Depression Among Older Adults with Diabetes Mellitus

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KEYWORDS

• Diabetes • Depression • Mood disorders • Aging • Collaborative care

KEY POINTS

- Depression is highly prevalent in the general population and increases the risk for type 2 diabetes mellitus (DM).
- Comorbid depression and DM are associated with negative health outcomes, such as accelerated cognitive decline and increased mortality.
- Depression impinges the patient and the family caregiver's ability to effectively manage DM, decreases adherence to treatment, and undermines the successful physician-patient relationship.
- Effective models for treating comorbid depression and DM exist, and some components of these models are implementable in individual clinics.

INTRODUCTION

Diabetes mellitus (DM) is one of the most common chronic conditions among older adults. About 26.9%, or 10.9 million, US residents aged 65 years and older had diabetes in 2010.[1] Depressive disorders are serious chronic diseases that increase morbidity and mortality,[2] erode quality of life,[3] and increase medical expenditure.[4–8] Depression and DM often co-occur. Data from a range of settings suggest that the prognosis of both DM and depression, in terms of severity of disease, complications, treatment resistance, and mortality, is worse for either disease when they are comorbid than when they occur separately. Comorbid depression in patients with DM is strongly associated with increased burdens of DM symptoms,[9] poor self-management and treatment adherence,[10] increased health care services utilization

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and medical expenditures,[11] and an increased risk of DM complications.[12] DM complications, such as myocardial infarction, amputation, or loss of vision, can in turn precipitate or worsen depressive episodes. Nevertheless, few studies have extensively examined the associations between depression and DM in the older adult population. Also, recent studies have found that the combination of DM and depression may increase the risk for dementia, suggesting increased brain toxicity.[13] The purpose of this review is to summarize the clinical presentation of late-life depression among older adults with DM, potential mechanisms of comorbidity of depression and DM, importance of depression in the successful management of DM, and available best practice models for depression treatment.

DISEASE DESCRIPTION

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. To be diagnosed with major depression, a patient must have depressed mood or anhedonia and at least 5 of the following 9 symptoms nearly every day for at least 2 weeks:

- Depressed mood
- Marked diminished interest/pleasure
- Sleep disturbance (increased or decreased sleep)
- Appetite disturbance (increased or decreased appetite; typically with weight change)
- Fatigue/loss or energy
- Diminished concentration or indecisiveness
- Feelings of worthlessness or excessive or inappropriate guilt
- Psychomotor retardation or agitation (a change in mental and physical speed perceived by other people)
- Recurrent thoughts of death or suicide (not just fear of dying)

They must also experience functional impairment related to these depressive symptoms.

Older adults, however, do not always present with the typical symptoms of depression. In particular, depressed or sad mood may be less evident or not even present. In these cases, anhedonia may be a better indicator for depression.[14,15] Depressed older adults may experience sleep disturbances (sleeping too much or too little) or changes in appetite (eating too much or too little). Decrease in self-efficacy, motivation, and ability to participate in self-care may also indicate underlying depressive symptoms. Signs of such symptoms can be subtle. Older adults may reply with “I don’t know” to simple questions, decline to participate in physical, speech, or occupational therapy, and feel negative or hopeless about treatments offered. Some may easily give up tasks during these therapies. Older adults who experience loss of self-worth or sense of loneliness due to depression may complain “nobody needs me” or “I feel I am just in everyone’s way.” The symptoms of late-life depression are often attributed to normal aging, grief, physical illness, or dementia and providers and patients miss important opportunities to initiate treatment for what is a treatable health problem.[16]

Most older adults with clinically significant depressive symptoms do not meet standard diagnostic criteria for major depression or dysthymic disorder.[17,18] Patients in this group fall short of meeting diagnostic criteria for major depression because of fewer or limited duration of depression symptoms. Nonetheless, studies suggest that these patients carry similar disease burden: poorer health outcomes, functional impairment, and higher health utilization and treatment costs.[19–21] Moreover, these