Depression Self-Care May Aid Diabetes Control

BY BETSY BATES
Los Angeles Bureau

LOS ANGELES — Adherence to a self-care action plan helped primary care patients exceed national goals for reducing their depression, reported Dr. Doriane C. Miller, associate division chief of general internal medicine at Stroger Hospital of Cook County in Chicago.

The study of 403 depressed adults in rural South Carolina has implications for improving outcomes for patients with diabetes, whose depression undermines their ability to manage a complex disease, Dr. Miller said at the annual meeting of the American Association of Diabetes Educators.

Patients at CareSouth, a series of federally qualified health centers serving mostly minority, low-income residents, were screened using the Patient Health Questionnaire-9 (PHQ-9), an instrument made available by Pfizer (www.pfizer.com/pfizer/phq-9/index.jsp).

Those whose scores indicated they had clinically significant depression were enrolled in a collaborative self-management program that included the Depression Self-Care Action Plan (www.collaborativeselfmanagement.org/uploads/ManagingDepression.pdf).

Focusing on "simple goals and small steps," the plan helps patients establish concrete ways to stay physically active, engage in pleasurable activities, spend time with supportive people, incorporate relaxation into their daily lives, and identify life stresses and ways to begin to deal with them.

It's a "living process document," reviewed at appointments and adapted to the reality of patients' often troubled lives, Dr. Miller said.

After 1 year, 56% of patients had reduced their depression scores by more than 50%, compared with a national goal of 40%. Fully 85% of patients had documented their self-management of depression, compared with a national goal of 70%. Approximately one-fourth of patients participating in the depression collaborative, sponsored by the Health Resources and Services Administration's Bureau of Primary Health Care, had diabetes as a comorbidity.

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DR. MILLER

Perhaps most dramatically, 53% of patients no longer met the PHQ-9 threshold for depression, compared with a national goal of 40%.

"We find this kind of self-care action plan can be a very useful tool for people who have depression and, particularly, people with diabetes [who have depression]," said Dr. Miller, who also serves as national program director of Quality Allies, an effort aimed at improving ambulatory care that is sponsored by the Robert Wood Johnson Foundation and the California HealthCare Foundation.

As many as one in four patients with diabetes have depression, but it can be missed in quick office visits or disguised as hostility, apathetic noncompliance, or a seeming inability to concentrate and follow directions.

People with diabetes are especially burdened by a sense of hopelessness and helplessness about downstream consequences of their disease, such as amputation, blindness, myocardial infarction, or stroke, Dr. Miller said.

"It can have a strong influence on their thinking," she said. "[They start thinking] 'if it happened to my brother, my grandfather, my mother, it's going to happen to me. It's just a hopeless situation and something I need to bear.' "

Diabetes care can be severely impacted by depression, on many levels, she continued. "Patients oftentimes will self-medicate their depression by eating more. They won't check their blood sugar [levels]."

When concentration is hampered by depression, patients will return to the office failing to recall even a simple care plan they agreed to on a previous visit.

"If you're not able to address some of the underlying causes for medication nonadherence, you're not going to get anywhere in terms of clinical treatment," she said.

Dr. Miller currently screens all of her patients with diabetes using two pivotal questions (see box) and the PHQ-9 at least once a year. When a patient screens positive for depression, she sees them more often than usual—at least three times in 90 days if they are receiving an antidepressant—and rescreens them with the PHQ-9 every 4-6 weeks.

She has seen clear benefits of this approach in her own practice, she said.

She described a patient in her late 50s whose diabetes control was falling apart even as she coped with the loss of a job and ensuing financial difficulties and weight gain.

By identifying her depression and helping her to implement a self-care plan, Dr. Miller was able to watch as her patient became more physically active and lost weight, began an earnest job search, and returned to HbA_{1c} levels in the range of 7%-8%, down from a level of 10%.

Dr. Miller has no financial ties to Pfizer, sponsor of the PHQ-9. ■

Questions Can Reveal Depression

Screening for depression in patients with diabetes can begin with two simple questions, according to Dr. Doriane C. Miller of Rush University Medical College and Stroger Hospital of Cook County in Chicago.

She asks every patient at every visit:

- How's your mood?
- What do you do for fun?

Sometimes patients' responses, along with clues from their facial expressions, vague aches and pains, and noncompliance with a diabetes care plan, can be enough to warrant a more targeted depression screening with an instrument such as the Patient Health Questionnaire (PHQ-9), she said.

Depression Twice as Common Among Diabetes Patients

BY BRUCE JANCIN
Denver Bureau

KEYSTONE, COLO. — Depression is twice as common in diabetic adults as in the general population, William H. Polonsky, Ph.D., said at a conference on the management of diabetes in youth.

Moreover, coexistent depression and diabetes is associated with significantly greater all-cause mortality risk than either condition alone, hence the need to regularly screen adult diabetic patients for depression and to promote vigilance among patients and their families regarding its signs and symptoms, added Dr. Polonsky of the department of psychiatry at the University of California, San Diego, and president of the Behavioral Diabetes Institute, also in San Diego.

Multiple large epidemiologic studies indicate that at any given time, 17%-20% of adult diabetic patients meet diagnostic criteria for moderate to major depression, a rate up to twofold greater than that in adults overall.

South Carolina investigators recently studied the impact of depression and diabetes on all-cause and coronary heart disease mortality in 10,025 participants in the population-based National Health and Nutrition Examination Survey–I Epidemiologic Follow-Up Study.

During 8 years of follow-up there were 1,925 deaths, including 522 due to coronary heart disease. Compared with subjects who were nondiabetic and nondepressed, adjusted all-cause mortality was increased by 20% in those who had depression but not diabetes, by 88% in subjects with diabetes but not depression, and by 150% in participants with both diabetes and depression.

Coronary heart disease mortality was increased by 29% in individuals with baseline depression, by 126% in those with diabetes but not depression, and by 142% in subjects with both conditions (Diabetes Care 2005;28:1339-45).

Several studies also have shown threefold greater rates of new-onset coronary artery disease and retinopathy over a 10-year follow-up period in depressed diabetic patients compared with nondepressed diabetic patients, Dr. Polonsky said at the conference, sponsored by the University of Colorado and the Children's Diabetes Foundation at Denver.

Screening regularly for depression is a simple matter, even in a busy office practice.

DR. POLONSKY

Other studies have demonstrated that depression makes it harder to initiate and maintain constructive behavioral change. In persons with diabetes, depression is associated with worse glycemic control as reflected in hemoglobin A_{1c} levels 2.0%-3.3% higher than in nondepressed patients, along with an increased hospitalization rate and greater functional disability.

Screening diabetic patients regularly for depression is a simple matter, even in a busy office practice. Many screening questionnaires are available that patients can fill out in the waiting room. Or the physician can simply ask two straightforward questions:

- During the past month, have you felt down, depressed, or hopeless?
- Have you had no interest or pleasure in doing things?

A yes response to either screening question warrants further inquiry. By far the most widely used tool for this purpose in adults is the Patient Health Questionnaire-9. An Internet search for "PHQ-9" will provide the scale itself for free, as well as the history of the test instrument, how to score the PHQ-9 properly, and other useful information.

Antidepressant therapy in diabetics is as effective as in nondiabetics. But if baseline glycemic control is good, antidepressant therapy will have little impact on diabetes-specific outcomes, according to Dr. Polonsky.

That was shown in a preplanned subgroup analysis involving 417 depressed elderly patients with type 2 diabetes in the Improving Mood–Promoting Access to Collaborative Treatment (IMPACT) trial. This analysis compared usual antidepressant therapy in the primary care setting with enhanced care given in collaboration with a depression care manager who provided patient education and medication management as needed.

After 1 year, patients in the collaborative care arm were significantly less depressed and had better overall function than did those assigned to usual care; however, HbA_{1c} values in the groups didn't differ (Ann. Intern. Med. 2004;140:1015-24).

Dr. Polonsky, who works chiefly with adults, said the data regarding depression in diabetic adolescents are more limited and equivocal. "It's not clear that their depression rates are as high as in adults," he noted. ■