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Psychosocial aspects of diabetes mellitus

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Abstract. *Complex environmental, social, behavioral, and emotional factors, known as psychosocial factors, influence living with diabetes mellitus (DM), both type 1 and type 2, and achieving satisfactory medical outcomes and psychological well-being. Thus, individuals with DM and their families are challenged with complex, multifaceted issues when integrating diabetes care into daily life. To promote optimal medical outcomes and psychological well-being, patient-centered care is essential, defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions". Lifestyle changes are equally important, in addition to medical interventions in the management of chronic medical diseases or disorders. The impact of DM reaches far beyond the physical symptoms of the disease, often the emotional distress and psychosocial impact on the quality of life of these patients complicates the effective management of their disease. Medical management of DM requires patient implementation of a treatment regimen. Thus, psychosocial factors impacting self-care such as diabetes distress (burdens of DM and its treatment, worries about adverse consequences), lack of social and economic resources, and other psychological states (e.g., depression, anxiety, eating disorders, cognitive impairment), as well as health literacy and numeracy, should be monitored. Evaluation is indicated during major disease and life transitions, including the onset of complications and significant changes in treatment or life circumstances, with prospective monitoring for 6 months. Future direction in diabetic care should be to screen patients early and often and prevent the diabetes distress. This should be considered a priority while developing a treatment plan not an afterthought.*

Keywords: *diabetes mellitus; psychosocial aspects; diabetes distress; psychiatric comorbidities*

Introduction

An individual's health behavior is influenced by his or her social, economic, cultural, profession and conditions of life, and physical environment. In medical literature, many medical experts have reported on the psychological and psychosocial components of almost all chronic diseases, especially for diabetes mellitus (DM) [1–5]. Lifestyle changes are equally important, in addition to medical interventions in the management of chronic medical diseases or disorders. On the other hand, patient participation is very important in the successful in the management of DM. Diabetic patients must practice self-monitoring of treatment, and must be involved too in other aspects prevention of acute and chronic vascular and nervous complications, such hypoglycemia, ketoacidosis, diabetic nephropathy, diabetic retinopathy, or diabetic foot [6–8].

The impact of DM reaches far beyond the physical symptoms of the disease, often the emotional distress and psychosocial impact on the quality of life of these patients complicates the effective management of their disease [9]. DM has a negative impact of life. About 40 % of diabetic patients reported their medications interfered with their ability to live normal life. Diabetic patients frequently perceive that diabetes would negatively affect their future [10–12]. Untreated psychosocial disorders in DM, may lead to more physical symptoms [13], cardiovascular complications [14] and depression [15, 16]. Depression may lead to cognitive and further aggravate the vicious cycles of self-care ability [17]. Many previous studies have largely been on the relationship between depression and DM [18, 19]. However, sub-syndromal depressive and milder emotional conditions, such as dysthymia, anxiety, stress and distress [20] are far more prevalent than major depressive disorder especially at community care levels [21, 22].

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Psychosocial aspects of living with diabetes

DM makes many demands on lifestyle and poses debilitating and life-threatening complications which overall have a negative impact on a patient's well-being and social life [1].

Lifestyle management of diabetes involves weight reduction in obese or overweight patient and change in dietary habits. This is usually difficult for most patients and imposes a psychological burden of on them [2].

In some parts of the world unemployment issues may prove an enormous hurdle for a patient with DM. Some employers are prejudiced and ignorantly believe that DM will result in poor work performance and/or frequent hospitalization and complications. Discrimination in the workplace was reported to be 5–11 % in a study in Switzerland [20].

DM also increases risk of depression. In a meta-analysis, the odds having depression was two-fold in patients with diabetes compared with those without. Anxiety and eating disorders have also been reported to be common in patients with DM [21].

At the first Oxford International Diabetes Summit (2002), virtually all (98 %) the participants representing medicine, politics, nursing, and patients' groups called for psychosocial aspects of DM to be included in national guidelines. They put forward that psychosocial factors are critical to successful outcomes in diabetes management. This summit was prop by the results of the milestone [22] DAWN Study (Diabetes Attitudes, Wishes and Needs) on the psychosocial dimensions of diabetes. The DAWN Study was the world's largest international psychosocial study in persons with DM. It included 5000 people with diabetes and 3000 diabetes healthcare professionals across 13 countries. The results of the DAWN Study showed that as a 41 % of the patients had poor psychological psychosocial well-being. These psychological problems were recognized by providers as affecting patient's diabetes self-care. However, despite this, only 10 %, of these patients received psychological care.

This study also showed that across the world, relation also showed that across the world, the relationships that patients have with family members, colleagues at their workplace, or groups of friends, is a critical factor in improving the patient's sense of well-being, and leads to more effective self-management of DM [1, 2, 22].

Pathophysiology of diabetes and comorbid depression

Depression is two to three times more common in DM than general population [23]. While, the common belief is that depression is a consequence of dealing with a major illness like DM, emerging evidence suggests that depression can be a risk factor of developing DM [24]. People with pre-existing depression were found to have a 60 % risk of developing DM, while people with preexisting DM only had a 15 % risk of developing depression [25].

Depression creates a deep sense of futility, amotivation, lack of energy, and hopelessness. It is therefore not surprising that when DM and depression coexist, there is a strong association of poor compliance with diabetes care, poor glycemic control, and hence an increased risk of long-term complications [26].

Diabetes distress

While comorbid psychiatric disorders like depressive disorders are a relative well-known phenomenon another lesser known and rather new phenomenon is: diabetes distress or diabetes related distress [2]. More simplistically diabetes distress can be as a quality issue of life due to combination of medical and psychological burden of DM as a chronic and complex malady that creates an emotional distress that often remains hidden from providers and at times from the suffer as well. However, diabetes distress can influence diabetes management and treatment outcomes in an unfavorable way. It should be emphasized here that diabetes distress is not a psychiatric disorder but it is rather an affective state resulting from constant worry about adherence with diet, exercise, blood glucose monitoring while feeling scared, anxious, overwhelmed, at times angry and burnout. The level of diabetes distress is not to be much higher in patients who are younger, female non-white had higher BMI, and, patients who are being treated with insulin versus patients who are treated with oral hypoglycemic agents [27]. Diabetes distress does not appear to be related with duration of DM. However, using DM management with insulin injections as proxy of severe illness (compared to DM managed by diet or medication, it can be predictive of patients with more emotional distress [28, 29]. When patients are dealing with greater level of diabetes related emotional distress, they are shown to have lesser compliance with anticipated treatment plan like adherence to dietary regimen, exercising on regular basis monitoring of blood glucose levels frequently, and taking medications as prescribed [18].

Psychiatric comorbidities of diabetes mellitus

Depression is not the only psychiatric comorbidity associated with DM. Patients with DM have a 20 % lifetime risk of developing an anxiety disorder [24, 27]. Another rather common and potentially dangerous comorbid psychiatric disorder patient is eating disorders. These have been reported in association with DM, especially affecting older adolescent and young women with type 1 DM [2].

Depressive spectrum disorders

Depressive disorders can be of different nature and vary in severity on a spectrum. They may have an adjustment disorder, a depressive state resulting adjustment to a big stressor like being diagnosed with DM or finding out that one has developed a major complication of DM, or more indolent and persistent depressive state on a chronic basis that reach the full syndrome state of major depressive episode. Many patients with DM suffer from a depressive disorder, due to direct results of having a major medical illness like DM [2].

Adjustment disorder

This is a psychological disorder response to an identifiable psychological stressor within last 3–6 months of presentation. The prevalence rate is around 2–8 % in the community, but it is much higher (12 %) in patients who are hospitalized due to medical condition [30]. The symptoms are usually not severe enough to impact functioning and quickly resolve on its or with short term supportive therapy, interpersonal the-

rapy (IPT), or cognitive behavioral therapy (CBT). In some cases, symptoms continue to persist after 6 months, at which point adjustment disorder is labeled as chronic and may require more long-term psychotherapy [2, 30].

Persistent depressive disorder

Persistent depressive disorder (PDD) is a simmering low intensity depression of chronic nature lasting for at least 2 years. PDD usually starts early life following a major adverse event. Most patients suffer from this illness for 5 to 10 years [30]. Longstanding depression gives rise to a characteristic personality with self-doubt, self-esteem, tendency to depend on others, interpersonal sensitivity, demanding nature, passivity, and pessimistic outlook life.

Major depressive disorder

Major depressive disorder (MDD) episode is described as a pervasive sense of depression on most days than not, lasting for at least 2 weeks. This is accompanied by neurovegetative symptoms like disturbance of sleep, loss of interest in pleasurable activities (also called anhedonia), lack of concentration and difficulty with memory, decline in appetite or overeating, low energy, tendency to blame self or ruminate, change on psychomotor activity level, feelings of worthlessness and hopelessness with suicidal ideation. In order to make diagnosis of MDD, other psychiatric disorders such as substance-induced mood disorder caused by a medical condition need to be excluded. Depressive symptoms as part of bereavement and in adjustment reaction in response to a major life event stressor should be excluded [30].

Anxiety disorders

Though not mentioned in the literature as frequently as depression, anxiety spectrum disorders are quite common in patients with DM. Patients with DM have a 17–20 % higher lifetime prevalence of developing an anxiety disorder in comparison to other age matched controls who do not have DM [28]. Anxiety disorders can significantly impact a person especially in adolescents or young adults suffering from a chronic illness like DM. It has been shown that patients who higher levels of anxiety symptoms independent of depressive symptoms have suboptimal glycemic control as they were like to do frequent blood glucose monitoring [32]. Patients with DM may confuse their symptoms of hypoglycemia as having an anxiety or panic attack and that may getting the help they getting the help they need at that crucial time [2].

Other common psychiatric condition comorbid with diabetes mellitus *Diabulimia and eating disorders*

Diabulimia, also known as manipulation of insulin dosing, is characterized by either decreasing or skipping of the dose of insulin as a purging mechanism of losing weight. Diabulimia is the second most common method of weight control in adolescent girls with type 1 DM. Restriction of insulin doses may or not may be associated with other eating disorders. As many as 30 % of young adolescent patients with type 1 DM are considered to have some level of eating disorder. Children with DM were 2.4 % more like to have an eating disorder than the their peers who did not have DM

[31]. However combination of diabulimia and binge-eating disorder (BED). Is the most common way of weight control in adolescents [31, 32]. The patients who eating disorders and who are manipulating insulin doses are likely to have higher mean glycated hemoglobin levels when compared to patients with DM who did manipulate insulin without a comorbid disorder [32]. Around 10 % of adolescent girls aged 12–19 years with type 1 DM found to meet the criteria of an eating disorder compared to 4% of age matched controls, while 15 % of the girls met partial diagnostic criteria compared to 8 % of the controls [31, 33]. The patients with type 1 DM who have also comorbid eating disorders, are more likely to develop microvascular complications, have more episodes of their diabetic ketoacidosis and hospitalizations [30]. Neurocognitive difficulties like deficient memory, learning difficulties, and performance intelligence quotient are some of the common neurocognitive deficits seen in seen in early onset type 1 DM. Some of neurocognitive deficits are mild and may go undetected [34].

The most common eating disorder seen in patients with DM is binge eating disorder (BED). BED is characterized by consumption of unusually large amount of food in a short period of time, usually within 2 hours with a feeling that they have lost control on their eating behavior [2, 30].

Bulimia nervosa (BN) is another quite common eating disorder that may be seen up to 27 % of DM patients [36]. Bulimia nervosa is highly associated with body image issues and low self-esteem along with comorbid psychiatric disorders including depression, bipolar disorder, anxiety disorders, social anxiety, borderline personality disorders, and substance abuse disorders. BN patients have 2 % per year risk of dying due to medical complications associated with bingeing and purging from suicide [35].

Conclusions

Diabetes distress is a rather new front for the health care providers who already struggle with providing the optimal care to their patients. An optimal treatment plan requires paying attention to every nuance of a complex condition like diabetes mellitus in the time constraint environment of current health care provision. However, recognizing signs of diabetes distress evaluating patient for it and managing it appropriately may prove to be the best investment of time when developing the long-term treatment plan of the patient. Future direction in diabetic care should be to screen patients early and often and prevent the diabetes distress. This should be considered a priority while developing a treatment plan not an afterthought.

Conflicts of interests. Authors declare the absence of any conflicts of interests and their own financial interest that might be construed to influence the results or interpretation of their manuscript.

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Психосоціальні аспекти цукрового діабету

Резюме. Складні екологічні, соціальні, поведінкові й емоційні чинники, відомі як психосоціальні, впливають на життя осіб із цукровим діабетом (ЦД) як першого, так і другого типу і на досягнення цільових результатів медичного та психологічного самопочуття. Тому особи з ЦД та члени їх родин зазнають складних, багатограних проблем при інтеграції в повсякденне життя. Для отримання оптимальних медичних результатів та психологічного благополуччя необхідна допомога, орієнтована на пацієнта, яка визначається як «надання допомоги, що поважає та відповідає індивідуальним уподобанням, потребам та цінностям пацієнта та гарантує, що цінності пацієнта керують усіма клінічними рішеннями». Зміни способу життя не менш важливі, крім суто медичних втручань, у лікуванні ЦД. ЦД призводить не лише до розвитку судинних і неврологічних симптомів захворювання, часто емоційний дистрес та психосоціальний вплив на якість життя цих пацієнтів ускладнюють ефективне управління недугою. Медичний менеджмент ЦД потребує від пацієнта виконання

призначеного фахівцем лікування. В оглядовій статті підкреслюється необхідність контролю за психосоціальними факторами, які впливають на перебіг захворювання, психологічним станом (наприклад, депресія, тривожність, порушення харчування, когнітивні порушення), а також медичної грамотності та самоконтролю ЦД. Рекомендовано проводити скринінг на наявність когнітивних порушень, деменції та депресії в осіб віком понад 65 років під час першого візиту та щорічно за потреби, оскільки згадані стани можуть бути також проявами хронічного порушення мозкового кровообігу або дисциркуляторної енцефалопатії, а значить, їх своєчасна діагностика й лікування дуже важливі для подовження тривалості життя пацієнтів. Завданням ендокринологів є визначення початкових порушень у психоемоційній сфері для запобігання їх трансформації в більш тяжкі психічні порушення, які потребуватимуть втручання лікаря-психіатра.

Ключові слова: цукровий діабет; психосоціальні аспекти; супутні захворювання; якість життя

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Психосоциальные аспекты сахарного диабета

Резюме. Сложные экологические, социальные, поведенческие и эмоциональные факторы, известные как психосоциальные, влияют на жизнь людей с сахарным диабетом (СД) как первого, так и второго типа и на достижение целевых результатов медицинского и психологического самочувствия. Поэтому люди с СД и члены их семей испытывают сложные, многогранные проблемы при интеграции в повседневную жизнь. Для получения оптимальных медицинских результатов и психологического благополучия необходима помощь, ориентированная на пациента, которая определяется как «предоставление помощи, уважающей и соответствующей индивидуальным предпочтениям, потребностям и ценностям пациента и гарантирующей, что ценности пациента управляют всеми клиническими решениями». Изменения образа жизни не менее важны, помимо чисто медицинских вмешательств, в лечении СД. СД приводит не только к развитию сосудистых и неврологических симптомов заболевания, часто эмоциональный дистресс и психосоциальное влияние на качество жизни этих пациентов затрудняют эффективное управление болезнью. Медицинский менеджмент СД тре-

бует от пациента выполнения назначенного специалистом лечения. В обзорной статье подчеркивается необходимость контроля за психосоциальными факторами, которые влияют на течение заболевания, психологическим состоянием (например, депрессия, тревожность, нарушения питания, когнитивные нарушения), а также медицинской грамотности и самоконтроля СД. Рекомендуется проводить скрининг на наличие когнитивных нарушений, деменции и депрессии у лиц старше 65 лет во время первого визита и ежегодно при необходимости, поскольку упомянутые состояния могут быть также проявлениями хронического нарушения мозгового кровообращения или дисциркуляторной энцефалопатии, а значит, их своевременная диагностика и лечение очень важны для увеличения продолжительности жизни пациентов. Задачей эндокринологов является определение начальных нарушений в психоэмоциональной сфере для предотвращения их трансформации в более тяжелые психические нарушения, требующие вмешательства врача-психиатра.

Ключевые слова: сахарный диабет; психосоциальные аспекты; сопутствующие заболевания; качество жизни