness. These findings contrast with general population research that estimate a depressed episode lasts 8–12 weeks, implying that depressive episodes in patients with diabetes are longer-lasting and more severe.

There have been few studies of depression in children and adolescents but these suggest that rates of depression are also elevated in either type 1 or type 2 diabetes with prevalence rates ranging from 9%–26%. As observed by Thomas Willis, epidemiologic studies have demonstrated that the association between depression and diabetes is bi-directional. A meta-analysis of 9 cohort studies found that adults with depression had a 37% increased risk of developing type 2

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diabetes after accounting for factors common to both disorders, body mass index and poverty. There was considerable heterogeneity across studies with the risk varying between a non significant increased relative risk of 1.03 to 2.50. A further meta-analysis of 13 studies found incident depression was increased by 15% (OR 1.15 (95% CI 1.02–1.30)) in people with diabetes at baseline. People with diabetes are affected by general population risk factors for depression, marital status, childhood hardship, and socioeconomic deprivation. Furthermore, depression is linked to a variety of diabetes-specific risk factors. When compared to non-insulin drugs or dietary and lifestyle therapies alone, patients with type 2 diabetes who use insulin have higher rates of depression. This does not rule out the possibility that insulin is to blame, but it could be a reflection of disease development and the higher treatment demands placed on an individual when insulin is started. Diabetes consequences, particularly sexual dysfunction and severe peripheral neuropathy, have been shown to predict the onset of depression. In a specialized outpatient clinic, the presence of 2 or more complications was associated with a greater than 2-fold increase in the risk of depression in people with type 2 diabetes, with neuropathy and nephropathy showing the strongest association with depression. Other diabetes specific risk factors include recurrent hypoglycemia and poor

glycemic control. Two trials have reported that intensive self-monitoring of blood glucose has an adverse effect on depression rates in people with type 2 diabetes although other studies found no effect.

The two-item depression exam, which asks patients if they have a poor mood or have lost interest in routine tasks, is familiar to many nurses. If the patient replies yes to either question, a validated questionnaire such as the patient health questionnaire or the ospital anxiety and depression Scale is used to determine the severity of depressive symptoms. A positive result on either test does not always indicate that the patient is depressed, but it does indicate that they should be evaluated by a trained therapist.

Because routine screening in primary care settings is no longer part of the assessment, some diabetic and depressed patients will go unnoticed. Because of stigma, language hurdles, cognitive issues, and disengagement with health services, some people with depression may go unnoticed. Because it is not culturally acceptable to admit to having depressive symptoms, some individuals may instead claim increased somatisation (physical symptoms). Due to language challenges and cognitive issues, screening can be challenging; as a result, many patients simply stop attending their scheduled checkups.