

## DEPRESSION IN DIABETIC PEOPLE – UNVEILING THE HIDDEN ENEMY

### DEPRESSÃO EM PESSOAS DIABÉTICAS – DESVELANDO O INIMIGO OCULTO

### DEPRESIÓN EN PERSONAS DIABÉTICAS – REVELANDO AL ENEMIGO OCULTO

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## ABSTRACT

Depression occurs in Diabetes Mellitus (DM) patients, being often cared for and mistaken by health workers and by patients themselves, as sensations of annoyance, sadness and melancholia. Studies show that depression can be a major difficulty in the coping process of the disease. The aims of this study were to understand how the DM-type 2 patient identifies and experiences depression, describing signs and symptoms present in their daily routine and identify the coping strategies used. The study sample was composed of diabetic type 2 insulin-dependent patients, over fifty years old that attended to the program Preventive Medicine Service – Unimed G.V. (Medical work Co-Operative of Governador Valadares). The methodological and theoretical reference used was the oral thematic history proposed by Meihy. Data from thirteen interviews were analyzed and the concepts emerged enabled the identification of three central themes: life conditions of a diabetic person that influence depression, identification of depression and the meaning of depression for a diabetic patient. Signals and symptoms of depression indicated by diabetics were: lack of appetite, irritability, fear of complications and others. The participants recognized depression through changes perceived in the behavior, melancholia, anxiety, crying for no apparent reason, loss of interest, difficulty to concentrate, insomnia and thoughts about death. Depression as described was related to feelings of loneliness, financial and marital problems. The nurse must be trained to perceive and interfere early in depression, develop an effective plan of care and of adherence to treatment, using educational programs and utilizing the various therapeutic alternatives.

**Keywords:** Diabetes Mellitus type 2; Depression; Coping.

## RESUMO

A depressão ocorre em portadores de DM, sendo frequentemente velada e confundida por profissionais de saúde e pelos próprios pacientes com sensações de angústia, tristeza e melancolia. Estudos mostram que a depressão pode dificultar o enfrentamento da doença. Este estudo teve como objetivo compreender como o portador de diabetes mellitus identifica e vivencia a depressão; descrever sinais e sintomas relacionando-a à vida cotidiana; e identificar os recursos de enfrentamento utilizados. Participaram diabéticos tipo 2 insulino-dependentes, acima de 50 anos acompanhados no programa do serviço de Medicina preventiva da UNIMED GV (Cooperativa de Trabalho Médico de Governador Valadares). O referencial teórico metodológico utilizado foi a história oral temática proposta por Meihy. Dados provenientes de 13 entrevistas foram analisados, os conceitos que emergiram favoreceram a identificação de três temas centrais: condições de vida da pessoa diabética influenciando na depressão, identificação da depressão e o significado da depressão para o diabético. Os sinais e sintomas de depressão indicados pelos diabéticos foram falta de apetite, medo das complicações e outras. Os colaboradores identificaram a depressão com mudanças percebidas no comportamento, melancolia, angústia, choro sem motivo aparente, perda de interesse, dificuldade de concentração, insônia e pensamento de morte. A depressão descrita esteve relacionada a sentimentos de isolamento, problemas financeiros e conjugais. O enfermeiro precisa ser capacitado para perceber e intervir precocemente na depressão, elaborar plano de cuidados efetivos e adesão ao tratamento do diabetes e da depressão a partir de programas educativos e no emprego das mais variadas alternativas terapêuticas.

**Palavras-chave:** Diabetes Mellitus tipo 2; Depressão; Adaptação.

## RESUMEN

La depresión en los diabéticos suele estar velada y, en general, los profesionales de la salud y los propios pacientes la confunden con sensaciones de angustia, tristeza y melancolía. Hay estudios que muestran que la depresión puede afectar el tratamiento de la enfermedad. Este trabajo tuvo como objetivo comprender cómo las personas con Diabetes Mellitus detectan y sienten la depresión, describir señales y síntomas que la relacionan con la vida cotidiana y determinar los recursos que se usan para enfrentarla. Participaron diabéticos tipo II con más de 50 años dependientes de insulina con seguimiento en el programa de servicio de medicina preventiva UNIMED GV (Cooperativa de Trabajo Médico Governador Valadares). La historia oral temática, propuesta por Meihy, fue el referente teórico metodológico utilizado. Se analizaron los datos recogidos en 13 entrevistas; los conceptos resultantes permitieron identificar tres temas centrales: condiciones de vida del diabético que influyen en la depresión, identificación de la depresión y el sentido de la depresión para los diabéticos. Las señales y síntomas de depresión indicados por los pacientes fueron: falta de apetito y miedo a las complicaciones, entre otros. Para los profesionales, la depresión se manifiesta a

*través de alteraciones comportamentales, melancolía, angustia, llanto aparentemente sin motivo, pérdida de interés, dificultad para concentrarse, insomnio y pensamientos de muerte. La depresión descrita estaba vinculada a sentimientos de aislamiento, problemas financieros y conjugales. Los enfermeros deben ser capaces de percibir e intervenir temprano en la depresión, elaborar un plan de atención eficaz y adhesión al tratamiento de la diabetes y de la depresión a través de programas educativos y de otras alternativas terapéuticas*

**Palabras clave:** Diabetes mellitas-tipo 2; Depresión; Cubriendo.

## INTRODUCTION

In the past few years, studies about depression have increased and their findings indicate the creation of three hypotheses, being the first one being the intensity and competence of repetitive treatment regimens that burden patients and become part of their daily life; duration of diabetes mellitus (DM), causing permanent stress; and the number of the disease complications that increase over time and affect the quality of life of the individual. Remember that DM and depression are part of a set of common metabolic disorders, and may be associated with each other, involving several factors of daily life.

DM is associated with an increase of depressive symptoms and of clinical depression, and it is known that the influence of this association extends to the direct impact of metabolic control to adaptive, educational and socioeconomic aspects. It is difficult to establish a casual relationship between symptoms of depression, glycemic control and diabetic complications. What seems to exist is a cyclical relation in which the aggravation of one has direct and indirect effects on the other.

Individuals have their own organic and historical characteristics that serve as reference to the meaning of life. When they receive the diagnosis of diabetes, it is like their lives have interrupted their projects, desires and expectations, and they start to feel vulnerable, dependent and experience changes in life which are transformed in feelings of hopelessness, anger, guilt, insecurity, fear of complications and even fear of death. However, after the period of denial, the individual accepts his or her new condition and continues on their path, referring to all sorts of problems and considering that life is permeated by pleasure and pain, happiness and sorrow, hope and despair, and the meaning of these values can be found in each situation and at various times of their lives. It is necessary to distinguish depression as a normal response to intermittent stress that lasts a few hours or possibly a day or two, from the illness depression, a prolonged state of despondency characterized by several affective and somatic symptoms.

The prevalence and incidence of DM is increasing at an alarming rate and almost in an epidemic way, according to statements from the World Health Organization (WHO) and the International Diabetes Federation.<sup>1</sup>

Currently, we noticed an enhancement in the early diagnosis of diabetes cases, that a few years ago, around the year 2000, was done only after the onset of one or more serious complica-

tions, in many cases irreversible. Diabetes has a prevalence rate of over 20% of the population in Brazil and in most countries around the world. The age range of the individuals is over 60 years, and in Middle East, the prevalence is more than 30%.<sup>1</sup>

This percentage of the world population with diabetes has an impact on public health and hospitals, in the planning of costs in healthcare of all governments, reaching a consumption of 15 to 25% of the total funds allocated to healthcare in Brazil.<sup>2</sup> The impact is also related to DM being the main chronic disease to causing about 40% of the morbidity and mortality from cardiovascular diseases, the major illnesses that affect people today.

If currently there are 150 million of people with DM worldwide, the prediction made by public health organizations, both nationally and internationally, is that in 2025 there will be around 300 million people with diabetes.<sup>2</sup> Important interventions have to be taken by all health professionals, government and health-care authorities, organizations, pharmaceutical industries, especially changes in guidelines and directives to be followed by these institutions for the effective control of diabetes.<sup>2</sup>

In Brazil there are 10 million diabetics, of which 90% are type 2 diabetics, a version of the disease strongly associated with habits of modern life. Half of this population does not know that they are sick, and the others 5 million Brazilians are already in a stage of the disease known as impaired glucose tolerance, i.e., if they do not take care of themselves will develop the disease.<sup>3</sup>

DM is a complex syndrome with multiple etiologies which effects multiple organs and systems. It is caused by defects in the secretion and/or action of insulin, characterized by chronic hyperglycemia and disordered in the metabolism of carbohydrates, lipids and proteins<sup>4</sup>

In the nursing area, there is a vast amount of literature on studies about DM carriers, both nationally and internationally. The majority of them address issues about self-care and health education for diabetics,<sup>5</sup> among other relevant subjects regarding the disease. Some of these studies describe assessments by health professionals, the experience of the person living with diabetes and reports of the individual and/or family facing the disease.

Among the subjects related to DM, psychiatric aspects have been described for at least a century,<sup>6</sup> and can influence the progression of this disease. Specifically, according to the cited author, depressive symptoms can impair adherence to the treatment, worse than metabolic control and enhance the risk of DM complications.

Authors affirm that DM nearly doubles the risk of depression. One in three diabetics may appear depressed and diabetic women present high risk of developing depression, which varies systematically varied in prevalence due to the tool and sample used; no difference between DM type 1 and type 2 was found in the data.<sup>7</sup>

The word “depression”, in colloquial speech, is used to denote both a normal emotional state, such as sadness, and a symptom, syndrome or disease, establishing itself in different levels of behavior related to the psychosocial context. Sadness is a universal human response to situations of loss, defeat, disappointment and other adversities.<sup>7</sup> As a clinical symptom, depression can arise in several medical conditions, including: dementia, schizophrenia, alcoholism and other diseases. It may also occur as a response to a stressful situation or to different social and economic circumstances.<sup>7</sup> As a syndrome, depression includes not only mood changes (sadness, irritability, inability to experience pleasure, apathy), but also cognitive, psychomotor and vegetative alterations, such as changes in sleep and appetite.<sup>8</sup> It is emphasized that psychiatric symptoms associated with an organic disease can have a devastating effect on the physical health of an individual.

Depression is a clinical disease of psychiatric origin, very frequent in the population, being, in general, disabling and in severe cases, prevents the person from performing his or her daily life activities, including taking care of himself or herself. It is potentially lethal, as it includes risk of suicide, and, in some cases, the cost can be very high, both for the patient and his or her family and for the community. The low productivity of effected people and work absences represent important losses,<sup>9</sup> and can result in many days of disability and in 12 times the recurrence of chronic heart diseases, hypertension, diabetes and back pain.<sup>10</sup>

Studies have been conducted in the Nursing field in order to suggest the inclusion of patients’ answers to the syndrome or depression.<sup>8</sup> This should be seen as a disease, but also a condition characterized by a group of people’s reactions to life events, often exacerbated by debilitating chronic degenerative diseases, such as diabetes mellitus (DM). In the nursing field, the professionals involved have recommended that NANDA-I develops a nursing diagnosis os depression.

As a human response, depression was not yet accepted as a nursing diagnosis by the North American Nursing Diagnoses Association (NANDA-I). In 1982, Marjory Gordon proposed a nursing diagnosis of dysfunctional depressive reaction and defined it as an acute decrease in self-esteem with response related to a signal of low self-esteem and a sense of self-competence.<sup>11</sup>

Depression can present neuropsychological and hormonal alterations that could have hyperglycemic effects and lead to disorders in glucose metabolism. The overlap of pathophysiological changes of both conditions could explain the frequent

occurrence of depressive symptoms in diabetic patients.<sup>12</sup> In our professional experience we have observed a considerable increase in the number of patients with DM who reach primary healthcare services and different outpatient clinics, reporting symptoms suggestive of depression.

There are two factors that seem to be related to depression in diabetic patients: the acceptance of the disease and the patient’s inability to deal with changes imposed by the disease in some aspects of daily life.<sup>13</sup> Depression is an important concern for DM carriers, and may be precipitated in different life stages when the disease manifests. Studies show that depression usually begins between 27 and 35 years-old, affecting 5-8% of the population at some point of their lives,<sup>13</sup> being two times more prevalent in women<sup>14</sup> and three times more prevalent in diabetics.<sup>15</sup>

Depression is a mental disorder which affects a person’s proper physical and psychological functioning. Studies have established an association among depression, poor glyce-mic control,<sup>7</sup> low adherence to lifestyle changes necessary for the management of the disease, and increased risk of chronic complications of DM.<sup>16</sup>

Depression in patients with DM appears to be related to alterations in the clinical course of the disease. Depressive symptoms are related to poor glycemic control, increased severity of clinical complications, besides decreased quality of life and impairment of social, economics and educational aspects related to DM.<sup>17</sup>

Other factors seem to be associated directly with depressive symptoms in the diabetic patient, such as being single, that can be responsible for lowered ability to accept the disease and the necessary changes in lifestyle.<sup>18</sup> The low level of education makes the understanding of complications of a chronic disease and its treatment difficult.<sup>7</sup> Financial problems also are shown to be related, to a lesser extent, with occurrence of depressive symptoms in patients with DM.<sup>17</sup>

Therefore, considering that depression is a characteristically hard to recognize and mistaken by many health professionals and by the depressed people themselves, we conducted this study to understand the experience of patients with DM regarding to depression.

## METHODS

Since the purpose of this study is to comprehend the lived experience, the qualitative methods seems more appropriate, due to encompassing reality that cannot be quantified, going deep into the world of human actions and relationships.<sup>19</sup> The presuppositions of verbal history were used to the data collection and analysis, as it is a methodological resource to direct the data collection and analysis and, in this study, verbal histories reveal hidden aspects, i.e., depression in patients with DM.

We believe that the method contributes to humanization of the researcher's perspectives, which cares more for quality than quantity of the data obtained. This is a technique and source through which knowledge is produced.<sup>20</sup>

There are three types of verbal histories:<sup>21</sup> verbal history of life, verbal thematic history and verbal tradition. In this study, it was chosen to use the verbal thematic history along with patients with DM that presented depression and were receiving treatment in the Preventive Medicine Service of UNIMED of Governador Valadares, through the program "Living with Diabetes".

A survey of the 120 registered patients, who were accompanied for eight months, was conducted. The diabetic patients who attended the service had, on average, 66 years-old, a majority were women (82%), a minimum wage of household income, Catholic religion, number of children ranging from two to seven, were undergoing psychotherapeutic treatment (90%) and only three were medicated with antidepressants. All are using antihypertensives and other drugs. Those who participated in the study were 13 diabetics type 2, aged over 60 years, using insulin and attending the program.

The patients who met criteria were contacted and information about the research was given. After agreeing to participate, the researcher randomly chose the acronym DM 1 for the first interviewee, and so on. Upon approval from the Ethics in Research Committee of the Federal University of Minas Gerais (nº ETIC 272/04), they signed, giving Informed Consent. Data collection was conducted through non-participant observation and semi-structured interview, comprising five parts that sought to characterize the participants, obtain information and perceptions about living with DM and about depression reported in monthly nursing consultations as part of the program. In these, researchers approached data related to identification of patients with DM, their clinical condition of health and disease, living with depression, their daily activities, their observation of the environment in which they live and the guiding questions: "What is depression for you?" "In which situations do you feel depressed?" "How do you live with depression being diabetic?"

Data analysis demanded processing information to characterize the clients attended in the service, organization of the transcribed interviews, notes from field observations, including reflections and comments of the researcher and the transcripts of the data collected. Concepts emerged from the speeches. The identification of categories is a central element in the analysis of the collected histories. Categorization means grouping concepts that seem to belong to the same phenomenon, and saturation occurred after the eighth interview, as predicted by some authors.<sup>19,22</sup> The historical background was built from the concepts, that were identified and grouped, about health status changes and trajectory of the disease-depression phenomenon.<sup>20</sup>

Experience and meaning of having depression for the diabetic patients were described, as well as the coping mechanisms used.

## RESULTS AND DISCUSSION

The historical trajectory was constructed from interviews and guiding questions, with three central themes emerging that characterize depression in a diabetic person: life conditions of diabetic person that influence depression; identification of depression; and the meaning of depression for a diabetic patient.

### CHARACTERISTICS OF DEPRESSION IN A DIABETIC PERSON

#### CATEGORY 1: LIFE CONDITIONS OF A DIABETIC PERSON THAT INFLUENCE DEPRESSION: COMPLICATIONS AND CHRONICITY

The disease has a social construction, with different meanings for each individual, and ends up influencing the perception of symptoms by themselves. The patients with this syndrome may be unaware that they have it or they can know about it, but not adhere to treatment, because they think it is unnecessary, since there are no significant clinical manifestations. According to authors,<sup>23</sup> depression arises either with the onset of signs and symptoms of diabetes complications, and as a consequence of its chronic nature. Thus, many times people with diabetes due to unawareness of the signs and symptoms of depression, and of its consequences and severity, interpret them as temporary and insignificant. This way, patients slow to seek healthcare with health professionals capable of diagnosing depression and start earlier a treatment, avoiding complications of diabetes and of depression, which are late and irreversible. The onset of complications brings fear and insecurity for some participants, which is clearly perceived in the statements about diabetes.

The control of chronic disease involves living permanently with its symptoms and feelings, and only after, to try adjusting their identities and seek changes in the way of dealing with body image and alterations in lifestyle. Adaptation to illness and disability are part of a continuous process in life. As demonstrated in the speech of a participant:

*[...] Look, what I understand about depression is, it is standing in a corner, only worried, with one thing in mind, one doesn't stop of thinking about it and if the person lets it, it is just gets worse [...] (DM 1).*

## CATEGORY 2: IDENTIFICATION OF DEPRESSION

Depression is a mental disorder that has consequences for the proper physical and psychological functioning of a person. Studies have established an association among depression and poor glycemic control,<sup>24</sup> low adherence to necessary changes in lifestyle for diabetes management, besides the enhanced risk of DM chronic complications.<sup>25,26</sup> Even with the inherent difficulties of recognizing depression and its adverse effects in patients with DM, being by healthcare team or patient failures, this situation is diagnosed and treated in less than one third of all cases.<sup>27</sup>

Depression in patients with DM appears to be related to changes in the clinical course of the disease. Depression symptoms are related to poor glycemic control, increase and severity of clinical complications, besides decreased quality of life and impairment of social, economic and educational aspects linked to DM.<sup>28</sup>

Depression is not only diagnosed based on physical or moral dejection, feelings of sadness, crying, discouragement, can also arise during the detection of the disease in cases of diabetes. Confirmation of diagnosis of a disease can cause distress, anxiety, fear, denial, helplessness, and low self-esteem. In the case of diabetic patients, the signs and symptoms identified as depression are insomnia, body aches, irritability and anxiety, among others, thus bringing changes in health status.

Diabetes mellitus is a silent disease because it does not always have clear signs and symptoms. It is associated with increased depressive symptoms and of clinical depression, and it is known that the influence of this association encompasses direct impact on metabolic control and even adaptive, educational and socioeconomic aspects. It is difficult to establish a causal relationship among symptoms of depression, glycemic control and DM complications. What seems to exist is a cyclical relationship, in which the aggravation of one has direct and indirect effects on the other.

## CATEGORY 3: THE MEANING OF DEPRESSION FOR A DIABETIC PATIENT

The factors related to depression perceived by the diabetics were social, financial, family and marital, and as a coping mechanism they reported resorting to the need of socialization and leisure, family support, medications, support in religion, support from the multidisciplinary team, and even in death as a solution to the problem.

### SOCIAL FACTORS

In the reaction to feeling of loneliness, it is possible to notice the participants' feelings who reported social isolation, personal loneliness and loneliness with your partner. It is perceived that feeling of loneliness can be awakened in a person when she or he is socially excluded. If this happens, the person ends

up feeling lonely and suffers from it, because the human being needs to feel as a participating as a member of groups. Exactly because society excludes this person, she or he suffers due to not opting for loneliness.

*[...] Sadness, anxiety? Be depressed, cannot see anyone, wants to stay in a corner alone. For me it is this, this is depression [...](DM 2).*

*[...] Our life becomes restricted. We have no joy, no satisfaction of being in a social environment [...](DM 3).*

### FAMILY FACTORS

Depression can impact family relationships, and, consequently, cause family problems. It is important to highlight that problems, disagreements or disorders of any nature can trigger loss of glycemic control and, also, initiate a depressive episode in a patient. Marital problems are often related to behavior changes. This affirmation can be identified in speeches of DM 4 and DM 5, respectively.

*[...] Ah! I think it is this way. Family every day, we have a problem, you know? And there is no hope for that. Any family problem is this way, let me explain (silent), sad, right? (laughing). I am also very worried [...]*

*[...] Ah [pause] when [pause] things don't go well, we have a little problem with the husband or business or something happened with your daughter, and it begins, that's when it starts [...]*

*[...] Then I start to roll around in bed, then I start to think, and comes the thought of the daughter, of the grandson, of the granddaughter [...].*

Depressed individuals report that it is more difficult to interact with others. A study<sup>23</sup> shows that depressed people give less eye contact, speak more slowly and softly, also talk with monotony and their speech may be dominated by negative thoughts, including sadness and hopelessness.

### MARITAL FACTORS

The disease is usually accompanied by marital complaints and, in general, interactions between depressed people and their spouses are characterized by more aggression.<sup>29</sup> Marital problems seem to have great influence in the progression of depression, however, spousal support can provide more efficient and lasting improvements in depression symptoms, since the participation and support of the partner can make a big

difference in the decrease of symptoms of depression. Thus, it is observed in the DM 6 report, perception of marital problems lived by her.

*[...] Of course, making the things he likes, the way he wants it, giving everything is his hands (silent) and we keep living like this (silent), there is not another way, always doing what he wants! (expressing anger) [...].*

## FINANCIAL FACTORS

Financial problems associated with the disease lead the individual to disabilities that remove him or her from social functions, such as work. In general, the absence from work due to health problems or help in the daily activities at home or even retiring, results in a series of immediate financial problems, such as the discomfort of unemployment, feelings of worthlessness or difficulties in getting money.

These problems are also present for self-employed people, are not retired and still need financial help from family and friends for food expenditures, continuing to pay their health-care plan and medications. The act of not working, especially for men, interferes with the sense of responsibility as a provider for the household, while women depend on help from their children to pay for the extra expenses with the disease. It is observed in the speech of DM 3, the dimension of the problematic lack of financial resources when he or she stopped working to take care their health.

*[...] The situation that always makes me depressed is the financial situation, it's necessary for me to think about my children who need help and sometimes I do not have the means to help them. I get more satisfied when I am able to meet their needs [...].*

The reduction in family income by retirement, the commitment of helping their children, lack of collaboration and comprehension of their partners, make people feel more depressed and unable to react. This assertion is evident in the speech of DM 1 that, despite being retired, still sees difficulty of living under the dependence and financial restriction of her husband.

*[...] Glad I have my retirement, after my husband got old, he does not give me money, and you need to see it, even for his children and grandsons [...].*

## COPING MECHANISMS FOR DEPRESSION

In everyday language, cope and coping are terms used with different meanings such as confronting, fighting against

something or a situation, face, to stand up to, play against, looking ahead, face unafraid, resist, endure, tolerate, bear; always implying a reaction to something difficult, a problem or a challenging situation.

The concept of coping implies an adaptive role in behavior and in the relationship between organism and adverse environment. Coping efforts of a participant can be perceived in the DM 5 speech's below.

*[...] So, for me, when I feel it is coming, depression is setting in, I know it is the beginning of something that I have to stop and fix it (silenced) and take care of myself to not let the thing go ahead. To take form and overcome you [...].*

Participants' coping efforts can be confirmed by their statements and supported in the literature. Some personal factors interfere in the coping strategies for depression, such as aging, personality, culture, specific self-care skills, values, beliefs, emotional state and cognitive capacity. Among the environmental factors that interfere in coping strategies are a support system, access to health services and physical and financial resources.<sup>30</sup>

## DEATH AS SOLUTION

The result of a low self-esteem state following a disruption of feelings of high self-esteem, can lead people to have suicidal thoughts, as they see death as a solution.<sup>31</sup> Sometimes, threats of suicide are ways that distressed and depressed people to ask for help and understanding or to avoid conflicts. If repeated threats of suicide occur, these people must learn other strategies to meet their needs. Often people experience moments of introspection and fear. This fear can be of their own death and the sense of fragility of life, as well as fear of religious laws. Suicidal behavior, in fact, is a desperate attempt to solve a problem, although it is an inadequate alternative.

*[...] So bad you are, you think that death (pause) rests you, gives you the peace that you want and don't have, you know (silenced), so that's way you wish dead, because death it's sleep, not to think, do not know (pause) sleep, sleep [...](DM 4).*

## RELIGION AS SUPPORT

It is noticed that the collaborators *Nhá Benta*, *Torrone* and others have religion as comfort. The connection between body and spirit is recognized by mankind for millennia. In past centuries, the scientific community considered faith and spirituality as signs of superstition and ignorance, but recent research are starting to relate faith with good health. The "scientific" find-

ings of those studies are increasingly encouraging doctors to study the relationship between faith and healing.<sup>25</sup>

*[...] Yeah, those things, you look back, you see all the time things worse than ours. You have to thank God that you still are capable of doing a lot of things, even sew, thank God, I sew with my hands this way; and who does not have two arms like I saw the other day? It is not another chance from God? [...]* (DM 7).

The patient who has faith handles better adversities of life, since spirituality has its positive aspect.

*[...] I have a lot of faith in God, I have a lot of willpower, I can, yes. The solution is to ask God and live, because what can you do, right? Just keep living [...]* (DM 5).

#### SOCIALIZATION AND LEISURE

Social support can be defined as the support available in the family, work and interpersonal environments, in order to maintain an adequate overall functioning of the individual, especially in adverse situations.

*[...] I go out, I try to entertain, make a visit (silent), not to stay like this, sit at home, then I think it is worse [...]* (DM 6).

Lack of social support also appears to be a factor associated with depression symptoms in diabetic patients. Authors<sup>32-34</sup> emphasized that patients with better social support have fewer depression symptoms, as described by DM 8 and DM 5, respectively.

*[...] I never felt depressed, because I have the support of my wife and my kids, who never leave me alone [...]*.

*[...] Ah! (silenced), I don't think about the problem. I try to divert my thoughts, I think about the good things, I go to my daughter's house and stay there with my grandchildren, I play with them, I don't watch TV, nor see anything, I don't listen to music, nothing, nothing. I just want to play, go out, I go shopping, walk, I go to the mall, sit there and eat a tasty snack, you know, these things [...]*.

This support is present in various ways: in church groups, service clubs, groups of preventive medicine, which provide contact with other people dealing with prevention of complications from chronic degenerative diseases, handicraft workshops, among others. The patients' participation in educational programs for diabetics, leads to improvement of depression symptoms.

#### FAMILY SUPPORT

Family support is considered a keystone in the evolutionary process of human being. Family is pointed as a receptacle for anxieties and fears, which need to have support to improve the human relationships among its members, in order to overcome taboos that are usually present. The strengthening of the family to act as support can be achieved by the presence of a nurse, as a professional active in social and health services, and that is responsible for giving information and education. The nurse is seen as the mediator in the relationship and the one who contributes to each person be and become better.<sup>35,36</sup>

At the beginning, it is hard sometimes to accept that someone close is suffering from depression and the first barrier to overcome is acceptance of the problem and the effects that depression has on the individual; then, it is possible to stop fighting these effects and start to work constructively and positively to help who suffers from the problem. All families function as an unit and, therefore, a problem faced by one member will affect all other members. From this perspective, nursing should focus on interactions with other subsystems (health professionals, relatives, friends), instead of studying and interacting only with the depressed person, evidenced by the following statements.

*[...] I never felt depressed, because I have the support of my wife and my kids, who never leave me alone [...]* (DM 8).

*[...] Ah! (silenced), I don't think about the problem. I try to divert my thoughts, I think about the good things, I go to my daughter's house and stay there with my grandchildren, I play with them, I don't watch TV, nor see anything, I don't listen to music, nothing, nothing. I just want to play, go out, I go shopping, walk, I go to the mall, sit there and eat a tasty snack, you know, these things [...]* (DM 5).

#### DRUG THERAPY

Drug therapy aims to reduce and, if possible, remove all signs and symptoms of the depressive syndrome and, still, to restore the occupational and psychosocial performance. It is the responsibility of the psychiatrist, whose function is to diagnose, medicate and monitor the development of depressive signs and symptoms, from the acute phase to the stabilization of treatment. The treatment of depression has been focused on administration of antidepressants, and the therapeutic success can be achieved after one or two weeks of treatment. It is very important that family and the multidisciplinary team are aware of the individual's resistance to accept the drug therapy, since the motivation for treatment is essential and an early termination or reduction of doses without medical consent, resulting in treatment failure.

[...] Gosh, one those little pills will take away the things that don't give me pleasure, heck they won't! Then I started to react by myself... Today I can react, without medication (spoke with a firm voice)... Yeah, I react in time so I don't depend on the medication [...] (DM 5).

[...] The doctor prescribed the antidepressant and scheduled a time for me to come back, but, only with the antidepressant, and then I came home and such, took the antidepressant and (pause) I did not sleep. Look, at the end I was starting not to eat, I was not eating (whispered). Look, in the situation that I was, I already didn't want to eat, there was no food that attracted me, to eat or not was the same thing and I wasn't talking to anybody, I did not want to see or talk to someone [...] (DM 9).

[...] I do not know. I pray, take a soothing, then I control [...] (DM 7).

#### SUPPORT OF THE MULTIDISCIPLINARY TEAM

It is important the support of a multidisciplinary team for diabetic patients. When conducting an evaluation of diabetics' theoretical knowledge of an interdisciplinary program, it was emphasized that "although the team believes that acquisition of knowledge is no guarantee of applying them every day, the change in lifestyle requires time, awareness and acceptance of the disease". The following statements confirm:

[...] I do not feel this support at home, but with the psychologist, yes... Ah, lately I have been heard by the psychologist and I was able to transmit, and I clarified these problems to her and she gave her opinions, it has been a strength for me [...] (DM 3).

[...] When you have these games here, we go back home seeming lighter [...] (DM 2).

[...] I love making new diet recipes in the special cooking class for we diabetics that the program offers [...] (DM 9).

If a person with diabetes or depression does not assume his or her condition as a chronic disease carrier, possibly he or she will be put in a situation of risk of complications, resulting from his or her lack of self-care.

Nursing has the commitment to help transform this situation, seeking to mobilize people, inspiring reflections about the everyday practice, as the improvement depends on the individual.<sup>37</sup> This statement is corroborated by the collaborator.

[...] After I started attending this program, my life has changed, I just don't come more often because my husband complains [...] (DM 6).

[...] we feel important when we talk to you that are so caring [...] (DM 7).

The treatment of depression in diabetic people, although is not curative, when conducted with responsibility and commitment of all those involved, it searches to maintain better life conditions for these people.

## FINAL CONSIDERATIONS

The history of each participant is an interpretation of their experiences in the search for meanings to understand how people with diabetes have lived with depression, their ideas and behaviors and what means to assume that we do not operate as informants, but also as interpreters. This interpretation makes us face a truth, that the other is a spoken and subjective reality acting in our thoughts. The subjective act of verbalizing, in trying to understand the meanings of the recounted events, involves capturing the personal experience of others, in a continuous effort to form an interpretation and understanding of a particular phenomenon.

The manifestation of the past in the immediate present for people reveals the meanings attributed to experiences and how they are reconstructed from cultural conventions. Life retold is nothing more than the main way of searching for meaning in the lived experience and that it was shared with others. The thematic stories told by the participants bring with themselves an individualized universal for each subject that told and heard them. It is a telling and listening marked by subjective experiences.

I realized that depressed diabetic patients respond less to programs aimed at changing health habits and that the parallel treatment of depression can be an important for success of those interventions in lifestyle. In addition to depression, other psychological changes follow the passage of time and could also lead to lower adherence to treatment and poor metabolic control.

Whoever tells a story always talks about itself, whomever listens recognize itself in it, because when we tell a story we are talking about ourselves. Moreover, the stories universalize the human dilemma for the patient, easing his loneliness due to abandonment, while, at the same time, make them understand that they themselves are responsible for making their choices.

Knowledge and inquiries are transmitted across generations through stories that portray life experiences. These experiences come from the universal, but need to be individualized, distinguished and made subjective.



In the current nursing practice, influenced by the frame of human relations, the focus is no longer the physical/biological status of the disease, but it is considered the person in a context of patient relations, in which the nurse would be exploring his or her “being” a professional as a tool for assistance. Humanization of care is needed. To know the patient, identifying their needs is an essential task for nurses and other health professionals.

Psychiatric nursing and nursing care to mental health of individuals should not exist as something separated from nursing in general, and vice versa. The interaction between nurse and person with diabetes contributes to the process of adaptation, as it assists in the promotion of adaptive responses, serving as base to direct nursing actions.

Nursing actions to depressed diabetic people deserve further thoughts, discussions and nurses’ maturity, once the holistic care is the relentless pursuit of their own nursing knowledge. The orientation provided in an educational process, whether individual or in a group, assist in the comprehension of reality, being essential for the learner, in this case for diabetic people, to overcome its resistance and to reconstruct values, what takes time. Nursing is really effective in interpersonal relationships through interactive process.

I emphasize this characteristic of the nurse to explain that an interaction with a depressed diabetic person is established when opinions are valued, points of view and from communication. The nurse is the link among several professionals, since he or she is the professional who performs more exchanges between people with diabetes and other professionals in order to supplement their needs for health promotion. Thus, in addition to refer people to other professionals, nurses reinforce care that is provided in an integrated manner. Therefore, I believe that from awakening of consciousness, most people will not fulfill orders without questioning them, it being essential that this fact occurs to overcome resistance in order to consolidate the changes.

In order for people with diabetes and depressive manifestations to adhere to necessary actions for disease control, the educational process must be based on real needs of people, being indispensable to establish an interaction between health professionals and patient to promote physical, psychological, social and spiritual well-being.

As nursing professionals start incorporating in their practice the multifaceted condition of people with diabetes and understand the meaning of depression, valuing their culture, uniqueness and social context, they will enable better quality of life to these human beings. Given the actions proposed by the nurse, they have autonomy to assess, therapeutic management and developing a plan of care. I see this as relevant, because occurred exchange of information among the multidisciplinary team for execution and recognition of this work.

We should collaborate with assisted patients, in the sense that they recognize their own responsibility in seeking treatment when necessary and that the longer they postpone this decision, the harder it will be to break habits associated with depression. They need to know that there are psychological and biological approaches to the treatment of depression, and alternatives totally feasible and appropriate for everyone.

The commitment of nursing is with life, i.e., with the quality of life of the individual in psychological distress under their care, regardless the severity of the diagnosis of each case and its duration.

I realized that our participants had many limitations, few alternatives or options to leave the comfortable position they have acquired over time, but are being perseverant, despite fearing change. All the participants sought to demonstrate their speaking as optimistic and hopeful, making us believe that such programs provide therapeutic alternatives, despite the mishaps encountered.

In the opportune moment, when there were not options or exits, there was investment in this program with the assistance of nurses, who brought forth this reality. It is with great joy and pride that I witnessed these participants fully adapted and, most important, independent, responsive and affectionate with caring contributions given by me when we were together.

I hope I have contributed to improving quality of life of these people and also for the growth of other health professionals.

I believe that the most important thing of all that was learned in this study, is the largest contribution to nursing, a fact confirmed in the perceptions of an author,<sup>38</sup> who claims nurses are able of making a difference.

## REFERENCES

1. Sociedade Brasileira de Diabetes. Consenso Brasileiro sobre diabetes. Diagnostico e classificação do diabetes mellitus e tratamento do diabetes tipo 2. [Cited 2002 Jul 20]. Available from: [www.diabetes.org.br](http://www.diabetes.org.br).
2. Brasil. Ministério da Saúde. Secretaria de Políticas de Saúde. Plano de reorganização da atenção à hipertensão arterial e ao diabetes mellitus: hipertensão arterial e diabetes mellitus. Brasília: Ministério da Saúde; 2002.
3. Malerbi DA. Evolução crônica do diabetes mal controlado. In: Atualização em Diabetes do tipo 2 para o clínico não-especialista. São Paulo: Sociedade Brasileira de Diabetes; 1998, p.10.
4. Anderson RJ, Freedland KE, Clouse RE, Lustamam PJ. The prevalence of comorbid depression in adults with diabetes. *Diab Care* 2001; 24:10069-78.
5. Zanetti ML. Papel educativo do enfermeiro e o locus de controlo da pessoa diabética, 1990 [dissertação]. Riberão Preto: Escola de Enfermagem de Riberão Preto, Universidade de São Paulo, 1990.
6. Maudsley H. The pathology of mind. 3<sup>th</sup> ed. New York: Appleton; 1899.
7. Lustaman PJ, Griffith LS, Clouse RE. Recognizing and managing depression in patients with diabetes. In: Rubin RR, Anderson BJ. *Practical psychology for diabetes clinicians*. Am Diab Assoc. 1996; 143-52.
8. Zauszniewski JA, Chung CW, Krafcik K, Souza VD. Psychometric testing of the depressive cognition scale in women with type 2 diabetes. *J Nurs Meas*. 2001; 9(1): 61-72.

9. Organization Panamericana de la Salud-OPAS. Organization Mundial de la Salud- OMS. Programa de Salud Mental. Division de Promocion de Salud. Modelo para la capacitacion de la enfermera general en ai identificacion y manejo de los transtornos afetivos.Generalista I. Genova: OMS; 1999.
10. Willians A, Strasser PB. Depression in the workplace: impact on employees. *AAOHN J*. 1999 Nov;47(11):526-37.
11. Maas ML, Buckwalter KC, Hardy MD, Reimer TT, Titler MG, Spech JP. Nursing care of older adults diagnoses, outcomes, and interventions. St. Louis: Mosby; 2001.
12. Leedom L, Meehan WP, Procci W, Zeidler A. Symptoms of depression in pacientes with type 2 diabetes mellitus. *Psychomatics*. 1991;32:280-6.
13. Robins LN, Regier DA. Psychiatric disorders in America the epidemiologic catchment area study. New York: Free Press; 1991.
14. Culbertston JA. Depression and gender an international review. *Am Psychol*. 1997; 52:25.
15. Gavard JA, Lustman PJ, Clouse RE. Prevalence of depression in adults with diabetes an epidemiological evaluation. *Diabetes Care*. 1993; 16:1167-78.
16. Carney C. Diabetes Mellitus and major depressive disorder: an overview of prevalence, complications, and treatment. *Depress Anxiety*. 1998; 7(4):149-57.
17. Van TM, Mccasckill CC, Lane JD. Depressed mood is a factor in glycemic control intype 1 diabetes. *Psychosom Med*. 2001; 63:551-5.
18. Roy A, Roy M. Depressive stomptoms in African American type 1 diabetics. *Depress Anxiety*. 2001; 13:28-31.
19. Minayo MC. O desafio do conhecimento - pesquisa qualitativa em saúde. 3ª ed. São Paulo: Hucitec-Abrasco; 1994.
20. Freitas SM. História oral. Possibilidades e procedimentos. São Paulo: Humanitas da USP; 2003.145 p.
21. Meihy JCSB. Manual de história oral. São Paulo: Loyola; 1996.
22. Camargo A. História oral e política. In: Moraes MD. História Oral. Rio de Janeiro: CPDOC/Fundação Getúlio Vargas/Diadorim; 1994.
23. Moreira RO, Papelbaum M, Appolinario JC. Diabetes Mellitus e depressão: uma revisão sistemática. *Arq Bras Endocrinol Metab*. 2003; 47(1):19-29.
24. Lustman PJ, Griffith LS. Depression in women with diabetes. *Diabetes Spectrum*. 1997; 10:216-23.
25. Carney RM, Freedland KE, Lustman PJ, Griffith LS. Depression and coronary disease in diabetic patients: a 10 - year followup. *Psychosom Med*. 1994; 56:149.
26. Carney C. Diabetes Mellitus and major depressive disorder: an overview of prevalence, complications, and treatment. *Depress Anxiety*. 1998; 7:149-57.
27. Bailey BJ. Mediators of depression in adults in diabetes. *Clin Nurs Rev*. 1996; 5(1):25-42.
28. Lustman PJ, Griffith LS, Clouse REE. Depression in adults with diabetes: results of a 5-year follow-up study. *Diabetes Care*. 1998; 11:605-12.
29. Van TM, Mccasckill CC, Lane JD, Edwards CL, Bethel A, Feinglos MN, *et al*. Depressed mood is a factor in glycemic control intype 1 diabetes. *Psychosom Med*. 2001; 63:551-5.
30. Kelsey JE. Depressão e família. [Cited 2004 Jun. 24]. Available from: <<http://www.Manipulário.Far.Br/dicas-de-saúde/q20502.htm>>.
31. Miyaoka Y, Miyaoka H, Motomiya T, Kitamura S, Asai M. Impact of sociodemographic and diabetes-related characteristics on depressive state among non-insulin-dependent diabetic patients. *Psych Clin Neurosci*. 1997; 51:203-6.
32. Ross EK. Sobre a morte e o morrer. 8ª ed. São Paulo: Martins Fontes; 1998.
33. Bailey C J, Turner RC. Metformim. *N Engl J Med*. 1996; 334:574-9.
34. Myaoka Y. Impact of sociodemographic and diabetes-related characteristics on depressive state among non-insulin-dependent diabetic patients. *Psych Clin Neurosci*. 1997; 51:203-6.
35. Connel CM, Davis WK, Gallant MP, Sharpe PA. Impact of social support, social cognitive variables, and perceived threat on depression among adults with diabetes. *Health Psychol*. 1994; 13:263-73.
36. Osinaga VLM. Saúde e doença mental: conceitos e assistência segundo portadores, familiares e profissionais [dissertação]. Ribeirão Preto: Escola de Enfermagem da Universidade de São Paulo; 1999.
37. Pace AEEC. O conhecimento dos familiares acerca da problemática do portador de Diabetes mellitus. *Rev Latinoam Enferm*. 2003 maio/jun; 11(3):312-9.
38. Malerbi DA. Evolução crônica do diabetes mal controlado. In: Sociedade Brasileira de Diabetes. Atualização em Diabetes do tipo 2 para o clínico não-especialista. São Paulo: Sociedade Brasileira de Diabetes, 1998; 2:10.
39. Rogers M. Enfermagem no ano 2020: cinco cenários futuros. Toronto: Canadian Nurses Association; 1997.