

ORIGINAL ARTICLES

DIFFERENT FORMS OF FAMILY CARE FOR ELDERLY IN CHRONIC SITUATION¹

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ABSTRACT

The study aimed to understand how the family rearranges to produce the necessary care to the elderly who live alone. This is a case study with a qualitative approach, using focal life story technique, operated by in-depth interviews. To organize and analyze the data we use therapeutic itineraries, drawing the path taken by the search for care by the elder and the family. This study highlights the places of elderly care, considering the fact the elder resides alone. The family participates in the caring process by through daily telephone daily, regular visits, and financially supporting the health care plan; there is also the presence of a relative in meetings with physicians, helping with general expenses and with the maintenance of the house, who become the main caregivers of the elderly. The way the elder and the family experience several chronic diseases that affect the first is so unique and dynamic, leading us to understand that the moment is more than just a chronic condition, but rather a whole situation of falling under a cycle of chronic illnesses. Thus, the observation of this experience allowed us to observe that this type of care generates the necessary attention required by the elder, even though there is no one residing, or even present most of the times at the same physical space. The formats of family care are highly personal, as they are produced and shaped according to their reality, with the daily lives of relatives, and the elder, based on the last one's needs.

Keywords: Aged. Chronic disease. Family.

INTRODUCTION

The family is the main source for caring of the ill person, which is capable to support the sick in a continuous, prolonged and extremely personalized manner, thus requiring intense reorganization of its daily routine⁽¹⁻²⁾. This caring produced by the family can be intensified when the relative is in a chronic condition.

The standard for chronic condition was first adopted by the World Health Organization; later, it was developed and amplified by Eugênio Vilaça Mendes (2012)⁽³⁾. Mendes' concept organizes the standard for chronic condition to events that can slowly evolve, presenting multiple causes that can vary from time to time, and do not present regular or predictable patterns, as seen in acute diseases. It is important to consider that each symptom can lead to others, thus resembling a vicious cycle. And if an acute condition can evolve to a chronic one, the last can also present

moments of acuteness, more or less exuberant, which can be interpreted in urgencies or emergencies. In this idea, a full range of events can be considered more than just as chronic diseases, including persisting infectious diseases, the conditions related to maternity and the perinatal period, the maintenance of health conditions using life cycles, the long-term mental disorders, the continuous physical and structural impairments, the metabolic diseases, as well as those health conditions characterized by illnesses accompanied by suffering, without being an illness described inside the biomedical standards.

In this complex confluence of factors that affect the health conditions, it is necessary that the ill person and the relatives search for other ways to face the new necessities that arose in their daily life, once the chronic condition does not only affect the ill, but all that relate to the person⁽⁴⁾.

The goal of this research comes from the confluence of factors, as the chronic condition can last for a long period in the life of a person before reaching

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the cure, or, which is most frequent, to be under control for the rest of the life of the sick, thus requiring an adaptation of the family daily routine to manage the new situation. For the health systems, the chronic conditions are a challenge, as they demand another format to organize and approach the necessities of continuous and prolonged medical follow up, as such conditions require in services and professionals, demanding from these an articulated network of actions and practices to help not only with the most preponderant acute diseases⁽³⁾. This implies in the production of more caregiving practices, and less interventionist ones, for the control of the condition⁽²⁾.

It is also necessary to think this is even a bigger challenge to the elder population, once more and more the population is aging, increasing the chronic diseases, to a point that 79/1% of Brazilians aged 65 years or above present at least one of them⁽³⁾. Therefore, aging can be placed as a predisposing factor to the increase number of health issues, especially in the outcomes of chronic conditions, despite aging is not a decisive element for such results.

However, if we can reanalyze the standard set for chronic condition – previously mentioned in this study⁽³⁾, in which different cycles of life also are conditions that require attention from services and professionals, the load of chronic aggravations that elder people add to the other preoccupations of the ill person and the family in the last one's routine, which need to be managed to deal with all the other situations in life. Hence, the ill person and each member of the family develop singular ways to experience such events, creating their own ways to live life⁽¹⁻²⁾.

Such singularity was observed in the experience with a 79-year-old lady and her family, participants of our study, which despite there was an illness and many chronic aggravations, was active enough in her own way to live life, with her own dynamics, being supported by her sons and her son-in-law, who respected her desire to have "her own home", making us reflect other concepts of being an elder and falling ill. Therefore, the family in this study, because they did not reside in the same physical space as the elder, has many arrangements in their daily lives to provide care to her many necessities.

This situation, which seems more and more frequent in Brazil, was shown in a study with elders that live alone, highlighting the importance to understand the support networks and family arrangements built so these elders can have some quality of life⁽⁵⁾. Therefore, the aim of this study was to

understand how the family rearranges its routine to provide the necessary care to the elder person who lives alone, and has concomitant chronic aggravations.

METHODOLOGY

This is a qualitative study, with the "situation study"^(6,2672) approach, a method that is considered more suitable, as it enables to deepen the understanding of the situation, and in a context of life specificities and the caring of an elder person by her relatives, it gives "relief to the sinuosity of the relationships of the many established orders throughout the time, specially those with intense affective load".

To apprehend the family experience, it was used the life story, handled with in-depth interviews, a methodological strategy that permits a profound comprehension of caring and illness experience. Such experience is reported connected to the many other happenings of the daily life; it also allows to apprehend the way the elder and her relatives interpret and give meanings and reasons to this experience, as it was established as a conversation for research purposes⁽⁷⁾.

The participant of this study is Ms. Mocinha, an elder with 79 years old, suffering several concomitant chronic aggravations, among those arterial hypertension; resident in the city of Cuiabá, Brazil. As there is a focus to comprehend the way the family organizes itself to take care of the elder, the members of this family were also included, such as the youngest daughter, Ana, and Ms. Mocinha's son-in-law, Carlos, as they are the main caregivers. The interview occurred in four meetings between February and August 2011, at the residence of Ms. Mocinha, with the presence of Ana and Carlos.

The criteria of inclusion of the participants of the research are consonant to the matrix research in which this study is linked, and they are: being a person under chronic condition and the relatives that have used any legal proceeding for at least one year to guarantee the right for healthcare services. The preference to be an elder person with an aggravation of arterial hypertension is justified by the accelerated aging of Brazilian population, and because of epidemiological importance of such aggravation in this section of the population⁽⁸⁻⁹⁾.

The *corpus* of analysis was composed by the integral transcription of the testimonies of the four meetings, as well as the field observations, which included informal conversations with the participants,

the ways of telling the elements of analysis and their modulations in the diversity of the oral and body language, including gestures, and the affection, as well as the context of life and the formats how the relationships among the members of the families are expressed. All the information gathered was registered in a research diary⁽⁷⁾.

As a strategy to organize and analyze the data, the design of the path followed by the elder and her family to search for care, as an analytical tool, which enables to understand the sickening experiences of people and families, and their ways to produce meaning and the necessary care⁽⁹⁾. By drawing the path followed, it was evident the different “places” of care of the elder, as in the story of Ms. Mocinha, care is not located in geographical space, either at her home or at the house of her sons, but in fact, in the way of organization of her daily life, and in the many multiple family reorganizations.

With a careful reading of this great and rich *corpus*, it was possible to visualize the axis direction “family’s way of caring”; which include two categories: a) “Who takes care of Ms. Mocinha”; b) “How is Ms. Mocinha taken care”. To better organize, and make the explanation better understood, these two categories were presented and analyzed as a whole, considering their importance in the life of the elder and the family.

All ethical standards were followed during the research, including the signature of the Free and Clear Consent Agreement (FCCA) by the interviewees. The matrix research in which this study is linked was previously approved by the Committee of Ethics of the College Hospital Julio Müller, under protocol 671/CEP-HUJM/09.

Analysis and discussion

Ms. Mocinha had four children: Alceu, the first-born, Anelice, Anelita – deceased – and Ana, the youngest; all live in nearby districts around the residence of the elder; however, Ana is the one who lives closer, living on a closer district than the others. The elder has many different chronic aggravations, such as arterial hypertension, dyslipidemia, labyrinthitis, and because of a fall that occurred two years ago, some difficulty in walking. Such aggravations have occurred for the past twenty years, in a complex sequence of synergy due to their concomitances.

The representation below demonstrates both the places of residences and care by the family, which here will be called “places of care”, as well as the paths used to find professional care to Ms. Mocinha, covered by

her family, giving more emphasis to the logics that motivated this search; therefore, these are the elements explored in the discussion to be presented hereafter.

The illustration presents, in the center, the two main “places” of care by the family, which are the house of Ms. Mocinha and the residence of her youngest daughter and Ms. Mocinha’s son-in-law, Ana and Carlos, as these are important elements to understand the way how the family organizes itself to take care of the elder. It also provides a focus into the services and the professionals used throughout the past twenty years of sickness, being possible to observe the temporal sequence of the search, following the numbered arrows.

In the beginning of the field work, there were questions how an elder could live alone in her own house, despite the number of aggravations that she suffers and that can be analyzed as factors of fragility, amplified by her advancing age. Once the researchers learned the case, the elder and her family, it was possible to understand this format of organization of the spaces of daily life, based on care, as it preserves important elements in her way of living.

Hence, one of the ways of caring performed by Ana is the daily telephone calls to Ms. Mocinha (Image 1, arrow B), in which she uses to have a constant follow up of her mother’s health status. For the elder, the calls are a way to ask her daughter for assistance when needed, as it is also interpreted as a guaranteed way to have a close relationship between daughter and mother: “*Whenever she needs something, she gives me a call*” (Ana). It is also how the other sons make themselves present in the elder’s daily life, as they live further than Ana, and visiting their mother is not possible on a daily basis, besides these calls also help to demonstrate affection. Weekend rides and frequent visits are other formats the sons have to make themselves present in the routine of Ms. Mocinha:

“Sometimes, the girls take me to their homes [...] he [her son] comes here and we have lunch together”.

This intense affective exchange sewed in the routine activities and the caring accent present in the testimonies of the elder, when referring to her sons, who on their side demonstrate that if it is the choice of their mother to live alone, it does not mean she is unsupported or lonely. In this sense, this study demonstrates that, even living alone, elders can have a certain level of family care present in their lives, especially with the support of their sons, such as in the case of elder women who live alone⁽⁵⁾. This presence

does not mean it is necessarily physical, such as in the case of Ms. Mocinha:

"Because of everything that is needed to be done! Every son has his own family, his own routine... They have to take care of their own business! Right? But

they still have some time for me! Thanks be to God!"; the same situation was reaffirmed by her daughter: "Because she lives by herself; but we never let her down, you know?" (Ana).

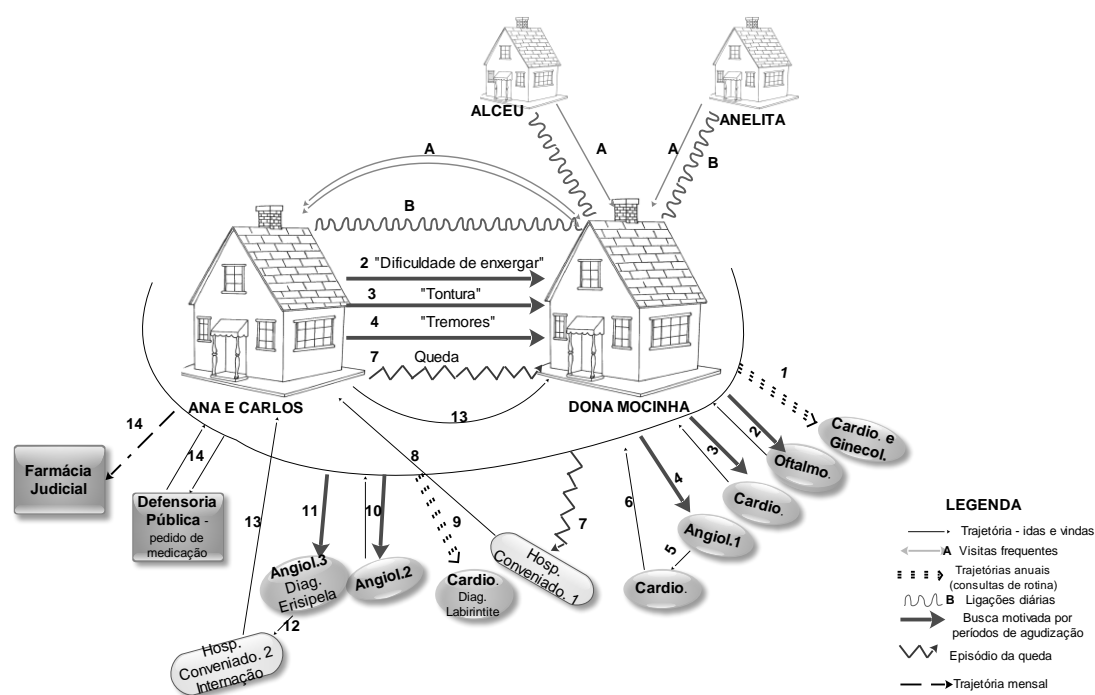


Image 1 - "Places of care" visited by the family, and the paths used to find professional care for the elder person by her family, 2011.

Another way the sons found to organize the caring of the elder was paying for her healthcare plan in a cooperative medical care:

"It's shared, you know? And then each one pays one part. [...] Each one of them pays a part of the monthly bill. This is because I can't afford it" (Ms. Mocinha).

When the path used to search for care was highlighted in Image 1, it was possible to absorb the importance of the support given by the healthcare plan offered to the elder and her family, as by the concomitance of aggravations she has, the search for health professionals of various specialties is considerably intense. An example of this search was when two different angiologists were sought to solve an edema in Ms. Mocinha's leg (Image 1 arrows 10 and 11); when searching for a trusted cardiologist who supports the elder for twenty years and is sought for both annual routine consultations (Image 1, arrows 1 and 9), as well as in other situations, when Ms. Mocinha presented dizziness, and later, shaking

(Image 1, arrows 3 and 5). At the same time, the search for a hospital covered by the healthcare plan (Image 1, arrow 12) for hospitalization, during a period of twenty-nine days, due to erysipelas, diagnosed by one of the angiologist visited.

The decision to acquire a healthcare plan (or other ingredients) generates a significant burden in family budget, particularly from those originated from the expenses with medical consultations; and because of that, it usually involves the participation of the members that do not share the same residence of the ill person⁽¹⁰⁾. This is the case of Ms. Mocinha, being the division of the monthly healthcare plan bill among the sons a way to not overly encumber one or another, and at the same time, having the guarantee of care by a health professional when needed. It was also considered over the use of public free healthcare service due to the agility of the private support over the public one:

"And it is faster for those in need [commenting over the healthcare plan]" (Ms. Mocinha)

It is important to highlight that the many visits to health professionals are also a type of caring, once it demands an active movement from the family members. This occurs due to the fact that inside the network of health services and professionals that belong to the supplementary health system, which is the case of the health cooperative, there is no organized and programmed follow up of the ill person. It is perceived that the professionals are limited to some punctual interventions when there is any episode of intensification of the general health status, despite the fact the patient is an elder person who presents several other concomitant chronic aggravations, just as Ms. Mocinha. The time spent in this follow up could be configured as a caring longitudinality, which is a regular health support by specialized health professionals, in a mutual relationship, so dear to the treatment in chronic conditions⁽³⁾.

The punctuality of professional care demanded by the family each time the elder requires attention can be observed from the analysis of Image 1 (arrows 3, 4 and 10), when expressing not only the sequence of the search, but also the professionals and services searched, which are in a great number. When observing the directions of the arrows in Image 1, they most commonly point from the family to the health services and professionals, thus evidencing the direction and determination of each path used to search for healthcare support, then leading to the conclusion that the family is the one responsible for the caring process, specially if taken into consideration that it is the family who gives the organicity to the assistance given by the different health professional sources and spaces⁽¹¹⁾.

In regards to the daily care provided to Ms. Mocinha, Ana, and her husband Carlos, who despite living in a nearby district, they need to get organized to support the elder, and perform them. Image 1 evidences that there are two main "places" of caring, demonstrated by the picture of the two largest houses, thus showing that, despite being located in different spaces, are effectively bonded together. Therefore, when facing any direct necessity of care required by Ms. Mocinha, Ana and Carlos visit the home of the elder:

"We would get off from work and take her! [...] Whatever is necessary to be done to help mother we do it!".

As it is possible to conclude from the affirmation by Ana is that there is a personal and professional cost for the caregivers, who have to "get off" their

workplace to take care of Ms. Mocinha, whenever there is an urgent need for such support. And this caring is being molded everyday, according to the situations experienced by the family.

This care intensifies after the episode of the falling (Image 1, arrow 6), when she spent fourteen hours left on the floor of her bedroom on a cold day; taking care of her is much more concerning:

"Taking care of her, for starters, we never though she was going to fall someday (Carlos)"; in which Ana reinforces the statement, by saying "We NEVER imagined she was going to fall someday! NEVER." Fearing for another fall, due to the fact Ms. Mocinha was complaining about frequent dizziness at the time, Ana and Carlos decide to ask her to stay in their house for a certain period (Image 1, arrow 8):

"She spent the whole night [at the hospital] and then, early next day we came! That was the time she spent with us in our house. She didn't even come here [the residence of the elder]!" (Ana)

After some time, Ms. Mocinha starts to present an edema on her left leg, and the family searches for vascular specialist physicians (Image 1, arrows 10 and 11), later with a diagnose of erysipelas, forcing the elder to be hospitalized for twenty-nine days for treatment (Image 1, arrow 12). During her hospitalization, the family gets organized, taking turns, so there is always one member present at the hospital, making company to Ms. Mocinha.

After this period of hospitalization, the elder goes to live with Ana and Carlos, where she stays to seven months, for a full recovery. The decision of both Ana and Carlos to move Ms. Mocinha back to her own residence calls attention to the meaning of the place of care and its organization. It is possible to perceive, in the testimonies, that the daily care provided to Ms. Mocinha is intense and is necessary to have it in different spaces and different formats. Hence, it is understood that the residence is not only an static and physical structure, but also a dynamic space, a belonging one, where the elements can be rearranged when events occur and mobilize the family members, such as an illness⁽¹¹⁾. Because of that, in the story of Ms. Mocinha, it seems that there is no specific geographical space in which the care takes place, as the family is organized to give attention to de elder, despite being in separated places, but always trying to have "her own house" as the "space of living" and of being taken care.

There is an agreement with the affirmation that the family is a health care system, an which there is a

dynamic unit that presents a process of the singular and self-centered care, which occurs when there is an interaction between the health state of its members, taking decisions about the health and the disease of these individuals; therefore, the act of care occurs on a regular basis, as a reciprocal attitude⁽¹²⁾. Therefore, care can occur in different physical spaces, or when needed, in a single place, such as seen in the moment that Ms. Mocinha spent a long time at the residence of Ana. It is understood, as described by the testimony of the elder, that being taken care of in her own residence or at her daughter's house did not represent any difference for her, as she also feels "at home": *"It was the same thing as here [Ms. Mocinha]."* It is possible to learn that the relationships are established among people, who provide a meaning to the space of care, making it effective, and not the opposite. The decision to respect the will of living by herself, as Ms. Mocinha requires, is also a way to take care: *"At her place she is... free! [Ana]"*

After the episode of the fall, Ms. Mocinha started to use a cane to support her walking pace, and then the care required is more intense, which also include home chores. This care is performed by Ana, and her niece, Mariana: *"On Saturdays, Ana comes, or Mariana, and they do it [to clean the house]! (Ms. Mocinha)"; "I do the whole thing! So she [her mother] doesn't have anything to do! (Ana)."*

These different formats of care of the elder person are barely seen by health professionals, who consider as caring activities performed by the family or other caregivers only those related to hygiene, nutrition, ambulation, the administration of prescribed medication, among other of this nature, which are most of the times included in the evaluation of functional capacity for self-care^(13,14). Considering that manuals contribute to an important manner to apprehend the necessity of the care demanded by the elder person; however, it is necessary to amplify such comprehension with other studies that demonstrate the routine of family care in other dimensions, more subtle, and because of that, less noticeable.

Hence, it is possible to see that Ana and Carlos are the most common caregivers of the illness story of the elder, as they are a couple that daily demonstrate efforts to combine their work routine, the necessities of their own residence, and their free time is spent to fill the necessities of Ms. Mocinha's multidimensional care requirements. As such, the designation of care is

here being used in its broader sense, as the basis for living: *"Anything happens I just need to call her [Ana] (about Ms. Mocinha)."*

The idea of a "more present caregiver" seen in the story of this family embodies a considerably concrete experience to be developed into the concept of "main caregiver", presented in the Manual of the Caregiver of the Elder Person⁽¹³⁾, in which describes that this person is daily responsible for the sick elder, thus supporting this person's necessities, protecting the elder's physical comfort, safety and well-being. This study focuses on the multidimensions of the caregiver, which the previous concept is unable to demonstrate.

However, as it was previously demonstrated in this study, the family provides much more than the direct care, needed due to the chronic and acute aggravations experienced by Ms. Mocinha; they also offer her all support she needs to live alone, which potentiates the ability of her self-care. According to what was apprehended in the observation of the way of living of the elder during the field work, despite the support in the daily routines, such as personal hygiene and the time for medication, there is a great number of "small and invisible care practices" that permit her to live her own life, at her own residence, in her particular way, with follow ups when going to physicians' appointments, with eventual trips, when going shopping, cleaning the house, among others.

The concept of caregiver described in the practical guide of the caregiver of elders was built based on the situations in which the elders have limited or impaired capacities of self-care. Then, the idea that the caregiver is a member of the family or member of the community who takes care of another person, indifferent of the age, who required attention because is bedridden, under a physical or mental struggle⁽¹⁴⁾. But if understanding the family caregiver as the one who takes for him or herself the responsibility to take care of an ill person, in a diversity of possible formats of care, in which can be observed in the case of Ana and Carlos, who assume the holistic care required by Ms. Mocinha as the main priority of their own lives: *"We spend this time with her because we want HER health [emphasis]! And so we don't care anymore with the other side [the financial one]! [...] And it is because of that that we even quit some jobs! (Carlos)."* This idea, of caregivers of elder people, presented by Ana and Carlos demonstrates another way to consider such concept, as it was possible to observe, they fulfill all the necessary conditions so that the elder can have means to live her own life, in which this "provision of

conditions” permits Ms. Mocinha to achieve the most elevated potential of self-care, more than the expected from an elder at the same age and health condition.

It is possible to perceive that the way the elder and her family experience the many chronic aggravations that she faces works in a singular manner, giving Ms. Mocinha and her relatives other senses, depending on how it affect their daily routine. Thus, in the concept of the situation of chronic illness^(15,16), it seems more interesting to understand the experience of concomitance of chronic aggravations by Ms. Mocinha and her family, and therefore, this nomenclature was used in this present research. It is also important to add that self-care is performed based on the elder’s potential, despite the fact she has some physical limitations, of different intensities, including the dependence of her overall health condition. In this matter, there is an agreement with some authors^(17,325) who affirm that the concept of “incapacity is mostly a social construction, as not all people with some physical impairment are unable to perform tasks”; and based on that, “it is more than simply an impairment, it is the meaning that the society imposes to such state, as well as its level of dependency”, drawing the lines separating impairment and self-care.

The care provided by the family has its own dynamics and interactivity, not closed to a certain unidimensionality, linearity, and fragmentation, but on the other hand, it can be configured in a complex system as “a relative phenomena that links/relinks, transforms, keeps, or produces the happenings, the components and the individuals.” It is given by “the action/negotiation/deliberation of the caregivers through the necessities raised, normalized or not, or of many other solicitations required”^(18,74). Then, “it can be apprehended, misapprehended, transmitted, and shared despite being unique, particular, and singular, however in non-isolated moments, spaces, and movements among the multiple situations of the social living”.

The multidimensional care performed by Ana and Carlos has led the researchers to think it as inherent to the own process of living of the human being in his routine, transposing the limit, aiming to keep or improve health. Care, as it is, assumes a holistic and integrative perspective of the countless dimensions of life, so that the assisted person can make use of possible potentials of self-care, which is not directly determined by the health status. Therefore, when considering the family as the main nucleus of caregiving, it has to be interpreted that it does not only

take care of the health conditions of the elder, but also worries about this person’s well-being and happiness. And to make sure this care is fully provided, in which the conditions are not clearly established, but are under construction on a daily basis and internalized by the family dynamics, thus generating their own format of care⁽²⁾.

FINAL CONSIDERATIONS

The approximation of the chronic situation experienced by Ms. Mocinha and her family, which enable the researchers to observe how these individuals provide the needed care to the elder, even if they do not reside in the same physical space as Ms. Mocinha. The several chronic aggravations experienced by the elder differs the care potential the family provides. This potential is directly linked to the potential of self-care that the elder is able to achieve, despite her physical limitations, showing that self-care does not necessarily depend on the person’s full “functional capacity”, as the elder has adapted herself to her reality, taking care of herself in a very particular way. The sum of all these potentials – the elder’s, with her own processes of self-care, and the family – permits that the last gets organized and reorganize their daily lives to answer the necessities of the elder, even though there is no one single residence for both sides.

The ways of care are personalized, as they are produced and modeled according to the reality, with the routine of the members of the family and the elder, according to her needs. Because of that, in this study, the caregiver was seen as the person that performs the care of many different formats, not only those related to the biological aspect, as this diversity also include the many necessities of the elder and her family.

Not residing in the same space as the elder is also interpreted in a format of care, as it enables the elder to develop her own potentials of care, always supported by the family when needed, despite respecting the will of the elder, demonstrating that family care is not focused only with her biological health of her organs and limbs, but with her general well-being and happiness. As a conclusion, this study demonstrated there is no specific place to perform family care, once care is intrinsic in this family relationship.

DIFERENTES MODOS DA FAMÍLIA CUIDAR DE PESSOA IDOSA EM SITUAÇÃO CRÔNICA

RESUMO

O estudo teve por objetivo compreender como a família se reorganiza para produzir os cuidados necessários à idosa que reside sozinha. Estudo de caso de abordagem qualitativa, utilizando a história de vida focal, operacionalizada pela entrevista em profundidade. Para organização e análise dos dados utilizamos uma das ferramentas do itinerário terapêutico, o desenho da trajetória de busca por cuidado empreendida pela idosa e família que, neste estudo, evidenciam os espaços de cuidado da idosa, pois esta reside sozinha. Assim, a família cuida e se faz presente no cotidiano da idosa através de ligações telefônicas diárias, visitas constantes e custeando seu plano de saúde, além de acompanhar em consultas, ajudar nas despesas e manutenção da casa, sendo estes últimos realizados fortemente por uma filha e seu genro, constituindo-os cuidadores principais da idosa. O modo da idosa e sua família vivenciar a experiência de diversos agravos crônicos que acometem a idosa se dá de maneira singular e dinâmica, levando-nos a compreender mais do que uma condição crônica, mas sim, uma situação de adoecimento crônico. Assim, a aproximação desta vivência de situação crônica nos permitiu observar que esta produz o cuidado necessário a idosa, mesmo que não residam, na maior parte do tempo, no mesmo espaço físico. Os modos de cuidar da família são personalíssimos, pois são produzidos e modelados de acordo com sua realidade, com o cotidiano dos membros da família e da idosa, mediante suas necessidades.

Palavras-chave: Idoso. Doença crônica. Família.

DIFERENTES MODOS DE LA FAMILIA CUIDAR DE LA PERSONA MAYOR EN SITUACIÓN CRÓNICA

RESUMEN

El estudio tuvo como objetivo comprender cómo la familia se reorganiza para producir los cuidados necesarios a la anciana que vive sola. Estudio de caso con enfoque cualitativo, utilizando la Historia de Vida Focal operacionalizada por la Entrevista en Profundidad. Para organización y análisis de los datos utilizamos una de las herramientas del itinerario terapéutico, el diseño de la trayectoria de la búsqueda por cuidado realizado por la anciana y familia, que en este estudio, muestran los espacios de cuidado de la anciana, pues esta vive sola. Así, la familia cuida y está presente en el cotidiano de la anciana a través de llamadas telefónicas, constantes visitas y en el pago de su plan de salud, además de acompañar en consultas y ayudar con los gastos y el mantenimiento de la casa, siendo estos últimos realizados estrechamente por su hija y su yerno, que constituyen los principales cuidadores de la anciana. El modo como la anciana y su familia vivencian la experiencia de varias situaciones crónicas que afectan a la anciana se produce en forma única y dinámica, que nos lleva a comprender la experiencia de más de una condición crónica, sino una situación de enfermedad crónica. Por lo tanto, el enfoque de vivenciar esta situación crónica nos permitió observar que se produce el cuidado necesario a la anciana, mismo que no vivan, en la mayor parte del tiempo, el mismo espacio físico. Los modos de cuidar de la familia son muy personales y modelados de acuerdo con su realidad, con la vida cotidiana de los miembros de la familia y la anciana, conforme sus necesidades.

Palabras clave: Anciano. Enfermedad crónica. Familia.

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