

Arterial hypertension in the family: the need for family care*

A HIPERTENSÃO ARTERIAL E A FAMÍLIA: A NECESSIDADE DO CUIDADO FAMILIAR

LA HIPERTENSIÓN ARTERIAL Y LA FAMILIA: LA NECESIDAD DEL CUIDADO FAMILIAR

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ABSTRACT

This qualitative study was performed from March to July 2007 in the city of Maringá, Paraná State, Brazil, and aimed to understand the family's experience with arterial hypertension (AH), using Grounded Theory as the methodological framework. Informants were 14 families that live with different AH stages. The data were obtained through open interviews. The results showed that family participation is an important factor for disease treatment and control, and that this action is differentiated when individuals present some sort of dependence. If dependence occurs, there is caregiver overload; when dependence does not exist, family participation is sporadic, being limited to helping the patients in the drug treatment and accompanying them to the medical appointment. In some cases, other family members present habit changes relating to food and practicing physical activities. The results reinforce the need for family-centered hypertensive patient care.

KEY WORDS

Hypertension.
Family.
Health home-care.
Caregivers.

RESUMO

O estudo, de caráter qualitativo, foi desenvolvido no período de março a julho de 2007, em Maringá – PR, com o objetivo de compreender a experiência da família com a hipertensão arterial (HA), utilizando a *Teoria Fundamentada nos Dados* como referencial metodológico. Os informantes foram 14 famílias que convivem com diferentes estágios da HA. Os dados foram obtidos por meio de entrevistas abertas. Os resultados revelaram que a participação da família é um importante fator para o tratamento e controle da doença, e que esta atuação é diferenciada quando o indivíduo apresenta alguma dependência. Se ocorre dependência, há sobrecarga do cuidador; quando esta não existe, a participação da família é esporádica, resumindo-se em auxiliá-lo no tratamento medicamentoso e acompanhá-lo em visitas ao médico. Em alguns casos, outros membros familiares apresentam mudanças de hábitos relacionadas à alimentação e à prática de atividades físicas. Os resultados reforçam a necessidade de uma assistência ao hipertenso centrada na família.

DESCRITORES

Hipertensão.
Família.
Cuidados domiciliares de saúde.
Cuidadores.

RESUMEN

El estudio, de carácter cualitativo, fue desarrollado en el período de marzo a julio de 2007, en Maringá – PR, con el objetivo de comprender la experiencia de la familia con hipertensión arterial (HA). La *Teoría Fundamentada en los Datos* fue utilizada como marco metodológico. Los informantes fueron 14 familias que conviven con diferentes niveles de la HA. Los datos fueron obtenidos por medio de entrevistas abiertas. Los resultados revelaron que la participación de la familia constituye un importante factor para el tratamiento y control de la enfermedad y que esta actuación es diferenciada cuando el individuo presenta alguna dependencia. Si ocurre dependencia, aparece una sobrecarga para el cuidador; cuando esta no existe, la participación de la familia es esporádica, resumiéndose a auxiliarlo en el tratamiento medicamentoso y a acompañarlo en las visitas al médico. En algunos casos, otros miembros familiares presentan un cambio de hábitos, relacionados a la alimentación y a la práctica de actividades físicas. Los resultados refuerzan la necesidad de ofrecer una asistencia al hipertenso centrada en la familia.

DESCRIPTORES

Hipertensión.
Familia.
Cuidados domiciliarios de salud.
Cuidadores.

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INTRODUCTION

In recent times, family-related issues have been debated in several social areas and contexts. The health field is not an exception and family-oriented works have been one of the most discussed and meaningfully studied strategies in academic circles.

In such a context, family is presented, represented and re-presented by distinct definitions, notions, concepts, types, and attributions, and can be dealt with under different theories⁽¹⁾. Family structure transformations and reorganizations are also broadly discussed, since the nuclear-based, still hegemonic family model has been undergoing a change process, in spite of not being able to re-ordain their members' behaviors yet⁽²⁾.

Besides being a space that replenishes people with protection, and in which members have a sense of belonging to a united group that provides them with ties of love and affection, family has also been defined as a health system to its constituent members⁽³⁾. Whenever family feels fragile under a disease situation, they apply cultural knowledge and values, beliefs and practices as a guideline aimed at maintaining its components' welfare.

Confronting diseases in family environments depends upon some factors, such as the family's life framework, the role performed by the ill member, the implications of the illness impact in each of the family members, and family re-alignment all through the ailment period⁽⁴⁾.

Chronic disease conditions show that, depending on the degree of gravity people assign to the situation, a number of re-arrangements might be brought about, or not, to the family environment⁽⁵⁾. When the condition is asymptomatic, such as arterial hypertension (AH), changes are close to zero initially; however, they become more and more intense when the patient's health status worsens, especially when any sort of dependence occurs, a situation that requires reframing each and every member's roles.

AH is a serious public health problem in Brazil and in the world, a massive source of economic, social and life quality hassles. The illness is deemed as one of the most relevant risk factors for the development of cardiovascular, cerebrovascular, and kidney-related diseases, accounting for at least 40% of deaths by cerebrovascular accident, 25% of deaths by coronary arterial disease, and 50% of terminal kidney disease⁽⁶⁾ when combined with diabetes. Among aggravation processes, cerebrovascular diseases are considered as the most frequent ones, those which most produce physical sequelae, and consequently the ones that demand stronger family support regarding care giving processes.

AH is defined as a systolic arterial blood pressure (SAP) of =140 mmHg and a diastolic arterial blood pressure (DAP) of = 90 mmHg for individuals who are not taking medica-

tions for hypertension. Depending on the scores presented by pressure, AH is classified as follows: Stage 1 AH is defined as a SAP between 140-159 mmHg and a DAP between 90-99 mmHg; Stage 2 AH is defined as a SAP equal to or over 160 mmHg and a DAP equal to or over 100 mmHg⁽⁶⁾.

Control and prevention actions involve measures that encompass individual and family health monitoring. Family involvement is one of the proposals for AH treatment-support programs. A number of studies note the participation of family members in the process of supporting a change of lifestyle, such as the adherence to a dietary treatment. These lifestyle changes also become a positive factor for public health because the healthy family members will receive preventive treatment⁽⁷⁾.

In addition, the family takes on a significant proportion of its members' health care status. As such, families should not be considered only as mere caregivers; they should, otherwise, be taken as active unities, be heard in their doubts, have their opinions taken into account, and led to lively participate in the whole care giving process^(8,9).

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Despite the family's participation and support, blood pressure may not be controlled. As a result, other consequences may occur, the most relevant of them being the physical dependence caused by a cerebrovascular accident. Depending on the gravity of dependence, a family structural reordering process is considered as a necessary step, and this new series of actions might bring forth strong impacts, usually generated by inevitable situations related to intimacy, finance, domestic routines, and family relationships^(10,11).

However, with the current nuclear-based family model, families are expected to be capable of identifying the member, who will undertake the responsibilities of maintaining the daily activities of the dependent member, regardless the distance such family may present from this hegemonic model⁽¹⁰⁾.

In this context, whenever a person with AH is assisted, with or without dependence, it becomes important to consider all aspects concerning how family members experience such condition in the family environment. Derivative needs must be especially dealt with in a way of subsidizing the elaboration of effective strategies that contribute to improve attention level to the person with AH. Therefore, aiming at competing for the enhancement of professional knowledge, this study has the objective of comprehending family experiences with arterial hypertension.

METHOD

This qualitative study applied the principles inserted in the Data-Based Theory (DBT) as a guideline in the process of data collection and analysis. The purpose of DBT is to build a

theoretical model that make easier the comprehension of social phenomena, that is, aspects related to human behavior. A whole series of systematic procedures is used to develop the model; laying the ground of theoretical formalization of observed reality on the data the series itself create⁽¹²⁾.

The research was carried out with 14 families in the city of Maringá, Paraná, between March and July, 2007. Families were reached out by the researcher from the database of some municipal healthcare centers and distributed into five sample groups: families who experience controlled AH; families who experience non-controlled AH; families that count on a member under physical dependence due to AH; families in which a family member died due to AH aggravation processes; and families who have a child with AH. Two families participated in more than one group.

In order to collect data, open interviews were carried out, presenting the following guiding question: *How has your family experienced arterial hypertension?* Two families had to be re-interviewed so that some aspects could be clarified. One family refused to be interviewed due to scheduling conflicts discordance. A field diary was also elaborated so that the researcher's observations and impressions, as well as the behavior of family members during the researcher's visits, could be reported.

Counting on the agreement of participants in the interviews, they were recorded and later integrally transcribed and enriched with information reported from the field diary and remembrances of non-verbal behaviors. After the transcription and thorough readings, a process of open codification and data categorization was established. This present study shows one of the themes identified during the implementation of the study, and refers to family participatory processes in taking care of the individual with AH.

During study development, all the ethical norms involving research with humans were followed as established by Resolution 196/96 of the Ministry of Health. Thus, we required the Municipal Health Department of Maringá, PR, to officially authorize the project. The project was also approved by the Ethics Committee on Research with Human Beings of the State University of Maringá (Legal Opinion number 034/2007). All family members who took part in the interviews signed up two copies of the Term of Informed Consent (TCLE).

DATA PRESENTATION AND DISCUSSION

Family care giving behavior toward AH individuals originated the theme *Receiving family care*; the project is composed of three categories: *Family involvement in care giving*; *Becoming the caregiver*; and *The care giving hardships*.

1. Family involvement in care giving

This category describes family experiences related to care giving participation in assisting people with AH, or to

the consequences brought about by the disease. The research showed that family involvement is greater when the disease is followed by physical dependence. The family, in these instances, besides taking part in care giving activities toward the dependent person with AH, also strongly stimulated self-care actions and search for independence.

Dependent family members also feel the need for learning some self-care activities. As a result, families adapt to the situation in order to facilitate and encourage self-care:

Now he eats on his own. I try to overcook the meat, minced meat [...] (Wife – F4).

The caregiver is defined as a family member who is usually more engaged in the care giving activities and who takes on a significant role of facilitating independence and self-care. This person participates in care giving activities that promote rehabilitation for the dependent family member as well as prevention of other chronic diseases:

I walk with him, I go downtown with him... (Wife – F4).

The active participation in the care giving process by the family member leads the caregiver to perform important tasks that provide support to the control of hypertension risk factors in addition to supplying the disease treatment demands⁽⁹⁾.

A number of patients with AH, aiming at improving their health status, do their best to perform the rehabilitation activities in order to return to their daily life routines; such efforts are recognized by both caregivers and family.

She never said she wouldn't go (to physiotherapy sessions). She is quite committed... There were some days when I thought she wouldn't go, but she changed her mind and decided to go... (Husband and patient with hypertension - F5).

Family routines are altered and/or adapted whenever family members face AH within family environment, and both the family and the life of the patient with hypertension undergoes changes.

It's hard because things change a lot... (Son and patient with hypertension – F10);

...I avoided making them (candies) because if she saw them, she would feel like eating them, of course. If I did, I wouldn't be helping her, and she loved candies... (Daughter – F6);

Some people ended up quitting their jobs in order to provide family care giving support.

When she had the stroke, I used to gamble for a living, and on the day she got sick I quit it in order to take care of her... (Husband and patient with hypertension – F5).

Change of daily home tasks is frequently reported, as well as leisure activities, which end up being neglected. This happens mostly when there is no other family member to relieve the caregiver some days of the week. The need and responsibility of steady care, in fact, limit the caregivers freedom.

...it's been calmer in these last two years, but the first two years were tough..., because you can't do anything, because, you know, life goes on... (Daughter – F2).

This changing condition was also found out by other authors⁽¹¹⁾ who concluded that whenever families faced a chronic disease in one family member, this fact provoked routine changes, such as quitting job activities, eating habits, and having leisure time. Such changes, however, provide a pleasant and encouraging environment that favors the dependent family member in their limitations, even when the chronic condition brings forth hardships and interferences in self-care activities, especially in those related to the independence originated by care giving itself⁽¹³⁾.

Routine changes also take place in the AH patient's lifestyle, both in the lives of those who are dependent on family members and those who are not. Depending on the role the AH patient plays in the family, these changes occur in higher or lower frequency that is reflected in other family members. One of the researched families reported on the hardships of performing family leisure activities after a cerebrovascular vascular accident:

...it's difficult, because he can't drive anymore. Now, we have to count on others to leave home... (Wife – F1).

In families where patients with AH do not suffer from physical dependence, different behaviors can be pinpointed in the various family members; while some modify their routine in order to help the family member with hypertension, others are not concerned at such changes.

The most common changes reported by family members are: adaptation and participation in activities like medical treatment care giving, eating routine readaptation, adherence to physical activities, and taking the patient to medical appointments.

Eating habit changes almost always originate from the diet restrictions imposed on the patient with AH.

We all eat the same food, nothing is different (Patient with hypertension – F8).

I diminished the amount of salt for every one... My daughter suffers from low pressure, and she complains that her pressure is kept low for eating too much saltless food (Patient with hypertension – F12).

Some cases indicated that family members changed eating habits in order to make daily life activities easier, not because of health concerns. Family constituents adhere to the routine of the patient with hypertension. According to observations in the following reports, family members make use of unrestricted food whenever they have the opportunity:

They are concerned at...well...when they are preparing a Sunday barbecue and the meat is sort of fat, and there's beer, they say: mom will not drink it... (Patient with hypertension – F12).

Food is the same. He ((husband) spills a bit more salt on his own, in his plate, because his pressure is low... (Patient with Hypertension – F11).

This picture shows that disease prevention activities are neglected, showing the misconception that the care of chronic conditions should begin only from the moment AH is diagnosed in the patient. However, it is worth highlighting that AH has a genetic feature. This piece of information, therefore, should encourage all family members to be more concerned about prevention given that the disease is associated with improper habits, sedentary life style, and aging, all important risk factors for disease aggravation processes⁽⁹⁾. This situation, however, is a result of family interactions with health professionals who still use predominant health Cartesian-based practices; these practices, confer low value to disease prevention issues.

Disease disclosure can also lead families to suffering and grief, and the need for new strengths to adapt to the new demands:

Look, it's hard in the beginning, it's not easy to accept that, it's difficult. A husband that worked hard and steadily, now lies down on a bed, it's not easy, not at all... (Wife and patient with hypertension – F1).

These feelings are usually connected to family routine change processes, the need for a steady care, the overload of family members who experience dependence, the non-participation of all family members in the care giving process, and the proximity of imminent death; these factors work for families as stressing issues.

Experiencing a chronic condition is permeated by practices associated with feelings of suffering both to the patient with AH⁽¹⁴⁾ and to the other family members. The situation in people's daily lives can be understood as a stressing occurrence whose impact surprisingly arises and comes to stay, thus altering the healthy condition of individuals or groups⁽¹⁵⁾.

In some moments, families clearly exposed thoughts on their expectations regarding the death of the family member, because of the high dependence intensity of the individual.

We don't know what's coming next, if God will suddenly take him... but he is very ill... (Daughter – F2).

When family members are older people in an advanced dependence status, families experience an anticipated sense of mourning, once they know that death can happen at any time, and thus, conformity to life's finite pattern can be a way of minimizing their sorrow.

2. *Becoming the caregiver*

The process of having a family member as carrier of physical dependence occasioned by non-controlled AH is faced by families in singular ways, sometimes generating misunderstandings among their members and other times creating a sense of union among everyone. Anyway, the presence

of dependence normally brings forth the need for a health-care system to cope with the new situation to be faced, and the support of the healthcare technical team is highlighted as a factor that facilitates home care giving practices⁽¹¹⁾.

In this study, all people undergoing dependence triggered by AH had a family member as a caregiver. This factor widens the confidence of the person who depends on care giving and makes possible the care process to be performed by people to whom he has connections and affective ties⁽¹¹⁾. The kinship degree is also a determining factor in the choice of who the caregiver will be. The closer the family relationship, the greater the chances of a person to be responsible for the care giving^(9,16).

Whenever dependence is observed, only one person usually plays the role as major caregiver, and this person is generally represented by the female in the family^(9,16-18); however, this role is not always an option, and it is usually grounded in some cultural aspects of society and family. The predominance of women in this function is justified, for instance, in the fact that they are more responsible, according to their family raising practices, for family care giving or for homecare activities, which leads them to the non-performance of extra-home job activities^(17,18). Responsibilities taken on by women towards family care are embodied into the symbolic repertoire of family norms. Women, therefore, tend to undertake the domestic and health care of family members, from children to elderly people, and/or dependent family members⁽²⁾.

Although care is perceived as a common activity for women, they experience some hardships in performing the tasks due to the degree of dependence of the carrier:

It was like taking care of a little child who was learning how to walk, and it's even worse, because it's impossible to hold... (Husband and patient with hypertension – F1).

In some situations, it is the men who take on the task of being the major caregiver. In this present study, this was observed in three families; in all of them, the dependent family member was wife/mother and in the immediate family there was no other woman to undertake this function. Moreover, the economic situation did not allow for the hiring of someone who could take on daily care practices.

There was no way out. If we had good salaries, we could pay someone to help, but we don't... (Husband and patient with hypertension – F3).

A study carried out along with caregivers who rendered home services for elderly people also revealed the presence of men as caregivers for dependent people, as their wives had another job and they were the only ones available to perform care tasks⁽¹⁶⁾.

When the caregiver takes this function on, he/she regulates the care giving activities and undertakes the majority of responsibilities concerning the dependent family member. Their diverse functions are as follows:

...later, my mother was unable to walk for practically four years; not to say that everything was up to us... shower, bring her to the wheeled chair, we did everything... (Daughter – F6).

...I had to carry him to the wheeled chair. I had to hold him, because He was not able to stand on his own... (Wife and patient with hypertension – F1).

Family's attitude of taking on care giving practices is permeated by a series of factors, such as gratitude, love, and even retribution for the family member's actions during his life.

It's my mother, we have to take care of her because she took care of us. So, that's why God put children in the world, to help caring for when people come to the age my mother is (Daughter – F6).

Whenever children feel responsible for caring for their dependent parents' they generally do it as a way of rewarding them for being given birth to and brought into this world⁽¹⁸⁾.

Families with children who carry any chronic condition, point to a situation where responsible caregivers must double attention once children require even more needs.

It happened three times a day... Then, when that time came, I had it already memorized in my mind. I took his medicine to school (Grandmother and patient with hypertension – F13).

In these families, care giving is taken on by either the mother or a maternal figure (grandmothers or others). In the Brazilian culture it is also expected that women remain with the ill child, which, whenever necessary, and as a result, makes them reduce or abandon their external work schedule⁽⁴⁾.

When facing disease situations, families also act according to their knowledge based on previous experience or from the advice of friends, neighbors, or relatives. They also look for expert support, aiming at being guided on adequate ways to perform the care giving process.

...the girls came here, taught me and I began to learn how to do it [the wound dressing]... (Husband and patient with hypertension – F3).

The family-based caregiver is usually much more focused on the health status of the family member undergoing a chronic condition and is a reference for the acquisition of knowledge on the disease and care procedures. This process teaches them how to perform wound dressing on skin lesions aggravated by hypertension; they receive and search for information on the family member's disease and also acts as a multiplier of care giving experiences for other people by means of their interactions. Some studies highlight that the first step in the care giving path is to be fully educated about the disease treatment and as a result, to learn how to totally manage the care giving process⁽¹⁹⁾.

Other reports also indicate that when the caregiver is duly informed on the family member's disease, his knowledge allows for understanding the situation experienced

by the person, and facilitates the understanding of established care giving practices that have to be performed.

Because cardiac children's immunologic system is less resistant than others...then, there's where you have to be extra careful... (Care giving mother – F14).

The guidelines conveyed to family members lead them to convey information, experience, and care giving proceedings to other people in their social network.

One of these days I was talking to a guy and he said: I take [the medication] every other day. And then I said: doing this is useless... you have to take it every day, because I have already experienced a blowing pressure... (Husband and patient with hypertension – F3).

This is a reason for health professionals to invest in family guidance procedures, since families interact with people in their social framework and can help spread healthcare information throughout the community.

As a result of the participation of the other family members in the care giving practices, we observed that whenever family members become actively involved in the process, the main caregiver's overload is relieved.

...it was my family who helped me. They came to help me care of him... They cleaned the house, and did everything; washed and ironed the clothes, everything was so neat and tidy, and I was free to take care of him... Everybody arrived here and was willing to massage him, his feet, his hands, nieces, his granddaughter, all relatives... (Wife and patient with hypertension – F1).

Other family members, mostly men, do not get involved in direct care assistance. They help financially or in the displacement of the dependent person in order to receive health assistance.

In taking care of her, medicine was everything they bought... My brother... he took her to the hospital, and knew who the correct doctor was, and the right things to forward... (Daughter – F6).

Whenever other family members directly or indirectly take part in care giving activities, task overload is distributed and caregivers are more able to adapt to the work routine without leaving all responsibility to the family member who take on the position of being the major caregiver. Whenever this situation takes place, some difficulties regarding family member relationships are observed and expressed in accusations and conflicts. Resentment and sorrowful feelings were also observed by another study, as the expected help from other family members was frustrated⁽¹⁷⁾.

3. The care giving hardships

Among the families observed by this study, those who experienced more substantial difficulties to perform care giving were the ones in which the member with hypertension displayed physical dependence, usually during the first

two care giving years and mostly due to the need of steady attention to the sick person.

Nowadays care giving is easier, it was very difficult in the beginning... (Daughter – F2).

We rented a hospital-like bed... and I had to sit down on the chair next to it... it was like this for six months. Tough, because we did not sleep... Because she turned her body to awkward positions... (Husband and patient with hypertension – F5).

A female caregiver also referred to the absence of her brothers in the care giving process to her mother, who had a cerebrovascular accident, since they had assigned to her full responsibility for the assistance.

Family... they came here and stayed for five minutes. A doctor's kind of visit. That's what doctors do, go to the rooms of the sick for five minutes... (Daughter – F6).

This kind of behavior from some family members makes family relationships very tough; moreover, it generates deeper suffering for the dependent member, as well as emotional weariness on those who are responsible for the care giving process. This situation often deteriorates their existing health conditions, since most of the times they also experience chronic conditions.

...now, at 50, I found out that I had high pressure (Husband and patient with hypertension – F5).

Pressure problems came after his stroke. He didn't have anything before, only diabetes. I have diabetes for 10 years now (Wife and patient with hypertension – F1).

Another factor that made the care giving process difficult is the physical and emotional condition of the dependent family member.

Sometimes I sat him here on this sofa, and he wanted to sit on the other... there was no comfortable place for him. In shower time he made a scandal; if neighbors could hear him, they would say someone was ill-treating the old man... (Daughter – F2).

In addition to all above-mentioned hardships, families also noted the economic troubles, which were also discussed in another study⁽¹¹⁾. The existence of a chronic condition in the family environment usually brings forth financial expenses, be it in the purchase of medication that is not supplied by the public network or the maintenance of someone to help in the care giving process. Such hassles can also arise from the need a family member has of abandoning a job position. When the condition of quitting a job affects the family member who used to be the house's main source of income, economic hardships tend to increase, sometimes demanding the support from relatives and friends to supply basic needs.

When the stroke came, (the treatment process) was all private... So, since this money belongs to him, we'll spend it with him. But soon later it wasn't enough anymore... (Wife – F4).

Family lives in a house... bought by the oldest son... (Field Diary – F4).

Depending on the seriousness of dependence, families necessarily have to reorder and several times this rearrangement procedure can originate difficulties, and economic ones are also noted in this scenario⁽¹⁰⁾.

In two observed families, the wife was the family member who had had an CVA. In both cases, husbands took on the care giving process and domestic activities; however, since they had already retired, they had to quit some additional activities that brought in extra income,

...because as I have to count on my pension, I'm in trouble. My daughter can't help either... If we had good income, we could pay a person to help us... (Husband and patient with hypertension – F3).

Financial support, which in general is undertaken by other family members and participation in some activities that the caregiver cannot do on his own, turn the care giving process into an easier task; however, some family members end up taking part neither in supporting nor supplying the needs to the sick person's; therefore, leading relationships among family members to be very tense and causing an overload to caregivers.

It is not a rare case to observe reports of financial hardship among families. When the proportion of those difficulties grow substantially, some families end up making dramatic decisions in order to demand other family members to provide financial support for the maintenance of care giving practices.

Due to financial difficulties and family involvement, the care giving son decided to institute legal proceedings concerning his rights, and demanded his brothers and sisters to share expenses with him (Field Diary – F10).

The lack of recognition and acceptance of co-responsibility on the part of an extensive family concerning care giving processes can also bring forth an overload to the other family members, mostly regarding family financial

issues. The support from the extensive family allows expenses to be shared, as well as favoring family union during their involvement in the care giving actions.

FINAL CONSIDERATIONS

Considering family interaction with and participation in care giving processes, assistance to patients with hypertension has been highlighted in several studies. There has been an increasing number of academic researches that corroborate the success originated in the association between family care and professional care. However, family beliefs and conceptions on health and professional assistance procedures do not change proportionally; for this reason, many families are subject to experiencing the need of "living with hypertension" within their environments.

In the above-mentioned context, the comprehension of the process of family engagement in care giving toward individuals with hypertension contributes significantly to the professional practice, favoring reflection and consequently possible changes of professional behavior regarding assisting the patient with hypertension and his family. In addition, it provides support that promotes new ways of seeing and understanding families based on their conceptions, care means, and needs.

Health professionals are expected to relentlessly invest in creative actions in approaching individuals with hypertension and their families. Strategies should be elaborated so that limited concepts inherited from the biologicist model that permeates health assistance can be left behind, providing families with support, investing in health counseling, rescuing and reckoning habits, beliefs, and values; thus, widening healthcare actions and encouraging users themselves to control their own arterial pressure. Whenever professional intervention is extended to the whole family, and when it takes into account its needs, family care can be a reflection of the professional assistance; thus, undertaking a holistic and humanized character.

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