

Psychiatric disorders in diabetes

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Abstract

Diabetes and psychiatric disorders share a bi-directional relationship, with both affecting each other adversely. Just as achieving glycaemic control is important, so is ensuring that the person enjoys a good quality of life. All individuals with diabetes must be screened regularly for co-morbidity, especially depressive and anxiety disorders. Multiple evidence based psychotropic pharmacological interventions are available for management of these psychiatric disorders. Additionally, non-pharmacological interventions play a key role in comprehensive management of such patients.

Keywords: Anxiety disorders, Depression, Diabetes mellitus, Mental disorders, Primary health care.

Introduction

Primary care physicians have to take care of the person with diabetes as a whole. Just as achieving glycaemic control is important, so is ensuring that the person enjoys a good quality of life. Individuals diagnosed with diabetes are known to have poor quality of life. Co-occurring psychiatric disorders are important determinants of quality of life in individuals with diabetes.

Diabetes and Psychiatric Disorders

Diabetes and psychiatric disorders share a complex, bi-directional relationship, with both affecting each other adversely. Individuals diagnosed with diabetes have a higher prevalence of major depressive disorder, generalized anxiety disorder and eating disorders. Similarly, those diagnosed with major depressive disorders and schizophrenia are at higher risk of diabetes. The prevalence of major depressive disorder is twice among individuals with diabetes as compared to general population. Additionally, the risk of developing diabetes among individuals with depression has been found to be up to 60%.¹ Diabetes is associated with greater frequency of suicidal thoughts and attempts.²

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Impact of Psychiatric Disorders on Diabetes

Co-occurring psychiatric disorders among individuals diagnosed with diabetes are associated with poorer medication adherence, poorer compliance with diabetes self-care, higher functional impairment, poor glycaemia control, higher prevalence of complications, increased emergency room visits, higher frequency of hospitalization, and increased cost of medical care.³ It becomes imperative, therefore, to screen, diagnose, and manage these disorders as early as possible. The personal touch and close physician-patient bonding that characterizes primary care makes primary care practice the perfect platform to achieve this.

Screening and Diagnosis

All individuals with diabetes must be screened regularly for co-morbidity, especially depressive and anxiety disorders. Screening instruments and symptom check lists offer simple, less resource intensive way to identify those likely to be having psychiatric disorders. Patient health questionnaire (PHQ), and symptom checklist-90 (SCL-90) are examples of such instruments.⁴ The simplest tools for primary care are the Whooley 2-item questionnaire⁵ and the World Health Organization (WHO-5) questionnaire.⁶ Detailed diagnostic tools are also used in psychiatry, but are limited in utility in primary care settings due to time constraints.

Management

Motivational interviewing, stress management strategies, coping skills training, family therapy and collaborative case management can be included in primary diabetes care.⁷ Even the busiest physician can find time to offer "diabetes therapy by the ear", i.e., words of comfort.⁸

Multiple evidence based psychotropic pharmacological interventions are available for use. However, it is important to keep in mind the impact of such medications on glycaemic control.⁹ Medications for common disorders with lesser impact on glycaemia are listed in the Table. One must refer to a mental health professional in case of doubt.

Referral to Mental Health Professionals

Presence of moderate to severe psychiatric disorders, dependent use of psychoactive substance (such as

Table: List of medications with better glycaemic profile that can be used for management of psychiatric disorders*.

Disorder	Drug	Dose Range (mg/day)	Common side effects
Depressive Disorder	Fluoxetine	10-40	insomnia, agitation, sedation, GI distress, and sexual dysfunction
	Sertraline	50-150	
	Citalopram	20-60	
	Escitalopram	10-20	
	Bupropion	200-400	
Anxiety Disorders	Fluoxetine	20-80	Insomnia/agitation, GI distress insomnia, agitation, sedation, GI distress, and sexual dysfunction
	Sertraline	50-200	
	Citalopram	20-60	
	Escitalopram	10-30	
Bipolar Mood Disorders (for manic phase)	Haloperidol	5-20	Extrapyramidal side effects, increased prolactin levels Sedation, autonomic side effects, extrapyramidal side effects Lesser propensity to cause sedation, extrapyramidal side effects
	Ziprasidone	80-200	
	Aripiprazole	15-30	
Psychotic disorders (including schizophrenia)	Haloperidol	5-20 (Acute phase) 1-10 (Maintenance phase)	Extrapyramidal side effects, increased prolactin levels Sedation, autonomic side effects, extrapyramidal side effects Lesser propensity to cause sedation, extrapyramidal side effects
	Ziprasidone	80-160	
	Aripiprazole	15-30	

*Based on accessible published literature. Physicians advised to confirm in light of most recent literature. Dosages as mentioned in Sadock, Benjamin J.; Sadock, Virginia A (Eds). Kaplan & Sadock's Comprehensive Textbook of Psychiatry, Lippincott Williams & Wilkins, 8th Edition, 2005; Benjamin James Sadock, Virginia Alcott Sadock. Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry, Lippincott Williams & Wilkins, 10th Edition, 2007.

Choice of medicine to be guided by the risk-benefit analysis. Dose needs to be modified as per the stage of treatment, treatment response, side effects.

alcohol and tobacco), progressive worsening of psychiatric symptoms, emergence of psychotic features, suicidal behaviour, requirement of pharmacological intervention for psychiatric problems warrant referral to psychiatrist.

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