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Perceptions of pregnant women with gestational diabetes mellitus: diagnosis, hospitalization and confrontation

Percepções de gestantes com diabetes mellitus gestacional: diagnóstico, hospitalização e enfrentamentos

Percepciones de las gestantes con diabetes mellitus gestacional: diagnóstico, hospitalización y enfrentamientos

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This is a qualitative-descriptive study conducted in 2018, at a university hospital in the state of Goiás, which aims to investigate how pregnant women with gestational diabetes mellitus experienced their diagnosis and hospitalization and to identify coping strategies for dealing with the disease. Semi-structured interviews were conducted with six pregnant women. Data analysis was inductive, from the full transcription and curious and exhaustive reading of interviews, later organized in thematic axes and analyzed based on chronic diseases, pregnant women and coping. Four themes emerged: *Perceptions about the diagnosis*; *Experiences related to hospitalization*; *Coping strategies*; and *Relationships between emotions and gestational diabetes mellitus*. There were feelings such as anxiety and anguish regarding the diagnosis and difficulties with dietary changes during hospitalization. The main coping strategies were related to self-care and social/family support. Regarding emotional aspects, there was no consensus that it is a determining factor for changes in the disease.
Descriptors: Diabetes, Gestational; Adaptation, Pychological; Hospitalization; Pregnancy complications; Emotions.

Este é um estudo qualitativo-descritivo realizado em 2018, num hospital universitário goiano, e que tem como objetivo investigar como gestantes com diabetes mellitus gestacional vivenciaram o diagnóstico e a internação e identificar as estratégias de *coping* para o enfrentamento da doença. Realizou-se entrevistas semiestruturadas com seis gestantes. A análise dos dados foi indutiva, a partir da transcrição na íntegra e leitura curiosa e exaustiva das entrevistas, organizadas a *posteriori* em eixos temáticos, analisados embasados nas doenças crônicas, gestantes e *coping*. Emergiram quatro temáticas: *Percepções sobre o diagnóstico*; *Vivências relacionadas à internação*; *Estratégias de enfrentamento;* e, *Relações entre emoções e diabetes mellitus gestacional*. Verificou-se sentimentos como ansiedade e angústia frente ao diagnóstico e dificuldades com mudanças alimentares na hospitalização. As principais estratégias de enfrentamento relacionaram-se ao autocuidado e suporte social/familiar. Nos aspectos emocionais, não houve consenso que seja fator determinante para alterações na enfermidade.
Descritores: Diabetes gestacional; Adaptação psicológica; Hospitalização; Complicações na gravidez; Emoções.

Este es un estudio cualitativo-descriptivo realizado en 2018 en un hospital universitario de Goiás, que tiene por objeto investigar la forma en que las mujeres embarazadas con diabetes mellitus gestacional experimentaron el diagnóstico y la hospitalización e identificar las estrategias de *coping* para hacer frente a la enfermedad. Se realizaron entrevistas semiestructuradas a seis mujeres embarazadas. El análisis de los datos fue inductivo, basado en la transcripción completa y en la lectura curiosa y exhaustiva de las entrevistas, organizadas después en ejes temáticos, analizadas en base a las enfermedades crónicas, las mujeres embarazadas y *coping*. Surgieron cuatro temas: *Percepciones sobre el diagnóstico*; *Experiencias relacionadas con la hospitalización*; *Estrategias de enfrentamiento*; y, *Relaciones entre las emociones y la diabetes mellitus gestacional*. Hubo sentimientos como la ansiedad y la angustia ante el diagnóstico y dificultades con los cambios de dieta en la hospitalización. Las principales estrategias de enfrentamiento estuvieron relacionadas con el autocuidado y el apoyo social y familiar. En los aspectos emocionales, no hubo consenso de que es un factor determinante para cambios en la enfermedad.
Descriptores: Diabetes gestacional; Adaptación psicológica; Hospitalización; Complicaciones del embarazo; Emociones.

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INTRODUCTION

At a global level, it is estimated that 425 million individuals, aged between 20 and 79 years, have some type of diabetes mellitus[1]. Considering the same age group, Brazil ranks 4th in the world, with the highest rates of diabetes mellitus in its adult population, estimated at 14.3 million people[1].

These estimates are mainly related to economic conditions, considering their increase in countries that are in transition from low to middle income and are also associated with population growth and aging[1]. In 2030, diabetes may become the seventh leading cause of death worldwide[2]. It is also estimated that, when it comes to gestational diabetes mellitus (GDM), for every 10 pregnant women, one or two will have the disease[3].

GDM corresponds to hyperglycemia diagnosed during pregnancy, which may or may not remain after delivery, and must be evaluated and controlled, as it may cause pregnancy impairment[4]. The high rates of this disease, in the last 20 years, can also be related to ethnic issues, obesity and physical inactivity, and should therefore be evaluated and controlled[4,5].

Considering perinatal risk factors related to diabetes and its outcomes, a survey with 201 pregnant women with type 1, type 2 and gestational diabetes executed in a high-risk prenatal clinic showed a higher occurrence of cesarean section delivery, prevalence of prematurity, followed by macrosomia and fetal malformation[6]. Therefore, the importance of not underestimating the prevalence of hyperglycemia in pregnancy is highlighted.

For pregnant women, having GDM is a risk factor for later development of type 2 diabetes or glucose intolerance after delivery[3]. Thus, hyperglycemia during pregnancy is considered a health issue that needs attention[6], because pregnancy, despite being considered a normal experience of human development, is a period of transition marked by major transformations, not only on a physical aspect, but also mental[7]. However, gestational risk factors predisposing to the development of diabetes can be identified in the prenatal medical appointments, thus representing assistance in the care of this population[8].

The emotional repercussions of pregnancy tend to be associated with ambivalent and contradictory feelings, such as insecurity and fear[9]. In the case of pregnant women with GDM, these feelings tend to add to the concerns related to the disease, such as anguish with what may happen to self and the baby[9]. In addition, pregnant women with GDM need to adapt to changes in dietary routine and constant monitoring of blood glucose[9], and this new context may represent a stressful situation.

Coping proves to be important in the experience of diabetes by pregnant women and can be conceptualized as: a set of efforts by the individual in the creation of strategies and/or resources to deal with adverse conditions[10].

Coping can be made up of varied determinants and represents attempts of personal adjustment to threatening obstacles of the subject's adaptive resources[10]. Also, they are strategies used in face of circumstances in which there is no preparation, control and prior knowledge[10], creating a set of efforts when dealing with a stressful events that promotes the need to develop a way of coping in the individual. Such strategies can change over time, varying according to personal experiences and the stage of life[11].

Coping strategies can be classified into two major groups: those who focus on emotion and those who focus on the problem. Strategies focused on emotion correspond to construction of mechanisms to regulate emotional responses caused by a stressful event. Strategies focused on the problem aim to act directly on the source that causes stress, seeking to change and/or solve it[10].

The practices aimed at GDM are an important element of protection and help, considering that the experience of the disease, when together with pregnancy, can promote varied feelings and experiences capable of causing suffering[4]. In this context, this study is justified in seeking to expand the understanding of knowledge about the experience of GDM.

Considering the increasing incidence and prevalence of GDM in pregnant women, and that diabetes is capable of causing important physical and emotional repercussions in this specific slice of the population, as well as long-term complications for mother and baby, in addition to psychosocial and affective factors that must be considered in adherence to treatment[12]. Thus, this study aims to investigate how pregnant women with gestational diabetes mellitus experienced their diagnosis and hospitalization and identify strategies for coping with the disease.

METHOD

This is a qualitative-descriptive study with women admitted to a high-risk maternity ward in a university hospital in the state of Goiás, who were diagnosed with GDM. This ward works in an emergency room, in order to attend urgent and emergency counseling by the health units of the municipality where data were collected.

As inclusion criteria, we considered patients over the age of 18 who had diabetes developed during pregnancy, were aware of the diagnosis, aware and lucid during hospitalization, as well as in conditions to get to the interview room, and with interest participating in the research.

The information was collected between May and June of 2018. The instrument used was the interview, guided by a semi-structured script, which addressed the sociodemographic data of the participants, as well as their perceptions about the diagnosis of diabetes, the emotional aspects involved, as well as the coping with the disease and hospitalization for diabetes control.

Data collection started with reading the maternity papers to identify hospitalized patients with GDM. Subsequently, each patient was approached on their hospital bed. From this, each patient was individually invited to participate in the research through individual interviews, which were recorded and performed in the room for individual psychological care at the maternity hospital.

We chose the number of interviewees based on the data saturation criteria[13]. The participants were fictitious names.

The interviews were transcribed in full, read with curiosity[14], understood as a genuine interest in the richness of details of speeches, in an exhaustive[15] and detailed way, which later resulted in the construction of four thematic axes that described the participants' perceptions regarding the moments of diabetes.

The thematic axes were analyzed based on the theory of coping, anchored in the perspective of coping strategies focused on emotion and focused on the problem. Coping strategies represent an attempt to personally adjust to threatening obstacles to the adaptive resources of individuals[10].

We sought to contemplate the guidelines and regulation rules in research involving human beings, and the project was submitted to and approved by an Ethics in Research Committee, under No. 2,631,379. Through the Free and Informed Consent Term (ICF), participants were informed of the research objectives, the implications of participation and the consequent anonymity, in addition to the possibility of withdrawing at any time, without any prejudice to the treatment received in the hospital.

RESULTS

Six women participated in the study, and they were given fictitious names of flowers: Violet, Orchid, Rose, Tulip, Camellia and Jasmine.

Regarding the participant's sociodemographic characterization, the average age was 34.6 years, varying between 30 and 42 years of age. For educational level, two (Violet and Rose) had university level, while the others had finished high school.

Regarding work, the mentioned activities were: municipal public server (Violet), maid (Orchid), educator and housewife (Rose), cook (Tulip), seamstress (Camellia) and hospital receptionis (Jasmine). Regarding marital status, four were legally married (Orchid, Rose, Tulip, Camellia) and two cohabited with a partner (Violet and Jasmine). And regarding religion, most of the interviewees declared themselves evangelical.

During the interview, all interviewees were on the third trimester of their pregnancies, with a gestational age between 28 weeks and 06 days to 40 weeks and 01 day. The time of diagnosis of GDM were between 05 days and 21 weeks. Between participants, Orchid and Jasmine had already gone through a diagnosis of GDM in previous pregnancy.

Four themes emerged from the interviews: 1) *Perceptions about the diagnosis*; 2) *Experiences related to hospitalizaiton*; 3) *Coping strategies*; and 4) *Relationships between emotions and gestational diabetes mellitus.*

Perceptions about the diagnosis

For the interviewees, the perception about the diagnosis related to the difficulty of recognizing themselves as ill, as seen in the following speeches:

When dr. J. said I had diabetes, I said 'whatm diabetes? Skinny as I am? (points to own body). (Rose)

It's news to me, right, because I had never been hospitalized for diabetes, especially because I thought it was more related to weight, at first I thought I had done the wrong test (laughs), because on the day I did the first drawn it was altered and I did not even notice that I had fasting glucose and I didn't notice I had fasting glucose and I had eaten an yoghurt, so I thought it was because of that, but I did it again after and it was still altered. (Jasmine)

Concerning the expression of feelings, anxiety, anguish and fear were reported:

It scared me, you know, because diabetes is already something very bad, it is a very serious, a very serious disease, I was afraid, more for the baby, because it hurts him more, you know. (Jasmine)

At first I was a little scared, I didn't know what it was like, but then it was normal, I just had to control it. (Tulip)

I don't know, millions of things, that my pregnancy was not going forward, a lot of things. (Camellia)

[...] we get scared too, you know, we don't even know what is waiting for us next, then you arrive at the hospital and listen to a lot of things from the girls who are already there, from some who have miscarried, like this week a little dead boy was born, then you get scared, right. (Camellia)

The repercussions of the diagnosis of GDM were also related to the complaint regarding limitation of food:

I was a little scared, I'm very addicted to chocolate and now I can't eat it (laughs). (Jasmine)

Also as part of perceptions of the diagnosis, some of the pregnant women demonstrated attention and knowledge regarding the illness caused by diabetes, reporting the possible complications of the disease for the baby:

There is no problem for the mother, it is the child who can become too big, heavy and at the time of delivery have complications and develop diabetes in the future. (Violet)

I thought about A. right away, I said 'wow, he may be born blind, he may be born with a problem', I think about the baby right away. (Tulip)

The genetic matter appears as an important element for the development of the illness:

Usually, doctors say that if you have a case in the family, you have a 50% chance of developing it. (Violet)

Then I thought, right, because my mother had it and my grandmother had it and she passed away from it, it must be something related, it goes from generation to generation. (Rose)

For the incidence of the illness and its expressions, tranquility comes up:

Normal. Like I told you, I don't suffer. I know, I already knew, you know, I've been through this twice before. (Orchid)

I already had gestational diabetes in my first pregnancy, but I didn't have to go to the hospital, the diet at home was fine. (Jasmine)

Experiences related to hospitalization

The reported emotions were associated with feelings such as anxiety, insecurity and blame:

I was anxious, not knowing what it would be like, because I had never gone to the hospital to be hospitalized. (Violet)

How is it? I don't know, I was never hospitalized like that, very bad. (Camellia).

There are times when you want to leave, then you look away and I think no, if I do and then something happens I will feel guilty, I'm here, better here, it's bad but it's better than staying home and getting worse, right. (Tulip)

Much concern. Then it gets worse when the baby doesn't move, then I think 'my God, she it suffering, what is happening' and when something like that weighs on our conscience we shouldn't have eaten, shouldn't have drunk

that little soda, then she doesn't move and I say my God, I killed my daughter, then she doesn't move and I keep poking her until she moves. (Rose)

They also reported the period of separation from family members and the constant concerns about loved ones:

[...] just worry, right, just what makes me worry about my children who are there without me. (Orchid)
I was already tearful because my kids can't come (laughs). (Jasmine)
Horrible (laughs). Too bad, to be without our husband, without our kid. (Camellia)
[...] not being able to tell that I'm alone, my husband cannot stay, there cannot be more people in the room. (Violet)

Hospitalization was also related to changes on daily routine:

It makes perfect sense, if you put everything there together, if you see that your life at home is like and your life is like inside a hospital is totally different. At the hospital you don't get stressed [...] you are there to rest, you have everything in hand, you have food, you have a clean place [...]. (Orchid)
The first time I stayed in, it was to the knowledge passed by the nutritionist, then they went to inform me. The second time I did not like it, wow what bad food from this hospital, no, I want to go home. The second one I thought was bad, then this third one, which I was already worried about with the end of the pregnancy [...]. (Rose)
It's a different routine that changes, you know, you're not used to this routine, there's nothing for you to do here. (Tulip)
I still don't understand why I'm not here (laughs). (Jasmine)

Regarding the treatment, difficulties with dietary restrictions and the adequate follow-up of nutritional prescription were also reported:

[...] here it is a different menu than what I'm used to at home [...]. (Tulip)
Wow, now that it's changing because this past weekend was my son's birthday, you know, then I ate cake, things I couldn't (laughs), but it's being difficult, the diet is difficult. (Jasmine)

Financial worries were also present:

I would say that this worries me a lot, you know, even more because of the fact that when we are here, we are not making money, you know, but when I'm at home I'm also not making money, I can't handle it anymore. So, it worries me. (Orchid)

Coping strategies

The pregnant women used coping strategies focused on the problem and emotion, in addition to social and family support to deal with their disease, with attention to food and the adoption of healthier eating habits:

[...] there's no point in fighting, wanting to eat everything you can't, because you can't. (Violet)
The food is very important, that sometimes, we are not able to eat at home like we do in the hospital, time is another thing that I'm sure makes a difference [...]. (Orchid)
But I also thought about the baby, if the woman does not follow correctly, there may be problems for the baby, then I did the diet [...]. (Pink)
The first thing I did was to change my eating habits. (Tulip)
[...] even though I didn't pass the diet on to myself, I took some things on my own that I know are not good [...]. (Jasmine)

Coping strategies with a focus on emotion became valuing hospitalization as self-care, in addition to not thinking, and the desire to escape from the hospital:

[...] I joke that, when I get hospitalized, I go to my hotel. Because here I don't wash, don't iron, don't cook, I don't take care of children, here I really rest, here I don't really rest my mind, because I care about them, you know, with my children, but nevertheless I rest my body [...] I try to forget my life there, I try to live here, because if I stay here thinking about there, it will not be good [...]. (Orchid)
Lately, I've been walking, I go down there for a while, I watch TV, I keep quiet. (Tulip)
I try not to think about it at home. Even then I think, because I am worried about my girl, but I thought, when I'm thinking too much then I will change my focus, go out, talk, walk so that I don't think too much. (Rose)
They are with their father, but they are crying, wanting me to leave (laughs). Then he is already afraid to stay longer, even more now that they gave me a pot of this size to pee I said so I'm leaving (laughs). (Jasmine)
Only the fear, the desire to leave, the desire for this week to end for her to be born soon. (Camellia)

In addition to the strategies focused on the problem and focused on emotion, social and family support, represented by both social support by other hospitalized patients, such familial, represented by mother and husband:

Yeah, I talk to the girls, each one has a different story, and we end up sharing it. (Tulip)
Do I do anything? I keep talking to the girls, just talking, looking at the other's little baby. (Camellia)
Your mother calls and says you have to think positive, your husband says, then you start to feel more like that, then you see that there are people who are worse than you, but the fear is still there. (Camellia)

[...] because if it were for my husband, I would already be at home too (laughs). He never stayed away from me, because he was the one who accompanied him. (Jasmine)

As support, we also noticed expectations about baby care, which seems to have been used as a coping strategy for the experience of hospitalization and the repercussions of diabetes:

Yeah, because I know he's here (points to belly), he needs me. And I'm with him and he's with me. (Orchid)
Thinking about him (points to stomach), thinking about my baby alone, because if I think about things outside I will leave now (laughs), because I'm only here because of him, it's not even because of me, it's because of him. (Jasmine)

Religiosity/spirituality were also present on the participants' speeches, presenting itself as an ally to coping to diabetes during pregnancy:

I stay calm. I pray to God a lot, asking to have a good time, okay. (Violet)
God, he above all (laughs). He who is my strength, my strength, He who helps me, who guides me, who protects me is in Him that I have strength for everything. (Orchid)
I read the bible a lot, right, so I like to look for a text that helps me to strengthen and know that I have to leave it in God's hands, so that by his will everything will happen. (Rose)

Relationships between emotions and gestational diabetes mellitus

Here came the way in which pregnant women identify a possible relationship between emotional state and lack of glycemic control:

So it is a lot, it all affects a little, and when you ask me if I think that the psychological has to do with what I go through, for me it has everything to do, because when I am well psychologically I am well in everything [...]. (Orchid)
I think there is, because when you're upset like that, worried even the day the doctor said I had to be hospitalized, she went up there! (Tulip)

However, others demonstrate the non-relationship between emotional state and lack of glycemic control:

I don't think so. I don't see it. (Violet).
I don't know, I can't tell you. (Camellia).

The emotional aspects were also related to the self-perception of physiology and behavior:

There are times when I think it's emotional and there are times when it's like this, I ate a pizza and it didn't increase, I spent the whole night crying and she went to almost 300 (laughs). Then I think, is it really the emotional thing that is happening? I am fasting and I am high, I was angry, there it is, you know, this is on my mind, is it, is it not (laughs). (Rose)
I think this is more of my emotional control. I'm very nervous and when I get nervous I eat a lot, that's where I get a candy that is what calms me down, the chocolate (laughs). (Jasmine)

DISCUSSION

Considering experiences of a pregnancy with diabetes, an investigation showed that the diagnosis provided care for the disease, fear and guilt in regards of the use of drugs to control the disease and difficulty in understanding the consequences of the diagnosis in the medium and long term[16].

Another study showed that the diagnosis represented challenges and demands on pregnant women, in addition to an initial shock and subsequent balance[17]. In yet another study, there was a desire for care and attention in regards of the disease, as well as suffering and concern regarding the diagnosis, treatment and lack of care on the part of health professionals, as well as complaints about the lack of information about GDM for that population[18]. Such research agrees with the participants of this study when reporting anxiety, anguish, fear and concern for the baby. In the diagnosis, it was evident that diabetes is capable of promoting varied feelings and perceptions in each individual who finds out about the disease[19].

The diagnosis also stimulated reflections, challenges and demands of pregnant women. It was evidenced that the participants had difficulty in facing the unexpected changes resulting from the diagnosis, changes that are represented mainly by dietary restriction, distance from family and/or other children and changes in daily routine. These findings corroborate other findings about the challenges faced by self-care of diabetic pregnant women, in which initial shock at the diagnosis is expressed[19,20].

Other investigations point out: that the disease negatively impacts the lives of pregnant women[21], being able to change the family configuration and significantly change routine and habits of the pregnant woman and her family[22], possibilities of complications for the pregnant woman and the fetus, ignorance of ways of monitoring and treatment of GDM[19,23], which is in agreement with the research presented here.

Women with GDM tend to face difficulties in dealing with self-care, mainly related to dietary restrictions, in addition to feeling changes in sleep and rest resulting from pregnancy, as well as regretting changes in routine and practice of daily activities[24]. In this study, difficulties with food were highlighted, in agreement with a study that pointed out problems with dietary restrictions and the proper follow-up of nutritional prescription, related to changing habits, social support and difficulty in dealing with deprivations[25].

For the difficulties to adhere to the treatment of GDM, it is pointed out that it is necessary to raise awareness and encourage participation in educational programs, with a multidisciplinary team, and that these spaces can favor subjective aspects of becoming ill, in addition to the pathological condition[12]. Thus, the construction and maintenance of a new lifestyle must start from the idea that each pregnant woman is unique, being necessary to understand their social, affective and cultural context for adherence to treatment, favoring care[12,20].

In turn, the use of medications is recommended only in cases where excessive fetal growth or high glycemic control is observed[5,15]. Although therapeutic proposal used for the control of GDM is efficient, it does not exempt, in many cases, the need for hospitalization of the pregnant woman. This hospitalization can occur at various periods of pregnancy, due to the lack of glycemic control, being of paramount importance the monitoring of the pregnant woman by a multiprofessional team[6] that will seek to establish bonds of trust and security with the pregnant women, for attention and support to demands[20].

The pregnant women in this study showed common concerns related to food and the distance from family members and other children. A prolonged hospitalization can corroborate the manifestation of emotional conflicts and feelings of guilt, helplessness, tiredness and concern, mainly linked to pregnant women who have other young children who demand maternal care[9].

The feeling of guilt is linked mainly to the use of medications during pregnancy to control the disease[16]. In the changes that occurred as a result of hospitalization, the view of hospitalization as a possibility of rest is also noted, but also the impotence due to the lack of mobility during hospitalization.

Hospitalization can also economically influence the family unit, and the expectation about possible financial difficulties, which is also a factor of emotional changes[9].

Strategies with a focus on the problem were related to food, then turned to appropriate nutrition practices. And, strategies focused on emotion were linked to hospitalization as a form of self-care, valuing the hospital space as capable of promoting attention to the disease and moments of reflection on the illness. Other resources also highlighted as important, such as social/family support, expectations of care, escape/avoidance, such as strategies focused on emotion, and religiosity/spirituality, agree with other studies[9,22].

One study considered the support network and emotional support in facing diabetes mellitus by pregnant women, it was observed that the majority made use of strategies focused on the problem related to the care of the disease during pregnancy, following up with health professionals[22].

Regardless of the coping strategies used by the individual to deal with stressful events, the satisfaction and validation of the subject's response will depend, mainly, on his flexibility and his availability to change in the face of the stressful event. In addition, new conditions of great stress will require a new personal adjustment to the threatening obstacles[26].

Pregnancy with a disease, such as diabetes, seemed to provide special uniqueness in her pregnancy. Being evidenced signs of suffering before the context experienced[4]. The interviewees had several coping strategies that helped them to broaden their perception of illness and the need for care and self-care.

Regarding emotional aspects, there is an emphasis on the management of chronic diseases, because emotions can influence the stabilization and/or worsening of many diseases, as in the case of diabetes. In this sense, emotional support and the use of coping strategies are part of living and living with chronic diseases[27].

It is considered that emotions are also important in the care of chronic diseases, since they can possibly influence both the stabilization and the worsening of the disease[27], even considering that there was no consensus among the participants on whether emotional changes influence the glycemic control.

CONCLUSION

The diagnosis aroused feelings such as anxiety, anguish and fear, as well as difficulty in understanding GDM at the beginning, and identifying with the disease, as well as the challenges caused by changes in food and the period of absence from family members.

Strategies focused on the problem were represented by dietary changes, in order to adhere to treatment, while strategies focused on emotion were related to the performance of brief physical activities such as walking, talking about feelings and the experience of hospitalization as relief of anxiety.

Family/social support and religiosity/spirituality also corresponded to an important element to help with self-care and hospitalization experience. Emotions were related to changes in eating behavior, such as the constant desire for foods not included in the diet and the reflex in glycemic changes. However, there was no consensus that emotions are a determining factor for the lack of blood glucose control.

It is necessary to consider that this study explored only a portion of the population of pregnant women diagnosed with GDM, hospitalized for disease control, living in a municipality in the state of Goiás, such aspects may represent a limitation of this study, as it explored the perceptions of only six pregnant women hospitalized, therefore, the data are not subject to generalization.

However, the results found provided an important knowledge of the difficulties experienced by diabetic pregnant women during hospitalization and visibility of the perception of these women about being affected by a disease during pregnancy, their coping process, and even the changes triggered by hospitalization. Such findings represent knowledge in meeting the health needs of women with GDM.

The suffering caused by the experience of a pregnancy with diabetes could be minimized by providing information on the subject and supporting the health teams in valuing and embracing the insecurities, fears and uncertainties experienced during this period by pregnant women, which could promote more security and strengthening of pregnant women with GDM.

Also, it is important to invest in research with pregnant women experiencing conditions such as diabetes, which seek to favor forms of knowledge about the disease and its possible complications and, appropriate self-care strategies. The valorization of experiences and perceptions is intended to expand the possibilities of health teams to provide assistance, strengthening the performance in health, in a humanized and sensitive way to the impacts and adversities of a pregnancy with diabetes.

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Contributions
Maira Julyê Mota Fernandes contributed in the conception, collection and analysis of data, and writing. **Cintia Bragheto Ferreira** participated in the analysis of data, writing and revision.

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