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ORIGINAL ARTICLE

APPLICATION OF THE CALGARY FAMILY ASSESMENT MODEL IN THE HOME CONTEXT AFTER ENCEPHALIC VASCULAR ACCIDENT*

APLICAÇÃO DO MODELO CALGARY DE AVALIAÇÃO FAMILIAR NO CONTEXTO DOMICILIAR PÓS ACIDENTE VASCULAR ENCEFÁLICO

APLICACIÓN DEL MODELO CALGARY DE EVALUACIÓN FAMILIAR EN EL CONTEXTO DOMICILIAR TRAS UN ACCIDENTE VASCULAR ENCEFÁLICO

Fernanda Misawa Buzarelo[1]
Thamires Fernandes Cardoso da Silva Rodrigues[2]
Rafaely de Cássia Nogueira Sanches[3]
Anderson da Silva Rêgo[4]
Cremilde Aparecida Trindade Radovanovic[5]

ABSTRACT

Objective: to apply the Calgary Family Assessment Model in the home context in a family that lives with a person affected by cerebrovascular accident. **Methods:** This is a case study, qualitative, which used the Convergent Care Research and was anchored in the Calgary Family Assessment Model as a theoretical reference. Performed with a family that experienced the home recovery of one of its members affected by cerebrovascular accident. Fifteen meetings were held, being the first during hospitalization. Data collection was performed between February and June 2014, conducted with the patient and two relatives, recorded in digital media and later transcribed in full. For data analysis, a genogram and ecomap were constructed, as well as field journal data. **Results:** The construction of the genogram and the ecomap, strategies of the referential, allowed the understanding of the family relations, the interaction between the members and the social networks to support the family. **Final considerations:** The use of the model with the methodological framework enabled the family to help solve the challenges arising from daily care.

Keywords: Nursing Assessment; Family Relations; Stroke; Holistic Nursing; Community Health Nursing.

[1] Nurse. Master in Nursing. State University of Maringá (UEM). Maringá – PR, Brazil. E-mail: fermiss@bol.com.br
[2] Nurse. Doctorate student in Nursing. State University of Maringá (UEM). Maringá – PR, Brazil. E-mail: thamy_nutri@yahoo.com.br
[3] Nurse. Doctorate student in Nursing. State University of Maringá (UEM). Maringá – PR, Brasil. E-mail: rafaely.uem@gmail.com
[4] Nurse. Doctorate student in Nursing. State University of Maringá (UEM). Maringá – PR, Brasil. E-mail: anderson.dsre@hotmail.com
[5]Nurse. Doctor in Health Sciences. Adjunct Professor, Department of Nursing and Graduate Program in Nursing, State University of Maringá (UEM). Maringá – PR, Brazil. E-mail: kikanovic2010@hotmail.com

Corresponding author: Thamires Fernandes Cardoso da Silva Rodrigues. Address: Avenida Colombo, 5.790 - Campus Universitário - Bloco 002, sala 001, ZIP Code: 87020-900 - Maringá – Paraná – Brazil.

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RESUMO

Objetivo: aplicar o Modelo Calgary de Avaliação Familiar no contexto domiciliar em família que convive com pessoa acometida por Acidente Vascular Encefálico. **Métodos**: Trata-se de estudo de caso, qualitativo, que utilizou a Pesquisa Convergente Assistencial e ancorou-se no Modelo Calgary de Avaliação Familiar como referencial teórico. Realizado junto a uma família que vivenciava a recuperação domiciliar de um dos seus membros acometido por Acidente Vascular Encefálico. Realizaram-se 15 encontros com entrevistas, sendo o primeiro ainda durante a hospitalização. A coleta de dados foi realizada entre os meses de fevereiro a junho de 2014, conduzidas com o paciente e dois familiares, sendo gravadas em aparelho digital e posteriormente transcritas na íntegra. Para a análise dos dados, construiu-se genograma e ecomapa, bem como utilizou-se dados do diário de campo. **Resultados**: A construção do genograma e do ecomapa, estratégias do referencial, permitiu à compreensão das relações familiares, da interação entre os membros e as redes sociais de apoio à família. **Considerações finais**: O uso do modelo em conjunto com o referencial metodológico, possibilitou o auxílio à família para resolução dos desafios advindos no cotidiano de cuidado.
Descritores: Avaliação em Enfermagem; Relações Familiares; Acidente Vascular Encefálico; Enfermagem Holística; Enfermagem em Saúde Comunitária.

RESUMEN

Objetivo: aplicar el Modelo Calgary de Evaluación Familiar en el contexto domiciliar en familia que convive con persona acometida por Accidente Vascular Encefálico. **Métodos**: estudio de caso, cualitativo, que utilizó la Investigación Convergente Asistencial y se ancoró en el Modelo Calgary de Evaluación Familiar como referencial teórico. Fue llevado a cabo junto a una familia que vivenciaba la recuperación domiciliar de uno de sus miembros acometido por Accidente Vascular Encefálico. Se realizaron 15 encuentros con entrevistas, siendo que el primer ocurrió aun durante la hospitalización. La recogida de datos fue realizada entre los meses de febrero y junio 2014, conducidas con el paciente y dos familiares, siendo grabadas digitalmente y posteriormente transcritas en la íntegra. Para el análisis de los datos, se construyó genograma y ecomapa, así como se utilizaron datos del diario de campo. **Resultados**: La construcción del genograma y del ecomapa, estrategias del referencial, permitió la comprensión de las relaciones familiares, de la interacción entre los miembros y las redes sociales de apoyo a la familia. **Consideraciones finales**: El uso del modelo en conjunto con el referencial metodológico, posibilitó el auxilio a la familia para resolución de los retos advenidos en el cotidiano de cuidado.
Descriptores: Evaluación en Enfermaría; Relaciones Familiares; Accidente Cerebrovascular; Enfermería Holística; Enfermería en Salud Comunitaria.

INTRODUCTION

Cerebrovascular diseases (CVD) are the leading cause of morbidity and mortality in Brazil. Between 2005 and 2016, CVD accounted for 13% of hospitalizations in the country, representing 57.1 admissions per 100,000 inhabitants[1]. Among the pathologies into this classification, stands out cerebrovascular accident, with a 30-day mortality rate of 18.5% and a 12-month mortality rate of 30.9%, and the recurrence rate after one year of 15.9%[2].

People who survive the event suffer from functional disabilities, which alter daily life as well as quality of life. A study, developed in the northeast of the country, with 118 patients who were affected by cerebrovascular accident, identified that 37% had a moderate to high degree of dependence, and the most difficult activities were urination (73.8%) and evacuation (66, 9%)[3].

Its sudden event is characterized by a stressful event for both the subject and the family, which experiences changes that result in a process of family reorganization[4]. The transition phase from hospital to home care is the time

when the family needs to adapt to the changes that occur in its functioning and with the wider systems. This way, families play an important role in the care of dependent patients resulting from a cerebrovascular accident, becoming the main caregivers[5]. However, sometimes, they do not have the necessary preparation to assist people who demand care, resulting in physical, emotional and psychological distress for the care-giver[6,7]. In addition, health professionals often neglect guidance and social support to caregivers, exposing them to excessive stress, which can affect their health[4].

Understanding the family reorganization process enables health professionals to identify the group's real demands in order to minimize their desires and implement strategies with and for the family, valuing their potential and involving them in care[8]. In this sense, the Calgary Family Assessment Model (CFAM) proves to be an ideal systematized tool to be used. Because it allows a quality health practice, to increase the possibilities for care, making it more effective, providing quality of life for the family and the person affected by cerebrovascular accident [8,9].

The CFAM is based on the researcher's personal and professional experiences, as well as on his or her beliefs and relationships with the research partici-pant. It is a multidimensional structure, integrated and anchored in systems, communication and theoretical founda-tions, which seeks to identify the strengths and weaknesses of the family system[10]. Thus, the health team, recognizing the family reorganization movement after the cerebrovascular accident and its consequences, as well as the experiences and feelings experienced in relation to care, can direct care and minimize the suffering faced in this process of adaptation, contributing to promotion of general well-being[11].

However, there is a small amount of research that applied CFAM to identify and recognize families, especially in a primary care setting after hospitalization. And so there are changes in care, it is central the involvement of social actors and professionals in the practice of care[12]. Considering that the caring and dealing with problems is peculiar to each group, this study aimed to apply the Calgary Family Assessment Model in the home context to the family that lives with a person affected by cerebrovascular accident.

METHODS

This is a qualitative case study with the Convergent Care Research (CCR) as a methodological reference and is anchored in the theoretical framework of the Calgary Family Assessment Model (CFAM), extracted from the master's dissertation entitled *Experience of the family in the home care to the adult with incapacity due to a cerebrovascular accident: Nursing Intervention.*

CCR, which consists of the intentional articulation with the care practice[12], was adequate to the researchers' goal of monitoring the recovery and adaptation of the family after hospital discharge due to cerebrovascular accident. It is developed in the following stages: a) Conception - consists in the definition of the theme, these emerge from the professional practice of the researcher, verifying the professional experience, areas of interest and information available in the literature; b) Instrumentation - methodological procedures are defined, such as the choice of research space, the participants and the technique for collecting and analyzing information; c) Persecution - refers to data collection; d) Analysis - due to the complexity of the CCR, it may require the use of several analytical methods and techniques; e) Interpretation - it comprises three central processes that correspond to the logic of the analysis of its findings: synthesis, theorization and transference[12].

The search for the participants was given at the Regional University Hospital of Maringá by hospitalized patients due to cerebrovascular accident. The following inclusion criteria were adopted: families with a family member over 18 years of age, affected by the first episode of cerebrovascular accident, who had a

moderate, severe or very severe degree of dependence, identified from the application of the Mini instrument Dependence Assessment[13]. As for the exclusion, the criteria were: not to be resident in the study municipality, death of the family member who was ill, to have professionals care givers contracted and institutionalization of the person with illness. Initially, 22 families were approached; five met the eligibility criteria and accepted to participate in the study, however, one family requested their exclusion from the study after two home visits, claiming that they did not need to be accompanied by the researchers. Four families participated, however, for this communication, it focused on the events/outcomes of only one family unit.

The initial approach was also during hospitalization, at which time patient and family counselors were guided about the objectives and activities that would be developed during the research. After hospital discharge, visits and interviews began at home. The deponents were the main caretaker (wife), the sick person and one of the couple's daughter/son.

Interviews took place between February and June 2014, the family was followed up at least once a week for four months, totaling 15 meetings, with an average duration of two hours each. The visits were carried out by two master student nurses, through semi-structured interviews, alternated between recording and patient care, such as bathing, feeding, health orientations, among other activities. This period of follow-up was defined based on the fact that the first three months after the cerebrovascular accident were considered the most critical[14] and during this period the recovery gains were upward and minimize the existing sequelae.

The first visit happened one week after discharge, since the immediate period after hospital discharge is a phase of reorganization of the family unit for care, when many doubts arise. The first two meetings were aimed at promoting the rapprochement of the main researcher with the family and for the preparation of the genogram and ecomap. However, the data complementation occurred during the other meetings. After the construction of the figures (genogram and ecomap), they were validated by the family.

From the first meetings, the frequency of the next ones was defined according to the family's need. The main investigator provided guidelines for daily care, demonstrating how to perform procedures, and made available to the family through telephone service. The nursing assistance provided and/or guided was based on national and international protocols and the professional experience of the researchers.

The statements were recorded in digital media and later transcribed in full. The researchers made inferences and interpretations guided by the theoretical framework adopted for the construction of the structuring categories of CFAM, starting from the dimensions indicated by the transcribed material, as well as from the field journal. In the journal, the information obtained during interactions with the sick person and his/her family was recorded. These originated from the conversations during the meetings, from the observations of the researcher, as well as from all the activities carried out during the meetings. After each visit, the key points were immediately noted in the field journal, so as not to forget important events.

The data were analyzed according to the pre-established categories by the CFAM, being: family structure, development and functioning. This strategy is considered multidimensional and proposes to evaluate the family, based on the personal and professional life experiences of nurses, as well as on the beliefs and relationships with the participants[10].

The structural category evaluates the structure of the family, that is, members, affective bond between its members and its context. The most used instruments are the genogram and ecomap, which are useful for delineating the family's internal and external structures[10]. The development category refers to all transactional processes of evolution associated with family growth[10]. So that, one can identify and understand, through stages, what the moment of the vital

cycle the group is and thus, describe the its trajectory.

In the evaluation of the functional category, details are given of how members behave with each other in daily activities. It is a photograph of family life, observed and presented by itself. This evaluation covers two basic aspects: the instrumental and the expressive. The instrumental aspect of family functioning concerns the daily activities of the family, and in the expressive, the focus of evaluation as an interaction between all family members. Therefore, we chose to use CFAM, as it allows us to know the family in their environment, raise their needs and build care alternatives specific to each condition[10].

Study conducted in accordance with the guidelines of Resolution n. 466/2012, approved by the Standing Committee on Ethics in Research Involving Human Beings, under opinion no. 502,185/2013. The two family members of the study signed the Term of Free and Informed Consent (TCLE) in two copies of equal content, and the family member's TCLE was signed by the caregiver, due to physical limitations that prevented the person from signing it, however, it was consented and authorized verbally.

To preserve the identity of the participants, the family was named as a season of the year, as an analogy to the "seasons" of life, since everyone experience different phases and can be compared to the seasons of the year. The family under study went through periods of renewal, when life's obstacles forced them to seek new possibilities, just as in autumn, when the flowers and leaves dry and fall to give place to "the new", And so, each person participating in this research was identified with the name of a flower, these being specific to autumn.

RESULTS

Structural and development category

The Autumn family is an extended family, composed by five people: the couple, two children and a granddaughter. The children were about to leave home to start their own family or to live by themselves. The family lives in the same yard, with another type of family rearrangement, that of the Orchid daughter, widow, who lives with her daughter in the back house, constituting a single-parent family.

His father is Dragon flower, 58-year-old, dependent on care due to cerebrovascular accident. He lives with his wife, Rose, 53, a housewife and his main caregiver. The two have been married for 35 years and keep a relationship of great affection and mutual respect. The Mayflower son lives with the couple. He is a 26-year-old, a driver in a paint company, single, has an 11-year-old daughter, who has a distant relationship with his father (Mayflower). According to the reports of Rose and Dragon flower, the son faces problems with the use of licit and illicit drugs and, when it is under the effect of substances, he becomes violent, verbally attacking and insulting all the family members.

The oldest daughter is Orchid, 29 years old, has been working as a kitchen assistant, widow for three years, has a daughter, Daisy, six years old who spends part of her time at the grandparents' house. The family composition and its relationships are represented in the genogram below (Figure 1).

All family members, except the child, have chronic diseases. Dragon flower has complications resulting from cerebro-vascular accident, such as spastic gait, asthenia, dyslalia and memory loss. In addition, he presents as comorbidities Systemic Arterial Hypertension (SAH), smoking (from the age of five, when he smoked his first cigarette, influenced by his father), and polycystic kidney disease grade IV, with the possibility of initiating dialysis treatment (Figure 1). Rose has SAH, hypothyroidism and is a smoker, uses several continuous medications, however, does not perform periodic medical follow-up.

Mayflower also has arterial hypertension, is a smoker and a drug user for seven years. Orchid, the oldest daughter, has panic disorder, anxiety and insomnia and keeps a distant relationship

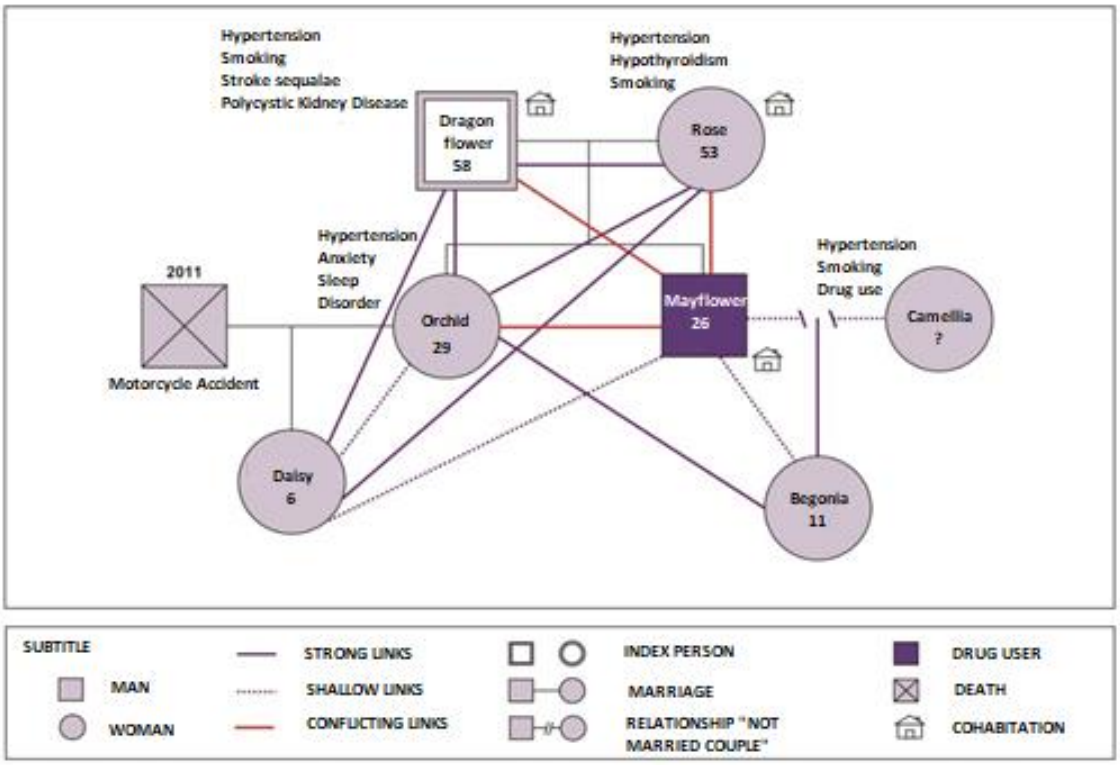

Figure 1 – Autumn's Family Genogram. Maringá-PR. 2014
Source: Adapted model of Musquim et al[15].

with her daughter, such a separation occurred after the husband´s death, in a tragic way (motorcycle accident). This event brought negative repercussions for Orchid, due to the constant sadness in her life. Always reclusive to talk as little as possible with the family group.

In the ecomap (Figure 2), it is highlighted the family nucleus and, around it, the nets of support and care that are part of the group's daily life after the illness of Dragon flower. The family has as care network: the university hospital which, in addition to emergency assistance and hospitalization, also followed Dragon flower after discharge; the hemodialysis sector of a private institution, where he began to be assisted by a multiprofessional team; members of the extended family, identified as allies, not only for the emotional support offered, but also for financial contributions. The participation of the couple and the son Mayflower in a support to stop smoking group; Daisy´s school; the closest friends and the religion, that besides the spiritual help, helped them with the expenses for the treatments.

Researchers, being nurses, also represented a source of physical and emotional health care for the family. According to Rose's report, the presence of the researcher at the time of returning home made her feel safer for the development of the care, mainly regarding the bath, administration of medication and feeding. In addition, the researcher carried out entertainment activities, which involved the family, such as educational games and music, aiming to provide a family moment.

Since the illness of Dragon flower, the couple has had financial difficulties. First, because the home provider is unable to perform his job duties, in addition to not getting the approval of the retirement. Second, because Rose cannot perform her activity as a seamstress, since she is directly involved with the daily care of the husband. In addition, it was mentioned the increase in expenses with the treatments required due to the cerebrovascular accident.

The interviewees reside in an area covered by the Family Health Strategy (ESF), however, Rose reported receiving

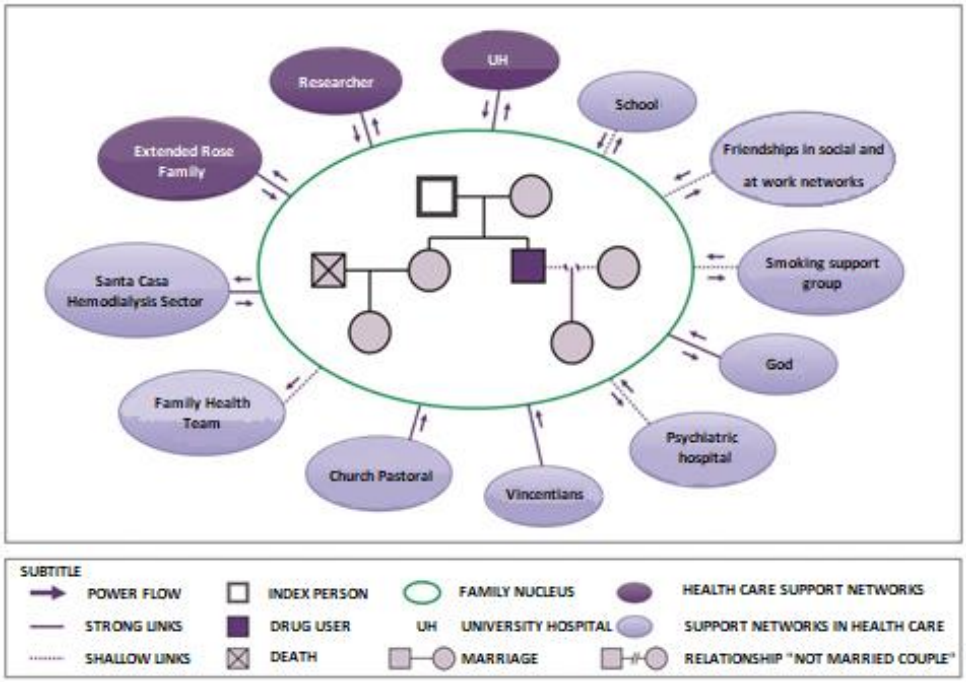

Figura 2 – Ecomapa da família Outono. Maringá-PR. 2014.
Fonte: Modelo adaptado de Musquim et al[15].

few visits from the professionals, finding it necessary a better support by them, due to the need for care of Dragon flower, turning out as a fragile bond between family and service.

Functional Category

As presented previously, Rose suffers from the accumulation of responsibilities in relation to the care of her family, so that this overload had repercussions on physical exhaustion, social isolation and financial imbalance, since she did not count on the children's assistance to take care of Dragon flower and for household activities. The overload of the deponent was intensified due to the difficulty or lack of communication with the children, their desires and feelings, mainly because the two had severe emotional disorders and neglected by themselves. It can be identified that all the members from the autumn family suffer from social isolation.

The group also must deal with the Mayflower's problems of drug addiction. Such situations have contributed to the development of health problems of parents. According to the reports of the couple, the day that Dragon flower suffered the cerebrovascular accident, "he got very nervous" after being attacked by his son. Nowadays, drug dependence is the problem that brings to greater concern. The family to "help" Mayflower, led him to an involuntary hospitalization. However, a few weeks after returning home, he went back to drug use, and was not followed up by the Alcohol and Drug Psychosocial Care Center (CAPSad) of the municipality.

It was also observed, the bonding, which was already strengthened before the process of illness, between Dragon flower, Rose and the granddaughter, Daisy. Since Daisy spends much of the day in the company of the grandparents and keeps a very close and affective relationship. However, it was observed the intensification of conflicts between the parents, Mayflower and Orchid, due to his brother's jealousy. Even in the face of all the adversities faced by the participants, they showed hope of renewing intrafamily relations and having a promising future for the whole group.

DISCUSSION

The results allowed to evaluate a family that experienced the cerebro-vascular accident, identifying the main

characteristics of its structure, development and functioning. It was found that this peculiar group dealt daily with complex issues that extrapolated the limitations coming from the cerebrovascular accident, such as drug dependence (licit and illicit), mental disorders, isolation, conflicts and distractions that bustle daily life.

These findings expose the primacy of family relationships, which can be evidenced in networks of affection and support, security, differences, rooting of values, customs and beliefs, externalized by conflicts, sorrows and rejection[16]. It should be noted that the links between the family and the support networks necessarily involve people who are closely and intensely related to the sick person, and the nuclei of abidance[10], those that participate in specific moments , with relationships of lower affective intensity, were not analyzed.

The Autumn family is in the stage of the children leaving home. However, although couples naturally assume that one day their children will leave them, more and more these expectations are not met. A study carried out in the main Brazilian capitals, with people from 18 to 30 years old, found that 51.5% still lived with their parents, especially in the 18-24 age group (65.1%)[17].

This way, it is important that the family reorganize the hierarchical primary functions performed by each member, adapting to the new roles of parents and adult children. This implies the renegotiation of emotional, financial and domestic commitments[7].

Another event that changed the structure of the family studied was the loss of one of its members in a sudden and violent way, which had a negative repercussion on all relatives, even on the mother-daughter dyad. According to the literature, mourning and sadness are deep in relation to deaths, and produce a sense of lack of reference, compromising the circle of primary relations, and even making it difficult to keep links between people][16].

In this sense, it is up to the nursing professional to be attentive to the groups that suffer from the mourning of loved ones, to identify possible dysfunctionalities that compromise the family frame, without, however, judging the behavior adopted, and if necessary, refer to the psychologist who is part of the ESF, through the Family Health Support Center (NASF). Considering that each one reacts to mourning in a different way. Helping them cope with suffering, and if necessary, engaging the other professionals that make up health teams, such as psychologists and occupational therapists, to re-establish the group's functionality.

Among all the problems faced by the participants, we highlight the dependence on licit and illicit drugs, which cause concern, suffering, health problems, and negative experiences, such as violence, mistrust and theft. The context of substance abuse, especially of the most vulnerable groups (pauperism, unemployment, illiteracy, among others), includes fear, threats to life, from drug dealers, experiencing small daily deaths, represented by thefts and lies, take in all people who live closer to the drug-addict[18].

It is also necessary to consider that drug dependence is characterized by a complex and multifactorial process, which includes stressful conditions, such as mental disorders, financial problems and an environment that generates high levels of anxiety, such as the process to becoming sick, which contributes to the susceptibility of drug use[5].

Sometimes, due to the desperation and the scarcity of information and resources, the families appeal to the involuntary and/or compulsory hospitalizations of their loved ones. It should be noted that Law no. 10,216/2001 allows these types of resources[19]. However, when analyzing the assumptions of this law, which include humanization, de-hospitalization, and recognizes as persons, those who have mental disorders and drug addiction. Involuntary and/or compulsory hospitalization does not guarantee them the right to life; on the contrary, it constitutes a violation of their right to health[20]. It is necessary that psychiatric hospitalizations be analyzed critically considering the needs

of the user. It should be noted that such steps cannot be punitive, but rather must be guided by a singular care, autonomy of the user and their relatives. And because of infringing the autonomy of the dependent subject, family ties may shudder, demanding professional support, in order to aid in the reconstruction of such relationships[21].

Also, observing the organization of the autumn family, we can observe the accumulation of activities associated with the main caregiver, resulting in physical, emotional and financial overload. This problem is frequently found among families who take care of a family member after cerebrovascular accident, since usually only one member is selected to take care of the sick person[4]. The literature points out that care-related overload is a complex construct, involving several aspects and consequences in the life of family caregivers[22]. These aspects are related to the development of physical symptoms and to the fatigue, difficulties and financial imbalance and of intrafamilial, social and occupational relationships, as well as psychiatric symptoms, use of psychotropic medications and social effects, so that the greater the limitation of the greater relative is the overload of the caregiver[4,23].

Merely the caring task already causes health problems for the caregiver, such as depressive symptoms or loneliness. In this perspective, health professionals should assist these people, as well as their own health demands, and with a view to health education, to solve doubts, guide them in how to perform care efficiently, avoiding adverse events and work-related injuries, rest and the need to pay attention to their own physical and mental health[4].

Regarding to the external structures, it was observed that the group under study has access to support devices, such as relatives nearby, some friends, school, health services and religion. These resources are important because they manage physical, emotional and financial support, social relationships, comfort and generate a sense of belonging[24]. It must be understood that the assistance of other individuals in the process of recovering the sick person is a strong element in the aid and problem solving[24], causing an improvement in the quality of life of all. Thus, it is necessary for health professionals to recognize the networks that each family has, expanding the strategies for the relief of tensions and sharing responsibilities.

Thus, one of the great working potentials in the ESF scenario is its ability to support and strengthen families to deal with critical situations, such as limitations resulting from cerebrovascular accident, in order to minimize overload and distress[25]. According to the public policies advocated by the Ministry of Health, the relationship between the ESF and the affiliated population is based on link building. In this way the teams must implement changes in health care, in front of the proposals of a care model, centered on the user[26].

However, it can be seen from the reports of the deponents that, the service is still offered in a fragmented way, focusing on curative interventions, which disregard the social and emotional demands of the subjects. To overcome this reality, a new frame of reference, based on ethical commitment to life, health promotion and recovery, is essential to guarantee access to the necessary care, bonding, co-responsibility with the user, integrality of the assistance and stable monitoring of the results achieved[27].

Another important coping strategy consists in the spirituality referred to by the couple, which strengthens them and helps them to maintain the desire to fight against their situation, even when in the presence of illness and distress. Through spirituality, internal conflicts can be alleviated, acting as a "bumper" against negative health impacts, as well as providing emotional relief and feeling of belonging to a group. This group, which does not make distinctions about race, gender, purchasing power, if limitations or not, sheltering them in fact[27]. This way, spirituality grants a unique comfort to the suffering imposed by chronic and/or stigmatizing diseases. In this framing, professionals need to recognize spirituality as a valuable tool in the

health-disease process, which cannot be ignored, but respected, because this encourages families to deal with such situations[28].

To this end, it is necessary to train more sensitive and empathic professionals to provide holistic and humanized care, with a view to the family unity, with all its complexity, recognizing the different family configurations, as well as their pains and suffering, respecting the culture, belief, behavior and current family rules[18]. Since only technical and scientific knowledge is insufficient to supply all the aspects that make up the human being and their relations [27].

As for the limitations, it is worth noting that he did not interview all the members who constituted the Autumn family, which would enrich such research with other opinions and perspectives. However, this study has substantial aspects to health science, especially to quality nursing care, because it anchors itself in a dense referential, such as the MCAF, that allows to glimpse and understand the multiple configurations of a family, with all its limitations and potentialities.

FINAL CONSIDERATIONS

The MCAF strategy allowed the evaluation of the family in its multidimensionality, understanding from the holistic view its structure, its development and its functionality in the face of the illness process, and thus, to help and strengthen it in the face of adversity. The elaboration of the genogram and the ecomap was able to identify family relationships and to understand the interaction between the members of the group and the networks of support for care.

It was also noted that the process of illness modifies, consolidates or weakens the bonds, resulting in psychosocial suffering for the group in general. It is understood that the family can be a care provider, but it needs to be assisted. It is up to the nursing professionals, due to their proximity to the population, and the characteristic of the care, to understand and to know the care reality unveiled, in all its complexity. So, to recognize which structures, relationships and tasks support the period of adaptation in which the family take on homecare, new understandings and solutions, to subsidize the holistic and humanized care of the nurse. As well as identifying the fragilities and potentialities of each family unit, stimulating it and orienting it in the search for more effective ways to promote its health, offering well-being and life quality.

It is suggested that future research develop strategies aimed at better monitoring families after hospital discharge of family members with disabilities from chronic diseases in the primary care setting. Essentially in the immediate period after hospital discharge, as this is a phase of reorganization of the group for care, which raises doubts, to improve care, to minimize negative charges and expenses with readmissions.

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