

# Prevalence of Anxiety and Depression Disorders among People with Diabetes Monitored at the Diabcarmet Center in Thiès (Senegal)

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## Abstract

**Introduction:** The association of diabetes and anxiety-depressive disorders in the same person is problematic. The aim of our work was to evaluate the prevalence of depressive and anxiety disorders in diabetic patients and to highlight the link between anxiety and depressive disorders and diabetes.

**Methodology:** In our transversal and descriptive study, with analytical purposes, we studied 50 cases. The study took place over a period of 4 months (from April to July 2022), focusing on diabetic patients.

**Results:** Our study included 50 patients with a mean age of 55 ±13 years with a range from 30 to 80 years. The sex ratio was 1.17. The prevalence of depressive disorders was 28% and of anxiety disorders 36%.

On bivariate analysis, age, sex, and occupation were associated with depression, and only age was associated with anxiety.

On multivariate analysis, female gender (OR=33.8; CI=3.89-293.32), age over 50 years (OR=6.71; CI=[1.31; 34.38]), occupational inactivity (OR=15.5; CI=[3.47;69.16]) exposed diabetic patients to an additional risk of depression and only age over 50 years (OR=3.97; CI=[1.07; 14.72]) exposed diabetic patients to an additional risk of anxiety.

**Conclusion:** Our study highlights the importance of screening for anxiety and depression in diabetic patients to prevent complications and their progression.

**Keywords:** Depression; Anxiety; Diabetes; Prevalence

## Introduction

Diabetes is one of the most serious chronic somatic diseases due to its progressive nature and numerous complications [1]. Among psychiatric disorders, anxiety and depressive disorders are of increasing global concern. Their progression is meteoric throughout the world, but particularly in developing countries, especially in Africa, making them a public health problem. Worldwide, the International Diabetes Federation reports that in 2021, 537 million adults will be living with diabetes, or 1 in 10 adults. This number is expected to reach 643 million by 2030 and 783 million by 2045 [2]. In Africa, an estimated 24 million people had diabetes in 2021, and this number is expected to increase to 55 million in 2045: an increase of 129%, justifying the label "epidemic of the 21<sup>st</sup> century". In Senegal, the prevalence of diabetes among people aged 18 years

and older is approximately 3% [3]. An estimated 792 million people worldwide live with a mental disorder, representing more than 10% of the world's population. WHO estimates that 121 million people suffer from depression. In the African Region, the prevalence of depression is 4.59% and that of anxiety disorders is 3.59% in 2019 [1]. Clinical research in recent years has highlighted the close relationship between psychiatric pathologies and somatic diseases that are known to be important public health problems: hypertension, coronary heart disease, and cerebral and vascular pathologies.

Numerous risk of developing depression is three times higher in type 1 diabetics and about twice as high in type 2 diabetics compared to non-diabetics [3]. The presence of psychiatric disorders such as depression and anxiety worsen the prognosis of diabetes, accelerates the onset of complications, and significantly alters the quality of life of

people with diabetes. We have examined the complexity of the different major public health issues that are diabetes, depression, and anxiety; to do so; we conducted a study among diabetic patients followed at the DIABCARMET Center of the Saint Jean de Dieu (SJD) Hospital in Thiès, Senegal.

#### The aim of our work is:

-To evaluate the prevalence of depressive disorders in diabetic patients followed at the DIABCARMET center of the SJD hospital in Thiès, Senegal.

-To evaluate the prevalence of anxiety disorders in diabetic patients followed at the DIABCARMET center of the SJD hospital in Thiès, Senegal.

-To highlight the relationship between anxiety and depressive disorders and diabetes.

-To prevent the complications of anxiety, depressive disorders, and diabetes.

## Methodology

### Type and period of the study

This was a cross-sectional, descriptive study with analytical purposes over a period of 4 months (from April to July 2022), focusing on diabetic patients followed at the DIABCARMET center of the SJD hospital in Thiès in Senegal.

### Study population

**Inclusion criteria:** Diabetic patients, regardless of age and sex, known for at least 6 months to the DIABCARMET center of the SJD hospital in Thiès and hospitalized or consulted during the study period, which extended from the month of April to July 2022.

Diabetic patients who agreed to answer the questionnaire.

**Exclusion criteria:** Diabetic patients followed at the DIABCARMET center of the SJD hospital in Thiès who did not agree to participate in the survey.

Diabetic patients followed at the DIABCARMET center of the SJD hospital of Thiès and hospitalized, who presented unusable records.

### Data Collection

Patients admitted to the DIABCARMET center of the SJD hospital in Thiès between April and July 2022 were recruited randomly. Those who agreed to participate in the study were given a questionnaire beforehand. And had access to their hospitalization files for paraclinical examination data. Data were collected using a standard survey form, including epidemiological, clinical, paraclinical and evolving information. The epidemiological data concerned age, sex, geographical origin, profession, ethnicity, Medical history and background (high blood pressure, diabetes), type of housing (individual or collective), duration of diabetes, type of treatment and follow-up. We collected 2 clinical elements such as decompensation and diabetic neuropathy. Paraclinically, the data focused on serum creatinine and glomerular filtration rate. Data on depression and anxiety were collected using the Hospital Anxiety and Depression scale (HAD).

### Data Entry and Analysis

Excel 2010 was used for data entry and descriptive analysis. For quantitative variables, the mean, standard deviation, median, minimum, and maximum were calculated. For qualitative variables,

we extracted the numbers and frequencies and made a graphical representation. For the relational analysis, we performed a chi-square independence test using SPSS 20 software to see if there was a relationship between the variables. It was significant when the P value was less than or equal to 0.05.

### Ethical considerations

We respected the anonymity of each file consulted during the processing, analysis, and dissemination of the results. Each file was given a unique identification number.

### Study constraints and limitations

During the processing of the files, we encountered difficulties related to the lack of data for certain files (Pathological History, Electroencephalogram (ECG), results of paraclinical examinations, living conditions, etc).

We were also sometimes faced with the difficulty of translating the entire HAD (Hospital Anxiety and Depression scale) questionnaire for patients who did not speak English or French, or the refusal of patients to spend so much time on a questionnaire.

## Results

### Sociodemographic Characteristics

A total of 50 patients were included in the study.

**Gender:** The male sex was most represented in our sample with 54% males. The sex ratio was 1.17 [Figure 1].

**Patient age:** The mean age of our patients was  $55 \pm 13$  years, with extremes ranging from 30 to 81 years. The age group over 50 years was the most representative. It represented 64% [Figure 2].

**Occupation:** Housewives were the most represented with 24%, followed by merchants with 20%, then drivers and farmers with 12% [Table 1].

**Marital Status:** All (100%) of our patients were married.

### Characteristics of Diabetes

All our patients were type 2 diabetics.

**Duration of the disease:** In our study, 66% of our patients had had diabetes for at least 5 years [Figure 3].

**High Blood Pressure (HBP):** In our study, 66% of our patients were hypertensive [Figure 4].

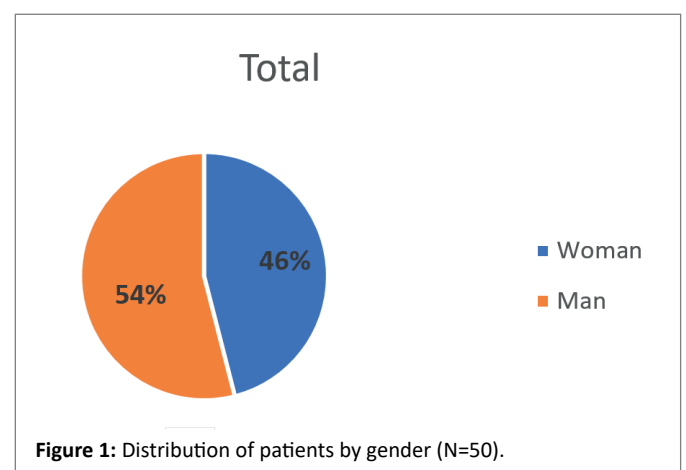
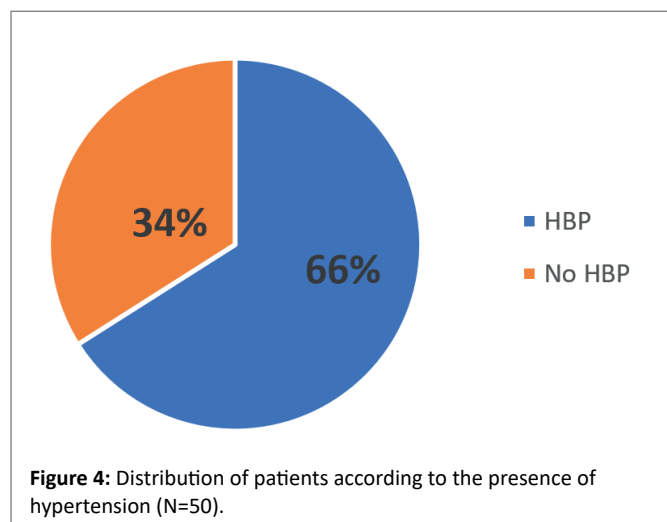
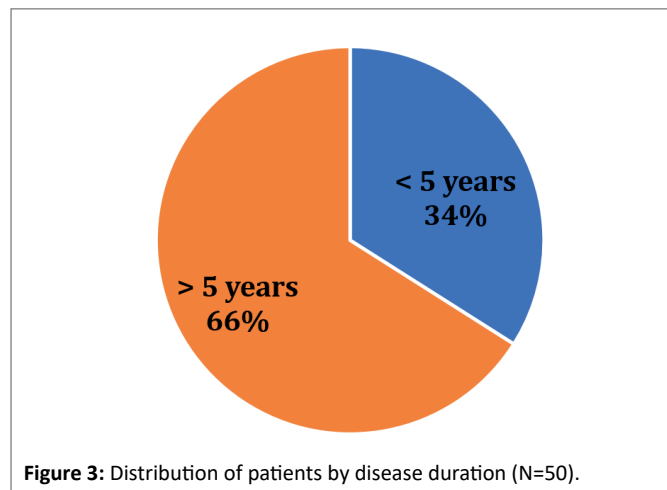
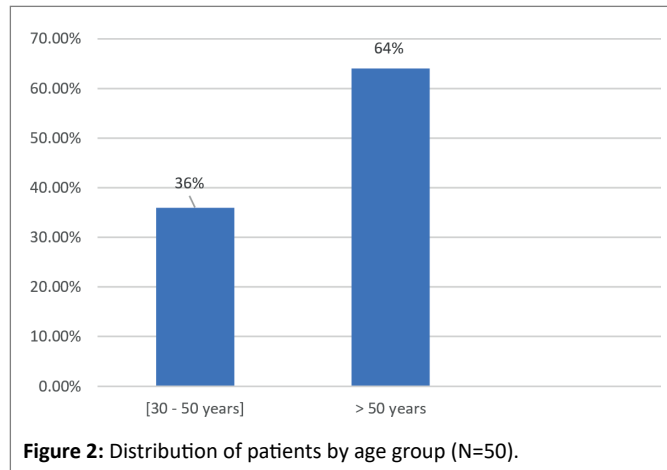


Figure 1: Distribution of patients by gender (N=50).

## Chronic complications

**Renal Damage:** Renal function was assessed by GFR values and according to the classification of stages of chronic kidney disease (see Appendix). GFR could not be calculated using the MDRD formula in 6 of 50 patients because of missing serum creatinine values. We found that 93% of the diabetic patients had chronic renal insufficiency [Table 2].



**Diabetic Neuropathy:** In our study, 70% of our patients had diabetic neuropathy [Table 3]. Diabetic neuropathy was assessed based on the symptoms described by the patients.

## Treatment

In our study, 63% of patients were on Oral Antidiabetic Drugs (OADs), 35% on dual therapy of OADs and Insulin, and 2% on Insulin alone [Figure 5].

## Prevalence and factors associated with depression in diabetic patients

The prevalence of depression was 28%. According to this bivariate study, only three explanatory variables have p-values lower than 0.05 and are therefore potentially associated with the depression variable [Table 4]. These variables were age, sex, and occupation. Therefore, only these variables were retained for multivariate analysis.

In the multivariate analysis, female gender (OR=33.8; CI=[3.89; 293.32]), age over 50 years (OR=6.71; CI=[1.31; 34.38]), occupational inactivity (OR=15.5; CI=[3.47; 69.16]) exposed an additional risk of depression in diabetic patients.

## Prevalence and factors associated with anxiety in diabetic patients

The prevalence of anxiety was 36%. According to this bivariate study, only one explanatory variable had a p-value less than 0.05 and was therefore potentially associated with the anxiety variable. This variable

**Table 1:** Distribution of patients according to their occupation.

Occupation	Number	Percent
Housewife	12	24%
Trader	10	20%
Cultivator	6	12%
Driver	6	12%
Accountant	3	6%
Seamstress	3	6%
Pensioner	2	4%
Secretary	2	4%
Lecturer	2	4%
Teacher	1	2%
Unemployment	1	2%
Carpenter	1	2%
Restaurateur	1	2%
Total	50	100%

**Table 2:** Prevalence of renal dysfunction in our study.

GFR outcomes	Number	Percent
No chronicrenal failure	3	7%
Cronicrenal failure	41	93%
Total	44	100%

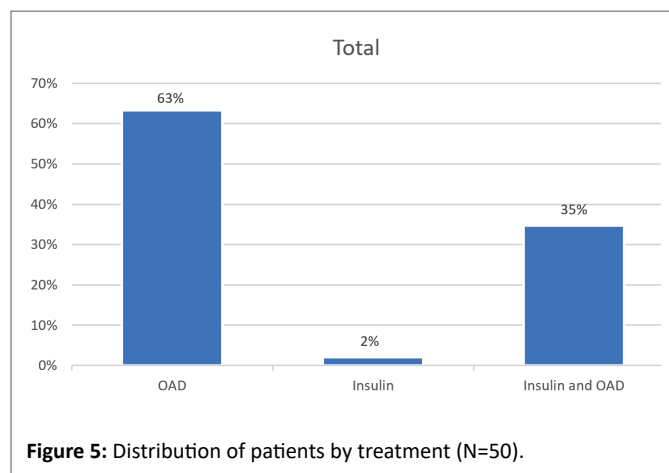
**Table 3:** Distribution of our patients according to the presence of diabetic neuropathy.

Diabetic neuropathy	Number	Percent
Yes	35	70%
No	15	30%
Total	50	100%

**Table 4:** Prevalence and factors associated with depression in diabetic patients.

Characteristics		Percentage of patients with symptoms of depression (28%)	Odd Ratio	IC à 95%	P value
Gender	Female	56%	33,8	[3,89; 293,32]	0,001 *
	Male	3%			
Age	[30-50 Years]	10%	6,71	[1,31; 34,38]	0,02 *
	>50 ans	41%			
Occupation	Employed	11%	15,5	[3,47; 69,16]	0,001 *
	Unemployed	67%			
HBP	HBP	33%	2,33	[0,55; 9,85]	0,30
	No HBP	18%			
Diabetes treatment	OAD	19%	∅	∅	0,30
	OAD and Insulin	47%			
	Insulin	0%			
Diabetic neuropathy	Neuropathy	31%	1,83	[0,43; 7,82]	0,55
	No neuropathy	20%			
Renal function	No chronic renal failure	33%	0,93	[0,08;11,21]	0,990
	Chronic renal failure	32%			
Duration of Diabetes	<5years	18%	0,43	[0,1; 1,82]	0,30
	>5years	33%			

\*Statistically significant difference



was age and was the only one retained for multivariate analysis [Table 5]. On multivariate analysis, age over 50 years (OR=3.97; CI=[1.07, 14.72]) conferred an additional risk of anxiety in diabetic patients.

## Discussion

### Prevalence of anxiety and depressive disorders in diabetic patients

Our results show that symptoms of depression and anxiety are significantly prevalent in diabetic patients: 28% suffered from depressive symptoms and 36% from anxiety disorders. We found several studies in the international literature that support our results and the existence of comorbidity between diabetes and psychiatric disorders, such as the studies by Commander MJ and Hermans N, et al. [4,5].

The study by Hermans N, et al. [5] also indicated the existence of anxiety and depressive disorders associated with diabetes in one third of the sample, with a significant association between depressive state and diabetes. Anderson RJ, et al. [6] documented in their study that approximately 30-40% of diabetic patients reported elevated depressive symptoms and 10-15% of diabetic patients suffer from depressive disorder, depending on clinical criteria. A study conducted in Tanzania [7] showed a high prevalence of depressive symptoms in diabetic patients of 87%, which is significant but much higher than our findings.

Another study conducted in Botswana [8] found a prevalence of 30.4% of depressive symptoms in diabetic patients, which is almost overlapping with the results of our study, which found a prevalence of 28% of depressive symptoms.

The study by Rekik N, et al. in Tunisia, which was conducted using the HAD scale that we used, showed that 24.8% of diabetic patients had depressive symptoms, a result close to ours. The same study showed that 61.4% of the same diabetic patients suffered from anxiety, which is almost double our results [9]. The difference in our results regarding anxiety could be due to the fact that all our patients were type 2 diabetics. Also, the study by Rekik N, et al. in Tunisia was based on a sample in which 42% of the patients were type 1 diabetics and on insulin alone (compared to 2% in our study). In fact, the study by Lustman PJ, et al. showed that daily insulin use is a risk factor for anxiety [10].

On the other hand, a study in India found that a significant proportion of diabetic patients suffered from anxiety and depression compared to healthy controls (27.6% vs 12.7% for anxiety and 26.3% vs 11.2% for depression) [11], which is almost like the results of our study.

**Table 5:** Prevalence and factors associated with anxiety in diabetic patients.

Characteristics		Percentage of patients with symptoms of anxiety (28%)(36%)	Odd Ratio	IC à 95%	P
Gender	Female	48%	2.62	[0,8;8,59]	0,20
	Male	26%			
Age	[30-50years]	19%	3,97	[1,07;14,72]	0,05 *
	>50 years	48%			
Occupation	Employed	53%	2,86	[0,82;10]	0,39
	Unemployed	42%			
HBP	HBP	42%	2,39	[0,64;8,91]	0,10
	No HBP	24%			
Diabetes treatment	OAD	38%	∅	∅	0,10
	OAD and Insulin	35%			
	Insulin	0%			
Diabetic neuropathy	Neuropathy	43%	3	[0,72;12,55]	0,20
	No neuropathy	20%			
Renal function	No chronic renal failure	29%	0,83	[0,07;10,04]	0,900
	Chronic renal failure	33%			
Duration of Diabetes	<5years	47%	2,04	[0,61 ;6,82]	0,10
	>5years	30%			

The differences in the prevalence of anxiety and depressive disorders in our population could be attributed to the difference in the study period (in the case of seasonal depression), the culture of the population studied, socioeconomic differences, but also to the use of scales other than the HAD diagnostic scale (Beck scale, Raskin scale, Caroll scale).

#### Risk factors associated with sociodemographic characteristics

**Gender:** Our study showed that the prevalence of symptoms of depression and anxiety was higher in diabetic women. This finding is consistent with other studies [8,11,12]. The fact that female sex is an exposure factor could be explained by the hormonal theory. After the age of 30, estrogens gradually decrease in women, leading to a decline in well-being [13,14]; another study finds that hormonal changes (pregnancy, menopause, and oral contraceptive use) make women more vulnerable to the risk of stress, anxiety, and depression [15].

**Age:** Our study found a significant association between age and anxiety and depressive disorders. In fact, the risk of anxiety is 3.97 times higher, and the risk of depression is 6.71 times higher in older patients.

In the literature, we found several studies that support our conclusions; a study conducted in 2014 among people with diabetes in Guinea concluded that elderly diabetics are at the highest risk of developing depressive disorders [16]. Another study conducted in Guinea in 2011 found a significant association between anxiety and age [17].

The higher risk of emotional disorders in older people with diabetes can be explained by the fact that many risk factors increase with age, such as deterioration of physical health, gradual loss of autonomy, cognitive decline, and reduction of the social network [18].

**Occupation:** Our study found a significant association between occupational activity and depressive disorders. In fact, the risk of

depression is 15.5 times higher in patients who are not employed. We have found studies in the literature that are consistent with ours. In a study conducted in Botswana, unemployment and homemaker status were reported as risk factors for depression [8].

Regarding anxiety, we did not find a significant association with occupation in our study. However, the literature presents different results from ours and finds a significant association between occupational status and anxiety. In fact, a study conducted in Morocco in 2004 showed that housewives and the unemployed were more at risk of developing symptoms of anxiety and depression than those who were employed [19]. Another study conducted by Al-Mohaimed AA, in Kuwait shows that patients with occupational inactivity are less likely to have anxiety disorders [20].

In the literature, we found that anxiety and depression in the economically inactive were due to a low socioeconomic level due to lack of income [21]. The difference between the literature and our results regarding anxiety may be because in our study population, occupational inactivity was mainly present among women who, although housewives, would benefit from an average or middle socioeconomic level.

#### Risk factors associated with diabetes

**High blood pressure (HBP):** In our study, we did not find a significant association between hypertension and depression, nor between hypertension and anxiety. However, in the literature, the presence of chronic pathologies related to diabetes is reported as a risk factor for depression in diabetic patients, as shown by Téllez Zenteno JF [22].

More precisely, the presence of hypertension associated with diabetes is reported as a risk factor for anxiety and depressive disorders, as in the study carried out in 2011 in Tunisia by Zouari H, et al. [23].



**Diabetes treatment:** In our study, we did not find a significant association between the type of treatment and anxiety and depressive disorders, although most of our depressed and anxious patients were on OAD.

The Korean study by Lee HJ, et al. found that the association between depressive symptoms and insulin injection was not statistically significant [24].

However, a cross-sectional study by Noh JH, et al. showed a strong association between insulin therapy and depressive and anxiety symptoms in diabetic patients [25]. The authors explained that this association may be due to the inconvenience of injections, increased risk of hypoglycemia, stricter hygiene and dietary measures, and more frequent hospitalizations [25].

Another study by Davis TM, et al. showed that patients using OADs would have a better quality of life, which would prevent the onset of anxiety or depressive disorders [26]. The discrepancy between our study and the literature could be because the patients in our study were all type 2 diabetics; hence the prevalence of OAD treatment was only 2.04% of patients on insulin alone.

**Diabetic Neuropathy:** In our study, we did not find a significant association between diabetic neuropathy and anxiety and depressive disorders. In the literature, the prevalence of depression increases when patients suffer from chronic complications of diabetic disease, especially symptomatic neuropathy [27]. In a 2001 meta-analysis, de Groot M, et al. reported that patients with diabetes and depressive comorbidity had a higher prevalence of chronic complications of diabetes such as neuropathy [28].

**GFR:** In our study, we assessed renal function using GFR and subsequently found that there was no significant association between impaired renal function and anxiety and depressive disorders. However, in the literature we can see that studies have shown an association between these variables, such as a cross-sectional study conducted at Hedi Chaker University Hospital in Tunisia in 2011 [23].

This difference between the literature and our study could be due to the use of different scales to assess renal function, but also to missing paraclinical data during data collection in the files.

**Duration of diabetes:** Duration of diabetes in our study was not significantly associated with depression or anxiety. However, in the literature, duration was a risk factor for depressive and anxiety symptoms [27,28]. The discrepancy between our results and the literature may be because our patients were not diagnosed at the onset of the disease, which may have biased the duration of the disease that we considered.

### Limitations of the Study

These results should be interpreted considering certain methodological limitations. There was no control group utilized and that therefore, this study is preliminary. With a case control study, the difference of prevalence of depression and anxiety between the groups would be more significant.

In this study, it was difficult to have a control group 50 people matched for age, gender, and occupation with a chronic illness (not metabolic) that was not diabetes treated at the same hospital because there was lack of clinical and epidemiological data for many patients. Caregivers haven't possibility to use health digital software and write clinical data on paper which can be lost. It'll be relevant to carry study in this important area. We use a cross-sectional study which simply allowed us to detect the association and not the risk factors

incriminated in anxiety and depression in diabetic patients. Our results are representative of a single region in Senegal which is that of Thiès, which does not allow these results to be generalized to all patients with diabetes.

Despite its limitations, this work was able to detect a remarkable frequency of anxiety-depressive disorders in our patients and made it possible to identify certain factors that could influence them.

### Recommendations

At the conclusion of our study, we offer the following recommendations:

#### To the attention of health authorities

Adopt a systematic screening tool for psychiatric disorders when monitoring diabetic patients. This will automatically improve the identification of patients with signs of depression and/or anxiety.

-Encourage more studies to describe predictors of depression and anxiety in people with diabetes.

-Organize more diabetes screening buddies.

-Raise public awareness of the reality of mental illness.

-Computerize patient records.

-Make paraclinical screening more financially accessible.

#### To health care professionals

-Educate patients about the occurrence of psychiatric disorders after diabetes diagnosis.

-Insist that patients strictly monitor their pathology to avoid complications.

-Organize multidisciplinary care.

#### To the population

-Ensure good compliance with treatment.

Seek help and consult a psychiatrist without taboo if symptoms of anxiety or depression appear in diabetic patients.

### Conclusion

The link between diabetes and anxiety and depressive disorders is complex and multidirectional, but common. Numerous researches show that diabetes and anxiety-depressive disorders are associated in a non-accidental way and complicate each other. Our study allowed us to highlight the relationship between these different pathologies and highlights the importance of screening for anxiety and depression in diabetic patients to prevent complications and their progression.

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## Appendices

### 1-Identification

Identification	
File number	
Date of admission	
Address	
Telephone number	
Date of examination	
Diabetes severity	
Department / Hospital	

### 2-Epidemiologic data

Epidemiologic data		
N°	Descriptions	Terms
1	Age	
2	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
3	Marital status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widower
4	Occupation	<input type="checkbox"/>
5	Street address	
6	Ethnic	<input type="checkbox"/> Wolof <input type="checkbox"/> Pulaar <input type="checkbox"/> Toucouleur <input type="checkbox"/> Sérère <input type="checkbox"/> Diola <input type="checkbox"/> Manding <input type="checkbox"/> Mandiango <input type="checkbox"/> Other specify
7	Reference	<input type="checkbox"/> Primary care provider <input type="checkbox"/> University hospital <input type="checkbox"/> Health center <input type="checkbox"/> Private cabinet <input type="checkbox"/> Other specialty
8	Housing mode	<input type="checkbox"/> Collective <input type="checkbox"/> Individual
9	Other background or medical history	-HBP -Dyslipdemia -Sickle Cell Anemia -Psychiatric -Neurological -Asthma



### 3-About Diabetes

About Diabetes		
N°	Descriptions	Terms
10	Type of Diabetes	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2
11	Length of Diabetes	
12	Type of treatment received	<input type="checkbox"/> Mono therapy <input type="checkbox"/> Dual therapy <input type="checkbox"/> Triple therapy <input type="checkbox"/> Other
13		<input type="checkbox"/> Insulin Biguanides <input type="checkbox"/> Sulfonylureas <input type="checkbox"/> Others
14	Are you following your treatment regimen correctly?	Yes No
15	Other concomitant treatments	<input type="checkbox"/> Neuroleptics <input type="checkbox"/> Antiepileptics <input type="checkbox"/> Antibiotics <input type="checkbox"/> Analgesics <input type="checkbox"/> NSAIDs <input type="checkbox"/> Others
16	Have you had any side effects during your treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes, please specify:.....
17	HbA1c rate	

#### 4- Psychological disorders / HAD scale

##### Hospital Anxiety and Depression Scale (HADS)

**Instructions:** Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he or she will be able to help you more. This questionnaire is designed to help your doctor know how you feel. Read each item and circle the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought out response.

<b>I feel tense or 'wound up':</b>	<b>A</b>	<b>I feel as if I am slowed down:</b>	<b>D</b>
Most of the time	3	Nearly all of the time	3
A lot of the time	2	Very often	2
Time to time, occasionally	1	Sometimes	1
Not at all	0	Not at all	0
<b>I still enjoy the things I used to enjoy:</b>	<b>D</b>	<b>I get a sort of frightened feeling like 'butterflies in the stomach':</b>	<b>A</b>
Definitely as much	0	Not at all	0
Not quite so much	1	Occasionally	1
Only a little	2	Quite often	2
Not at all	3	Very often	3
<b>I get a sort of frightened feeling like something awful is about to happen:</b>	<b>A</b>	<b>I have lost interest in my appearance:</b>	<b>D</b>
Very definitely and quite badly	3	Definitely	3
Yes, but not too badly	2	I don't take as much care as I should	2
A little, but it doesn't worry me	1	I may not take quite as much care	1
Not at all	0	I take just as much care as ever	0
<b>I can laugh and see the funny side of things:</b>	<b>D</b>	<b>I feel restless as if I have to be on the move:</b>	<b>A</b>
As much as I always could	0	Very much indeed	3
Not quite so much now	1	Quite a lot	2
Definitely not so much now	2	Not very much	1
Not at all	3	Not at all	0
<b>Worrying thoughts go through my mind:</b>	<b>A</b>	<b>I look forward with enjoyment to things:</b>	<b>D</b>
A great deal of the time	3	A much as I ever did	0
A lot of the time	2	Rather less than I used to	1
From time to time but not too often	1	Definitely less than I used to	3
Only occasionally	0	Hardly at all	2
<b>I feel cheerful:</b>	<b>D</b>	<b>I get sudden feelings of panic:</b>	<b>A</b>
Not at all	3	Very often indeed	3
Not often	2	Quite often	2
Sometimes	1	Not very often	1
Most of the time	0	Not at all	0
<b>I can sit at ease and feel relaxed:</b>	<b>A</b>	<b>I can enjoy a good book or radio or TV programme:</b>	<b>D</b>
Definitely	0	Often	0
Usually	1	Sometimes	1
Not often	2	Not often	2
Not at all	3	Very seldom	3

Questions relating to anxiety are indicated by an 'A' while those relating to depression are shown by a 'D'. Scores of 0-7 in respective subscales are considered normal, with 8-10 borderline and 11 or over indicating clinical 'caseness'