

SELF-DESTRUCTIVE BEHAVIORS AND TYPE II DIABETES MELLITUS: POSSIBLE TRIGGERS FOR NON-ADHERENCE TO TREATMENT¹

COMPORTAMENTOS AUTODESTRUTIVOS E O DIABETES MELLITUS TIPO II: POSSÍVEIS DISPARADORES PARA A NÃO ADESÃO AO TRATAMENTO

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ABSTRACT

In Brazil, there are about 13 million people living with diabetes mellitus (DM), when poorly controlled, can generate several complications, such as peripheral neuropathy and even amputation of limbs. Most cases of leg or foot amputation are a consequence of lack of preventive self-care. Self-care is an act of self-preservation, however, there are behaviors incoherent with this search, the so-called self-destructive behaviors. This study aims to identify the possible triggers of self-destructive behaviors in patients diagnosed with type 2 diabetes mellitus (DM2) with peripheral neuropathy. This is a qualitative study, exploratory and interpretative in nature, with a descriptive character. A semi-structured interview was used as an instrument with eight patients with peripheral neuropathy due to DM. The data were analyzed from content analysis and categorized. Three categories were added that can influence self-destructive behaviors: a) the conception of health and disease: the need to look beyond the disease; b) DM2 and its invisibility; and c) the psychological dimension of DM care. From the interviews and theoretical contribution, this study sought to reflect on the possible crossings regarding the treatment of DM2.

Keywords: Self-destructive behavior; diabetes *mellitus*; psychology.

RESUMO

No Brasil, há cerca de 13 milhões de pessoas vivendo com diabetes mellitus (DM), quando mal controlada, pode gerar diversas complicações, como a neuropatia periférica e até amputação de membros. A maioria dos casos de amputação de pernas ou pés é consequência da falta de autocuidado preventivo. O autocuidado, é um ato de autopreservação, entretanto, há comportamentos incoerentes com essa busca, os chamados comportamentos autodestrutivos. Este estudo visa a identificar os possíveis disparadores de comportamentos autodestrutivos em pacientes com diagnóstico de diabetes mellitus tipo 2 (DM2) com neuropatia periférica. Trata-se de um estudo qualitativo, de cunho exploratório e interpretativo, possuindo caráter descritivo. Utilizou-se como instrumento uma entrevista semiestruturada com oito pacientes com neuropatia periférica decorrente da DM. Os dados foram analisados a partir da análise de conteúdos e categorizados. Foram elencadas três categorias que possam influenciar nos comportamentos autodestrutivos: a) a concepção de saúde e doença: a necessidade de olhar além da doença; b) a DM2 e sua invisibilidade; e c) a dimensão psicológica dos cuidados com a DM. A partir das entrevistas e de aporte teórico, este estudo buscou refletir sobre os possíveis atravessamentos no que tange à adesão ao tratamento da DM2.

Palavras-chave: comportamento auto destrutivo; diabetes mellitus; psicologia.

¹ Artigo empírico.

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INTRODUCTION

Currently, in Brazil, there are about 13 million people living with diabetes mellitus (DM), which represents 6.9% of the Brazilian population. This makes the country have one of the highest rates of diabetes in Latin America and, worldwide, it ranks 4th among countries with the most diabetics (Sociedade Brasileira de Diabetes, 2020). In Latin America, about 1 in 3 people do not have an early diagnosis of the disease and are at risk of developing serious complications and with high public health costs, according to the Brazilian Society of Diabetes (SBD, 2020). According to the World Health Organization (WHO, 2003), in developed countries, the average number of people with chronic disease who adhere to treatment is 50%, that is, adherence to treatment is not very high, which is worse. even in developing countries, where there is even less adherence. It brings direct consequences for people with the disease, for not undergoing treatment and developing other health problems, as well as resulting in high financial costs for the health system.

When poorly controlled, DM2 can generate several complications, which can be categorized as microvascular and macrovascular disorders, and may result in retinopathy, nephropathy, coronary disease, cerebrovascular disease, peripheral arterial disease and diabetic neuropathy (SBD, 2020). The latter is considered one of the main causes of peripheral neuropathy in the world, and can often result in ulcers, changes in the shape of the feet and fingers, amputations of the lower limbs (LL) and other disabilities, increasing the rates of hospital admissions and cardiovascular mortality. It is estimated that half of individuals with DM2 will develop this type of neuropathy at some point in their lives (Nascimento *et al.*, 2016).

Between 2011 and 2016, 102.56 amputation surgeries were performed by the Unified Health System (SUS): 70% in individuals with DM2, and the majority, totaling 94%, were lower limb amputations (Santos *et al.*, 2018). According to SBD (2014), most cases of amputation of legs or feet are consequences of lack of preventive self-care, that is, to result in such severity, one of the consequences is non-adherence to treatment.

Self-care, at its essence, is an act of self-preservation. In human beings, there is an innate sense of self-preservation, leading him to look for behaviors and contexts that provide/contribute to having more longevity during life, however, sometimes people engage in behaviors that are inconsistent with this quest, attitudes that are called self-destructive behaviors (Santos & Faro, 2018).

Self-destructive behaviors are considered attitudes that do not explicitly and manifestly express the desire for death, but rather in an incomplete, displaced and symbolic way, since “the constructive and destructive tendencies of the personality are in constant conflict and interaction to create, destroy and build, representing anabolic and catabolic processes of the personality” (Kovács, 1992, p. 175). They can be carried out directly - acts involving suicide - and indirectly, which consists of dangerous activities performed repeatedly, without necessarily having a conscious intention to die,

which may be, for example, the excessive consumption of alcoholic beverages, the use of any type of drug, consumption of cigarettes, eating excessive amounts of food, including those that are harmful to life, neglecting one's own health, self-mutilation, recklessly driving a car, among other behaviors (Daolio, 2012). Bleger (in Bastos, 2009) discusses self-destruction as a psychosocial process, through the analysis of its basic levels: individual, interrelationships (which begin in family relationships), the institution, and society as a whole. In cases of physical illness, intentional abandonment of treatment can be considered self-destructive behavior, explicitly or implicitly, slowly, progressively and subtly (Magalhães & Figueiredo, 2019).

Considering the data regarding the number of patients with diabetes and the propensity for diabetes in the future, as well as the consequences that this disease brings to individuals and to health systems, in addition to the practical experience developed by a psychologist residing in a medium-sized hospital in the central region of Rio Grande do Sul, this study arises, since it is no longer possible to think of a psychology that disregards death, public health and hospitalization (Sebastiani, 2003).

This study is part of the research carried out for the conclusion of the Multidisciplinary Residency in Physical Rehabilitation. The aim of this investigation is to identify possible triggers of self-destructive behavior in patients diagnosed with type 2 diabetes mellitus with peripheral neuropathy. The idealization of the study was motivated by the perceptions constructed during the consultations developed by the professional in the hospital area, in a low and medium complexity hospital in the interior of the State of Rio Grande do Sul, where it was often seen how much the behaviors and postures - a priori hospitalization - on the part of the patients did not help in the treatment of DM, neither in glycemic control, thus worsening his clinical picture. Still, it was motivated by the concerns arising from the posture, sometimes authoritarian, on the part of some professionals in the hospital area of the hospital, which ended up disregarding the uniqueness of the patient assisted, just as they did not consider or even reflect on the possible reasons that may have led such patients to this situation, not having the necessary understanding for a more humane and subjective assistance.

METHOD

A qualitative, exploratory and interpretative study of a descriptive nature was carried out.

PARTICIPANTS

Eight (N=8) patients with DM2 aged between 36 and 77 years participated, six male and two female participants. At first, the participants to be interviewed would be those who would be hospitalized for having peripheral neuropathy due to DM2, but, as a result of the pandemic caused by covid-19 and hospital beds being allocated to patients with this infection, patients with diabetes who

were available to participate and who were not hospitalized were also interviewed, using the non-probabilistic “snowball” technique. This technique serves to reach and study groups that are difficult to access, locating participants with the necessary profile for the research, therefore, asking them to indicate new participants with the desired characteristics to also participate in the research (Vinuto, 2014).

INSTRUMENTS

Data collection was carried out through a semi-structured interview, between the months of February and August 2021, in which questions were addressed about how the discovery of DM2 was, as well as the dynamics of the patient’s life since then, focusing on their reasons, feelings and behavior. For data analysis, we chose to work with qualitative content analysis, addressed in categories defined *a posteriori*. Content analysis consists of a group of paths that will present the meaning of a content. They present the open model, closed model and mixed model as forms of analytical category. In this study, the open model will be used, consisting of an *a posteriori* definition, which takes shape during the course of the research and analysis (Laville & Dionne, 1999).

PROCEDURES

After approval of the project by the Committee for Ethics in Research involving human beings, CAEE 41162920.1.0000.5306, opinion number 483074, participants were invited to participate in the research through the terms of free and informed consent. Afterwards, interviews were conducted, which were recorded in audio and then transcribed for later analysis of the interviews and these listed in categories. The participants were identified in the transcripts with the initials P (patient), added by numbers from 1 to 8 (P1, P2, P3, P4, P5, P6, P7 and P8), thus ensuring the privacy of the participants’ identities. The categories listed were: a) the conception of health and disease: the need to look beyond the disease; b) DM2 and its invisibility; and c) the psychological dimension of DM care.

RESULT AND DISCUSSION

In the course of research into possible triggers of self-destructive behavior in T2DM patients with peripheral neuropathy, contents emerged that match the complexity and multidimensionality that influence adherence to treatment for DM2. From the interviews, the results show that there is interference of intrinsic and extrinsic factors, such as: emotions, ways of being, experiences, suffering, family dramas, aspects of the disease, particularities of the treatment and the relationship with health professionals, as well as in relation to the health system, social context and historical, political and cultural factors (Reiners, 2008; Melo, 2019). The possible causes that can lead the subject to self-destruction

during the treatment of DM2 were categorized and are explained in the next subchapter. It starts with the first categorization.

THE CONCEPTION OF HEALTH AND DISEASE: THE NEED TO LOOK BEYOND THE DISEASE

In this first category, questions are listed regarding the process of understanding and constructing illness, both for those who are ill and for those who provide assistance to the sick subject. The need to understand how this understanding is structured arose from the perception of how much the idea arising from curative medicine, for the most part, carried out as therapy in the hospital field, is not enough to cover the complexity of treating a human being, as well as the repercussions that the current format of care influences on the behavior that the subject may have in the face of diseases, including the diagnosis of DM2.

Currently, it is known that pharmacological treatment alone is not more efficient than when combined with lifestyle changes (Silva & Alves, 2018). Thus, for an effective treatment for DM2, it is necessary to work together with the triad: dietary restructuring, medication intake and physical exercise practices (American Diabetes Association, 2018). In addition, despite being little emphasized, however important, it is perceived the need to consider the psychological aspects of the patient with DM during treatment, since the diagnosis of DM2 demands a restructuring of the subject's life and identity, as well as an adaptation to the limitations, frustrations and losses resulting from the disease (Diaz *et al.*, 2016).

Sometimes, a multifactorial understanding of the needs demanded for the treatment of DM2 is not carried out by the assisted patient, given that the medication is seen as a unanimous need by users with DM2, and may come to serve as the only basis for treatment, due to its legitimacy and recognition of its success in controlling diabetes. In this way, there is a need for the patient to recognize the effectiveness of physical activity and eating restructuring, which is often not validated (Costa *et al.*, 2018).

This reality was also perceived in the daily lives of the participants in this study, since some place their hopes for the effectiveness of the treatment only on medication and, therefore, see it as the only relevant practice for their improvement, as shown in the following excerpts:

P5 - Because we're treating it, taking medicine and what they tell me is that there's a cure for it [...] If there's another medicine, something I'm doing the other way around, I'll study it, right (...) I think it's a curable disease, not an incurable one. Only you have to find the medicine, which is the same as cancer.

P6 - Diet, no, I even ate everything. I only took this medicine, Metformin. But then it became very altered, so I had to start with Insulin.

P8- And then I was also prescribed, a year and a half ago, I started to treat it, let's say, to take medicine.

Disregard of other types of conduct and possible forms of care for DM2, believing that medicalization is the only effective therapeutic resource for recovery and treatment, can be influenced by several phenomena, as the biomedical model and its curative representation, in addition to the prevalence of the crystallization of the medical discourse, which is seen as unique and unquestionable, since, in the popular imagination, medical knowledge is considered an instrument of certainty (Leplantine, 2010; Ferreira, 2011).

As part of the biomedical model, medicalization is developed from a reductionist and magical perspective, which is built on the idea of acting and having control over something (Barros, 2002), thus, the body can be understood as just an organic configuration condemned to the correct use of certain substances, which dominate it and appear as saviors (Dantas, 2009). In this way, the realization of the culture of medicalization imposes quick medicalized solutions to social problems that, in fact, are complex and multifaceted (Conrad & Barker, 2011).

The following excerpts allude to the medicine culture:

P2: Then I said: okay doctor, what do I do? He: Now you are going to take medicine. He gave me the one from the little bag (he pointed to a bag), I take three, one in the morning, one at noon and one at night, so I continued taking that, always.

P5: So I told the doctor what was going on, so when they went to see me I had high diabetes (...). So I started to do the treatment, take medicine.

P7: Using medicine, then you go and do the tests, then the doctors tell you: "it came out altered and something", or increase a medicine and then, halfway through the year, you go to another consultation and it already decreases a little.

Another significant key that also seemed to key for the treatment of DM2 was related to the information passed on about the disease. A good key for the participants knew the least about DM and, sometimes, key superficial questions, with no clarity about the progression and possible conducts in view of the development of the disease. With this, it was noted that there is a predominance of misinformation regarding the existence of peripheral neuropathy in DM2, as key as patients stress that key know about the disease, this knowledge is, lots of sometimes constructed in a contradictory, erroneous way, overestimating certain aspects of the disease and disregarding others (Llanes, 2012), as the following excerpts demonstrate:

P1: The diabetic foot is very sensitive. I didn't know it was very common to affect (...) I know people who go blind, people who need hemodialysis, foot, if I tell you that I knew it was common, I'll be lying to you.

P2 - No, I didn't know. I had no idea it could affect the foot.

P8: (...) But I thought the wrong way, as I was thin, the way I am, I wouldn't have diabetes.

The lack of information, knowledge and lack of communication between patients and health professionals about the disease can lead to low adherence to treatment, especially non-drug treatment, are behaviors performed by the patient himself (Péres *et al.*, 2007). For changes in lifestyle to occur,

it is essential that information be provided on how to practice this type of self-care and what are the necessary changes to be made for the benefit of the subject in the treatment for DM2 (Silva & Alves, 2018).

This lack of information ends up having an impact not only on those who already have the diagnosis of DM2, but on those who do not yet have it, as it sometimes makes it impossible for the person to discover the disease in time to be able to prevent further damage, since the search for and use of the health service is constructed by the user based on their knowledge of their illness or health condition, as well as the need that they assimilate to their clinical condition (Malta *et al.*, 2017).

The lack of information was a point highlighted by the interviewees, as can be seen below:

P5: No, he didn't explain anything to me, he just told me that I had DM. Then I started consulting here, consulting there, taking medicine.

P4: Then I went to the health center and the doctor said that I didn't need to take medicine or anything. Then some time passed, then they gave me an ointment and I bought it, it didn't help.

P2: No, I was dumb waiting to talk, you never told me what it was and I never asked what it was, and I was never told either.

Along with the various reasons that contribute to low adherence to treatment, the relationship established between the person with DM and health professionals is also highlighted as a possible trigger, since these often, adopt an authoritarian model of guidance and communication, that is, they only transmit information about the disease and do not consider the uniqueness of each subject assisted in the process of understanding the information. This information usually comes from a vision of power, making the health professional have control over the life of the serviced user, in the sense that it is in their "power" to determine what is right and what is wrong. wrong for him to be healthy, thus being able to generate, through this hierarchical and asymmetrical relationship, resistance in people with diabetes (Gama *et al.*, 2017).

It is necessary that health professionals work together with the patient, in order to clarify possible doubts, as well as to better adapt the treatment, respecting the subjectivity of each one. However, there are often difficulties in this friendly and collaborative relationship, and sometimes the professional may be acting inappropriately, jeopardizing the treatment for DM2, thus resulting in the need for the patient to look for another professional/institution to continue his treatment (Carvalho *et al.*, 2019). This scenario may be a reflection of the training and conceptions of professionals regarding the disease, the patient and the treatment, since, according to studies already carried out, health professionals often encounter barriers to establishing a good therapeutic relationship, such as: inadequate and insufficient communication, lack of trust, lack of bonding, improper approach, hierarchy of relationships, pressure and threatening behavior and paternalistic behaviors (Reiners *et al.*, 2008; Graffigna *et al.*, 2014; Vest *et al.*, 2013; Ritholz *et al.*, 2011).

As he got to know each research participant better, another point in common between them was perceived that can make it difficult to adhere to treatment for DM2: the precarious financial

condition. Currently, studies show that low-income populations are more affected by chronic noncommunicable diseases (NCDs) because they are more vulnerable, with worse living conditions, at risk, in addition to having greater difficulties in accessing health services and services. prevention and health promotion practices, thus resulting in earlier deaths and a higher occurrence of sequelae (Almeida & Camera, 2019). Most of the participants in the studied group highlighted the difficulty it was and still is to adhere to a balanced diet, as well as follow continuous monitoring for dressings, due to financial difficulties to subsidize such needs. These situations are brought up by the participants in the following reports:

P4: "Then you have to have a more regulated diet", but there was no way. It's beans, rice and a little meat, when I could get it, and a little mix, a bean. There's no way you can do it, you just have to grab the medicine and live.

P3: The poor have no choice, the poor eat what they have. Do you think I'm able to feed myself with forty-pound salt? Eat what you have (...) I broke two ribs, I didn't even go to the doctor, due to lack of money for gasoline, I treated it at home, you know Dipyrone? I took a lot of that (...)I really wanted to lean over, receive something, because I really need it, I'm really poor. I swear to you, sometimes there is no bread to eat breakfast, there is no rice to eat (...) I can't buy a medicine to take, I can't buy metiorlate to put on my injured foot.

In view of what was stated by the participants, one can think about how much the social and environmental context will significantly interfere with the possibilities facing a disease. Barreto (2017) states that the health conditions of a population are negatively affected by poverty. precarious housing conditions, inadequate urban environment, unhealthy working conditions, thus aggravating the occurrence of the most diverse diseases and health problems, that is, it favors the occurrence of diseases in a more accentuated way among the most vulnerable. poor, minority ethnic groups and/or discriminated against.

Through this, one can reflect on which self-destructive behaviors can be provoked due to inequality in health, since such inequity causes unequal possibilities of enjoying scientific and technological advances by the population, as well as can describe different forms and factors that determine health and the disease. also to different chances of illness and death (Barreto, 2017). Thus, sometimes, the person with diabetes receives guidance regarding care and the ideal diet, but cannot follow it correctly due to financial difficulties (Grillo & Gorini, 2007).

TYPE 2 DIABETES MELLITUS AND ITS INVISIBILITY

In this second category - namely, Diabetes mellitus 2 and its invisibility - the existing crossings for the understanding of DM as a disease are addressed, as well as the impacts arising from its invisibility. The DM, in its different types, has its beginning and advances silently. Due to this fact, the discovery of having this disease usually happens when blood glucose levels are out of control and

its progression is already causing exacerbated damage to the body of the subject affected by the disease. This is what happened to the participants in this research, since all of them discovered DM after a clinical decompensation, resulting, in its entirety, in the search for an urgent and emergency service.

Most participants did not suspect that they had DM and, unanimously, believe that the greatest danger is its invisibility and silent progression, as can be seen in the following excerpts:

P3: I was dying without knowing it, he said that I could go into a coma in the hospital, because it was getting very high and it was very dangerous.

P1: It's a silent disease and it's through the mouth.

P4 - I was traveling and I was very sleepy, that tiredness a little out of the ordinary, you know, feeling bad, feeling bad, then I went to my supervisor and said, you know, then they gave me a day off to do the exams. So I told the doctor what was going on, so when they went to see me I had high Diabetes. That's why I fell asleep.

P8: (...) I was referred to the ER again, that's when I found out in the ER that they were treating the DM, but I said: Yes, but I don't have DM. They said: No, yes, your DM is super high.

The absence of symptoms is considered a relevant reason for low adherence to diabetes treatment, since most subjects need to see the impacts on the body in order to practice self-care (Espírito Santo *et al.*, 2012 cited by Silva & Alves, 2018). The need to see and make the disease palpable even implies considering it as a disease. As it is a silent disease, it is common for DM not to be understood as a disease, thus making it impossible to understand and perceive the need to change lifestyle habits, an act essential for the treatment of diabetes (Grillo & Gorini, 2007; Gross *et al.*, 2002).

For example, a qualitative study carried out with men with DM who lost lower limbs highlighted that, after diagnosis, patients underestimate and sometimes ignore the information provided by health professionals, on account of not visualization of the disease in the body, in addition to the fact that, in some situations after the discovery and treatment of the symptoms, the impression one has is that the disease does not exist again, which leads to not assuming self-care behaviors and results in complications generated by the disease (Lédon *et al.*, 2007).

The severity of DM is often questioned due to its silent progression. This questioning is often asked even after the diagnosis, which can result, as seen in this study, in doubts and even in carrying out tests with the body itself, as if it were a search for confirmation of the existence of the disease DM. This can be seen in the following speeches of the participants of this research:

P2: The problem with diabetics is to think that they are healthy and they are not, and then when they come back, it seems to come back worse.

P1: I thought I would never have consequences from Diabetes. Oh because a consequence of Diabetes is that one day you need hemodialysis, oh you can go blind, oh you can get dull, oh you can have wounds and not heal. But, as I myself would dig into my nails and it would hurt and heal, I say: "no, that's not true".

P6: I left, I continued drinking soda, eating meat, barbecue, these things, and in the end it went on, getting worse.

P4: My mother was pre-diabetic, they told her that she was pre-diabetic, after she did some tests. My uncle too, but he didn't die of Diabetes.

P7: (...) what bothers me during this time is the appearance of that part that appeared on my finger, because if I didn't have that, normal life, you know.

This conception can end up in a distorted view regarding what DM is and the possible impacts caused by it, which may lead to a lack of demand for health services, as well as the lack of care for DM, as shown in the above passages. The way DM is seen may significantly influence the degree of severity that the subject will associate with the pathology; in addition, the way a person will react to health risk problems is highly correlated with the personal resources available to seek support and assistance, with the perception of disease risk being one of these indicators (Burd, 2010; Malta *et al.*, 2017).

The minimization of DM severity has already been questioned and analyzed in other studies, such as Llanes (2012), which discussed beliefs that underestimate and discredit DM and its impact. This is in line with the findings of the study carried out by Hausner (apud Burd, 2010, p. 582), in which he points out that: "The general consensus seems to be: 'there are remedies' 'see how well people seem to be with diabetes' or 'I've never heard of anyone dying of diabetes'", emphasizing how much the discrepancy between what diabetes really is and how it is perceived is an alarming fact in a world where there is an increasing number of cases diagnosed illness.

THE PSYCHOLOGICAL DIMENSION OF DM CARE

In this last category, unique reactions to MD are addressed, as well as the similarities observed in the different ways of facing it. DM, which is a multifactorial disease, is characterized by a long duration, chronic, in biomedical terms, since its course is different, due to the impossibility of cure, thus having a prolonged contact with the health system (Brasil, 2018; Melo, 2019).

The diagnosis of a disease has an impact on the psychological of individuals. There is a singularity in the way of receiving and perceiving the diagnosis, that is, the individual, when receiving the news that he has a chronic disease, can present different feelings and reactions, because the disease can be perceived as a problem that causes suffering and emotional inadequacies resulting from the need to change one's lifestyle (Silva & Alves, 2018). Considering the human being, his subjectivity and emotions, this subchapter turns to the psychological dimension, seeking to raise some hypotheses of possible triggers of self-destructive behavior, since it is impossible to rigidly reduce the various reactions that can arise in a subject when he is faced with the diagnosis of an illness.

The diagnosis of DM can be accompanied by several reactions, sometimes contradictory. The impacts will depend on multiple variables, such as age, sex, the view that the subject has about the disease, the type of DM, the form of presentation, the social meanings of the disease, the impacts generated on daily performance, the perceived possibilities of control, the subject's psychic structure

and specific living conditions (Llianes, 2012). In this way, the way the disease will be perceived and the meanings that the subject attributes to it may contribute to low adherence to treatment, given that it will depend on how the disease process will be rationalized with their life history (Silva *et al.*, 2006; Lazo & Duran-Aguero, 2019).

With regard to the subjective reactions to the diagnosis of DM, it is possible to emphasize how multifaceted it is, therefore, there are countless possibilities that instigate or make the subject have unfavorable reactions to the disease, which can be influenced by environmental aspects, life events and situations associated with friends and family (Klonsky & Lewis, 2014 quoted by Santos & Faro, 2018). In order to relate this fact to the research participants, the following excerpts, which are from two interviewees, portray the influence that the loss of family members had on the initiation or continuation of treatment for DM. Faced with grief, both participants stopped treatment and/or developed behaviors that resulted in DM decompensation. Here are the excerpts:

P5: Then my mother passed away, I kind of relaxed. I stopped insulin, I stopped everything. The problems were coming back.

P6: I was 23 years old, I remember that my husband passed away, and I drank coffee and smoked. Sometimes I would stay awake at night, and drink water, and drink water, or drink coffee like that. Then it was 500 and something.

Adherence to treatment - as well as adaptation and even acceptance - will depend on a maturing process regarding the diagnosis of the disease, marking the beginning of a new path, where some areas of life are restructured and new meanings are constructed in the face of the get sick (Llianes, 2012). For Simonetti (2016), falling ill is as if the subject entered an orbit, with the disease often installed centrally in his life, and he may start to revolve around it, in a kind of orbit, which is arranged of four positions: denial, revolt, depression and confrontation.

For some subjects, the only immediate possibility before the disease is denial, since they do not have the necessary psychological conditions to face the diagnosis as a reality. When this happens, it is not done on purpose, but because at that moment it is the only reaction the patient can and can have, it is the only weapon he has. It is common for the subject to behave as if the disease did not exist, or minimizing its severity, thus being able to postpone the necessary care, leaving for tomorrow the appointment with the doctor, the performance of some examination and even the beginning of the treatment (Kluber -Ross, 1969; Simonetti, 2016).

Denial can take many forms, stubbornness being an integral factor that can constitute it, possibly showing itself through the insistence on keeping the state of affairs unchanged (Simonetti, 2016). One aspect repeatedly highlighted by the participants was the referring to the difficulties encountered in adapting to the necessary changes that DM demands, these were sometimes transformed into resistance or, as stated by one of the participants, stubbornness:

P7: Then they try to guide and stuff, but in fact we don't do it, you know, in fact we don't even do it because of this problem, because you would have to leave your "comfort zone" to buy your food and stuff.

P5: I drove two nails together into the foot, and I let it go for about three, four days, and then it got complicated, the nail was rusty.

P8: But the diabetic has a quality that you will notice in every diabetic, stubbornness (...) And that day I didn't treat the way I had to (...) Something you ask, ask I don't know, asks to do it and she doesn't do it, or, it takes time to do it and when she does it, it's past time, let's say, something more or less along those lines.

The phenomenon in question can also be understood when asked about injuries to their lower limbs (LL). The participants spoke as if this were something unpredictable, sometimes seeming to minimize the complications that can occur due to DM. The following excerpts are statements from patients who are in the process of recovering from the second injury to their foot, but who, even though they are already facing a similar situation, still seem to belittle the impacts arising from DM and peripheral neuropathy:

P7: I don't have a problem with healing, I never have, anything I get hurt, I keep getting hurt, because I'm always doing one thing or another lightly, but the guy, scratches, cuts, there's no problem, it heals, but the finger is not working.

P1: I don't know, it's unpredictable. You hurt and... It happened that this vein happened too.

P5: I think it's normal, one that won't heal anyway.

According to Llanes (2012), sometimes, the collective imagination of a lifelong illness can make the subject, in order to survive this experience, agree obligatorily and not complacently with the drug treatment, with the diet, with the exams and with the continuous supervision of aspects related to the body. In addition, the instituted chronicity influences the way in which the subject will see the performance of the activities developed so far, limiting them.

Based on everything exposed in this subchapter, it should be noted how necessary it is not to ignore the possible individual strategies adopted by each individual facing a disease, which are based on the subjective aspects of each one. Thus, the fact that the disease is an abstract, independent and universal entity, its psychobiological and subjective processes work together with cultural and social factors (Silva & Alves, 2018; Melo, 2019).

FINAL CONSIDERATIONS

Through this study, it was possible to enter and reflect on issues that often go unnoticed by professionals who help daily in the treatment of individuals with DM2 with peripheral neuropathy. The issues addressed in this research highlight how much there are crossings with regard to adherence to DM2 treatment, which involves factors of cultural, social, family and subjective contexts; Added to this is the demystification of individual issues that may constitute self-destructive behaviors and non-adherence to treatment for DM.

In view of all that has been exposed in this article, it is important to emphasize the possibility of reflecting on current health promotion projects in primary care, since citizens with more knowledge about DM, the possibility of its early discovery is larger, which may help to prevent such a harmful progression for users and the health system, and may, perhaps, not lead to peripheral neuropathy. Another important factor to be highlighted concerns the possibility of rethinking the training model for health professionals, developing strategies so that they can better develop building skills on health and disease with the individuals assisted, considering the disease as a singular process.

In addition, it is necessary to question the current reality of prevailing social inequality in health, since it will only be possible to produce equitable health based on questions and changes in the face of inequity in which some groups are at a disadvantage in terms of the opportunity to stay healthy.

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