

CONCEPTIONS AND PRACTICES OF NURSES WORKING WITH FAMILIES

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ABSTRACT: The objective of this study was to build theory about the conceptions of family developed by nurses linked to the Family Health Strategy. This is a qualitative study with a theoretical framework in symbolic interactionism and methodological framework in Grounded Theory. Twenty-one nurses were interviewed who were affiliated with the Family Health Strategy. The theoretical script constructed has three central categories, described as Conceptions of Family, Family Environment and Family Approach. Nurses build their conceptions based on three specific experiences within the social, economic and cultural environment they operate in. Their concepts of family address origin, space, structure and relationships. The family approach derives from these concepts and depends on specific skills and resources. The study provides a theoretical base for making decisions for family care as well as for teaching the family approach to nurses.

DESCRIPTORS: Family. Concept formation. Family health strategy. Family nursing.

CONCEPÇÕES E PRÁTICAS DE ENFERMEIROS NO TRABALHO COM FAMÍLIAS

RESUMO: O objetivo deste estudo foi construir teoria a respeito das concepções de família elaboradas por enfermeiros vinculados à Estratégia Saúde da Família. Trata-se de estudo qualitativo, com referencial teórico no Interacionismo Simbólico e com referencial metodológico na Teoria Fundamentada nos Dados. Foram entrevistados 21 enfermeiros com vínculo na Estratégia Saúde da Família. Resultados: O enredo de teoria construída foi denominado Família Viva, Família Conceituada e Família Abordada, e possui três categorias centrais descritas como Conjuntura familiar, Concepções de família e Abordagem familiar. O enfermeiro constrói suas concepções a partir de três vivências específicas dentro da conjuntura social, econômica e cultural em que está inserido. Seus conceitos de família abordam origem, espaço, estrutura e relações. A abordagem familiar deriva dessas concepções e depende de habilidades e de recursos específicos. O estudo proporciona fundamentação teórica para a tomada de decisões tanto para a assistência de família como para o ensino da abordagem familiar para enfermeiros.

DESCRIPTORES: Família. Formação de conceito. Estratégia Saúde da Família. Enfermagem familiar.

CONCEPCIONES Y PRÁCTICAS DE LOS ENFERMEROS QUE TRABAJAN CON LAS FAMILIAS

RESUMEN: El objetivo de este estudio fue construir teoría sobre las concepciones de la familia desarrollado por enfermeras vinculadas a la Estrategia de Salud de la Familia. Es un estudio cualitativo con marco teórico en el interaccionismo simbólico y en la Teoría Fundamentada en los Datos. 21 enfermeras fueron entrevistadas en el marco de la Estrategia de Salud de la Familia. La trama de la teoría construída tiene tres categorías centrales - Coyuntura familiar, Concepciones de la familia y Enfoque familiar. La enfermera construye sus concepciones de tres experiencias específicas en el entorno social, económico y cultural. Sus conceptos enfocan el espacio, la estructura y las relaciones. El enfoque de la familia se deriva de estos conceptos, y depende de habilidades y recursos específicos. El estudio provee fundamentaciones teóricas para tomar decisiones de atención a la familia y también para enseñar la aproximación familiar a los enfermeros.

DESCRIPTORES: Familia. Formación de concepto. Estrategia de salud familiar. Enfermería de la familia.

INTRODUCTION

The social and institutional movements after the Second World War in Europe indicated the need to transform the thinking about society, with a focus on people's quality of life and well-being, which entailed repercussions in practically all public service sectors. In the health sector, the influence of these movements led to the discussion about the universalization of the access to and the constitution of public responsibilities for the supply of services. Based on these guidelines, new health concepts and the proposal of new practices led the public policies to the approach of the territory, valuing popular participation, and indicated that the problems should be interpreted at the local level, close to people's daily life.¹

This approach of the territory gave rise to the focus on family care, as the family is naturally the mediator between individual and collective issues, between the public and the private.² Hence, the family started to be considered potentially important in the care for its members' health, as its balance can permit a healthy life and, at the same time, its disruption can influence illnesses or problems.

In this context, some countries became pioneers in formatting public health policies, focusing their actions on the strengthening of Primary Health Care, on the choice of community medicine, and of the Family Health Strategy (FHS) to guide this care level. Examples that have influenced Brazil include the health systems structured by Great Britain in the 1940's, by Canada in the 1960's and by Cuba after the Cuban Revolution in the 1950-60's. In the three countries, the family health proposal is based on the creation of bonding, the strengthening of health promotion and the change of lifestyles, including the assignment of clients and the attempt to offer Primary Health Care with high problem-solving ability.³⁻⁵

In Brazil, the first political construction that guided the family care model emerged after the enactment of the 1988 Federal Constitution, when the decentralization of care, the integrality of care and community participation were determined. Between the line, this local care approach led to a restructuring of Primary Care that culminated in the choice of the Family Health Strategy to reorder the Unified Health System, based on the regulations and political standards that followed the Constitution. The guidelines were based on the territorial assignment of the population and

on the local social and cultural determinants; on interdisciplinary work consisting of a minimal team set up for funding; on education and health as an expanded proposal; on the creation of bonding and accountability to the community; and on the proposal to use the family as a care focus.⁶

What is observed in the daily work of the Family Health teams, however, is that despite the proposed guidelines, the professionals still propose their fragmented and individualized therapeutic plans, without considering the socio-family structure in most cases, individually addressing the lifecycles, without longitudinality, within a care line that should be comprehensive.⁷

In that sense, the premise of this study is the acknowledgement of the family as a symbolic space, where the exchange between genders and generation and the social mediation between culture and society happen. Thus, it interferes directly in the people's health condition, in the subjectivity of their desires and in the relation constructed with daily life, represented by the social determinants;² it is also a premise in this study that the health team professionals, including the nurse, build their own (cultural and social) meanings of the family, which can interfere in their care for other families and, consequently, for their members.

In that context, some questions arise: What is the conception of family the nurses construct? How have they acknowledged the family? How has the family been used in practice to construct the therapeutic plans?

The objective in this study was to construct theory about the family concepts the nurses affiliated with the Family Health Strategy elaborate.

METHOD

A social and qualitative research was undertaken, using the Grounded Theory (GT) approach,⁸ which adopted Symbolic Interactionism as the theoretical reference framework. The research departed from the premise that the family approach in health is loaded with technical, social and cultural meanings and that, in the contact between professional and families, these meanings are modified to construct new conceptions.⁹

GT is a method that permits the conceptualization and consequent construction of theory about a certain reality, based on the researcher's systemic interaction with the collected data.⁸

Initially, to guide the data collection, it was defined that nurses would be sought divided among three distinct generations in terms of graduation and the health context at the time they concluded the course. Generation 1 represented nurses who graduated until 1997, when public experiences with the FHS were enhanced in Minas Gerais. The premise was adopted that the nurses in that generation migrated from their previous functions to Family Health through training courses and that they experienced the change of the hospital-centered care paradigm to comprehensive health care. Generation 2 represented nurses graduated between 1998 and 2006, between the intensification of FHS in Minas Gerais and the start of the exponential growth of nursing programs in the same state, as a result of the New Law of Directives and Based of National Education, which culminated in the National Education Plan in 2001. The premise was adopted that these nurses had already graduated within a new care paradigm, but without the systemization of the contents related to the FHS in the undergraduate curriculum matrix, and that they also started their activities through training courses. Generation 3 represented nurses graduated as from 2007, a period marked by the changes driven by the National Curricular Guidelines of the undergraduate nursing program, which meant a profound change in the courses' curriculum matrices. Another characteristic of this period was the maturing of the FHS and its consolidation in Brazil. It was conjectured that these nurses entered the teams with basic undergraduate education and in a new context, where Family Health was more consolidated already.

The choice to work with these three generations was intended to follow the guidelines to verify the reality, with a view to a comprehensive representation of the study phenomenon.

The nurses were interviewed based on a semistructured script with the following initial questions: What does family mean to you? What is the importance of family in individual care for people? How do you approach the family in the Family Health Strategy?

The data were transcribed and analyzed according to the phases proposed in GT: open coding with systemized line-by-line, paragraph-by-paragraph reading of each interview with a view to the construction of the initial categories. Axial coding, after the definition of the categories and organization of the set of data, their proper-

ties and dimensions were described, established relations between the central and the peripheral categories. The researcher's observations and reflections were also used, registered in memoranda after each interview, besides diagrams for the organization of the data in the construction of the categories. Theoretical sampling was used to refine the process and test the relation between the categories, in view of questions that emerged and left gaps in the theory. One of the gaps referred to the impact of political issues on the family approach and, therefore, nurses were interviewed in management function at primary health care services that worked in the FHS. The other gaps questioned how undergraduate education influenced the establishment of the family concepts. Therefore, nurses were selected who were active in undergraduate nursing teaching in subjects linked to the FHS. The goal of this sampling was to seek participants who maximized opportunities to discover the gaps in the relation between the categories, making them conceptually denser. In the delimitation of the theory, the entire method described was reviewed, in accordance with the analysis criteria of the GT.⁸

In this process, 21 nurses were interviewed who worked in the Family Health Strategy and been professionally active in care, management or teaching for at least one year.

Institutional Review Board approval was obtained for the project and the Terms of Free and Informed Consent at the *Universidade Federal de Minas Gerais*, under opinion 36741, on June 13th 2012, in compliance with National Health Council Resolution 196/96.

RESULTS

The central plot Family Life, Family Concept and Family Approach contains three central categories with specific properties and dimensions, called Family conjuncture, Family conceptions and Family approach. They imply mutual relationships and construct the theoretical model presented in the discussion.

Family conjuncture

Family conjuncture is the initial category in the theoretical scheme and represents the social, economic and cultural reality the families are inserted in, based on which the nurses build the family conceptions. Figure 1 represents the properties of this category:

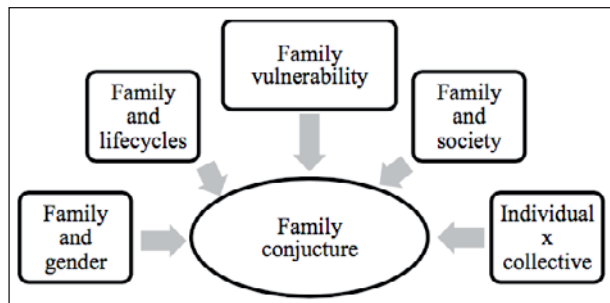


Figure 1 - Conceptual diagram of Family conjuncture category

In the discussions about Family and gender, the dichotomy between man and woman and the roles of each remain strong. In the family relations that involve health, women have a predominant role and are held accountable for care or its organization. Care is presented with female characteristics from two viewpoints. The first is when care has the meaning of zeal, of kindness and delicate skills, and is better executed by women; the second is when the relationship the services produce in Primary Health Care feminizes the relation with the users because it discourages the participation of men, whether due to the functioning hours of the primary health care services, overlapping with their work hours (the responsibility for finance and work is still represented as mainly male) or due to women's excessive burden of responsibility.

Concerning Lifecycles, this property presents three distinct subcategories: the Demographic transition, with a new reading of the families, represented by the reduction in the number of children (couples who chose to have one child or no children) and aging of the families (demonstrated by care delivered predominantly to elderly people, and by intergenerational families); Interventions in the family lifecycle, with the clear characteristic of a higher frequency of unions (marriages, stable relationships) and their direct consequences in the family constitution: families under different roofs and mixed families (cohabitation and consanguinity); and equal dilemmas in different families, in which the natural phenomena of the family lifecycle are represented, which present the same dimensions independently of the family structure. Getting ill, leaving home and feelings of loss are examples. They may have a greater or lesser impact depending on the family structure, but appear as inherent conditions in all structures.

Family vulnerability refers to conflicts the families experience both inside and external to the family institution. In internal issues, the problems expressed demonstrate structural weaknesses related to the individualization and the absence of bonding, even causing neglect in care among people. In external issues, vulnerability is declared through great family problems of social origins, such as drugs use, alcoholism, violence among family members and extreme poverty.

In Family and society, the social determinants produce distinct forms of relating with society in the family. The internal or external problems can make the family get closer or not to consistent social relationships. If, on the one hand, the family prepares its members for social life, for respect for rules and standards of joint life, for life in a solidary world; on the other hand, the loss of family structure can produce more selfish and less tolerant social relationships. The individualization process of the individuals appears in this characteristic, triggering the situation of family isolation that leads to the family's reduction of social relationships, with the consequent formation of a society with even less shared values.

To conclude the category Family conjuncture, the Individual X Collective represents family organization forms, sometimes centered on individuals, sometimes on the collective. Sometimes, individual issues are privileged over the family group and vice-versa. In families in which the organization is centered on a certain individual, whether due to the manifested need or the dominance that person exerts, the abdication of other family members towards that individual becomes characteristic. In the organization centered on the group, the social bond and the feeling of belonging are greater and the collective issues are privileged. In the family approach, these issues should be perceived for the family to be effective in the accountability among the individuals in the family and in the creation of solidary bonds.

Family conceptions

Family conceptions is the intermediary category in the theoretical scheme and, at the same time as it is influenced by the Family conjuncture in the construction of its concepts, it interferes directly in the nurses' forms of approaching the families. Figure 2 displays the properties of this category:

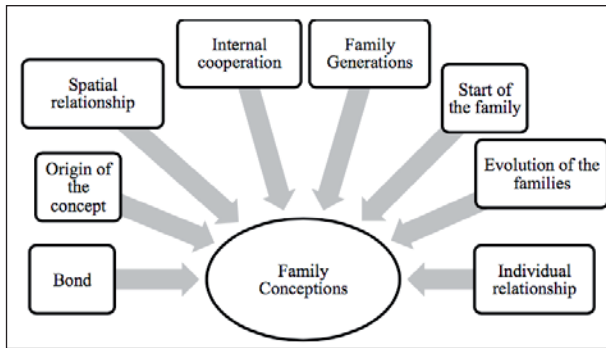


Figure 2 - Conceptual diagram of the category Family conceptions

Family is understood through properties that range from its emergence to the elaboration of stronger bonds with daily contact among its members. As a concept, it can be defined that the Family starts when people start to live together, creating affective bonds and/or social bonds, independently of blood relationships, in which healthy relational bonds need to be constructed, a feeling of belonging and shared objectives, even if temporary. This family is subject to internal influences in the way it gets organized according to genders, generations and lifecycles represented in its constitution. It also receives external influences, more or less intensely, represented by the extended family of its members.

The characteristic Origin of the concept explains the sources for the definition of family the nurses present. The starting point for the construction of the concept is the experience in their family, based on which they reference the values and the importance of living together. The personal experience in other realities, different from their families of origin, furthers the view on other family constitutions that broaden their concepts. Nevertheless, the final concept is molded based on their professional experience, in which they are confronted with the sociocultural conjuncture.

In this context, a second property emerges, which is the Evolution of the families, centered on the object tradition, which is considered important in the establishment of values and in the construction of healthy relationships, but which has been abdicated over the years, due to the emergence of new forms of living, defined by the complex current social conjuncture (as the social individualization process that affects the family).

These evolutionary elements of the family, from a traditional structure to new forms of living, were evidenced in the properties Spatial relation,

Family generations and Individual relationships. Although the ideal family image is nuclear (parents and children), living under the same roof with direct blood relations, in the nurses' daily reality, the change of this pattern is increasingly perceived, towards multiple forms of family organization, with compositions related to cohabitation (without parental bonds), living under distinct roofs (housing unit), intergenerational arrangements (more than two generations involved), sometimes without the direct presence of people responsible for that family unit. This scenario directly influences the professional activity, when the family approach is used, as it requires new competences and skills, such as the construction of therapeutic plans involving people who live in different homes to be able to intervene in specific individual problems.

Two properties emerge from this context of new forms of life, Internal collaboration and Bond. In this scenario, solidarity appears as a necessary element in configurations in which compulsory parental relationships are not highlighted. Beyond the affective bonds, the social bonds are necessary for the family units. Social bonds make the individuals accept the values, rules and expectations of the place they belong to. Feeling of belonging is important in this type of bond. The affective bond is related to emotional relations, love and kindness.

Family approach

The final category in this scenario is the Family approach, which grants the characteristic of a process to the theoretical model and represents the direct relation in the nurses' care for the families. Figure 3 represents its properties:

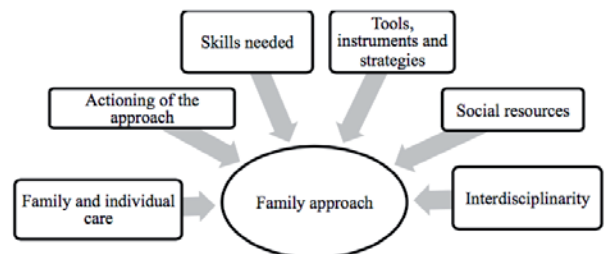


Figure 3 - Conceptual diagram of the category Family approach

The family approach can be understood as the family intervention planned to offer opportunities for the best possible internal organization,

in view of the situations the family experiences. Normally, it is put in practice based on specific problems, but should be expanded to promote healthy family and to prevent these problems. Beyond always addressing individuals as a group, the family should also be included in the discussions and in individual care.

For individual care, the family is considered fundamental for the success of the therapeutic plans. When it is participatory, the recovery from the problem and the maintenance of healthy conditions happen more effectively. It represents the safety needed for the individual, with the consequent guarantee of respect, as dealing with what is already known is nurturing. In view of individual problems, the family can get organized and grow in solidarity and co-accountability. Being together can strengthen the bonds and approximate the people in favor of a family good.

The Actioning of the approach can happen based on the health team, the family or the individual. In general, it starts with specific problems these agents observe.

According to the team, including the nurse, the family approach is actioned in conditions of therapeutic failure of individual treatments, the person's physical or cognitive disability, or the loss of the capacity to develop instrumental activities of daily living, such as reading and doing housework. The first person the team demands is the person recognized as responsible for that family, in the attempt to provide support for individual care. The approach of all members only happens later and, normally, takes place through non-systemized meetings. These contacts generally intend to increase the adherence to the proposed treatment.

The Actioning by the individual is based on individual needs, when (s)he considers that the family needs to cooperate with him/her to achieve the proposed objective. In this demand, social and emotional issues tend to be intertwined with the problems evidenced.

The family's request for an approach is almost always based on the family structure, when a member's individual problems interfere in the family dynamics, including issues that range from financial matters to extreme issues of violence.

The Place of the privileged approach for the Family approach is the home, mainly through the home visit. Therefore, it is the woman who has been held accountable for care and is found

daily during these visits that happen during office hours, which contributes to the gender issue in the family as, in most cases, men remain the providers and work for that, and are therefore absent from home at those moments. The family is rarely contacted at the health services. Individual contacts at these services are not used as tools to work with the families.

Another property of the Family approach verified in the data corresponded to Skills the professionals need to accomplish it. It is also a subcategory as to presents characteristic properties and dimensions that support its conceptual explanation. Before these skills, it is important to highlight the unpredictability in dealing with families, which means that, in view of that many possible family arrangements, the professional will always be confronted with unexpected issues. One way to anticipate these questions is to approach the families' reality, including the recognition of the territory where they live, in all of its social, cultural, resource and problem dimensions. The territory should be unveiled as a source of solutions, much more than as a promoter of problems. Another skill to prevent the risks of dealing with the unpredictable is to recognize the family dynamics, demonstrated by the act of heeding the most common family structures that exist within its territory, instead of working with ideal labels. The way the families are organized strongly depends on local issues manifested by the social determinants the families experience. Another necessary characteristic is to know how to listen and talk. The following are sides of counseling: one needs to know how to listen in order to appropriately identify the family needs, and one needs to know how to talk to promote the interventions needed. One learns to listen by dedicating time to people, sitting down to listen to them and making the demand of the other people important without prejudice. People gain aptitude to talk if they associate knowledge with common sense; interventions take some time to occur.

Theoretic plot: Family Life, Family Concept and Family Approach

The theoretic plot presented is called Family Life, Family Concept and Family Approach, representing the existing relationship between the core concepts Family conceptions, Family conjuncture and Family approach. In general, the conceptions the nurses elaborate about family are

influenced by their experiences in the context of the social, economic and cultural conjuncture. And the family approach they put in practice emerges based on the concepts they construct in view of this conjuncture and according to the resources they have at their disposal.

Family Life represents three strong experiences: the Family experience, which is the first the nurses experience, which gives rise to their initial representations, ethical values and emotional constructions about family; the Personal experience, which refers to the first family approach distant from the original family, generally highly different from their initial structure. The three experiences are contained in a conjuncture with complex relations among individuals, families and society.

In this plot, the conceptions are represented by the Family Concept. It demonstrates that the conceptual definitions of family depend on highly intertwined internal properties and emerge based on the relation of subconcepts, such as the family origin, the space it occupies, the internal structure and the relationship among its individuals. To address all of these variables, a comprehensive and non-excluding family concept needs to be constructed.

The Family approach establishes a process-based relationship for this theoretical plot, in which the nurses, after identifying and defining the family conjuncture, uses it in their therapeutic plans. This approach is linked to their activity as Family Health team members and the fundamental guidelines proposed, putting forward the family as the central axis of professional practices. As conditioning elements for this approach, skills emerge that are necessary for good work and the reading of available resources for this to happen.

DISCUSSION

The Family Health Strategy has greatly evolved since its implementation in Brazil, including the increased coverage across the national territory and the improvement of the administrative processes in the elaboration of epidemiological, monitoring and quality individuals.¹⁰

Despite this evolution, the teams' work, including the nurse, remains vertical, focused on individual lifecycle, using little of the family to support the therapeutic plans. A lot of work is done with the child, the woman, the chronically ill and the elderly, however, without integrating these actions with a family approach, including

the vulnerabilities the families and consequently their members are submitted to.¹¹

In that sense, building theory about the family conceptions and their process-based relationship with the family approach these nurses practice can evidence some questions for further elaboration and points for intervention, in the sense of enhancing the family care.

The theoretical plot presented shows some important factors. The first is that, if the nurses' conceptions about families are constructed based on three distinct experiences (family, personal and professional), they need to be addressed in these professionals' training process with a view to their activities in Family Health. This training is normally centered only on the approach of the programs and protocols proposed and in general lines, such as territory, registering and interdisciplinary work.⁶ Beyond promoting initial training to work with families, this distinguished educational approach should also be used in continuing education and in the recycling of the professionals who are already in direct contact with the families. The speed of the social changes and its influence on the family approach have been appointed by the nurses as reasons for difficulties to get professional recycling.¹¹

The second factor is the complexity of the family concept, based on a set of variables that range from structural and spatial relations to the establishment of distinct bonds. The family concept itself the nurses build can change according to the initial focus of their approach, ranging from more generalist and inclusive conceptions, when the center of care is the elderly, to more limited and prejudiced concepts, like in the approach that involves gender issues. That is a challenge for the family approach, which should take into account the individuality of each family unit to propose specific actions¹² and strengthens the extent to which the nurses' own cultural and family influences influence the care delivered.

The third factor is the family approach itself, which is identified as a set of skills and strategies that need to be used according to the available resources, including the use of specific tools like the genogram and ecomap.¹³ In that sense, it should be highlighted that there are barriers to be overcome, such as: the interruption of the work, the constant change of professionals and the physical structure of the primary health care services. In addition, advances are needed on some specific structural issues with a view to effective family care.

Beyond the structural issues, the difficulty to address family care holistically, not fragmented from individual care, makes it impossible to include this type of practice in the therapeutic plan, transforming the family approach into a procedure instead of a strategy to redirect the teamwork.¹⁴

These problems are similar to what the Family Health Strategy of the public health system in Cuba is currently experiencing, which has faced structural barriers and barriers related to the work of its professionals to be able to dimension the future steps, although it has matured longer than the Brazilian model.¹⁵ Nevertheless, despite structural and work shortages, the family approach linked to community strategies in health can greatly contribute to the change in the local population's health condition, even in extreme conditions like those represented by Kenya, in Africa.¹⁶

Thus, it should be highlighted that, despite the limits presented in this study regarding Family Health strategies, the advances achieved in the health of the Brazilian population after its implementation are beyond discussion, mainly when the professionals are able to adopt the family-centered approach.

FINAL CONSIDERATIONS

The results presented here appoint new inquiries and reflections, which can lead to the construction of other research hypotheses and, therefore, to a search for data that complements or strengthens the plot of this theory that is still under construction. It is important to deepen the extent to which the nurses' education, which is that heterogeneous among the teaching institutions, influences the family approach. It should also be understood better how much the aspects of the nurses' life interfere in their approach of the families.

One limit of the theory constructed so far refers to the condition that is to be discussed in the context of mononuclear families, i.e. individuals who live alone. According to the nurses, the family always appears in a minimal structure of two individuals, which sustains the internal discussions related to the family. Nevertheless, as a result of the new demographic composition in Brazil and the appointments of the most recent census, this condition tends to be increasingly common, so that it needs to be elaborated in further depth in this theory.

Another topic that was not clarified is about the possible concept of individualization that appeared that strongly in the data, sometimes

influencing the family, sometimes influencing society. Its effect should be evidenced, in the family approach as well as in other issues related to Primary Health Care.

Nevertheless, the results obtained thus far can be incorporated into the teaching of the family approach, mainly through the diagrams and relational processes of the theory developed. The nurses' technical preparation should be accompanied by other elements evidenced in this study, such as the early approach of the families in professional practice contexts. This contact with the families produces a knowledge that goes beyond citizenship and responsible engagement in care, complementing the education and preparation for the family approach.

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