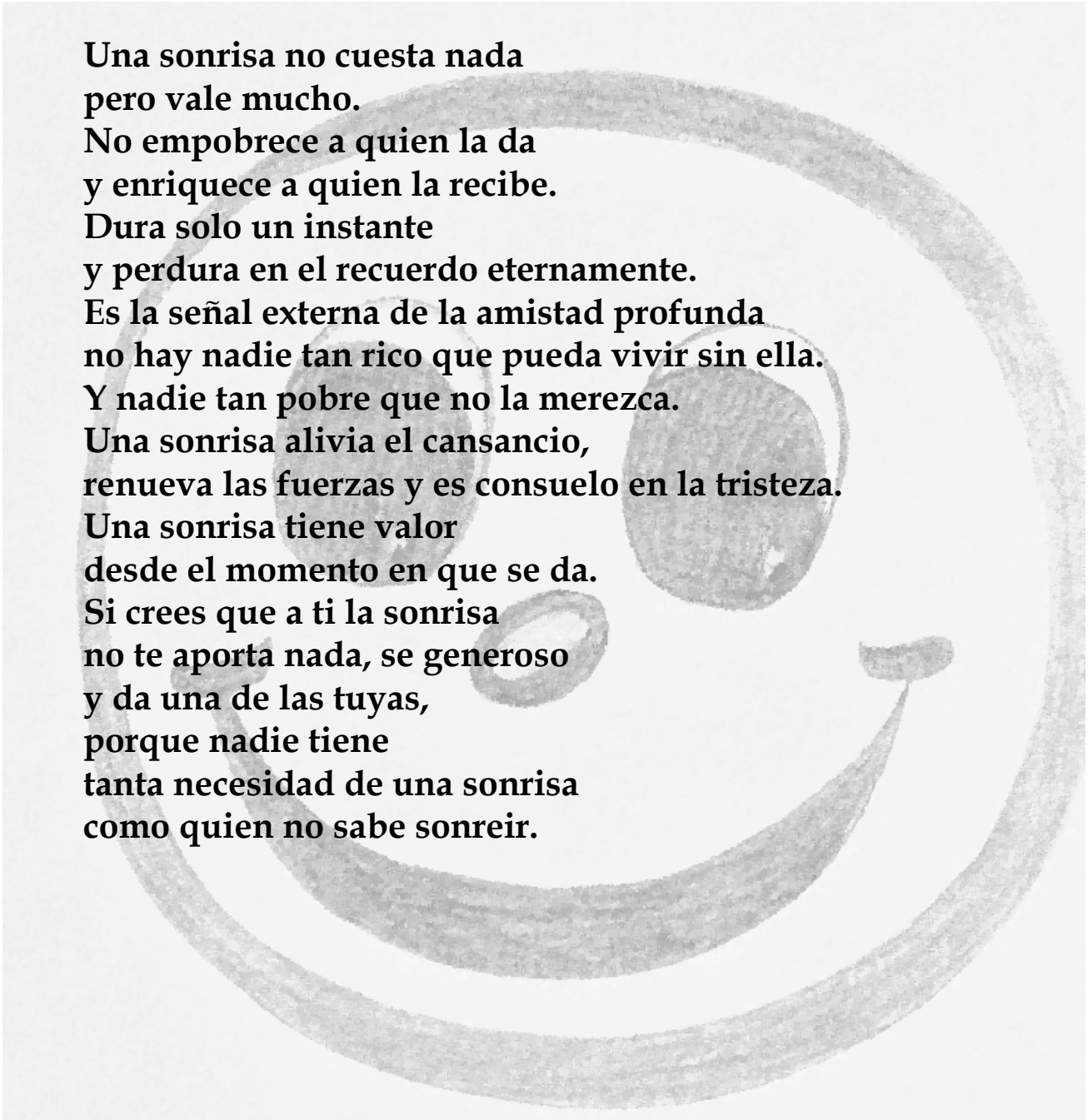
SONRISA

A Curriculum Toolbox for *Promotores* / Community Health Workers to Address Mental / Emotional Health Issues Associated with Diabetes

2nd Version

Southwest Center for Community Health Promotion
Mel and Enid Zuckerman College of Public Health
The University of Arizona,
Tucson, Arizona

UNA SONRISA



Una sonrisa no cuesta nada
pero vale mucho.
No empobrece a quien la da
y enriquece a quien la recibe.
Dura solo un instante
y perdura en el recuerdo eternamente.
Es la señal externa de la amistad profunda
no hay nadie tan rico que pueda vivir sin ella.
Y nadie tan pobre que no la merezca.
Una sonrisa alivia el cansancio,
renueva las fuerzas y es consuelo en la tristeza.
Una sonrisa tiene valor
desde el momento en que se da.
Si crees que a ti la sonrisa
no te aporta nada, se generoso
y da una de las tuyas,
porque nadie tiene
tanta necesidad de una sonrisa
como quien no sabe sonreir.

Project Sponsors and Human Subjects Approval

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This project was granted Human Subjects Approval from the Institutional Review Board (Social and Behavioral Sciences) of the University of Arizona (BSC B04.133).

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SOUTHWEST CENTER FOR COMMUNITY HEALTH PROMOTION

PROMOTING THE HEALTH OF MULTI-ETHNIC COMMUNITIES OF THE ARIZONA-SONORA, MEXICO BORDER
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For more information about SONRISA and to inquire about copies, please contact:

Kerstin M. Reinschmidt, PhD, MPH
Southwest Center for Community Health Promotion
Mel and Enid Zuckerman College of Public Health
University of Arizona; P.O. Box 210228
1145 N. Campbell Ave; Tucson, AZ 85721-0228
Tel: 520-318-7270 Ext. 18; Fax: 520-326-0435
E-mail: kerstin@u.arizona.edu

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Kerstin M. Reinschmidt and Jenny Chong

A note on visuals

To facilitate easy use, SONRISA uses the following visuals:

Visual	Meaning
	SONRISA
	Handout
Note to *Promotores* / CHWs	Note to *Promotores* / CHWs
	Summary of focus group statement
quote	Quote from study participant
	Quote from the literature
Group Discussion	Suggestion for group discussion
Group Activity	Suggestion for group activity

1. Introduction

As *promotores* / community health workers (CHWs) in the state of Arizona become more established over the years, they have also become more vocal about their needs. The goal of the SONRISA curriculum toolbox is to respond to the two commonly expressed needs of *promotores* / CHWs working with clients on diabetes prevention and management:

- ☻ To address the prevention and management of depression together with the prevention and management of diabetes.

- ☻ To prevent emotional burnout from helping clients cope with diabetes and other daily issues.

1.1. How SONRISA came about

☺ Recognizing the need

Several *promotoras* and individuals representing agencies that operate with or support *promotores* / CHWs are members of the regional Community Action Board that partner with the University of Arizona's Southwest Center for Community Health Promotion (Center). In October 2002, this Board requested that Center staff address depression within the Center's prevention-intervention research on diabetes prevention and management.

In response, the Center formed a Depression Working Group to develop and implement a culturally appropriate curriculum on diabetes-related depression. In 2004, Kerstin M. Reinschmidt, PhD, MPH, received funding (USMBHC / ADHS) for the SONRISA Project to develop a depression curriculum toolbox for *promotores* / CHWs in their work with patients with diabetes.

☺ Researching along the border (and in Phoenix)

Promotores working along the Arizona-Sonora border already have a lot of expertise in addressing depression associated with diabetes. The SONRISA Project built upon this expertise. During July and August of 2004, we collected and reviewed four depression curricula and material that had been developed with and for Hispanic and border populations from San Luis, Somerton, Nogales, and Phoenix, Arizona.

In addition, several focus groups were conducted to obtain information directly relevant to the needs of clients and their families, service providers (including *promotores* / CHWs) and the community. In November and December of 2004, and in

March and May of 2005, eight focus groups were conducted with clinical health care providers, *promotoras*, community members, patients and patients' family members. Following the request of *promotoras* in Somerton, *promotoras* from Yuma and Santa Cruz Counties participated in two focus groups, in addition to the planned focus group with *promotoras* from Cochise County. The focus groups were tape-recorded to increase documentation accuracy.

☺ **Designing SONRISA**

The review of the existing curricula and the analysis of the focus groups pointed to the importance of addressing stress and anxiety together with depression when working with individuals with diabetes. SONRISA thus includes all three mental / emotional health issues.

The first version of this curriculum toolbox was tested with *promotores* / CHWs during a one-day training / feedback workshop in Tucson in mid-May 2005. This workshop served two purposes: (1) to introduce SONRISA, and (2) to obtain the *promotores* / CHWs' feedback regarding the presentation of the educational material and its cultural relevance. This current second version is the result of the post-workshop revisions.

SONRISA is the product of the cooperation and dialogue between the University of Arizona and communities, presenting scientific knowledge in culturally relevant ways. It has an internal structure that allows for flexibility (See 1.3. How to use SONRISA). Most importantly, SONRISA takes a relational approach with ideas for social events (e.g. talking circles, sports, family support) to make mental / emotional health part of everyday life.

1.2. Who should use SONRISA

Promotores / CHWs should use SONRISA:

- ☻ To help their clients cope with mental / emotional health issues accompanying diabetes.

- ☻ To help themselves to prevent and cope with burnout caused by their work experiences.

While SONRISA is designed for *promotores*/CHWs working on diabetes prevention and management with the predominantly Hispanic populations along the U.S. Mexico border, the material presented in this toolbox is adaptable to other populations. It is also adaptable to other chronic diseases, i.e. to address depression associated with other chronic diseases such as cancer.

Some of the measures taken to make the present SONRISA curriculum toolbox culturally appropriate to Hispanic U.S.-Mexico border populations include the choice of language, words and ideas presented:

- ☻ SONRISA has an English, and a Spanish version.

- ☻ *Promotores* is the culturally more appropriate term for *community health workers (CHWs)* in Hispanic populations, while *CHW* is an umbrella term applicable to all populations. Both terms are used throughout the curriculum toolbox.

- ☻ *Mental health* is the medically appropriate term, while *emotional health* is the culturally more appropriate term. Again, both terms are used throughout the curriculum toolbox.

- ☻ The activities suggested in SONRISA are based on comments made during the focus groups we conducted.

1.3. How to use SONRISA

SONRISA offers *promotores* / CHWs a resource to learn about depression and other mental / emotional health issues associated with diabetes, to identify the severity of depression, to work with clients in cases of minimal to mild depression, and to know whom to refer to in cases of moderate to severe depression.

SONRISA is a curriculum toolbox in a very literal sense. Its "tools" can be used individually or in combination with other tools to produce a more comprehensive and relevant diabetes (or other chronic disease) curriculum, customized to your and your clients' needs.

Most of the individual sections that make up SONRISA simultaneously serve to inform you about mental / emotional health issues and to function as educational material in your work with clients or in *promotores* / CHW training workshops on mental / emotional health.

Section 2 discusses the roles of *promotores*/CHWs in helping to prevent or manage mental / emotional health issues related to diabetes. *Section 3* presents basic information on depression, stress and anxiety. You can use this information as teaching material for your clients, or for yourselves as *promotores* / CHWs – be it individually, during trainings, or in support groups. *Section 4* provides suggestions for working with patients, families or community members in preventing and managing depression, stress and anxiety associated with diabetes. Each section on patient, family and

community members is accompanied by guidelines and suggestions on how to use that information. *Section 5,* in addition to the information presented in *Section 4*, can help *promotores* / CHWs avoid or manage their occupational burnout by improving coping skills and setting priorities. *Section 6* contains administrative material that invites your participation in improving this toolbox, as well as suggestions for a certificate template if you are thinking of using the SONRISA material for training others. The *Appendices* contain additional information, resources and teaching materials.

1.4. A work in progress

Whether integrated into existing chronic disease prevention curricula or modified and revised based on further trainings, research and emerging partnerships along the Arizona U.S.-Mexico border, the SONRISA curriculum toolbox is a work in progress.

Information from SONRISA (on depression and stress) is being integrated into the Center's family intervention-research project. In the future, the information will be integrated into the patient and community interventions. SONRISA is a "living" toolbox to be used by *promotores* / CHWs to help them address mental / emotional health issues in their patient populations suffering from chronic disease. Adapt the suggestions in this toolbox to your population so that they are appropriate and relevant.

2. The roles of *promotores* / community health workers (CHWs) in helping clients to prevent or manage ill mental/emotional health issues while addressing diabetes

Addressing mental health issues in both clients and caregivers is extremely important. To adequately help clients, their family and community members to prevent or manage chronic diseases, *promotores* / CHWs need to be trained on helping others address mental / emotional well-being. In addition, they also need to acquire skills to maintain physical and emotional balance for themselves so that they can avoid work-related emotional burnout and be able to provide the best services to their clients.

Successful *promotores* / CHWs possess skills and characteristics (also see Section 5) that make them ideal agents to address both the physical and mental / emotional well-being of their clients. They have proven themselves and are trusted "bridges" between the community and the health care system and providers. Their personalities and generosity in offering social support as well as shared cultural backgrounds with their clients increase their ability to establish good relationships with them. The types of social support provided by *promotores* / CHWs include informational, appraisal (feedback, affirmation), emotional and instrumental (tangible aid in labor, money, time) support.[1,2]

With additional training, *promotores* / CHWs can explain the relationship between diabetes and depression (see Section 3). They can help increase understanding of mental/emotional health issues by educating communities about the biological origin of, and environmental influences on mental / emotional health. This may minimize personal responsibility and help reduce the stigma associated with mental / emotional illness. This may further lead to an increase in help seeking behavior.

Focus groups conducted for the SONRISA project provided insights into how the *promotores* / CHWs address mental / emotional health issues with their clients.[3]

[1] Eng E, Young R. 1992. Lay Health Advisors as Community Change Agents. Family & Community Health, 15(1):24-40.

[2] House JS. 1981. Work, Stress and Social Support. Reading, MA:Addison-Wesley.

[3] The results presented in the following parts of this section include data from the 2004/2005 focus groups done with *promotoras* in Yuma, Santa Cruz and Cochise Counties, and with Cochise County health care providers, patients, patients' family and community members.

SONRISA focus groups on social support

Focus group participants described the social support that should be delivered to address depression as follows:

- ☻ Informational support
    - Teach about prevention and health management of diabetes and/ or depression
    - Provide clients with informational brochures in Spanish and English
- ☻ Appraisal support
    - Encourage their clients to take care of themselves, for example, to go on walks
    - Motivate those with negative attitudes to change
- ☻ Emotional support
    - Show their interest in the people they work with in the community
    - Give attention to people who need someone to listen
- ☻ Instrumental support
    - Help patients find affordable resources

SONRISA focus groups on cultural work

In Hispanic communities, mental illness may be seen as *loquería* (craziness) and, outside their homes, community members may not want to talk about how they feel, because they do not want to be called *locos* (crazy). As trusted community members who translate back and forth the cultural values of their own and the medical communities, *promotores* / CHWs are in a position to educate their clients and decrease the stigma that surrounds depression and other mental/emotional health issues. In this way, clients may become more willing to seek and accept help for their mental health issues.

According to focus group participants, Mexicans or Mexican Americans are proud people who only accept help reluctantly. To hear about how some patients helped themselves or became better after receiving help can inspire others to act and take care of themselves. It is very important to treat depressed individuals with a lot of tact and respect, and to do so in culturally competent ways. Men and women clients should also be treated differently, because they experience and express mental / emotional health issues differently. While women tend to talk more about how they feel, men are more reluctant to do so, and can be more difficult to help. The relational approach discussed in the following section will be equally important for both men and women, but in different ways.

SONRISA focus groups on relational approaches[4]

A relational approach focuses on the positive aspects of social activities that include companionship, diversion, and enjoyment. Since *promotores* / CHWs develop relationships with their clients, the relational approach is a logical step to helping their clients avoid depression, or cope with depression or other mental / emotional health issues. Mental / emotional health can be part of something bigger by making it a social event that focuses on strengths rather than weakness and that focuses on fun activities rather than discussions of negative emotions. Fun-based activities help to maintain mental / emotional health, and can provide low-key therapy (Castro FG. 2004. Personal Communication. Arizona State University).

To have success with the relational approach, *promotores*/CHWs must be aware of the interests of the populations they serve. Focus group participants (*promotores*, patient, family and community members) were asked what they or others in the community liked to do for fun. Results suggest that Hispanic populations along the U.S. Mexico border enjoy their free time relaxing (they read, listen to music, watch TV, etc.), and engaging in social (such as spending time with family, and visiting friends) and some physical activities (such as walking or dancing).

This information can be used by *promotores* / CHWs to suggest activities that most clients would enjoy, while also selecting and balancing these activities to ensure they serve educational, inspirational, physical, and supportive purposes. Relaxation, social and physical activities are all good for physical as well as mental / emotional well-being. P*romotores* / CHWs can also offer activities, including talking circles that discuss readings, music, movies, etc., sewing or craft circles, healthy cooking classes, or walking groups. For the males, or the younger generations, it might be more appropriate to offer sports events or competitions. As family time seems to be valued in the predominantly Hispanic border communities, family activities that strengthen family relationships and family support should also be offered.

Example of relational approach

The relational approach has been successful in helping clients become less depressed in Yuma County. Support groups were so effective that the local *promotoras* now train motivators, i.e. community members who have already participated in the groups, to help run the successful support groups.

[4] Stressing the importance of a relational approach was inspired by Dr. Felipe González Castro (Castro FG. 2004. Personal Communication. Arizona State University).

SONRISA focus groups on working with patients, patients' families and community members

Since this curriculum toolbox is aimed at helping *promotores* / CHWs to address mental / emotional health issues, focus group participants were specifically asked about how *promotores* / CHWs already are providing help when working with patients, family and community members. Their answers speak to the different types of social support and cultural work mentioned above:

- *Promotores* / CHWs working with patients…
    - Spend time with patients
    - Inform and educate patients to take their fears away and to make them proud of knowing how to take care of their diabetes
    - Listen, show interest, and motivate them into health action
    - Translate and mediate language and culture issues
        - Health care providers need to know that Hispanic patients usually do not tell them that they are depressed, but instead tend to express their depression more in terms of physical symptoms and functional impairment.
        - Hispanic patients need to know that it is o.k. to ask for help. They may entrust their feelings to the *promotores* who can encourage them to get help from their health care provider.
    - Improve follow-up and help patients to stay in the health care system
    - Give classes on diet and exercise and mental / emotional health
    - Offer support groups

- *Promotores* / CHWs working with family members…
    - Explain to families that diabetes and depression make their family members act the way they do
    - Offer programs that strengthen family relations and support

- *Promotores* / CHWs working with community members…
    - Fill a void in communities…
        - that lack resources for diabetes and mental / emotional health care
        - where depression is not taken seriously until it becomes suicidal
    - Assess the seriousness of the depression or other mental / emotional health issue they are suspecting and – if only at the

beginning stages – start working with clients in strength-based approaches
- Keep their clients out of the overloaded and expensive mental health system when they don't need to be there
- Offer follow-up support to those who have already gone through the short-term mental health care system
- Offer support groups

SONRISA focus groups on training needs for *promoters* / CHWs addressing mental / emotional health associated with diabetes

Many *promotores* / CHWs working along the U.S.-Mexico border already receive training in physical health issues. However, when working with clients with chronic health conditions such as diabetes, physical health cannot be separated from mental / emotional health. Here is what *promotores* and health care providers during focus groups had to say about training needs of *promotores* / CHWs:

- ☻ Recognizing and addressing the issue with clients
  - Script on what to say and on what not to say
  - PHQ-9 as a tool …
    - o to assess depression and its severity
    - o to help know when referral for professional assessment, diagnosis and care is needed
  - Motivational interviewing techniques
  - Knowledge to increase health literacy
  - How to prevent and manage diabetes to prevent depression
- ☻ Referral
  - If, where, when and how to refer
- ☻ Limitations of *promotores* / CHWs
  - Cannot make diagnoses (i.e. tell someone they are depressed)
- ☻ How to cope with their own mental / emotional stressors

Some of these needs are addressed in this SONRISA curriculum toolbox. Others – such as the need for training to use the PHQ-9 – can be topics to be addressed in *promotores* / CHW trainings.

más vida

A diabetic woman who was helped by a *promotora* in managing her diabetes and depression *se siente con más vida*, i.e. feels more alive.

Source:
(1) Study Participant. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

3. Basics of mental / emotional health issues

Note to *Promotores* / CHWs

*Section 3 presents basic information on mental / emotional health issues. It discusses why it is important to address mental / emotional health problems, in particular, depression, stress and anxiety. This information can be used (1) to train the trainer (*promotores */ CHWs) or (2) to educate clients in an individual or group format.*

You can use the information in this section to help clients view mental/emotional health problems as treatable and not as something to be ashamed of. By de-stigmatizing mental / emotional health issues, people can better learn to cope with their mental / emotional health and by implication also with other aspects of their lives.

What is mental / emotional health?

Being healthy includes more than the smooth functioning of the physical body. It also includes mental / emotional functioning that is essential for a healthy outlook on life, for a productive and fulfilling live, and for overall well-being. Mental / emotional health refers to the healthy working of the mind and the way people cope in their everyday lives with personal, emotional, and spiritual issues. A combination of biological, behavioral, and socio-cultural processes, together with expected and unexpected life events shape mental / emotional health.

Mental health disorders are characterized by abnormal cognition (which refers to the general ability to organize, process, and recall information), emotion, mood, or social behavior. While it can be difficult to identify exact causes, most of the mental health disorders can be diagnosed.

Based on clinical definitions, mental health disorders fall into different categories including mood and anxiety disorders. These in turn, have several subcategories such as depression and panic attacks respectively. The signs and symptoms of these disorders overlap and can complicate the diagnosis process. The diagnosis is based on the symptoms reported by a patient, the intensity and duration of such symptoms, signs from the mental health examination, the patient's physical illnesses, and the clinicians' observations of the patient's behavior. This diagnosis is complicated even more by the different manifestation (signs and symptoms) of mental / emotional problems based on age, gender, and culture.

Being emotionally healthy includes being satisfied with oneself, having a positive attitude, and taking responsibility for one's actions, but not for other people's behaviors or other things that are out of one's control. In addition, spirituality plays an essential role for many people.

Everyone will experience sadness and melancholy at some points in their lives. These emotions are a part of the human experience. When these sad feelings persist and interfere with one's daily activities, however, the individual needs help to move beyond the sadness toward a more balanced life.

Each society has its own definitions of "normal" mental / emotional health. People who can function according to societal standards are considered "normal." People whose emotions and behaviors begin to interfere with their daily activities are said to be maladjusted. While unfortunate, societies tend to stigmatize those who do not fall within what is considered "normal." Stigma, whether subtle or overt, is reflected as prejudice, discrimination, fear, distrust and stereotyping. Fear of being stigmatized can prevent people from admitting even to themselves that they are depressed, let alone tell others about how they feel. Not surprisingly, stigma decreases the willingness to seek help from family, friends or professionals. It is important to help people overcome the stigma attached to depression and to seek knowledge and help for their problems.

Sources:
(1) U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health. Pp. 31, 39, 43, 44, 49, 454.
(2) Lozano-Vranich B, Petit J. 2003. The Seven Beliefs – A Step-By-Step Guide to Help Latinas Recognize and Overcome Depression. New York, NY: Harper Collins Publishers, p. 5.
(3) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

3.1. Why it is important to address mental / emotional health issues

Mental / emotional distress among people with diabetes is very common. It negatively affects the way people take care of themselves. When depression accompanies diabetes, it decreases people's quality of life and increases their suffering. Since depression associated with diabetes leads to more severe diabetes, it should be prevented or addressed as soon as suspected.

SONRISA focus group participants said that:

- ☼ 50% of patients with diabetes are diagnosed with depression, but more than that are suspected to have depression.
- ☼ People with diabetes who don't take care of their depression, don't take care of themselves.
- ☼ It is crucial to tell people that they are not "crazy" and that depression is clinical.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

WHY IT IS IMPORTANT TO ADDRESS MENTAL / EMOTIONAL HEALTH ISSUES

People with depressive symptoms but not diagnosed as depressed:

- ☹ Have more stress
- ☹ Are more anxious
- ☹ Are more self conscious
- ☹ Have less self esteem
- ☹ Have less coping skills
- ☹ Are more likely to become diagnosed as depressed

People with diabetes and minor depression:

- ☹ Have a higher risk of complications from diabetes and greater problems with disability in activities of daily living.

People with diabetes who are diagnosed as depressed are also more likely to:

- ☹ Have low control of their blood sugar
- ☹ Have other physical diseases such as heart disease
- ☹ Have higher health care cost
- ☹ Have higher disability rates

Sources:
(1) Gotlib IH, Lewinsohn PM, Seeley, JR. 1995. Symptoms Versus a Diagnosis of Depression: Difference in Psychosocial Functioning. Journal of Consulting and Clinical Psychology, 63(1), 90-100.
(2) Egede LE. 2004. Diabetes, Major Depression, and Functional Disability among U.S. Adults. Diabetes Care, 27(2), 421-428.

WHAT IS THE CONNECTION BETWEEN DEPRESSION, STRESS, AND DIABETES?

♣ People who feel constantly stressed or feel as though they have too much stress can become depressed.

♣ For many people, hormones released during times of stress can cause blood sugar levels to increase.

♣ Reducing stress can help to ease feelings of depression and help control blood glucose levels.

♣ In a family with diabetes, the family member with diabetes as well as other family members may feel stressed and depressed.

♣ Some people use food in response to stress. This can lead to excess weight gain which can lead to more psychological distress.

♣ Depressed or stressed, people with diabetes may not take good care of themselves. They may not exercise or eat healthy. They may drink alcohol. They may not check their blood glucose or take their medication.

Sources:
(1) Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!. Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.
(2) American Diabetes Association. Available at www.diabetes.org/type-2-diabetes/depression.jsp.

ISSUES OF COPING AND SUPPORT

Many people do not receive the psychosocial support and help they need to cope with a diagnosis of diabetes, with their newly named health condition, or its implications. Instead, they feel alone and not understood. Complications from diabetes can lead to disability, which by itself, or accompanied by the fear of death, can be traumatic.

People may feel that they are not in control of their lives and begin to blame all of their problems on their diabetes. Their emotional distress makes it difficult to impossible to follow a diabetes self-management plan and consequently diabetes symptoms worsen and complications arise. Feeling lonely, not understood, out of control, and maybe being unable to afford medications and medical services, people become bitter or angry, which in turn leads to conflicts with family members or friends.

Men and women cope differently with the mental distress caused by diabetes. Maladaptive coping may lead to drinking for men and increased depression and anxiety for women. While women tend to seek more communication than men, it is important that both men and women feel they are understood and supported by their family members or friends, by a *promotor/a* / CHW, or support groups.

Social support is a healthy way of coping and can help both women and men with diabetes to find the strength to learn more about diabetes and how to live healthy lives in spite of a chronic disease.

Sources:
(1) Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!. Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.
(2) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.
(3) Holden C. 2005. Sex and the Suffering Brain. Science, 208:1574-1577.

THE ROLE OF CULTURE
IN MENTAL / EMOTIONAL DISTRESS

Culture influences how people view and perceive events. People who share a cultural identity, share characteristics, such as ethnic group membership, language use and preference, cultural beliefs and practices. Culture can be protective and help the individual through negative experiences. However, it can also be maladaptive and harmful, forcing the individual to cope with the problem alone.

Different cultures attach different meanings to symptoms of depression and their severity based on what is considered "normal" within those cultures. Mental / emotional distress is often associated with stigma so that people who are suffering from depression may be reluctant to directly reveal their distress to others, or to themselves. In some cultures, distress and suffering may be expressed indirectly through idioms of distress. These idioms express distress in terms of physical symptoms, but simultaneously communicate distress as part of a social context.

In Hispanic cultures, nervios (nerves) is recognized as an idiom of distress that has a wide range of symptoms resembling those of depression or anxiety, including irritability, sleep disturbance, and tearfulness. As an idiom of distress, nervios goes beyond physical symptoms and communicates a social context that causes distress. To address nervios, both the physical symptoms and the sociocultural context that contributed to them need to be addressed.

Just as cultural stigma can cause unnecessary suffering, cultural strengths can be harnessed to help people through the difficult periods of their life. For example, in cultures where religion and spirituality are believed to have a direct impact on life, faith can be called upon to provide the support and comfort needed to help the individual seek and remain in treatment. Cultural factors influence how the individual experiences and expresses distress, and need to be taken into account because they influence health care seeking behavior, doctor-patient communication and self-care.

Sources:
(1) U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health. Pp. 82-83.
(2) American Psychiatric Association. 1994. Major Depressive Episode. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 320-327.
(3) American Psychiatric Association. 1994. Outline of Cultural Formulation and Glossary of Culture-Bound Syndromes. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 843-849.
(4) Koskoff, H. 2002. The Culture of Emotions – A Cultural Competence and Diversity Training Program. Video. ISBN 1-57295-361-6, 60 Minutes, VHS, Color.

3.2. Depression

Note to *Promotores* / CHWs

Although it is important to identify depression so that appropriate treatment can be given, labeling a client as *depressed* can do more harm than good. The term *depression* carries such a strong stigma that even if the patient accepts that she or he is depressed, the patient's family or friends may not. Although you should keep helping your clients understand that being depressed should not be seen as shameful or as something to be ignored, it often is better to describe depression in a way that is not socially charged. You could say *psychological distress* rather than *depression*, or you could use symptoms to talk about depression indirectly. For example, you could say: "We need to find ways to pep up your energy so that you do not feel tired all the time." In this section, you will find information that can help you address depression that accompanies diabetes.

3.2.1. What is depression?

SONRISA focus group participants said that:

☼ Depression is a foggy term. It could mean situational depression, or it could mean a formal diagnosis of depression. Depression also depends on the person, as everybody reacts differently.

☼ It is important to know the difference between mild, moderate and severe depression.

☼ Depression makes it difficult to do anything, i.e. to get up, to wash oneself, to work. It makes one feel like not wanting to do anything.

☼ People lose their *animo*, their spirit, or drive.

☼ Symptoms mentioned include:

- not eating / eating all the time
- sleeping all the time / not sleeping
- sadness without reason; not able to laugh like the others; not happy
- a big change of personality
- always in a bad mood
- *coraje* (irritable); *enojados* (angry); angry at the entire world; blame the father; get mad quickly
- tendency to quarrel with neighbors and family members who don't have diabetes
- not enjoying
- feeling abandoned / don't feel like talking to other people
- lock themselves in / remove themselves from the world
- especially men don't want to talk
- feeling not to be worth anything / feeling to be the ugliest / not liking anything about oneself / not feeling good
- feeling anxious
- wanting to kill themselves
- no visible symptoms

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

WHAT IS DEPRESSION?

While depression is very common among people of all ages and ethnic groups, there are certain groups that are affected more:

√ Depression is twice as common among women than among men.

√ Hispanics have higher rates of depression than non-Hispanic Whites.

√ Depression occurs more often among adults between the ages of 25 and 44, according to studies based on the population of the U.S.

Depression is a mood disorder that often coexists with other mental/emotional or physical disorders such as anxiety and diabetes respectively. The suffering that results from major depression affects not only the individual but also family members and friends.

Depression is defined as an emotional state marked by profound sadness, feelings of worthlessness, guilt and anxiety. Almost all adults will experience such emotions with the loss of a loved one, loss of employment or other tragic events. Major depression differs from these normal negative emotions both in duration and intensity. Major depression is not a passing "blue" mood, nor a sign of personal weakness. People with major depression need help to get better.

While symptoms can last for weeks, months, or years without treatment, persons with depression can recover with appropriate treatment.

Sources:
(1) U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health. Pp. 244-245.
(2) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

TYPES OF DEPRESSION

Major Depression

… a two-week period of a depressed, irritable mood or the loss of interest in pleasure in usual activities along with four or more symptoms manifested by weight change, disturbed sleep habits, agitation, fatigue, cognitive dysfunction, feelings of guilt or worthlessness, and suicidal tendencies. Symptoms usually develop over days to weeks and may include anxiety and mild depressive symptoms that last for weeks to months before the full Major Depressive Episode occurs.

Dysthymia

… a chronic, less severe type of depression that lasts for a two-year period or longer. Symptom free periods do not last more than two months. Diagnosis includes the presence, while depressed, of two or more symptoms such as poor appetite, overeating, sleep problems, fatigue, low self-esteem, poor concentration, difficulty making decisions and feelings of hopelessness. Dysthymia often has an early onset and a chronic course. If it precedes the onset of Major Depressive Disorder, people tend not to recover fully from the Major Depressive Episodes and are more likely to have frequent episodes.

Associated Features and Disorders

… people with a Major Depressive Episode also frequently show tearfulness, irritability, obsessive rumination, anxiety, phobias, excessive worry over physical health, feel pain, have panic attacks. Some also have problems with intimate relationships, social interactions, sexual functioning, work, and school.

Mood Disorder Due to a General Medical Condition

A medical condition like diabetes can have a profound impact on the individual's mood. The mood disturbance is diagnosed if it causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Sources:
(1) Mariposa Community Health Center. 2004. *Platicamos Salud*. Nogales, Arizona.
(2) Western Arizona Health Education Center, Inc. / Regional Center for Border Health (WAHEC/RCBH). 2004. Mental Health Curriculum, Draft Version. San Luis, Arizona.
(3) American Psychiatric Association. 1994. American Diagnostic and Statistical Manual of Mental Disorders DSM-IV™. Washington, DC: American Psychiatric Association.

WHAT ARE THE SIGNS OF DEPRESSION TO LOOK FOR?

PHYSICAL	
Change in sleep habits	Trouble falling asleep, wake up often during the night, want to sleep more than usual, also during the day.
Change in eating habits	Reduced appetite and weight loss, or increased appetite and weight gain.
Loss of energy, fatigue	Feeling tired all the time.
Feelings of restlessness	Always feel anxious and cannot sit still.
Decreased libido	Loss of interest in sex or intimacy.
Persistent physical symptoms	Includes headaches, chronic pain, constipation or other digestive disorders that don't respond to treatment.
Frequent accidents	Unintentional injuries, bruises.
PSYCHOLOGICAL	
Loss of interest in usual activities	No longer take interest in doing things that used to be enjoyable.
Depressed mood	Persistently sad, anxious, irritable, or "empty" moods.
Pessimism, hopelessness	Feeling that nothing will be right
Isolation or withdrawal	
Guilt, worthlessness	Feeling of never doing anything right, inappropriate guilt.
Morning sadness	Feel worse in the morning than the rest of the day.
Increased anger	Frequent arguments or loss of temper.
Loss of interest in personal care of appearance	
THINKING	
Decreased concentration and attention span	Cannot watch TV or read because other thoughts or feelings get in the way.
Confusion, poor memory	Less able to remember things as usual.
Slowed thought process	Difficulty making decisions.
Suicidal thoughts	Wants to die or is thinking of ways to hurt oneself.

Sources:
(1) Lozano-Vranich B, Petit J. 2003. The Seven Beliefs – A Step-By-Step Guide to Help Latinas Recognize and Overcome Depression. New York, NY: Harper Collins Publishers. P. 29.
(2) *Campesinos sin Fronteras*. CDMP Campesinos Diabetes Management Program. Somerton, Arizona. (Materials adapted from: Stanford Patient Education Center.)
(3) Stimmel, GL. 2000. Mood Disorders. In: Herfindal ET, Gourley DR (eds). Clinical Pharmacy and Therapeutics, 7th Edition. Baltimore, MD: Williams & Wilkins, 1203-1216.
(4) American Diabetes Association. Available at www.diabetes.org/type-2-diabetes/depression.jsp.

HISPANICS TEND TO EXPRESS THEIR EMOTIONS PHYSICALLY: FEELINGS AFFECT THE WAY HISPANICS FEEL, *PHYSICALLY*.

Physical manifestations are not imagined but real feelings.

Physical manifestations are called somatization.

Depression might be expressed as…

… *una pesadez*, a weight on the shoulder, a pressure on the chest, or the inability to take a deep breath

… *dolores hasta en los huesos*, or a bodily pain that stretches far into the soul

… *nervios* or *fatiga* which refer to lifelong general vulnerability to stressful events, or to a specific response to an emotionally distressing life event. Physical symptoms include headache, stomachache, trembling, sleep disturbances, the inability to function, and tearfulness.

Source:
(1) Lozano-Vranich B, Petit J. 2003. The Seven Beliefs – A Step-By-Step Guide to Help Latinas Recognize and Overcome Depression. New York, NY: Harper Collins Publishers. Pp. 35-36.

Group Discussion

What are some words used in your community to refer to depression?

Source:
(1) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.

ASSESSING DEPRESSION

The need for assessment

The *promotoras* / CHWs who participated in the SONRISA focus groups and pilot test frequently encountered people with diabetes who also seem to suffer from depression. While some *promotoras* / CHWs were already using a screening tool both in the clinical and the community setting, others stressed the need for access to and training in using a depression-screening tool.

Such a tool would support the *promotores* / CHWs' intuitive assessment of depression among patients with diabetes with a more standardized assessment. With training, *promotores* / CHWs could pre-screen individuals who suffer from depression along with diabetes before guiding them into the mental health service system, which – along the border – already is overextended.

By making depression screening a routine activity when working with diabetes, *promotores* / CHWs would be able to decide more easily approaches to address the clients' depression:

1) refer those who appear to have severe depression to professional mental health assessment, diagnosis and urgent care,
2) refer those screened with less than severe depression to their/a primary care professional for further assessment and possibly further referral,
3) work with patients screened in with less than moderate depression and advise them in ways of alleviating depression before seeking professional help.

To be able to refer a client to professional assessment with a primary or a mental health care provider, a referral system should be established. *Promotores* / CHWs can research the existence of such a system, or be pivotal in helping their communities develop such a referral system.

An assessment tool

Appendix B contains the Patient Health Questionnaire (PHQ-9). This screening tool is self-administered and is a component of the PRIME-MD diagnostic instrument for common mental disorders that was designed for primary care settings. The PHQ-9 is the10-item module for major depression that is based upon the criteria that had been described by the American Psychiatric Association (Fourth Edition). The PHQ-9 is a dual-purpose instrument that is half as long as many tests on depression. The first nine questions establish both criteria-based diagnosis of depressive disorders and the severity of depressive

symptoms. The final question of the questionnaire establishes functional impairment that is associated with the reported symptoms.

Originally designed in English for the U.S., the PHQ-9 has been translated into several languages, including Spanish. As a screening instrument, the Spanish version is acceptable, but in a study it missed diagnosing one out of four young depressed pregnant Honduran women. This further underscores the importance of using the PHQ-9 as a screening tool, not as a diagnostic tool.

With a PHQ-9 score of 10, a person may be at the beginning stage of moderate depression. At this point, professional help is recommended. However, the PHQ-9 may not pick up adequately on how depression is presented culturally in Hispanic populations. Thus, *promotores*/CHWs may want to counsel a person to seek professional assessment from their provider with a score higher than mild depression.

While it assesses the severity of depression, we should note again that the PHQ-9 is not a diagnostic tool. The diagnosis of depression is best left to a behavioral health specialist. In advising clients to seek professional mental health assessment, *promotores*/CHWs should stress that clients need help in recognizing and managing their emotions in order to better manage their diabetes.

Sources:
(1) Study Participant(s). 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.
(2) Kroenke K, Spitzer RL, Williams JBW. 2001. The PHQ-9 – Validity of a Brief Depression Severity Measure. J Gen Intern Med, 16:606-613.
(3) Kroenke K, Spitzer RL. 2002. The PHQ-9: New Depression Diagnostic and Severity Measure. Psychiatric Annals, 32(9):509-515.
(4) Wulsin L, Somoza E, Heck J. 2002. The Feasibility of Using the Spanish PHQ-9 to Screen for Depression in Primary Care in Honduras. Primary Care Companion J Clin Psychiatry, 4:191-195.
(5) The Primary Care Evaluation of Mental Disorders Patient Health Questionnaire. The Quality of Life Data Base. Available at: http://www.qolid.org/public/PRIME-MD.html.

3.2.2. What causes depression?

SONRISA focus group participants said that:

☼ The non-acceptance of diabetes causes depression.

☼ High levels of sugar lead to tiredness and people can no longer function as before which depresses them.

☼ Poverty depresses people with diabetes, because they cannot buy themselves medical services, medications and glucose strips. They cannot afford health insurance nor to go to the hospital for emergencies.

☼ Lifestyles, i.e. the lack of exercise, too many carbohydrates and not taking care of mental health, lead to depression as well as diabetes.

☼ Diabetes is not the sole cause of depression but it is a factor in depression.

☼ It is hard to separate out whether it is the diabetes that is causing the depression or the social and economic problems or the lack of health care. Prior to depression or prior to the diabetes diagnosis there may have been some other issues. People are dealing with lots of things and diabetes is only one of them.

☼ It is a hormonal imbalance in the brain.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

diabetes and depression

I have a friend who has both diabetes and depression. She feels very bad and cries a lot. Not even to buy "strips" I have money. I don't even have five [dollars] to go to the doctor. Depression and diabetes go together. And I call her every day to check on her. She wants to kill herself. What is a single person going to do, without money, with diabetes? She wants to kill herself.

Source:
(1) Study Participant. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

CAUSES OF DEPRESSION

Depression has many causes, although we still do not know all of its causes. Broadly speaking, genetics, psychological and environmental factors contribute to depression.

1. Genetic Factors
   The incidence of depression is higher among children of parents with depression than of the population in general. This indicates that the susceptibility to depression can be inherited.

2. Psychological Factors
   Persons with a tendency to become depressed exhibit certain personality traits, for example:
   - Low self-esteem
   - Pessimism
   - Excessive dependence on others
   - Have difficulties coping with stress
   - Incapable of dealing with their problems

3. Environmental Factors
   - Physical illness, severe or chronic
   - Abnormal hormonal functioning
   - Certain medications
   - A significant loss (job, loved one, etc.)
   - A difficult relationship
   - Financial problems
   - Any unwelcome changes in life patterns

NOTE: Usually depression is caused by a combination of all these factors. To prevent or alleviate depression, it is thus important to address its multiple causes.

Source:
(1) *Campesinos sin Fronteras*. CDMP Campesinos Diabetes Management Program. Somerton, Arizona. (With materials edited by Deena E. Staab, Ph.D.; Translation by Rebecca Calderon. Information compiled by D/ART Public Inquiries; National Institute of Mental Health.)

3.2.3. How does depression affect people with diabetes?

SONRISA focus group participants said that:

☼ Providers in Cochise County, Arizona estimate that about 50% of their patients with chronic diseases also have depression. They think that there are probably more than they diagnose.

☼ Behaviors or moods can be misconstrued to be depression when they actually are the physiological effect of high sugar.

☼ Diabetes affects both female and male bodies. There is a relationship between diabetes, difficulties with sexuality and depression.

☼ Depression affects diabetes self-care. People who are depressed don't want to take good care of themselves and their diabetes.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

HOW CAN DIABETES MAKE YOU FEEL EMOTIONALLY?

♠ People react differently to a diagnosis of diabetes.

♠ Some people may deny it and think that there must be a mistake!

♠ Some people may be angry and think "why me?" or "It's not fair!"

♠ Some people may feel guilty and that diabetes is their fault.

♠ Some people may get sad about having to make lifestyle changes.

♠ Some people may think about the complications and become scared or depressed.

♠ These reactions are normal.

♠ You should talk about your feelings with family member, friends, a *promotor/a*/CHW or your health care provider.

Source:

(1) Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!. Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.

3.3. Stress

3.3.1. What is stress?

Note to *Promotores* / CHWs

To draw attention to stress may be a good strategy to address the prevention and management of both diabetes and depression. Stress can increase sugar levels and high sugar levels can contribute to depressive symptoms. This section will provide you with information about stress, its causes and effects, and how to identify it.

"Stress" …

… is the response to something that causes your body to feel as though it is being attacked. This "something" can be physical or psychological in nature.

When under stress, the body prepares for the "fight-or-flight response." The physical symptoms of the fight-or-flight response are well known. The levels of many hormones increase, making a lot of stored energy (glucose and fat) available to cells to help the body get away from danger. The body responds with increased heart rate, blood pressure, sweating, metabolism and the tensing of the muscles.

In people with diabetes, glucose may stay in the blood because stress has blocked the body from releasing insulin or the insulin is not able to let the extra energy into the cell. Stress can also affect the blood glucose level negatively when people under stress neglect to look after themselves, forget to check their glucose level, drink more alcohol, or exercise less.

Sources:
(1) American Diabetes Association. Available at www.diabetes.org/type-2-diabetes/depression.jsp.
(2) U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health. PP. 238.

COMMON SIGNS AND SYMPTOMS OF STRESS

Irritability

Lowered self-esteem

Angry outbursts

Lack of interest

Diminished initiative

Tendency to cry

Depression

Suspiciousness / jealousy

Restlessness

Anxiety

Withdrawal

Critical with self and others

Appetite extremes

Source:
(1) *Campesinos sin Fronteras*. CDMP Campesinos Diabetes Management Program. Somerton, Arizona.

UNMANAGED STRESS CAN HAVE A PHYSICAL IMPACT IN THE FOLLOWING WAY:

Allergies

Anxiety

Arthritis

Asthma

Pain – neck / back / shoulder

Colds and flu

Depression

Diarrhea

Headaches

Heart Problems

Increased blood sugar levels

Insomnia

Peptic Ulcers

Sexual Dysfunction

Skin Problems

Stomach Problems

Source:
(1) *Campesinos sin Fronteras*. CDMP Campesinos Diabetes Management Program. Somerton, Arizona.

3.3.2. What causes stress?

CAUSES OF STRESS

Everyone experiences stress throughout the day and in their lives. People may feel stressed for different reasons. Some stress may be of little significance; such as daily hassles (for example, traffic during rush hour, burnt toast, disagreements and arguments), others may be of a more serious nature, such as death of a spouse, divorce, or illness.

Life events can also be stressful whether they are positive (a wedding or childbirth) or negative (the death of a relative or divorce). Interestingly, the same life event can be stressful for some people, but not for others.

In general, stress is not life threatening. Long-term stress, however, keeps stress hormones up, which in turn can result in a long-term high blood glucose level. If the stress is mental stress, the stress hormones that are so useful for the fight-or-flight response do nothing since you cannot fight or run away physically from the enemy to save your life from physical danger.

Sources:
(1) American Diabetes Association. Available at www.diabetes.org/type-2-diabetes/depression.jsp.
(2) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

STRESSORS CAN BE FOUND IN…

Everyday life

Life style

Ill health or injury

Life transitions

Relationships

Economic situation

Natural environment

Political situation

Meaningless or unfulfilled life

SONRISA

Source:
(1) *Campesinos sin Fronteras*. CDMP Campesinos Diabetes Management Program. Somerton, Arizona.

STRESS CAN BE MANAGED!!!

SONRISA

STRESSORS SPECIFIC TO ETHNIC MINORITY GROUPS

Some people may experience stressors that are specific to them as members of an ethnic minority group living in the United States. Personal as well as structural discrimination in education, occupation, housing, medical services, etc. can be very stressful. Poverty is another important stressor that has been linked to ill health.

Stressors specific to ethnic minorities make personal stress management difficult. These socially caused stressors thus need to be addressed to improve the health of ethnic minorities, which includes the prevention and management of diabetes and its complication.

Source:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

Group Discussion

What are some of the stressors specific to your ethnic minority group or your community and how could they be alleviated?

3.3.3. How does stress affect people with diabetes?

DIABETES AND STRESS

Stress affects people with diabetes in two ways:

1. Stress causes blood sugar levels to fluctuate.

2. Stress, and the situations that cause it, may cause changes in routine that help control glucose levels. Some changes and situations make people:
   a. Skip their meals and exercise
   b. Eat more
   c. Smoke more (or go back to smoking)
   d. Forget or postpone to take medicines
   e. Not check their blood glucose levels

Source:
(1) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.

Group Discussion

Can you think of what else stress can do to people with diabetes?

Source:
(1) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.

3.4. Anxiety

Note to *Promotores* / CHWs

A person with diabetes who shows signs of depression or who has been diagnosed with depression is also likely to suffer from anxiety. As with depression, anxiety can interfere with the every day management of diabetes. Also similar to depression, it can affect both the person with diabetes and / or family members. It is thus important to know a few basics about anxiety as a foundation for addressing anxiety together with depression.

3.4.1. What is anxiety?

ANXIETY IS…

… among the most common mental /emotional disorders. It is a strong emotional response of fear and dread. It also has physical signs such as rapid heard beat, sweating, trembling, dizziness, cold hands or feet, and shortness of breath.

There are different forms of anxiety, including:

♠ phobias	high-levels of anxiety caused by specific situations or objects
♠ panic attacks	brief and intense episodes of anxiety that often occur without the presence of immediate situations or objects
♠ general anxiety	non-specific form of anxiety that is experienced as excessive worrying, restlessness, and tension that is chronic and long-lasting

Anxiety disorders occur when the experience is disproportionate to the situations, difficult for the affected person to control, or interferes with everyday functioning.

Source:
(1) U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health. Pp. 40, 233.

3.4.2. What causes anxiety?

CAUSES OF ANXIETY

Anxiety is caused by a combination of genetic factors, psychological traits, and life experience.

While it is not exactly known why women are more likely to suffer from anxiety, it seems that women experience a wider range of life events as stressful, including those happening to friends. Men, in general, react to a smaller range of stressful events, namely those that affect themselves or close family members.

The different types of anxiety disorders share in common a state of arousal or fear. Anxiety has been understood as an abnormal or exaggerated version of arousal (fight-or-flight response).

More recently, researchers are looking for the causes of anxiety beyond the acute stress response of arousal because:

- ♠ With anxiety, the concern about the stressors is out of proportion to the realistic threat.
- ♠ Anxiety is often associated with elaborate mental and behavioral activities designed to avoid the unpleasant symptoms of a full-blown anxiety or panic attack.
- ♠ Anxiety is usually longer lived than arousal.
- ♠ Anxiety can occur without exposure to an external stressor.

Current research is looking into the processes of the brain to explore whether the unusual functioning of the fear pathways in the brain lead to the symptoms of anxiety.

Source:
(1) U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health. Pp. 238-239.

3.4.3. How does anxiety affect people with diabetes?

ANXIETY AFFECTS PEOPLE WITH DIABETES

- People who see their diabetes pessimistically as being forever (have a long timeline) are more likely to be anxious.
- Anxiety commonly occurs with depression.
- Anxiety that interferes with normal functioning will prevent a person with diabetes from taking good care of himself or herself.
- People with anxiety feel that they do not enjoy good health.
- People, especially women, are less likely to exercise if they have anxiety.
- Spouses of people with diabetes show the same level of anxiety.

Sources:
(1) Fisher L, Mullan JT, Chesla CA, Kanter RA, Skaff MM. 2002. Depression and Anxiety among Partners of European-American and Latino Patients with Type 2 Diabetes, Diabetes Care, 25(9):1564-1570.
(2) Kohen D, Burgess AP, Catalán J, Lant A. 1998. The Role of Anxiety and Depression in Quality of Life and Symptom Reporting in People with Diabetes Mellitus. Quality of Life Research, 7, 197-204.
(3) Lloyd CE, Zgibor J, Wilson RR, Barnett AH, Dyer PH, Orchard TJ. 2003. Cross-cultural Comparisons of Anxiety and Depression in Adults with Type 1 Diabetes. Diabetes/Metabolism Research and Reviews, 19:401-407.

4. *Promotores* / community health workers (CHWs) helping clients to cope

Note to *Promotores* / CHWs

Section 4 provides suggestions and materials on how to help your clients cope with their mental / emotional distress associated with diabetes.

The educational material on depression, stress and anxiety can be used (1) to train the trainer (promotores / CHWs), and (2) to work with patients (Section 4.1.), with the family (Section 4.2.), or in the community (Section 4.3.). Some of the material is repeated, but presented in a slightly different way for a different target group.

While the focus is on coping, the material presented can also help with preventing.

4.1. Working with patients

Note to *Promotores* / CHWs

Section 4.1. presents educational material on how to cope with depression, anxiety and stress as a patient. During the SONRISA focus groups, participants were asked about mental/emotional health issues related to patients with diabetes. The discussions offered insights into issues specific to Hispanic patients with diabetes and depression, the needs of Hispanic patients, and how *promotores* / CHWs can help patients. These focus group discussions, together with some of the material used by *promotores* / CHWs in the U.S.-Mexico border communities, form the basis for this section. The information presented here can be used in presentations, added to diabetes education curricula designed for patients, or used in support groups.

SONRISA focus group participants talked about:

♠ Hispanic patients, diabetes and depression:

☼ Hispanic patients are likely to know a member in their family who has had diabetes, who does not feel well because of the disease or who has passed away from diabetes. Such patients tend to be afraid of diabetes.

☼ In response to diagnoses, Hispanic patients may turn to a traditional coping mechanism to avoid stress: denial.

☼ Patients may also react to the diagnosis with depression.

☼ People with diabetes may isolate themselves. They may have little self-confidence, and may increasingly have conflicts with their doctor and their family.

☼ Hispanic patients may be scared of insulin. This fear makes them feel worse.

☼ The medication prescribed, or the diet recommended by physicians, may not work for Hispanic patients. Instead, they may have some unwanted side effects, such as trembling or anemia. Patients may thus stop taking medications or stop following a diet.

☼ Some Hispanic patients will tell their doctor how they feel but still reject medication. Others may not say anything but act depressed.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

SONRISA focus group participants talked about:

♠ **What Hispanic patients need from their health care providers:**

☼ Information about diabetes for patients and their families

☼ Information about depression associated with diabetes, and about the difference between stress and depression.

☼ An assessment of their feelings, even though they may not show any signs of depression.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

SONRISA focus group participants said that:

♠ ***Promotores*** **/ CHWs can …**

☼ … help patients move beyond denial by sharing stories of how other Hispanic patients have controlled diabetes, thus helping patients to accept their diabetes.

☼ … inform patients about depression associated with diabetes.

☼ … give patients information about diet and exercise that are beneficial for both their diabetes and their mental / emotional well-being.

☼ … help patients to set goals, solve problems, focus on the positive and to relax.

☼ … build personal relationships with patients. In their home countries, Hispanics often have long-term personal relationships with their doctors, but in the U.S., doctors usually see patients by appointment only and don't have much time. *Promotores* / CHWs can offer personal relationships.

☼ … refer patients to a behavioral health consultant at the clinic.

☼ … organize or lead support groups for patients.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

SONRISA focus group participants said that:

♠ By participating in support groups, patients…

☼ … can learn that they are not the only ones suffering from diabetes and depression.

☼ … with different levels of depression related to their diabetes can learn how to make diabetes part of their lives and how to feel good.

☼ … can share tricks and experiences on how to manage and cope with diabetes and mental/emotional distress.

☼ … can find support outside their family or circle of friends.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

4.1.1. Coping with depression

SONRISA

CONTROL DIABETES
TO PREVENT DEPRESSION!

WHEN TRADITIONAL RESPONSES TO EMOTIONAL DISTRESS ARE EFFECTIVE – AND WHEN NOT

Hispanics diagnosed with diabetes may react with denial. This means of avoiding mental / emotional distress may at first be effective.

With a chronic disease such as diabetes, however, a long-term reaction of denial is counter-productive. When denial leads to neglecting self-care, it leads to uncontrolled diabetes, which in turn leads to worsened symptoms and increased stress and depression.

After the initial reaction of denial has done its job in preventing emotional distress, patients diagnosed with diabetes need to establish strategies that are effective in keeping emotional distress caused by diabetes to a minimum.

Source:
(1) Lozano-Vranich B, Petit J. 2003. The Seven Beliefs – A Step-By-Step Guide to Help Latinas Recognize and Overcome Depression. New York, NY: Harper Collins Publishers. P.193.

Group Activity

Before going over the handout "Ways out of depression – how you can help yourself," divide the group of patients into teams of 3-4 people. Each team needs to compile a list of 5-6 ideas on how to cope with depression. Each group should share their list with the rest of the group.

Source:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

WAYS OUT OF DEPRESSION – HOW YOU CAN HELP YOURSELF –

☺ Admit to yourself that you are not feeling well emotionally.

☺ Avoid being alone. Seek family and friends to talk to.

☺ Get out of the house to feel better. Keep yourself active.

☺ Eat right; eat less; eat more frequently; cut down on sugar.

☺ Take your diabetes medications as prescribed by your doctor.

☺ Exercise moderately 2 – 3 times a week for about 20 – 30 minutes.

☺ Have a positive attitude and tell yourself you will feel better soon.

☺ If you have a huge task ahead of you, divide it into smaller, more manageable tasks.

☺ Avoid making important decisions that affect your life. Instead, try to take life "one day at a time" for a while.

☺ Treat yourself with love, patience and respect.

☺ Join a support group for people with diabetes or chronic diseases.

☺ If your clinic employs *promotores* / CHWs, meet them, talk to them and ask for help. They may offer or co-facilitate classes on diabetes management, or help you in some other way.

Sources:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.
(2) Western Arizona Health Education Center, Inc. / Regional Center for Border Health (WAHEC/RCBH). 2004. Mental Health Curriculum, Draft Version. San Luis, Arizona.
(3) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.
(4) *Campesinos sin Fronteras*. CDMP Campesinos Diabetes Management Program. Somerton, Arizona.

más positivo

Well yes, it's difficult, but if you already have it and you get stubborn about it, then you are going to get worse. But if you become more aware and tell yourself, "I have it and I have to go on a diet, I have to exercise, and I have to take care of myself", then you will do better. Even more so if you have kids and you don't want them to see you sick, laying in bed, or listening to your complaints. I always want to be healthy; not laying in bed and getting helped all the time. That's why I exercise and eat better. It is more positive for a person to think this way than for her to do nothing. If we don't want to eat healthy and we don't want to exercise, the disease is going to get worse and we'll only have ourselves to blame.

Source:
(1) Study Participant. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

muy positiva

When diabetes and depression come together, we haven't seen it much with my mother because she is very positive. She always tells us to strive, to be tenacious, to be self-assured, to say: I can! Even though she is the one with the disease, sometimes you'll see her lending us support because she is very positive. But there are times when she gets depressed and there we are, telling her that everything is O.K., everything is going to be alright, and she listens to us telling her this and that, and that we are going to get through this.

Source:

(1) Study Participant. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

MOBILIZING THE SUPPORT OF YOUR FAMILY AND FRIENDS

☺ Respectfully ask family members or friends for support.

☺ Choose the right time to ask, i.e. when you and your family or friends are relaxed, rested and in a positive mood. Except for emergencies, don't ask in the last minute.

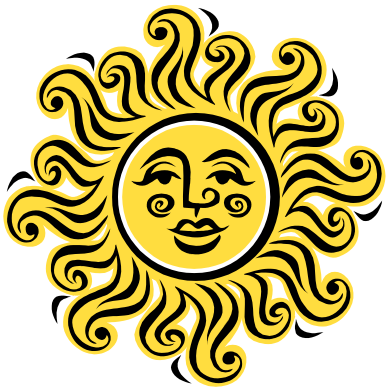
☺ Introduce your idea and explain why you need help. People need to know why their help is important. Tell them how it will benefit your diabetes management, and your overall physical and mental well-being.

☺ Be specific about what you need so that people don't have to guess. Sometimes, you may need affection; sometimes you may need a ride somewhere.

☺ When asking for help, speak calmly and clearly, and try to stay positive.

☺ Always thank people for their help and support.

Source:
(1) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.



LIGHT THERAPY

For the past 20 years, light therapy was hidden in the dark while antidepressants and psychotherapy were in the spotlight. This may change now.

The American Psychiatric Association in Washington D.C. has concluded that –in trials – the daily exposure to bright light has about the same effect as antidepressants in controlling seasonal affective disorder (SAD), or winter depression, and other forms of depression.

Independent of season, light therapy brought significant relief to outpatients with mild to moderate depression. Light therapy also increased the effect of antidepressants.

During research, light therapy is usually given in the early morning for 30 to 60 minutes. To increase its benefits, people with depressive symptoms need to sleep regularly.

Source:
(1) Bower. 2005. *Mood Brighteners: Light Therapy Gets Nod as Depression Buster.*

☼ DO YOUR OWN RESEARCH ☼

If you have mild to moderate symptoms of depression, prescribe yourself some natural "bright light." Begin by going to bed early. Then, in the early morning, go for a walk or do some garden work for 30-60 minutes. Ask a family member or a friend to come along or to help. Do you feel better throughout the day?

Group Discussion

Thinking about yourself, what are some of the things in your life that make it difficult for you to…

… accept that you have a life-long condition?

… follow your doctors' recommendations?

… develop and stick to your self-care plans?

What are some things you are doing now to manage your diabetes?

What are some things you are doing now to prevent or control depression?

What else could you do?

Source:
(1) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.

WAYS OUT OF DEPRESSION – SEEKING PROFESSIONAL HELP –

☺ If you don't start feeling better, talk to a *promotor/a* or community health worker. They can help you assess the seriousness of your distress and may advise you to seek professional help.

☺ Ask your doctor for a check-up to see if there are physical problems, such as uncontrolled diabetes, or medicines that are causing your emotional distress. Controlling your diabetes or getting off certain medications may make you feel better.

☺ If your depression symptoms are not severe and not caused by a physical condition or your medication, your doctor may refer you to a support group or diabetes / depression education program.

☺ If your depression symptoms are severe, but not caused by a physical condition or your medication, your doctor can help you find a mental / behavioral health specialist. Severe depression is a serious illness that needs to be treated. You have tried to feel better, and it is not your fault that you feel depressed.

☺ Remember that depression medications take up to two weeks to be effective. Most have side effects (such as constipation or a dry mouth), but they will lessen over time. If the medication does not work, ask your provider about other treatments.

☺ Some antidepressants affect glucose regulation. What can you do? Ask your doctor, read the labels, or ask your pharmacist. Check your glucose level after you take a new medication.

Sources:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.
(2) Western Arizona Health Education Center, Inc. / Regional Center for Border Health (WAHEC/RCBH). 2004. Mental Health Curriculum, Draft Version. San Luis, Arizona.
(3) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.
(4) *Campesinos sin Fronteras*. CDMP Campesinos Diabetes Management Program. Somerton, Arizona.

4.1.2. Coping with stress

FOR PATIENTS:
18 WAYS OF COPING WITH STRESS

1. Exercise

… is an effective way to cope with stress. It allows you to release built-up tensions and causes your body to produce endorphins (an opiate-like substance which promotes a sense of well-being). This chemical also enhances the effectiveness of your body's immune response that can help prevent disease.

- **Ask family members or friends to go for a walk with you, join a sports club or gym, or go to community dances.**

2. Diet and Nutrition

Emotional stress can deplete the body of certain nutrients. A balanced diet helps to prevent nutrient deficiencies and to keep the body in good condition. Note: If you drink alcohol or coffee, or if you smoke to cope with stress, you only worsen your health and your stress.

- **You can modify your traditional foods to be more healthy.**

- **Invite your family and friends to eat healthy food with you (low fat, low sugar, low carbohydrate). It will be good for all family members!**

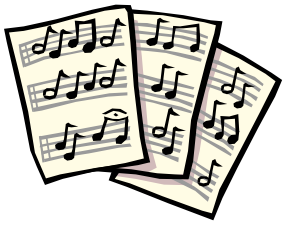
3. Awareness: Listen to your body

Pay attention to your body signals. For example, a knot in your stomach, headaches, insomnia or high blood pressure can be indicators of stress.

4. Alone Time / Meditation / Prayer

Take time to be alone with yourself to reach higher consciousness, to rest, to be at peace.

☻ **Ask your family and friends to respect your "out-time."**



5. Relaxation Techniques

There are many ways to reduce stress, including meditation, prayer, progressive muscle relaxation, guided-imagery, music, etc. You can experiment to find out what works best for you. Choose the techniques that you feel most comfortable with and that you can practice regularly.

☻ **Make relaxation part of your everyday life. Relax alone, or with others.**

6. Know What's Really Important to You

When you know what you want in life and what steps to take to get there, you will get a sense of purpose and direction.

☻ **What are your values? Do your family members and friends share these with you? Find like-minded people and make friends.**

7. Time Management

Learn to use time wisely. Prioritize what you need to accomplish. Spend time on top priorities.

☻ **Make a to-do list.**

8. Social Support

Have friends and family to whom you can turn in times of need. They help to buffer the impact of stress.

☻ **Family and friends can be a strong support system. Take good care of each other!**

9. Recreation

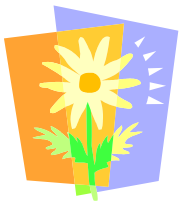
Do at least one thing every day that brings you joy, something that you love to do and that leaves you energized and refreshed. Your own special way to escape for a while.

- **Spend your free time with family members and friends.**

- **Do recreational activities alone, or together with family members or friends.**

10. Say "No"

… when asked to do something you really don't want to do.



11. Practice Stress Reducing Communication

Clarify what you hear by paraphrasing (i.e. "I understand you saying…," and practice active listening).

12. Positive Attitude and Lifestyle

When you learn to think positively, exercise, eat well and rest regularly, you'll be taking care of the most important person you know: YOU. Then you'll be able to take better care of others.

- **Practice positive thinking every day.**
- **Replace negative thoughts with positive ones.**

13. Take Risks / View Stressors in a Positive Light

Deal with stressors quickly and appropriately. Welcome change as an opportunity and challenge to learn and grow.

14. Monitor the Intake

… of sugar, fat, carbohydrates, salt, alcohol, and caffeine.

15. Organize Yourself

Create a pleasant environment; make your surroundings pleasant and comfortable.

16. Be Creative and Enjoy Laughter

Go easy on yourself. Don't take yourself too seriously.

17. Do Something

… for others.

18. Touch

Have some physical contact, a minimum of three hugs a day, a massage, a pat on the back, etc.

Sources:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.
(2) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.
(3) Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!. Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.
(4) Study Participant(s). 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

BE GOOD TO YOURSELF:

SOME WAYS TO MANAGE STRESS

Get up 15 minutes early	Prepare for the next day, the night before
Avoid wearing tight clothes	Use your time wisely
Simplify the way you prepare food	Turn a large task into several small ones
Ask for help when doing unpleasant work	View challenges in different ways
View problems as challenges	Look at the positive side of everything
Smile	Teach a child how to fly a kite
Give someone a compliment	Believe in yourself
Make time to play everyday	Stop thinking that tomorrow will be better – without making a major effort
Stop saying negative things about yourself	Set goals for yourself
Look at yourself winning	Watch the stars
Ask a friend for a hug	Dance
Say hello to a stranger	Listen to pleasant music
Practice breathing easy	Stop a bad habit
Read a poem	Stop and smell the flowers in the countryside
Buy a flower	Do something new-innovative

Source:
(1) *Campesinos sin Fronteras*. CDMP Campesinos Diabetes Management Program. Somerton, Arizona.

4.1.3. Coping with anxiety

COPING WITH ANXIETY FOR PATIENTS

If you suffer from anxiety, you can try to help yourself feel less anxious by…

- … practicing muscle relaxation and controlled breathing

- … repeatedly confronting your fears to learn how to cope with the situation and thus to reduce the symptoms of anxiety.

If you continue to suffer from anxiety, you should seek professional help. There are three possibilities:

- Cognitive-behavioral therapy
  Looks at the cause and effect of the relationships between thoughts, feelings, and behaviors. A critical element of this therapy is to increase the exposure to the stimuli or situations that provoke anxiety in order to lessen the symptoms and reduce the avoidant behavior. Overcoming one anxiety encourages people to encounter and overcome other feared causes of their anxieties.

- Medications
  Some of the medications for depression also treat anxiety.

- A combination of psychotherapy and medications. This option is for patients with more complex and severe anxiety.

Source:
(1) U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health. Pp. 241-243.

4.2. Working with patients, family members and friends

Note to *Promotores* / CHWs

Section 4.2. presents educational material on how to cope with depression, anxiety and stress as a patient, family member or friend. During the SONRISA focus groups, participants were asked about mental / emotional health issues related to diabetes in their family or among their friends. The discussions offered insights into how the diagnosis and the diabetes of one family member affect the other family members and friends, and what the family and others can do to help the person with diabetes. These focus group discussions, together with some of the material used by *promotores* / CHWs in the U.S.-Mexico border communities, form the basis for this section. The information presented here can be used in presentations, added to diabetes education curricula designed for patients, family members and friends, or used in support groups.

SONRISA focus group participants said that:

♠ **Diabetes Affects the Entire Family:**

☼ Families may not understand how diabetes affects their loved one. They may not know what to do, or how to help.

☼ Diabetes complicates family relationships. For example, children may feel that their sibling with diabetes is favored.

☼ Diabetes affects the wife – husband intimacy.

☼ Families shame the person with diabetes when they publicly say: "Don't eat this. You can't eat that."

☼ People with diabetes may be very argumentative with their doctors and family members.

☼ They may not talk to their families about how they feel, because they do not want to scare them.

☼ The younger generations may be upset about watching their aging family members deteriorate. They are scared of diabetes.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

SONRISA focus group participants talked about:

♠ How Families (Can) Help:

☼ Family members are the first in line for support.

☼ Wives, husbands or children help patients so that their sugar levels won't drop. They don't want their family member with diabetes to be tired, irritated or upset.

☼ Family members go to the doctor with the patient.

☼ Family members do not leave the person with depression alone. They take them out for a walk, distract them, or work along with them.

☼ Family members give their depressed loved one a hug, or talk to them.

☼ Family members know that eating well and walking is good for them as well.

♠ How Others Can Help

☼ Friends or neighbors can help people with diabetes who have no family support.

☼ Support groups are important so that the person with diabetes has other social interactions and does not become fully dependent on the family.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

SONRISA focus group participants said that:

***Promotores* / Community Health Workers Can…**

☼ … explain diabetes, depression and the relationship between diabetes and depression to families.

☼ … encourage families to keep up their supportive behavior and offer ideas on how they can support each other even better.

☼ … encourage families to eat healthy and exercise together.

☼ … offer support groups for persons with diabetes and their families.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

4.2.1. Coping with depression

HELPING A FAMILY MEMBER WITH DIABETES

Signs of HYPERGLYCEMIA (High Blood Sugar)

This happens when the person has eaten too much, has too little insulin in the body, is under a lot of stress, or has an illness. Hyperglycemia has a gradual onset, but may progress to diabetic coma. Be alert for these signs in the person with diabetes:

Frequent urination	*Dry skin*	*Drowsiness*	*Nausea*
Extreme thirst	*Hunger*	*Blurred vision*	*Decreased healing*

What can you do?
1. Test blood glucose. 2. Call your doctor when the blood sugar is over 200 mg/dL for several tests or for two days.

Signs of HYPOGLYCEMIA (Low Blood Sugar)

This often happens when the person has eaten too little, has too much insulin in the body or has exercised too much. Hypoglycemia has a sudden onset and may progress into insulin shock. Be alert for these signs in the person with diabetes:

Shaking	*Fast heartbeat*	*Sweating*	*Anxiety*
Dizziness	*Hunger*	*Impaired vision*	*Irritability*
Headache	*Weakness and tiredness*		

What can you do?
1. Drink ½ glass of juice or regular soft drink, 1 glass of milk, or eat some soft candies (but not chocolate).
2. Test blood sugar after 30 minutes after intake. Call the doctor if the symptoms did not stop.
3. Then eat a light snack such as ½ peanut butter sandwich and ½ glass of milk.

Source:
(1) American Academy of Physicians. Available at: http://www.aafp.org/. Adapted by BHSí.
(2) Diabetes Care: Hypoglycemia; Hyperglycemia. 1999. Novo Nordisk Pharmaceuticals, Inc. (Concept developed by Rhoda Rogers, RN, BSN, CDE. Sunrise Community Health Center, Greeley, Colorado).

WAYS OUT OF DEPRESSION – HOW THE FAMILY AND FRIENDS CAN HELP YOU COPE WITH MILD DEPRESSION –

☺ Talking about feelings can help the person feel better.

☺ Family members or friends can support each other by taking time to listen. Set some time aside each week to share happy and troubling feelings.

☺ Add positive activities into your life style. For example:

- Walking or gardening as a family can lift everyone's spirits.
- Volunteering as a family or individually at your church or local school can make you feel good.
- Visiting or calling a friend outside the family just to say "hi" can encourage you to think positively and to focus on brightening someone's day.

☺ Families can participate in a family diabetes education program offered or co-facilitated by *promotores* / community health workers.

☺ Families can accompany patients to the doctor to show their concern and support.

Source:
(1) Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!. Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.

DIABETES IN THE FAMILY: FAMILY MEMBERS' NEEDS ARE ALSO IMPORTANT

☻ Diabetes in one family member affects every family member.

☻ Diabetes means rethinking the use of time and resources. It means giving extra care and attention to the family member who now has to take medication or insulin, and who has to monitor glucose daily.

☻ Living healthy with diabetes requires changes. It requires making exercise a part of everyday life and getting used to making new, healthy food choices.

☻ Family members may feel ashamed or guilty for not being able to keep diabetes away from a loved one or for not being the one who has diabetes.

☻ There may also be unspoken, even unrealized, resentment at the attention and effort that is dedicated to one person's diabetes management.

☻ Family members need to recognize their own feelings of anger, fear, sadness or guilt when someone in their family gets diagnosed with diabetes. It is important to recognize the emotional upheaval the diagnosis can bring to both the diagnosed person and to the other family members.

☻ Sadness and anger on the part of all family members are quite normal at first, but should not linger on.

Source:
(1) Wendy Wendy Satin Rapaport, Diabetes Forecast, 12/15/05.

and that depresses me

My husband has diabetes and it is very difficult for him. He does not want his medications, nor watch his diet. He says he'll die anyways. And I try to make him walk, but he does not want to walk. He has lost 100 pounds, but it doesn't matter to him at all, and that depresses me, too.

Source:
(1) Study Participant. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

Group Discussion

Thinking about your family members with diabetes, how did they feel when they learned that they had diabetes? Do they still feel that way? Has anything changed for them?

How did you feel when you first learned that someone in your family had diabetes?

Source:
(1) Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!. Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.

Group Discussion

Thinking about your family, what are some of the things in your lives that make it difficult for you to:

… accept that someone in your family has a life-long condition?

… follow the doctors' recommendations?

… develop and stick to support strategies as a family?

What are some things your family is doing to prevent or control depression either in the patient with diabetes or the other family members?

What else could your family do?

Source:
(1) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.

Group Activity

1) Ask each group member to write down a brief story about the real-life problems of a person with diabetes and depression. They don't need to write down the real names, but should choose a story that reflects the participants' social and cultural contexts.

   Sample Story: Señora Molinar, a 53-year-old mother of 3 adult children has recently been diagnosed with Type 2 diabetes. Her husband has passed away from complications of diabetes a year earlier. Her children live in other states, where they work and have their own families. About every two weeks, she talks to them on the phone, but she has no money to visit. To help pay her bills, she now works at a restaurant kitchen 4 times a week. A neighbor woman comes and visits her once in a while.

2) Collect the stories and mix them up in a basket.

3) Divide the group into teams of 4-5 people and ask them to pull out a story from the basket.

4) Ask each group to read the story and to answer the following questions:
   a. What is happening here?
   b. What is the situation or problem?
   c. Has this ever happened to someone you know?
   d. Why do you think this situation or problem happens?
   e. How would you or your family handle this situation?

5) Have each team present their answers and ask the other group members for their input.

Source:
(1) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.

WAYS OUT OF DEPRESSION
– COPING WITH SEVERE DEPRESSION –

☺ Even family members who don't have diabetes may get depressed.

☺ Family members who continue to show signs of depression even after talking with others in the family or with friends may be severely depressed.

☺ A severely depressed person may feel embarrassed and say that "Nothing is wrong" or "I'm just sad. I'll get over it."

☺ Anyone who shows signs of depression for more than 2 weeks should consult a health care provider.

☺ Talk to a family member or friend you trust and who can help you find someone to treat your depression.

☺ Help a severely depressed family member or friend make an appointment with a health care provider.

Sources:
(1) Western Arizona Health Education Center, Inc. / Regional Center for Border Health (WAHEC/RCBH). 2004. Mental Health Curriculum, Draft Version. San Luis, Arizona.
(2) Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!. Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.

4.2.2. Coping with stress

FOR PATIENTS, FAMILY MEMBERS AND FRIENDS: 18 WAYS OF COPING WITH STRESS

1. Exercise

… is an effective way to cope with stress. It allows you to release built-up tensions and causes your body to produce endorphins (an opiate-like substance which promotes a sense of well-being). This chemical also enhances the effectiveness of your body's immune response that can help prevent disease.

☻ **As a family, or together with other families, go for a walk, a hike, play soccer or organize other family friendly games or dances.**

2. Diet and Nutrition

Emotional stress can deplete the body of certain nutrients. A balanced diet helps to prevent nutrient deficiencies and to keep the body in good condition. Note: If you drink alcohol or coffee, or if you smoke to cope with stress, you only worsen your health and your stress.

☻ **You can modify your traditional foods to be more healthy.**

☻ **Invite your family and friends to eat healthy food with you (low fat, low sugar, low carbohydrate). It will be good for all family members!**

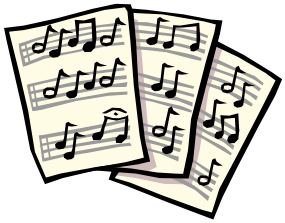
3. Awareness: Listen to your body

Pay attention to your body signals. For example, a knot in your stomach, headaches, insomnia or high blood pressure can be indicators of stress.

4. Alone Time / Meditation / Prayer

Take time to be alone with yourself to reach higher consciousness, to rest, to be at peace.

- **Respect your family member's and friend's need for "out-time."**



5. Relaxation Techniques

There are many ways to reduce stress, including meditation, prayer, progressive muscle relaxation, guided-imagery, music, etc. You can experiment to find out what works best for you. Choose the techniques that you feel most comfortable with and that you can practice regularly.

- **Encourage your family members to practice relaxation and give them space to do so. Find ways to relax as a family.**

6. Know What's Really Important to You

When you know what you want in life and what steps to take to get there, you will get a sense of purpose and direction.

☻ **What are your family values? Does everyone in the family share them? Do your friends? How can you find compromises that are best for everyone?**

7. Time Management

Learn to use time wisely. Prioritize what you need to accomplish. Spend time on top priorities.

☻ **If you are done with your family chores before the others, offer to help out.**

8. Social Support

Have friends and family to whom you can turn in times of need. They help to buffer the impact of stress.

☻ **Family and friends can be a strong support system.**
Take good care of each other!

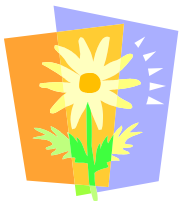
9. Recreation

Do at least one thing every day that brings you joy, something that you love to do and that leaves you energized and refreshed. Your own special way to escape for a while.

- **Spend your free time with family members and friends.**
- **Do recreational activities together with family members or friends.**

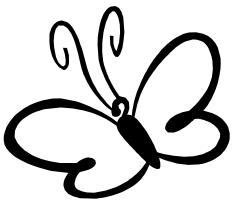
10. Say "No"

… when asked to so something you really don't want to do.



11. Practice Stress Reducing Communication

Clarify what you hear by paraphrasing (i.e. "I understand you saying…," and practice active listening).



12. Positive Attitude and Lifestyle

When you learn to think positively, exercise, eat well and rest regularly, you'll be taking care of the most important person you know: YOU. Then you'll be able to take better care of others.

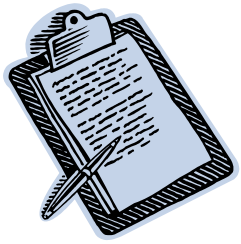
- **Help your family member or friend to think and live positively. Offer examples. Be an example!**

13. Take Risks / View Stressors in a Positive Light

Deal with what stresses you quickly and appropriately. Welcome change as an opportunity and challenge to learn and grow.

14. Monitor the Intake

… of sugar, fat, carbohydrates, salt, alcohol, and caffeine.



15. Organize Yourself

Create a pleasant environment; make your surroundings pleasant and comfortable.

16. Be Creative and Enjoy Laughing

Go easy on yourself. Don't take yourself too seriously.

17. Do Something

… for others.

18. Touch

Having some physical contact, a minimum of three hugs a day, a massage, a pat on the back, etc.

Sources:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.
(2) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.
(3) Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!. Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.
(4) Study Participant(s). 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

4.2.3. Coping with anxiety

COPING WITH ANXIETY FOR PATIENTS, THEIR FAMILY MEMBERS AND FRIENDS

Family members or friends can support a person suffering from anxiety by helping him / her…

- … to relax.

- … to confront his or hear fears to learn how to cope with the situation and thus to reduce the symptoms of anxiety.

- … to find patient, family or community programs or support groups led by *promotores* / community health workers that deal with some of the stressors of anxiety (such as diabetes).

- … to refer or accompany a person suffering from anxiety to seek professional help.

Source:
(1) U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health. Pp. 241-243.

4.3. Working with community members

Note to *Promotores* / CHWs

Section 4.3. presents educational material on how a community member can cope with depression, anxiety and stress. During the SONRISA focus groups, participants were asked about mental / emotional health issues related to diabetes in their community. The discussions offered insights into which community resources are needed and which are present, and the possibilities of addressing mental / emotional health issues on the community level. These focus group discussions, together with some of the material used by *promotores* / CHWs in the U.S.-Mexico border communities, form the basis for this section. The information presented here can be used in presentations, added to diabetes education curricula designed for community members, or used in support groups.

SONRISA focus group participants said that:

♠ **Border communities don't have…**

☼ … economic resources.

☼ … sufficient medical services for people lacking econ resources. There are no places for cheap check-ups.

☼ … community clinics that are open after hours o weekends.

☼ … sufficient mental health counselors to refer patients t

☼ … an adequate mental health system where people whc are not in crisis can find help to prevent a crisis.

☼ … public discussions on diabetes and mental / emot health issues.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

SONRISA focus group participants said that:

♠ Border communities have…

☼ … churches, including clerical persons and church groups.

☼ … people who live well with diabetes.

☼ … people who have gone through or recovered from depression.

☼ … people of all ages and talents.

☼ … support groups.

☼ … a behavioral health agency, such as SEABHS, that does a complete behavioral health assessment in times of crisis.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

SONRISA focus group participants said that:

♠ Border communities need…

☼ … public discussions on diabetes and mental / emotional health issues.

☼ … to offer coping resources for people who do not have families to ask for support.

☼ … prevention and early management opportunities and services, as well as post-treatment support. Support systems outside the formal behavioral health service system are needed such as support groups on diabetes and / or depression.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

SONRISA focus group participants said that:

♠ ***Promotoras*** **/ community health workers can…**

☼ … generate public discussions on diabetes and mental / emotional well-being by…
… giving public presentations
… participating in community health fairs

☼ … tap into community resources.

☼ … refer community members to community support groups.

☼ … offer support groups.

☼ … advise support group participants to see their medical provider about how they feel – if they are trained to assess the severity of depression, or invite someone who is trained to speak to their support groups.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

4.3.1. Coping with depression

yo no soy la unica

At first when I was depressed, I did not want anybody to know because I thought that I was going crazy. I kept that secret for two years and I did not want anybody to know that I was taking medications. But meanwhile I see that I am not the only one and I am comfortable with myself. Now I want people to know that it is not bad to say that you are feeling bad and that you are helping yourself.

Source:
(1) Study Participant. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

COMMUNITY SUPPORT GROUP

Group Discussion

Thinking about our community, what are some of the things in our lives that make it difficult for us to:

… accept that we have a life-long condition?
… stick to our health plans?
… follow our doctors' recommendations?

What are some of the things we are doing now to control our diabetes?
What are some things we are doing now to control or prevent depression?
What else could we do?

Source:
(1) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.

Group Activity

Divide the group into small teams of 2-4 people. Each team needs to write a list of 5-6 ideas on how the community can help to prevent and to cope with depression associated with diabetes. Each group should share the list with the other groups.

Which of these community-based ways of coping already exist?
Which of them could be created?

Make an action plan of how you can help establish and test the new ideas.

Source:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

Group Activity

Let's play **Life Event Bingo** to see how different people experience different life events.

1) See Life Event Bingo sheet (P. 108).

2) Ask participants to circulate leisurely in the group and to find someone who has experienced one of such life events during the past year. Ask that person to describe the event and how they responded to it, and then write the person's name in the appropriate box. The box in the middle is to be filled with any life event that is not mentioned. The first person to complete a vertical, horizontal or diagonal column, calls "Bingo." Emphasis should be on sharing rather than on completing all of the items.

3) Reconvene the group and ask participants to discuss what they have learned from each other and from doing this activity.

Source:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

LIVE EVENT BINGO

Divorce	Death of spouse	Outstanding personal achievement	Change in ability to communicate	Change in eating habits
Change of financial status	Son/daughter leaves home	Change in work responsibilities	Added someone to the family	Hospitalization of spouse or children
Change of personal habits	Change in residence		Change in social activities	Change in sleeping habits
Pregnancy	Retirement	Personal illness/injury	More arguments with spouse	Death of a close family member
Death of a close friend	Discrimination	Sickness in family	Marriage	Took out a mortgage

Source:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

WAYS OUT OF DEPRESSION
– HOW THE COMMUNITY CAN HELP YOU –

☺ Join a community-based support group for people with diabetes or other chronic diseases.

☺ Join an exercise group, such as a community walking group.

☺ Find out whether *promotores* / community health workers in your community offer or facilitate health promotion programs on diabetes and/or depression.

☺ Ask a priest or other clergy you trust…

… to talk to you about how you feel and who can help you to get out of or treat your depression.

… to convene special church meetings that address the issue of depression in the community. Seek and give testimonies of how people managed to get out of depression.

☺ Get active socially to get out of the house. Join in for a cause!

☺ Beautify your community!
Keep streets and parks clean, plant flowers, lobby for inspiring public art, etc.

Sources:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.
(2) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.
(3) Western Arizona Health Education Center, Inc. / Regional Center for Border Health (WAHEC/RCBH). 2004. Mental Health Curriculum, Draft Version. San Luis, Arizona.

4.3.2. Coping with stress

COMMUNITY SUPPORT GROUP

WAYS OF COPING WITH STRESS

Mention that there are many ways to reduce stress and ask participants how they reduce stress and seek relaxation:

How do you deal with stress in your everyday lives?

After identifying what participants do to cope with stress, focus on those strategies that utilize community resources. Try to find out which activities they prefer and which could use improvement:

What is your preferred way of dealing with stress?
Which of these activities could be improved or developed to be more effective?
How could the community help to make these activities more effective?

Now check whether the participants covered all the examples you have on your list. Ask whether the examples could be new ways of dealing with stress:

Have the following examples been mentioned? If not, why not?
Do they require a community effort?
Could they be new approaches to dealing with stress?
Will anyone try and report back?

Sources:
(1) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.
(2) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

FOR COMMUNITY MEMBERS:
18 WAYS OF COPING WITH STRESS

1. Exercise

… is an effective way to cope with stress. It allows you to release built-up tensions and causes your body to produce endorphins (an opiate-like substance which promotes a sense of well-being). This chemical also enhances the effectiveness of your body's immune response that can help prevent disease.

☻ **You can join a group in your community to**

Dance Walk Hike Jog Run Walk the Dog Play Soccer Garden

2. Diet and Nutrition

Emotional stress can deplete the body of certain nutrients. A balanced diet helps to prevent nutrient deficiencies and to keep the body in good condition. Note: If you drink alcohol or coffee, or if you smoke to cope with stress, you only worsen your health and your stress.

☻ **Take a class to learn how to cook and bake healthy.**

☻ **When you order at a restaurant, ask for low fat, low sugar and low salt foods.**

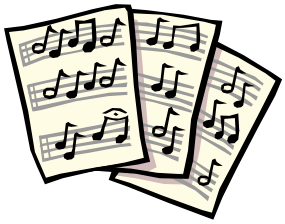
3. Awareness: Listen to your body

Pay attention to your body signals. For example, a knot in your stomach, headaches, insomnia or high blood pressure can be indicators of stress.

4. Alone Time / Meditation / Prayer

Take time to be alone with yourself to reach higher consciousness, to rest, to be at peace.

- **Practice daily prayer.**
- **Take a class to learn how to meditate.**
- **Find a quiet spot in your community to be alone, to rest, or to be at peace.**



5. Relaxation Techniques

There are many ways to reduce stress, including meditation, prayer, progressive muscle relaxation, guided-imagery, music, etc. You can experiment to find out what works best for you. Choose the techniques that you feel most comfortable with and that you can practice regularly.

- **Take a class to learn new relaxation techniques.**

6. Know What's Really Important to You

When you know what you want in life and what steps to take to get there, you will get a sense of purpose and direction.

☻ **What are your community values? Do you share them? Is your cultural heritage important to you?**

7. Time Management

Learn to use time wisely. Prioritize what you need to accomplish. Spend time on top priorities.

8. Social Support

Have friends and family to whom you can turn in times of need. They help to buffer the impact of stress.

☻ **Join a club to meet other people and make friends. Learn something about a culture you always wanted to know more about.**

9. Recreation

Do at least one thing every day that brings you joy, something that you love to do and that leaves you energized and refreshed. Your own special way to escape for a while.

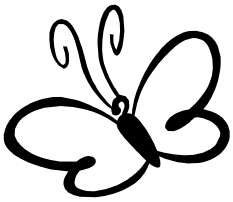
- ☻ **Schedule breaks, or take short vacations.**
- ☻ **Give yourself some time for your hobbies.**
- ☻ **Beautify your house and your community to enjoy "being" there.**

10. Say "No"

… when asked to so something you really don't want to do.

11. Practice Stress Reducing Communication

Clarify what you hear by paraphrasing (i.e. "I understand you saying…," and practice active listening).



12. Positive Attitude and Lifestyle

When you learn to think positively, exercise, eat well and rest regularly, you'll be taking care of the most important person you know: YOU. Then you'll be able to take better care of others.

- ☻ **Help people to think and live positively. Offer examples. Be an example!**

13. Take Risks / View Stressors in a Positive Light

Deal with stressors quickly and appropriately. Welcome change as an opportunity and challenge to learn and grow.

14. Monitor the Intake

… of sugar, fat, carbohydrates, salt, alcohol, and caffeine.

15. Organize Yourself

Create a pleasant environment; make your surroundings pleasant and comfortable.

16. Be Creative and Enjoy Laughing

Go easy on yourself. Don't take yourself too seriously.

17. Do Something

… for others.

18. Touch

Having some physical contact, a minimum of three hugs a day, a massage, a pat on the back, etc.

Sources:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.
(2) Diabetes Empowerment and Education Program (DEEP). 2004. UIC Midwest Latino Health Research, Training and Policy Center. Chicago, Illinois: University of Illinois at Chicago.
(3) Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!. Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.
(4) Study Participant(s). 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

4.3.3. Coping with anxiety

COPING WITH ANXIETY
FOR COMMUNITY MEMBERS

At the community level, a person suffering from anxiety can seek help from…

- … patient, family or community programs or support groups led by *promotores* / community health workers that deal with some of the stressors of anxiety (such as diabetes).

- … community-based mental health agencies or programs.

Source:
(1) U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health.

5. Coping strategies and priority setting for *promotores* / community health workers (CHWs)

Note to *Promotores* / CHWs

Section 5 offers materials to help promotores / CHWs prevent or cope with work-related emotional burn out. The material includes (1) information about promotores / CHWs' roles, skills, and qualities, and (2) coping tools.

SONRISA focus group participants talked about:

♠ **The need of *promotores* / CHWs for …**

☼ … help with how to help.

☼ … help with not getting depressed themselves.

☼ … coping skills so that they can continue to help others.

Source:
(1) Study Participants. 2004/2005. SONRISA Focus Groups conducted with *Promotoras* in Yuma, Santa Cruz and Cochise Counties; Health Care Providers, Patients, Patients' Family and Community Members in Cochise County.

The work of *promotores* / CHWs can be challenging and at times emotionally straining. Successful *promotores* / CHWs have learned ways to maintain and balance their own physical and emotional well-being.

Systematic and continuous *promotores* / CHW trainings and knowledge on how to cope with stress are key to coping with work-related emotional burnout and to being successful when working with clients suffering from chronic diseases.

It is a good idea to actively seek and attend trainings for *promotores* / CHW that are offered through different venues, including the agencies working with *promotores* / CHWs, state wide CHW organizations, or during the national CHW conference. *Promotores* / CHWs can also use the same coping skills they teach their clients to prevent and manage stress, anxiety and depression (see Section 3).

COPING STRATEGIES FOR *PROMOTORES*/CHWs

☺ Seek and attend trainings for *promotores* / CHW to

… update your knowledge of the roles, skills and qualities of *promotores* / CHWs and examine your reasons and motivations for being a *promotor(a)* / CHW

… learn more about the relationship between diabetes and depression

… learn how to help clients with mental / emotional ill-health in culturally and professionally appropriate ways

… learn how to identify depressive symptoms

… learn about resources in your community that can help clients to manage diabetes and address emotional health issues

☺ Set priorities and manage your time

☺ Tap into community resources to help you with your work

☺ Walk the talk

… Maintain a healthy life style

… Cope with stress

… Get support from family and friends

… Organize or join support groups for *promotores* / CHWs

WHERE DID THE *PROMOTOR(A)* / CHW MODEL COME FROM?

The roots of the community health worker model can be traced to Central and South America where volunteer social workers conducted educational programs in both rural and urban areas. The first community health workers held classes on pre-natal health.

WHAT IS A *PROMOTOR(A)*/CHW?

A *promotor(a)* / CHW is someone who dedicates herself / himself to helping members of her / his community. Women have taken this role on in their communities for thousands of years. They have been an important part of community health education throughout the world. Research studies have found that CHWs have many names and work in many settings, but that they still share certain roles, skills and characteristics.

WHAT ARE THE ROLES OF *PROMOTORES* / CHWs?

♣ Cultural mediation between communities, and health and human service systems.

♣ Informal counseling and social support.

♣ Providing culturally appropriate health education.

♣ Advocating for individual and community needs.

♣ Assuring that people get the services they need.

♣ Building individual and community capacity.

♣ Providing direct services.

Sources:
(1) Rosenthal EL. The National Community Health Advisor Study – Weaving the Future. University of Arizona and Annie E. Casey Foundation. Tucson, AZ: Mel and Enid Zuckerman Arizona College of Public Health, 1998. Available at: http://www.aecf.org.
(2) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

PROMOTOR(A) / CHW R0LES

Promotores / CHWs can ask themselves about their motivations and goals, and about how to accomplish their goals in the short and long-term. Knowing the answers to these questions may help in coping with work-related emotional distress.

● What are my reasons for becoming a *promotor(a)* / CHW?

1. _____
2. _____
3. _____
4. _____
5. _____

● What are my own personal goals as a *promotor(a)* / CHW?

1. _____
2. _____
3. _____
4. _____
5. _____

● What do I wish to do as a *promotor(a)* / CHW? What are 3 of my short-term goals?

1. _____
2. _____
3. _____

● What do I wish to do as a *promotor(a)* / CHW? What are 3 of my long-term goals?

1. _____
2. _____
3. _____

Source:
(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

PROMOTORES / CHWs HAVE MANY SKILLS

♣ Communication Skills
- ♦ Listening
- ♦ Use language confidently and appropriately
- ♦ Written communication

♣ Interpersonal Skills
- ♦ Counseling
- ♦ Relationship-building

♣ Knowledge Base
- ♦ Broad knowledge about community
- ♦ Knowledge about specific health issues
- ♦ Knowledge of health and social services systems

♣ Service Coordination Skills
- ♦ Ability to identify and access resources
- ♦ Ability to network and build coalitions
- ♦ Ability to provide follow-up

♣ Capacity-building Skills
- ♦ "Empowerment" – Ability to identify problems and resources to help clients solve problems.
- ♦ Leadership

♣ Advocacy Skills
- ♦ Ability to speak up for individuals or communities and withstand intimidation.

♣ Teaching Skills
- ♦ Ability to share information one-on-one
- ♦ Ability to master information, plan and lead classes, and collect and use information from community people.

♣ Organizational Skills
- ♦ Ability to set goals and plan
- ♦ Ability to juggle priorities and manage time.

Source:
(1) Rosenthal EL. The National Community Health Advisor Study – Weaving the Future. University of Arizona and Annie E. Casey Foundation. Tucson, AZ: Mel and Enid Zuckerman Arizona College of Public Health, 1998. Available at: http://www.aecf.org.

Which skills do you have?	Which ones would you like to develop?
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

PROMOTORES / CHW QUALITIES

Promotores / CHWs have been found to have many useful qualities. They are:

Friendly
Respected
Patient
Resourceful
Independent
Creative
Sincere
Reliable
Honest
Considerate
Sensitive
Dependable
Non-judgmental
Caring
Desiring to help the community

Source:
(1) Rosenthal EL. The National Community Health Advisor Study – Weaving the Future. University of Arizona and Annie E. Casey Foundation. Tucson, AZ: Mel and Enid Zuckerman Arizona College of Public Health, 1998. Available at: http://www.aecf.org.

Name three of your best qualities.

1. _____
2. _____
3. _____

Which three qualities would you like to improve on?

1. _____
2. _____
3. _____

SETTING PRIORITIES[5]

Step 1: Make a list of everything you need to do during the following day or the next week.

	Daily Activity	*Priority Score**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		

**Priority Scoring:*

U	***Urgent***
I	***Important***
M	***Medium importance***
N	***Necessary, but not so important***

[5] From Dr. Kathryn Coe.

SETTING PRIORITIES[6]

Step 2: Organize these activities by time of day to keep your expectations realistic. Learn to spread out your activities.

	Daily Activity	*Priority Score**	*Morning*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			*Afternoon*
11			
12			
13			
14			
15			
16			
17			
18			*Evening*
19			
20			
21			

**Priority Scoring:*

U	*Urgent*
I	*Important*
M	*Medium importance*
N	*Necessary, but not so important*

[6] From Dr. Kathryn Coe.

SETTING PRIORITIES[7]

Step 3. Now, the really hard part!!! Looking at the things that you scored with an *N*, make a list of things that you can give up, so that you have time to protect your health and guard your well-being.

What I really don't need to do	**Why I don't need to do it**

Congratulations!
You just reduced your stress load!

[7] From Dr. Kathryn Coe.

SETTING PRIORITIES[8]

Step 4. Make a list of people and organizations that can help you do the things you have to do. This makes it easier to get things done and helps you realize that while you give help to others all the time, you also need help!

	Daily Activity	*Priority Score**	*Partners*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

**Priority Scoring:*

U	***Urgent***
I	***Important***
M	***Medium importance***
N	***Necessary, but not so important***

[8] From Dr. Kathryn Coe.

WEEKLY PLANNER

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7 am							
8 am							
9 am							
10 am							
11 am							
12 pm							
1pm							
2 pm							
3 pm							
4 pm							
5 pm							
6 pm							
7 pm							
8 pm							
9 pm							
10 pm							

PROMOTORES / CHWs AND COMMUNITIES

What are the three main health problems in your community?

1. _____

2. _____

3. _____

What medical services are available in your community?

_____

_____

_____

What medical services are lacking in your community?

_____

_____

_____

Do people in your community have adequate access to medical services?

Yes ___ No___ If no, why not? _____

_____

What are your community objectives?

Short-term: _____

_____

_____

Long-term: _____

_____

_____

_____

List the community resources that can help you with these objectives.

_____

_____

_____

_____

Source:

(1) *Compañeros en la Salud*. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ.

WALK THE TALK

Maintain a healthy life style

Cope with stress

(See SONRISA Section 4.1.2., 4.2.2., 4.3.2.: *18 Ways of coping with stress*)

Get support from your family and friends

Organize or join support groups for *promotores* / CHWs

6. Resources for *Promotores* / CHW Trainings

Note to *Promotores* / CHWs

Section 6 contains (1) evaluation material that invites you to participate in improving SONRISA, and (2) a template for a certificate of attendance that can be used for SONRISA training workshops.

6.1. Evaluation Questions

Note to *Promotores* / CHWs

This evaluation question guide invites you to participate in improving the SONRISA curriculum toolbox. It is designed as a focus group style interview with all participants at the end of the training. It is advisable to tape record the evaluation session, or have someone take meticulous notes for later analysis. Should you or your agency prefer a written survey approach to evaluation, the questions can be modified to fit that format.

The purpose of the evaluation is to find out whether each of the SONRISA sections is appropriate and to indicate areas for improvement. They can also be used for evaluating the delivery of the SONRISA training.

The evaluation of your SONRISA training can help you determine which of the curriculum toolbox material can be adapted to your particular population. Please consider sharing the outcome of the evaluation with the authors of SONRISA to help them improve this "living" curriculum toolbox.

SONRISA

A Curriculum Toolbox for *Promotores* / Community Health Workers to Address Mental / Emotional Health Issues Associated with Diabetes

SONRISA Training/Feedback Workshop
Given by *[name of agency]*

[date of training]

Post Training Evaluation Question Guide

1a) Do you think that the SONRISA curriculum toolbox on diabetes-related depression will be useful for you in addressing depression in

…diabetic clients?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

…their families?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

…or communities?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

1b) Please give reasons for answering "yes" or "no" or "dk" (don't know).

2a) Do you think SONRISA will be easy for you to use in your community?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

2b) If "yes," why do you think so?

2c) If "no," why don't you think so?

2d) If "don't know," why?

3) How do you think SONRISA could be improved to make it easier to use?

4a) Do you think that the educational material is presented adequately? Please consider:

Basics of Mental/Emotional Health Issues: Depression, Stress, Anxiety

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

Community Health Workers Helping to Cope: Working with Patients, Family Members and Friends, and Community Members

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

Coping Strategies and Priority Setting for *Promotores*/CHWs

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

Appendices

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

(For each group under 4a) ask Questions 4b-4d.)

4b) If "no," how should the educational material be presented?

4c) If "yes," how can it be improved?

4d) If "don't know," why?

5a) Is SONRISA culturally appropriate for …

… traditional Hispanics?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

… acculturated Hispanics?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

… Anglos?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

… any other ethnic groups?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

… women and men alike?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

(For each group under 5a) ask Questions 5b-5d.)

5b) If "yes," why do you think so?

5c) If "no," why don't you think so?

5d) If "don't know," why?

6) How can SONRISA be improved to be more culturally appropriate?

7) In which ways can the SONRISA content be adapted to your needs for working with diabetic patients, their families and community members?

8) In which ways does SONRISA offer you, the *promotor/a* / CHW, skills that help to keep you free from depression and to maintain strong mental health? Do you think you will use the recommendations from SONRISA for yourself?

9a) Will you recommend SONRISA to your colleagues if they asked about depression?

of "yes" answers ___ # of "no" answers ___ # of "dk" answers ___

9b) If "yes," what do you like about SONRISA?

9c) If "no," which areas can be improved?

9d) If "don't know," why?

10) Overall, how satisfied are you with the SONRISA curriculum?

# of those Very satisfied _____
# of those Somewhat satisfied _____
# of those Neither satisfied nor dissatisfied _____
# of those Somewhat dissatisfied _____
# of those Very dissatisfied _____

11) Please provide any other comments that have not been made earlier.

Thank you!

SONRISA

6.2. SONRISA training certificate: Celebrating our success

Note to *Promotores*/CHWs

The certificate of attendance template in this section can be used for SONRISA training workshops. You can fill in the participant's name, and the day, month and year of the training. You can also insert your agency's logo in addition to the SONRISA logo already displayed on the certificate.

Certificate of Attendance

awarded to

[Participant's Name]

***For Participation in the* SONRISA Training**

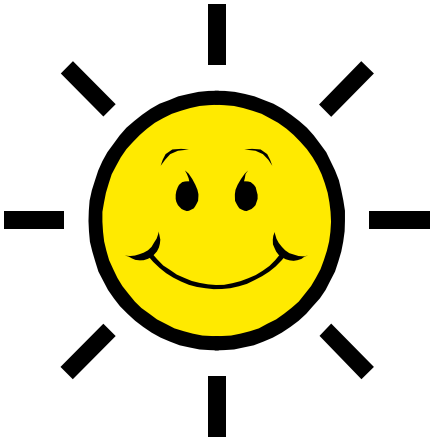
Presented on this [day] day of [month] [year] by
[name of your organization]

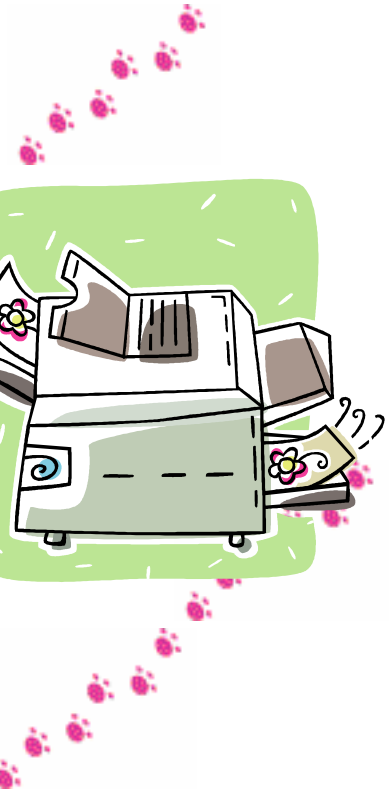
[place your agency's logo here]

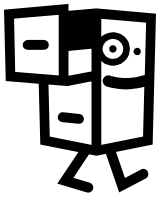
_____
signature

_____
signature

APPENDICES







APPENDIX A – Diabetes and diabetes support groups

- American Diabetes Association

Available at: http://www.diabetes.org/home.jsp (English)
http://www.diabetes.org/espanol/default.jsp (Spanish)

American Diabetes Association
ATTN: National Call Center
1701 North Beauregard Street
Alexandria, VA 22311
1-800-DIABETES (1-800-342-2383)
Monday - Friday, 8:30 AM - 8 PM Eastern Standard Time

- Diabetes Forecast (Healthy Living Magazine of the American Diabetes Association).

Available at: www.diabetes.org/diabetes-forecast.jsp

- NDEP's Publication Catalog. National Diabetes Education Program.

Available at: http://www.ndep.nih.gov/diabetes/pubs/catalog.htm#PubsHispLatino

- Starting a Diabetes Support Group. ADA.

Available at: http://www.diabetes.org/main/community/outreach/support.jsp

- Starting a Diabetes Support Group.

Available at: http://www.diabetesmonitor.com/b153.htm

APPENDIX B – Patient Health Questionnaire (PHQ-9)

- The MacArthur Initiative on Depression & Primary Care. Dartmouth College 2003.

Available at: http://www.depression-primarycare.org/

- PHQ-9, English version.

Available at:

http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/

- PHQ-9, Spanish version.

Available at: http://www.depression-primarycare.org/images/pdf/phq_9_quest_spanish.pdf

APPENDIX C – Books on diabetes and/or emotional health

- American Diabetes Association. 1997. Caring for the Diabetic Soul: Restoring Emotional Balance for Yourself and Your Family. Alexandria, VA: American Diabetes Association.

- Biddle S, Fox KR, Boutcher S. 2003. Physical Activity and Psychological Well-being. New York: Routledge.

- Delgado J. 2002. *Salud: Guía para la salud integral de la mujer Latina*. New York, NY: HarperCollins Publishers.

- González VM, González JT, Freeman V, Beth Howard-Pitney B. 1991. Health Promotion in Diverse Cultural Communities. Stanford University, Stanford Center for Research in Disease Prevention.

Available at: http://patienteducation.stanford.edu/materials/

Health Promotion Resource Center
Stanford Prevention Research Center
750 Welch Road
Palo Alto CA 94304
(415) 723-0003; Fax: 650-498-4828

- González V, Hernández-Marin M, Lorig K, Sobel D, Laurent D, Minor M. 2002. *Tomando Control de su Salud: Una guía para el manejo de las infermedades del corazón, diabetes, asma, bronquitis, enfisema y otros problemas crónicos* (Taking Control of Your Health: A guide for the self-management of heart disease, diabetes, asthma, bronchitis, emphysema and other chronic problems). Boulder, CO: Bull Publishing.

Available at: http://patienteducation.stanford.edu/materials/

Bull Publishing Company
PO Box 1377
Boulder CO 80306
1-800-676-2855; FAX: (303) 676-2855

- Lozano-Vranich B, Petit J. 2003. The Seven Beliefs – A Step-By-Step Guide to Help Latinas Recognize and Overcome Depression. New York, NY: Harper Collins Publishers.

☻ Satir V. 1986. Meditations & Inspirations. Berkely, CA: Celestial Arts.

☻ Words to the Wise: A Bilingual Course for Diabetes *Promotoras*. Public Health Division, New Mexico Department of Health, Diabetes Prevention and Control Program.

☻ Weintraub A. 2004. Yoga For Depression – A Compassionate Guide to Relieve Suffering Through Yoga. New York: Broadway Books.

☻ Weintraub A. 2003. Breathe to Beat the Blues: Manage Your Mood with Your Breath. CD. Yoga to Beat the Blues Productions, Tucson, Arizona.

APPENDIX D – Educational Materials

☻ Bonilla Z. 2002. *Guía de Capacitación para Promotoras de Salud de la Colectiva de Salud de las Mujeres de Boston. Taller de capacitación, La salud mental de la mujer latina. Modulo #10: Salud mental, depresión y estrés. Guía basada en el libro Nuestros Cuerpos, Nuestras Vidas.* Somerville, MA: The Boston Women's Health Book Collective.

Available at: www.ourbodiesourselves.org

Our Bodies Ourselves
34 Plympton Street
Boston, MA 02118
office@bwhbc.org
(617) 451-3666; FAX: (617) 451-3664

☻ Teufel-Shone NI, Drummond R. *La diabetes y la unión familiar* (Diabetes and the Family). Border Health ¡Sí!, Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, Arizona.

☻ Teufel-Shone NI, Drummond R, Rawiel U. 2005. Developing and Adapting a Family-based Diabetes Program at the U.S.-Mexico Border. Preventing Chronic Disease, 2(1):1-9.

Available at: http://www.cdc.gov/pcd/issues/2005/jan/04_0083.htm.

☻ Your Heart, Your Life. *Su corazón, su vida.* U. S. Department of Health and Human Services; Public Health Services; National Institutes of Health; National Heart, Lung, and Blood Institute, 1999.

APPENDIX E – Audio tapes/CDs

☻ Living a Healthy Life with Chronic Conditions (abridged version; audio book). An abridged audio CD of the book. Bull Publishing Company, 1994.

Available at: http://patienteducation.stanford.edu/materials/

Bull Publishing Company
PO Box 1377
Boulder CO 80306 USA
1-800-676-2855; FAX: (303) 676-2855

☻ *Movimiento por su vida* A music CD to help prevent and control type 2 diabetes; 6 original songs with Latin rhythms and motivating messages. A single CD can be ordered for free. National Diabetes Education Program.

Available at: http://www.ndep.nih.gov/diabetes/pubs/order.htm
National Diabetes Information Clearinghouse (NDIC)
1 Information Way
Bethesda, MD 20892-3560
Phone: 1-800-860-8747
Fax: (703) 738-4929

☻ Time for Healing: Relaxation for Mind and Body (long version). Two 30-minutes relaxation exercises with background music and the voice of Catherine Regan PhD. Bull Publishing Company, 1994.

Available at: http://patienteducation.stanford.edu/materials/

Bull Publishing Company
PO Box 1377
Boulder CO 80306
1-800-676-2855; FAX: (303) 676-2855

☻ Time for Healing: Relaxation for Mind and Body (short version). Bull Publishing Company, 1994.

Available at: http://patienteducation.stanford.edu/materials/

Bull Publishing Company
PO Box 1377
Boulder CO 80306
1-800-676-2855; FAX: (303) 676-285

☻ *Casete de relajación* (Spanish Relaxation Audio Tape). Two 20-minute relaxation exercises with background music and the voice of Virginia Nacif de Brey. Stanford Patient Education Research Center, 1995.

Available at: http://patienteducation.stanford.edu/materials/

Stanford Patient Education Research Center
1000 Welch Road, Suite 204
Palo Alto CA 94304
1-800-366-2624 (English) or 1-800-725-9424 (Spanish)
FAX: (650) 723-9656

☻ *¡Hagamos ejercicio!* (Let's Exercise!) Exercise audio cassette tape with illustrated guide with background music and the voice of Virginia Nacif de Brey. Stanford Patient Education Center, 1995.

Available at: http://patienteducation.stanford.edu/materials/

Stanford Patient Education Research Center
1000 Welch Road, Suite 204
Palo Alto CA 94304
1-800-366-2624 (English) or 1-800-725-9424 (Spanish)
FAX: (650) 723-9656

APPENDIX F - Websites

- American Foundation of Suicide Prevention (AFSP).

Available at: http://www.afsp.org

- American Psychiatric Association (APA).

Available at: http://www.psych.org

- Arizona Resources. SAMHSA's National Mental Health Information Center. Center for Mental Health Services.

Available at: http://www.mentalhealth.org/publications/allpubs/stateresourceguides/arizona01.asp

- *Bienvenidos a ADHS. El Departamento de Salud de Arizona. Salud Pública en Español.* Arizona Department of Health Services.

Available at: http://www.azdhs.gov/spanish_index.htm

- Center for Anxiety & Stress Treatment: Anxiety? Stress? Panic? Phobias? Worry?

Available at: http://www.stressrelease.com/

- Depression Health Center. WebMD.

Available at: http://my.webmd.com/medical_information/condition_centers/depression/default.htm

- Depression – You Don't Have to Feel that Way. American Family Physician. Published by the American Academy of Family Physicians. March 1, 2000.

Available at: http://www.aafp.org/afp/20000301/1523ph.html

- Families for Depression Awareness: Bringing Depression into the Light.

Available at: www.familyaware.org

☻ Hispanic Health Projects - *Promotoras*. Department of Anthropology. Idaho State University.

Available at: http://www.isu.edu/~carteliz/hhp-promotoras.html

☻ Mental Health Matters: Self Help Center: Video and Audio Tapes.

Available at: http://www.mental-health-matters.com/selfhelp/m_media.php

☻ National Alliance for Hispanic Health (NAHH).

Available at: http://www.hispanichealth.org/

☻ Diabetes Prevention and Control Program, New Mexico Department of Health, Public Health Division.

Available at: http://www.diabetesnm.org/index.htm
New Mexico Department of Health
Diabetes Prevention and Control Program
810 W. San Mateo
Suite 200 E
Santa Fe, NM 87505
1-888-253-2966
Program Manager: Judith Gabriele
Phone: (505) 476-7615
Fax: (505) 476-7622
Email: dpcp@diabetesnm.org

☻ National Mental Health Association (NMHA).

Available at: www.nmha.org

☻ Research on Parenting Curriculum for Latino Families. Children, Youth and Family Consortium.

Available at: http://www.cyfc.umm.edu/spanish/research.html or

Children, Youth & Family Consortium
McNamara Alumni Center, Suite 270
200 Oak Street S.E.
Minneapolis, MN 55455
(612) 625-7849, Email: cyfc@umn.edu

● Whole Person Associates, Stress and Wellness Specialists. 30 Scripts for Relaxation: A Stress and Wellness Resource from Whole Person Associates.

Available at: http://www.wholeperson.com/wpa/tr/30s/intro.htm

APPENDIX G – Working with migrant workers

☻ Castañeda, Xóchitl (Directora). *Historias del Ir y Venir y la Salud Mental: Manual para Promotores/as de Salud*. Octubre del 2003.

Available at: http://www.ucop.edu/cprc/iryvenir.pdf

Initiativa de Salud México-California
Centro de Investigación de Políticas Públicas de California
Universidad de California, Oficina del Presidente
1950 Addison St., Ste. 203
Berkeley, CA 94720-7410
(510) 643-4089, Fax: (510) 642-7861

☻ Castañeda, Xóchitl (Director). Tales of Coming and Going and Mental Health: Manual for Health '*Promotores/as*'. January 2004.

Available at: http://www.ucop.edu/cprc/promotorasmn.pdf or

California-Mexico Health Initiative
California Policy Research Center
University of California, Office of the President
1950 Addison Street, Suite 203
Berkeley, CA 94720-7410
(510) 643-4089, Fax: (510) 642-7861

☻ Health Network Programs. MCN Migrant Clinicians Network.

Available at: http://www.migrantclinician.org/network or

MCN Migrant Clinicians Network
– Main Office –
P.O. Box 164285; Austin TX 78716
(512) 327-2017; Fax: (512) 327-0719 fax

☻ Lanham, B (Compiler, Mental Health Educator, blanham@trhs.org). *La Fotonovela – Los Cuentos del Campo – Las historias que nos enseñan que a pesar de la sombra hay esperanza*. Farmworker Mental Health. Video and Presentation Guide. Terry Reilly Health Services.

APPENDIX H – Arizona counseling services

☻ Community Partnership of Southern Arizona, Regional Behavioral Health Authority. (CPSA, RBHA).

Available at: http://w3.cpsa-rbha.org/

☻ Mental Health Association of Arizona

Available at: www.mhaarizona.org

Mental Health Association of Arizona
6411 E. Thomas Rd.
Scottsdale, AZ 85251-
(480) 994-4407; Fax: (480) 994-4744

☻ Southeastern Arizona Behavioral Health Services (SEABHS).

Available at: http://www.seabhs.org/poc/view_index.php?idx=home

SEABHS
PO Box 2161
Benson, AZ 85602
(520) 586-0800

For emergencies:

1-800-586-9161	**SEABHS Crisis Hotline,** Graham, Greenlee, Santa Cruz or Cochise Counties.
1-800-SUICIDE 1-800-784-2433	**National Hopeline Network: USA**
1-800-273-TALK 1-8008-273-8255	**National Suicide Prevention Lifeline: USA**
520-622-6000 1-800-796-6762	**SAMHC Behavioral Health Services**, Pima County
911	**Life-threatening or medical emergency**

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American Diabetes Association. Available at www.diabetes.org/type-2-diabetes/depression.jsp.

American Psychiatric Association. 1994. American Diagnostic and Statistical Manual of Mental Disorders DSM-IV™. Washington, DC: American Psychiatric Association. Also available at: http://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1.

American Psychiatric Association. 1994. Major Depressive Episode. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 320-327.

American Psychiatric Association. 1994. Outline of Cultural Formulation and Glossary of Culture-Bound Syndromes. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 843-849.

Black SA, Markides KS, Ray LA. 2003. Depression Predicts Increased Incidence of Adverse Health Outcome in Older Mexican Americans with Type 2 Diabetes. Diabetes Care, 26(10):2822-2828.

Bower B. 2005. Mood Brighteners: Light Therapy Gets Nod as Depression Buster. Science News Online, 167(17), 04/23/05. Available at: http://www.sciencenews.org/articles/20050423/fob7.asp.

Egede LE. 2004. Diabetes, Major Depression, and Functional Disability among U.S. Adults. Diabetes Care, 27(2), 421-428.

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Diabetes Care: Hypoglycemia; Hyperglycemia. 1999. Novo Nordisk Pharmaceuticals, Inc. (Concept developed by Rhoda Rogers, RN, BSN, CDE. Sunrise Community Health Center, Greeley, Colorado).

Fisher L, Mullan JT, Chesla CA, Kanter RA, Skaff MM. 2002. Depression and Anxiety among Partners of European-American and Latino Patients with Type 2 Diabetes, Diabetes Care, 25(9):1564-1570.

Gotlib IH, Lewinsohn PM, Seeley, JR. 1995. Symptoms Versus a Diagnosis of Depression: Difference in Psychosocial Functioning. Journal of Consulting and Clinical Psychology, 63(1), 90-100.

Holden C. 2005. Sex and the Suffering Brain. Science, 208:1574-1577.

House JS. 1981. Work, Stress and Social Support. Reading, MA: Addison-Wesley.

Kohen D, Burgess AP, Catalán J, Lant A. 1998. The Role of Anxiety and Depression in Quality of Life and Symptom Reporting in People with Diabetes Mellitus. Quality of Life Research, 7, 197-204.

Koskoff, H. 2002. The Culture of Emotions – A Cultural Competence and Diversity Training Program. Video. ISBN 1-57295-361-6, 60 Minutes, VHS, Color.

Kroenke K, Spitzer RL, Williams JBW. 2001. The PHQ-9 – Validity of a Brief Depression Severity Measure. J Gen Intern Med, 16:606-613.

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Lozano-Vranich B, Petit J. 2003. The Seven Beliefs – A Step-By-Step Guide to Help Latinas Recognize and Overcome Depression. New York, NY: Harper Collins Publishers.

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Rosenthal EL. The National Community Health Advisor Study – Weaving the Future. University of Arizona and Annie E. Casey Foundation. Tucson, AZ: Mel and Enid Zuckerman Arizona College of Public Health, 1998. Available at: http://www.aecf.org.

Stimmel, GL. 2000. Mood Disorders. In: Herfindal ET, Gourley DR (eds). Clinical Pharmacy and Therapeutics, 7th Edition. Baltimore, MD: Williams & Wilkins, 1203-1216.

U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services, National Institutes of Health, National Institutes of Mental Health.

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Available at: http://www.qolid.org/public/PRIME-MD.html.

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Campesinos sin Fronteras. CDMP Campesinos Diabetes Management Program. Somerton, Arizona.

Compañeros en la Salud. 1993. Department of Psychology and Hispanic Research Center, Arizona State University, Tempe, AZ. Also see: Castro FG, Elder J, Coe K, et al. 1995. Mobilizing Churches for Health Promotion in Latino Communities: *Compañeros en la Salud*. Natl Cancer Inst Monogr., 18:127-135.

Mariposa Community Health Center. 2004. *Platicamos Salud*. Nogales, Arizona.

Stanford Patient Education Center.
Available at: http://patienteducation.stanford.edu/materials/

Western Arizona Health Education Center, Inc. / Regional Center for Border Health (WAHEC/RCBH). 2004. Mental Health Curriculum, Draft Version. San Luis, Arizona.

– Other Sources

Castro FG. 2004. Personal Communication. Arizona State University.

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