MEDICAL OBSERVER
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In the mood for lifestyle advice

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Appropriate treatment of mood disorders is vital to improve health and for prevention and treatment of lifestyle-related disease.

LIFESTYLE-related disease is underpinned by physical inactivity and unhealthy weight gain. In women, this often manifests during the reproductive years as disturbances including obesity, menstrual disturbances, polycystic ovarian syndrome (PCOS) and gestational diabetes (GDM). It then progresses to pre-diabetes, diabetes and cardiovascular disease (CVD) as women age (Figure 1).

Lifestyle-related diseases such as PCOS, type 2 diabetes mellitus (DM2) or CVD increase the risk of depression, while depression is a risk factor for lifestyle-related disease.[1]

Anxiety is also likely to be increased in those with lifestyle-related disease, however research findings are inconsistent and variable depending on the condition.

Mood and self-efficacy (the belief in one's capabilities to achieve a goal) affect motivation to improve lifestyle behaviours, making this a critical area for doctors to understand and appreciate.

Depression presents a major barrier to effective lifestyle changes to diet and/or physical activity that are critical to the prevention and treatment of lifestyle-related disease.

Furthermore, if someone has CVD, they may not realise their risk of depression is increased and so may not seek help for depressive symptoms, thereby further exacerbating their CVD risk in a negative cycle. Depression and anxiety are likely to increase lifestyle-related disease severity, complications, morbidity and mortality.

OBESITY

About 52% of Australian women are overweight. Women who are obese have a 50%-75% chance of developing DM2 and a high risk of CVD.[2]

Depression, anxiety and social dysfunction are increased in women who are overweight and decrease with weight loss.[3,4]

Mood and self-efficacy are also important predictors of the success of weight loss programs.[5]

POLYCYSTIC OVARY SYNDROME

Up to 10% of Australian women have PCOS.[6] This common condition causes hirsutism, abdominal obesity, increased androgens and anovulatory infertility. It also increases DM2 and CVD risk.

Increased depression, low self-esteem, sexual dysfunction and anxiety are found in women with PCOS. Given that mood impacts negatively on self-efficacy, that PCOS is common and that therapy requires self-motivation, self-efficacy and lifestyle change, it is vital that recognition and treatment of mood disorders in PCOS is part of an overall treatment plan.

TYPE 2 DIABETES

A recent meta-analysis of the literature on depression and anxiety in chronic disease found that depression is a risk factor for DM2, particularly in women and lower socioeconomic groups, while anxiety was likely to be related to poor glycaemic control.[1] Mood disorders in DM2 are also likely to impact on adherence to treatment regimens and outcomes.

CARDIOVASCULAR DISEASE

About 80% of those with DM2 will die of CVD. Diabetes is a particularly potent risk factor for CVD in women.

Further, 80%-90% of CVD in women is lifestyle related, and overall CVD is the number one killer of Australian women, accounting for 41% of all female deaths.[7]

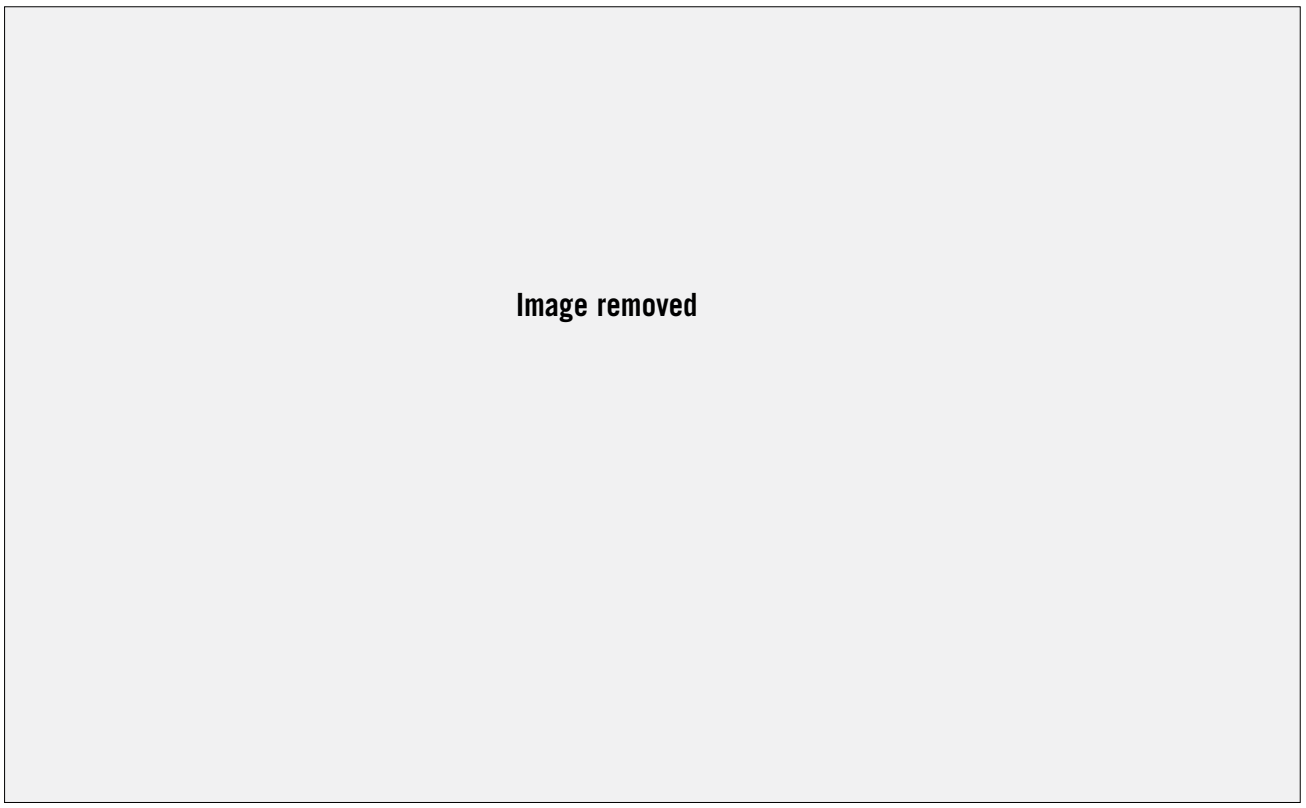

Figure 1: Lifestyle-related reproductive and metabolic diseases in women across the lifespan.

Potential role of health practitioners

- Assess prevalence and levels of depression and anxiety in women with lifestyle-related disease.
- Assess the role of negative mood as a barrier, and positive mood as a motivator towards healthier choices, behaviours and improved lifestyle.
- Seek assistance of multidisciplinary team (psychologist/dietitian) where needed.
- Increase perception of risks and adverse health impacts of excess weight and inactivity.
- Emphasise that weight maintenance in itself is important as women age.
- To avoid exacerbating depression and demoralisation, set small achievable goals (5%-10% weight loss) and focus on sustainable lifestyle changes, avoiding short-term fads.
- Consider the role of CBT as an effective treatment for improving health behaviours as well as depression and anxiety.
- Assess the need for pharmacotherapy.

The interaction between depression and CVD is complex, with research proposing pre-existing depression often occurs in CVD patients. However, depression is also common after stroke and myocardial infarction. A number of studies have noted that self-efficacy is important to overall physical and emotional wellbeing in patients who experience CVD.[8-10]

Mood is particularly relevant to cardiac rehabilitation[8, 11-12] and exercise[9] while the inter-relationship of mood, social support and social isolation must also be considered in any assessment and treatment plan for depression and CVD.[13]

TREATMENT

A large body of evidence highlights the essential components of diet and physical activity to prevent and treat lifestyle-related diseases.

Even a modest weight loss over three years of 5.6 kg through lifestyle intervention reduces the risk of developing DM2 by 58% in those overweight with impaired glucose tolerance.[14]

Research has shown that once mood disorders are recognised, therapeutic interventions, including education and cognitive and behavioural strategies, have been shown to reduce depression and anxiety and strengthen self-esteem and self-efficacy.[15]

They improve engagement in positive lifestyle change and glycaemic control[16] and improve outcomes with myocardial infarction rehabilitation.[17]

The Jean Hailes Foundation for Women's Health is a national, non-profit health organisation focusing on practical education opportunities for health professionals and women.

References available at **www.medicalobserver.com.au**