

The experience of rural families who remain in halfway houses during cancer treatment



A experiência de famílias rurais que permanecem em casas de apoio durante tratamento oncológico
La experiencia de las familias rurales permanecen en casas de apoyo durante el tratamiento del cáncer

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ABSTRACT

Objective: to understand the experience of rural families who remain in halfway houses during the cancer treatment of an adult family member.

Methods: qualitative research based on Symbolic Interaction and narrative research. Seven rural families participated in the study, 14 people staying in halfway houses in Santa Maria, Rio Grande do Sul, Brazil. The data obtained through interviews from November 2010 to May 2011 were analyzed with emphasis on content.

Results: the three themes were: halfway houses as a reference for permanence during treatment, everyday life and living together in the halfway house.

Conclusions: the experience was marked by the need to adapt to a context other than the rural one, with specific rules and routines, with discomforts and confrontations with urban culture characteristics and with what is experienced by other families who are also facing disease, which contributed to reframe the experience itself.

Keywords: Nursing. Family. Rural population. Neoplasms. Social support.

RESUMO

Objetivo: Compreender a experiência de famílias rurais que permanecem em casas de apoio durante o tratamento oncológico de um familiar adulto.

Métodos: Pesquisa qualitativa fundamentada no Interacionismo Simbólico e na pesquisa narrativa. Participaram sete famílias rurais, 14 pessoas hospedadas em casas de apoio em Santa Maria, Rio Grande do Sul, Brasil. Os dados obtidos por meio de entrevista, no período de novembro de 2010 a maio de 2011, foram analisados com ênfase no conteúdo.

Resultados: Os três temas abordados foram: casa de apoio como um local de referência para ficar, o cotidiano e a convivência na casa de apoio.

Conclusões: A experiência foi marcada pela necessidade da família adaptar-se a um contexto diferente do rural, com regras e rotinas específicas, com desconfortos e confrontos com características da cultura urbana e com o vivido por outras famílias também em situação de adoecimento, o que contribuiu para ressignificar a própria experiência.

Palavras chave: Enfermagem. Família. População rural. Neoplasias. Apoio social.

RESUMEN

Objetivo: Comprender la experiencia de las familias rurales que permanecen en casas de apoyo durante el tratamiento del cáncer de un familiar adulto.

Metodología: Cualitativa basada en el Interaccionismo Simbólico y la investigación narrativa. Participaron siete familias rurales (14 personas) que se alojan en casas de apoyo de Santa Maria, Rio Grande do Sul, Brasil. Los datos obtenidos a través de entrevistas, en el período de noviembre de 2010 a mayo de 2011, se analizaron con énfasis en el contenido.

Resultados: los tres temas que se trataron fueron: la casa de apoyo como un lugar de referencia para quedarse, la vida cotidiana y la convivencia en la casa de apoyo.

Conclusiones: La experiencia fue marcada por la necesidad de que la familia se adapte a un contexto diferente del rural, con normas y rutinas específicas, con incomodidades y confrontaciones con características de la cultura urbana y con las vividas por otras familias en situación de enfermedad, que ayudó a la resignificación de la experiencia.

Palabras clave: Enfermería. Familia. Población rural. Neoplasias. Apoyo social.

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■ INTRODUCTION

When a person falls ill it is an event that impacts and mobilizes all members of the family unit in a certain way⁽¹⁾. Having a family member diagnosed with cancer, regardless of age and life cycle stage, makes the family face new demands. Battling a disease, however, is an experience relating to family functions, that have the ability to take care of its members, as illness is a universal experience⁽¹⁾. Just as disease impacts how family functions, family interactions also impact the course of the disease, its treatment and cure, showing reciprocity between the patients and their families⁽¹⁻²⁾.

In this context, nurses must recognize that families, when faced with the illness process, need information and support, for, they tend to lose the skills involved in performing their functions, which could place them in a vulnerable situation. But, not all families remain vulnerable because, for, once the initial disorganization has past, they commonly restructure and retake control of their lives⁽¹⁾.

Although each family constitutes a unit with its own characteristics, the way how each family manages situations of illness and takes care of a sick member is related to the family group's prior experiences throughout life, their family belief system and the social-cultural context in which they live, and with which the family has a reciprocally influential exchange relationship where one influences the other⁽²⁻³⁾. Due to these factors, rural families experiencing illness conditions such as cancer, face events that are unique, particularly the need to move away from their environment and the group to which they belong, by immersing in a different and urban reality where the specialist oncology reference services can be found. This means entering unknown territory, both geographically and from the point of view of interpersonal interactions and health service dynamics, which contributes to changing how that family works⁽⁴⁾.

Depending on the type of cancer and the clinical condition of the person with the illness, the treatment requires daily presence, but not in the form of hospitalization. Under these circumstances, when possible, the families resort to transport services offered by the municipality of origin, traveling regularly, which presupposes the sick person has autonomy and independence⁽⁴⁾. If the patient is dependent, this can mean the need to stay in the city where the oncology service is located. Considering the territorial distances between the specialized units and places of origin, the lack of resources of families and limited investments from public policies in social assistance, the solution is to resort to the centers that offer support to sick people and their families, commonly called halfway houses.

The halfway houses are charities, usually initiatives by non – governmental organizations (NGOs), which offer help of various nature for people with illnesses and their families, such as hosting⁽⁵⁻⁷⁾. Studies related to halfway house receiving children with cancer stand out in the literature⁽⁷⁻⁸⁾. Although it represents an important resource accessed by patients and families⁽⁶⁻⁷⁾, not only rural, little is known about the meaning of this experience for those who live it, as well as the interactions and family arrangements in this context. This reveals a lack of knowledge, especially in the context of care for adult patients from rural areas.

It should be noted that, in a study developed in a halfway house for adults in Santa Maria/ RS, the profile of patients points to the prevalence of people over sixty years old, with incomplete elementary school education, monthly family income of up to two minimum wages and of the female sex. In addition, it was identified that approximately a third of families come from the rural area⁽⁹⁾. Considering the above characteristics, the shortage or lack of infrastructure and health care resources in rural areas and the limited social support network in the urban context for countryside families moving to specialized treatment centers^(4,9-10) shows that these families are part of a population group in a vulnerable situation. Vulnerability is understood in this study as the possibility of exposure, including to the illness, due to complex biosocial weakening processes that limit people's ability to act, restricting their affirmative relational capabilities in the world⁽¹¹⁾.

Knowing about experiences of other patients and rural families who need to resort to halfway house hosting can contribute to the understanding of the coping process and management strategies in the context of illness. This understanding may also allow professionals, including those from the nursing field, to identify the difficulties experienced by families and the support interventions needed by interacting with them, which, in a way, is in accordance with Ordinance 2866 establishing, as part of the Unified Health System (SUS), the National Policy on Comprehensive Health of Rural and Forest Populations (PNSIPCF). This Ordinance seeks, among its objectives, to contribute to the reduction of vulnerability in health and improve the quality of life of the rural and forest populations⁽¹²⁾.

Thus, this study's research question is "what is the experience of rural families who remain in halfway houses during the cancer treatment of an adult family member. The objective is to understand the experience of rural families who remain in halfway houses during the cancer treatment of an adult family member.

Considering that staying in halfway houses promotes interactions and construction of meanings that influence

the actions of families, the theoretical framework of this study is based on Symbolic Interaction. It is noteworthy that this framework allows the understanding of human action, based on social interaction, which refers to the action processed by the subjects in relation to themselves, others and the facts. Human action has a meaning for those who perform them because the person defines the experience, thinks about what they do and interprets the action itself and those of others to then act⁽¹³⁾.

■ METHOD

Narrative research was adopted as the methodological framework for this study, allowing access the experience of others, to extract, analyze and understand vivid personal stories. Narratives investigations are structured through three key elements: the temporal aspect, with the unfolding of actions and events; the aspect of context that includes the plot in which the juxtaposition of events and actions unfold, making meanings, causes and consequences of the facts explicit; and aspects that translate the worries, sufferings and annoyances⁽¹⁴⁾.

Under an interactionist perspective, the family is a group of individuals in symbolic interaction with each other and with others, sharing symbols, perspectives, *self*, mind and ability to take on roles. Because of their interactional experiences, family gives meaning to actions and events and acts⁽¹⁵⁾.

The study was conducted in Santa Maria/Rio Grande do Sul. Participants were selected among patients in cancer treatment in the hemato-oncology and radiation therapy services at the University Hospital of Santa Maria (HUSM), from information related to their origin and the place where they were staying, obtained through information provided by the nursing staff and confirmed by patients and families. Participants were seven rural families (14 people, seven patients and seven relatives), that suited the inclusion criteria, which are: to originally be from rural areas (residents in areas outside of cities, districts/towns); to experience the illness of a family member to cancer; to be staying at a halfway house; to have more than one family member present at the interview, including the patient; to be 18 years or older and be aware of the medical diagnosis. Those with limited communication were excluded.

The data collection technique used was that of open interview, focused on the following question: How has the family felt about staying at the halfway house? The interviews were held during a meeting with each family, from November 2010 to May 2011. The time and place for the interview was agreed upon with the participants,

taking place in the hospital's office or at the halfway house. Data collection ended when the purpose of the study was completed and the information allowed the understanding of the concepts identified, which happened through the depth and richness of content, i.e., through data sufficiency⁽¹⁴⁾. To guarantee anonymity to those who granted an interview, the narratives were coded with the letter F (family), followed by an ordinal number from 1 to 7 and the letter P for patients and the first letter of the link family (Ex. F son, E wife ...).

In the process of analysis, the narrative research method was used to elaborate categories with emphasis on content, following four steps: 1) subtext selection, in which the relevant parts of the narratives were selected and grouped to form a new text; 2) content category definition, in which subtext themes were drawn; 3) classification of the material into categories, when sentences or phrases were separated to determine categories; 4) description of the categories and names of the subjects⁽¹⁴⁾.

The research project was approved by the Research Ethics Committee with a Presentation Certificate for Ethics Assessment (CAAE) 0008.0.243.000-10. The ethical aspects of the informants have been respected, in compliance with the guidelines of Resolution 196/96 of the National Health Council, in force at the time. All participants signed the Free and Informed Consent Form.

■ RESULTS AND DISCUSSION

The study's participating families live between 38-400 kilometers from the hospital, in an average of 210 km. Five couples, a father and son and a mother and daughter were interviewed. Among the seven people inflicted by the illness, five were male, age ranged from 32 to 74 years, with an average of 52 years. The diagnoses were leukemia with brain metastases, brain cancer, prostate cancer, esophagus cancer, larynx cancer, cervical and lung cancer with hip bone metastasis. All of them were engaged in farming, and one was a retiree. Family members were between 24 and 61 years old, 5 were homemakers, one a nursing technician and one a farmer.

The narrative analysis allowed the categories that describe the experience of the rural families that are hosted by halfway houses during cancer treatment to be defined, and conform themes presented below.

The halfway house: a reference at which to stay

In the face of falling ill from cancer, rural families have sought health care services in locations close to where they

live. Usually they were referred to centers with resources of greater technological density, which are in cities often distant and unknown, a fact that validates findings from studies about health of the rural population^(4,10). Families often has nowhere to stay in these cities.

It was all new to us. We came without knowing where it was. We didn't know the distance, nothing... The city government used its resources, took us to the hospital and left us there. We came here without knowing anything. I was admitted directly to the hospital and she was left alone (F1 P).

Faced with the need to stay in the city, the family found itself in a situation that was causing insecurity and raising questions. The family then sought information about the places where they could stay and assessed the possibilities according to the resources available and the hosting network in the hospital vicinity. However, not all families had financial resources that would enable them to bear hotel expenses. These families often turn to halfway houses, which they call "pensions", and whose symbolic payment does not significantly impact family expenses.

So, from personal searches, information obtained from people who were currently undergoing or had undergone treatment, by recommendation of the hospital's social service or the municipality of origin, families resorted to halfway houses.

My daughter walked around asking. I don't know how they found this place, or found the phone number. I know that when they called there were no vacancies, it was always stacked with people. Then we left our phone number so that they could call us (F2 P).

It was the girl from the health department that told us about it, and the hospital mentioned it too. We thought it would be better to stay here. The place we stayed at is payed for by social support (F4 E).

We heard about these places from some neighbors who had a sick family member and who spoke of the pension, they mentioned it was free. But you had to go to social assistance. I went there and they sent us to this Halfway House. There are others that are paid (F6 F).

During the period in which the sick person is hospitalized, the family member that is with the patient has a place to prepare their meals, rest and stay overnight thanks to the halfway house. A temporary home⁽⁶⁾. When necessary, the patient also remained there, as was the case of those

who performed daily treatment and were unable to travel to their places of origin because of the distance and/or their physical and clinical conditions.

I was doing chemotherapy and started having reactions that took a toll on my body. Then the doctor thought it would be best for me to stay here instead of going home (F5 P).

We end up not going home because it's 400 km away. We depend on the city government or a private car to pick us up. It's better if we stay because of the expenses. We see more advantages in staying at the pension than going home (F1 E).

In view of making treatment possible, stay at a halfway house is the solution to a problem, because the presence of a family member accompanying the sick person ensures assistance in case of need and vigilance regarding the evolution of the illness, allows emotional support, contributes to the maintenance of family ties and the preservation of the identity of the person in treatment. Staying with the patient helps reduce anxiety levels and aids in decision making regarding treatment involving family members⁽¹⁶⁾.

However, remaining at the halfway house implies that family members that it will stay will undergo a period of estrangement due to their insertion in a context of coexistence and interaction that is distinct from that of the rural environment, which may cause suffering.

At first it was complicated. Because we didn't know anyone. There are people from all over Rio Grande do Sul there. At first, we feel shy, we don't know what to say... But today, now that we know everyone, we are interacting very well (F1 P).

The arrival here wasn't easy. We didn't know anyone. Everything was strange to us! We were not used to the city. As soon as you arrive it seems like a strange place. At home, it was just us two and animals. And here there are a lot of people (F3 E).

The arrival at the halfway house can have a similar meaning to the one attributed to the hospital, an environment that is hostile to human nature and triggers emotional vulnerability, in particular due to the inclusion in an interactional context that requires interaction with people and unfamiliar situations and interferes with life style, giving a sense of insecurity and loss of self-control, since, according to the literature, rural people tend to be more self-sufficient

and less likely to ask for help⁽¹⁷⁾. Feelings of fear for the possibility of experiencing difficult situations and not adapting to their temporary home were identified among users of a halfway house in the state of Paraná⁽⁶⁾.

In the interaction process that took place in this environment, situations are defined, meanings are assigned and actions will be developed. And so, the experience of staying in the halfway house will be defined by each person and by each family.

It's nice here, for someone who's spent an entire month locked up in that hospital, in that room, it's like... I'm free! I go to the yard, I get out, walk ... (F4 P).

Although at first staying at the halfway house initially caused estrangement, and to a certain point, some discomfort, narratives allow us to infer that the experience is gradually defined from the perspective that being in the Halfway House is better than staying in the hospital, giving a sense of family life and freedom, similar to living in rural areas.

Daily life in the halfway house: between coming and going from the hospital

The stay in the halfway house is a period marked by experiences that will be determined, among other things, by the bonds formed, which are dependent on the time and the frequency with which each family stays at the "pension". The longer the length of stay and the more regularly the family stays there, more adapted and integrated life becomes. This experience, according to the literature, constitutes a protective factor, for, when relating with people in similar situations, families are a source of support at this moment of their lives⁽⁸⁾.

I was discharged and went to the pension. We stayed for 30 days. It's been about nine months since we came here. Now it's been two months that we've been here. We know everyone (F1 P).

We get along with everyone I met and had treatment with. They are here and at the hospital. Even now we meet, because sometimes we manage to come on the same day. Others stop coming and eventually lose contact (F5 P).

Because they share the illness process, the people staying in the halfway houses share a daily ritual that, in a sense, refers to a domestic routine⁽⁶⁾. Thus, to fill the day with normal activities, the family sought alternatives, be it taking care

of themselves and their things, assisting in the house activities or doing something that would help distract them.

We wake up in the morning and have medication rounds. Here, in the morning, everyone is worried about doctors and tests (F6 E).

I spend time washing, giving medicine, which is time sensitive, and seated, talking and watching television, when there are no clothes to wash (F3).

Then we go to the hospital for treatment and come back here. Sometimes we cannot bear to stay inside and go out. Maybe take a walk outdoors to wake up. I like to walk and we go close by. I feel brand new when I take a walk (F4 P).

Meal and prayer time, usually held at night when most of the guests returned to sleep were identified as activities that can be developed collectively.

We practically had lunch all of us together. In the morning, we get up and go out to the hospital. Then, we meet at lunch or in the evening when we talked more (F1 F).

Some people spend the whole day in the hospital and come back at night. When they arrive, we ask about the family member, how their day was and then we start a conversation (F2 E).

We hold prayers every week, one day with a Pastor, another with a catholic, the other with another congregation (F3 E).

Despite the particularities of each person and the way of being of each family, the routine in the halfway house was directed to the following pre-established rules, considered as requirements for good living, to preserve the dynamics of institutional activities and to seek harmony between the guests.

Cleaning each one would do their own. We would clean up after ourselves. Each person can make their own lunch if they want something different, but you must leave everything in order. Maintain order in the bedroom, in the bathroom. There's a cleaning lady, but you have to help (F7 F).

We have dinner, lunch, drink coffee, sleep. It's well organized. But couples can't sleep together (F3 E).

Considering the daily lives of families, the research seized that interpersonal interactions occurred in the con-

text of getting to and from the hospital, and the activities developed when “coming back from” the hospital were restricted to personal care, with the patient, in aiding house demands and those proposed by the religious families. Regarding distraction activities, the data suggests a lack of alternatives, which limits the actions taken by families and appears to confer certain monotony to the everyday life in the house, in addition to centralization in the aspects that relate to the disease.

Regardless of rural or urban origin of the families, daily activities in the halfway house provide a similar routine to everyone who there remains and provides an identification by the experience lived. A warm welcoming atmosphere within the halfway house can constitute a source of comfort to the user and their companion, helping them to find the strength to overcome difficulties, providing solace and refuge to restore hope⁽⁶⁾.

In this sense, the halfway houses represent a support space and the possibility of continuity/clinical treatment feasibility, also being a *locus* of care, in which nurses can contribute proposing the development of health promoting actions, through sensitive listening, intercultural dialog, ludic resources, among others.

Living together in the halfway house: shared suffering and solidarity

In everyday activities at the halfway house, people define situations and the facts experienced, attributing meaning them. Permanence and distinct natures interactions established in the house emerge Settings that reveal the meanings attributed to the experience – simultaneous suffering and solidarity – are established in the house based on the permanence and distinct interactions. Suffering can be seen from the need of the sick person to move away from the rural life environment and context to undergo cancer treatment that requires, depending on the clinical condition and the patient’s level of dependence, a family member to accompany him or her.

I come with him almost every time. Because my mother in law comes, but she can't stay much because she has a husband. It's grueling! I also miss home. I could be there with them. I would like to be with my son, because time is passing by and I missing everyone (F1 E).

The data revealed that, among couples where the man is sick, the accompanying family member usually was the wife and, when it comes to the woman, it was the daughter. This family configuration in which the woman takes the

role of main caregiver validates the above study related to this issue and highlights the need for changes in the roles and the assumption of family tasks⁽¹⁸⁾.

For families of this study, the responsibility centered on a single person and stay lasted several days away from home, representing a depart from the other family members, fatigue and wear, which meets the factors noted in the literature review as overload generators to the family member responsible for care, among which stand out the lonely care, the degree of patient dependency and physical and psychological stress⁽¹⁹⁾.

As the vacancies available in halfway houses are restricted, the patient was only accompanied by one relative that, in a hospital situation, was the person who remained in the house. Regardless of the sick person also being hosted, the perception of being away from home, the other family members and the familiar environment gave both persons the feeling of being alone and helpless, without having anyone to turn to.

When we arrived, we were alone. No one spoke a word to anyone. We were learning alone, doing what we could. Today, people come and the next day we're talking and they are calmer too. We would have liked it if someone had done this with us... (F1 E).

The contact with different people, who came from different places, with unique customs and ways of living is not always pleasant and can cause fatigue and desire to isolate one’s self⁽⁷⁾. In situations where the sick person was debilitated, without clinical, physical or emotional conditions to remain in contact with the others, the space occupied by it was confined to the room, which was often collective. The withdrawal was also due to the way the person felt about their disease, especially those who had physical changes, such as wounds, mutilation and/or used devices such as catheters and drains. Self-awareness and impaired body self-image, which is revealed in feeling ashamed of their condition, and the fear of stigma may lead to voluntary isolation. In this context of coexistence, privacy becomes limited, which may enhance the feeling of discomfort and, in some cases, generate anxiety.

E. is quieter, he hardly talks and almost never likes being among the others because of that string that hangs from him [urine collection bag]. He just stays there quietly. At home, when visits come, he runs and hides so no one sees the urine bag. He says: My God, when am I going to get that bag removed? Here, I go down to drink tea with the others and he stays in the room (F3 E).

The physical structure of some halfway houses, in which the rooms are organized by sex, can also be a difficulty in the care provided by the family member, due to the impossibility of direct access. This situation can cause discomfort to the family member who cares for the patient, since that family member will need to go from one place to another to meet the sick person's needs, especially during the night, causing fatigue and physical stress.

The women sleep upstairs and the men sleep downstairs. E. has a medication that is given at midnight, 1:00am, or so. I have to get up come down and give him the medication (F3 E).

While coexisting in the halfway house constitutes an experience that can generate suffering, expressed by discomfort, wear, loneliness and helplessness, for some families this coexistence represents not only a place to stay during treatment, but a possibility for personal growth, reframing experiences and individual and family strengthening.

In this perspective, evidence from the study held to assess quality of life of people with cancer who searched for assistance in halfway houses point out that the support received there, in addition to that of family members and friends, was detrimental in crossing the most critical phase of the disease, and to rehabilitation, improving the quality of life⁽²⁰⁾.

During the time that they remained in the halfway house, especially at night, a greater possibility of interaction between people staying there was noted. Sharing tea during late afternoons allowed not only a cultural habit to be shared, but also for a characteristic of rural families to be shared, one that strengthens them as a system when interacting with people⁽³⁾. The friendships established are resources used to address situations of daily coexistence and minimize the difficulties⁽⁷⁾. Thus, getting closer to others and the friendly conversations that came about allowed experiences and confidences to be exchanged.

We talk to each other. Have some chimarrão. Of course, each with their own cup. But together, like a meeting. One person tells a story, then another. It's very nice! (F2 E).

There's a lady I get along well with. We knew each other from the time she was sent to the hospital. I talk to her, we drink chimarrão. Oh, I really like it! (F4 E).

Living together in an environment in which all share the same situation – to be living a process of falling ill

and being away from home – provides the formation of a common identity that binds and brings people together, resulting in potentiation of the ability to put yourself in the other person's situation^(8,15), and, in this perspective, act in an empathic, supportive and cooperative manner⁽⁴⁾.

Everyone helps each other. Whenever you eat you invite someone. Because only those who are in the same situation can understand the other person's problem. Those who don't go through the situation think: 'it doesn't matter if he eats or not' Now, when you're there, when you've been through that, you know what it's really like! Often, I was without food for being late... and I would get to sad ... You don't have the energy to do anything... So, we invite the person to eat, because you know it's hard for who's alone (F1 E).

One person helps the other, when one doesn't know something, the other goes there and teaches them. I didn't know anything, where the laundry area was, the rooms. One person took me there and taught me everything quickly (F3 E).

In the interactional context made possible by the halfway house, the experience was reflected in the other's experience, in the illness in its various manifestations, the need to enter and face an unknown world made up of the city, the hospital, the house itself, where feelings of sadness, fear, insecurity and loneliness communed. This reality proved to contribute to define the experience lived, giving it a meaning that refers to abandonment⁽⁴⁾. Thus, to identify the helplessness of the other – which is also their own – families respond in an empathic and cooperative way, realized in actions that show support, care and other forms of assistance that are within reach⁽⁴⁾. However, to experience an authentic welcome, based on a sympathetic and humane way, awakens feelings of gratitude and empathy⁽⁶⁾.

Faced with situations of suffering present in the experience, interactions established throughout the process experienced sharpened sensitivity to understand and help others, giving a feeling of support and individual and collective empowerment. Together, supporting each other, they were strong to tackle the disease, the treatment period and living in the halfway house.

Everyone who goes there has a health problem. We, who already know how it works, try to talk, talk, explain what we know. But, it's complicated. Each person is in despair, health is the main issue. Without health, we're not worth anything. I know I need strength to give him strength and still have enough for me. Here we learn we must be strong,

because sometimes the suffering of others is greater than our own. We create friendships with people. Many are gone and we are still in contact (F1 P).

The frequent coexistence in halfway houses and sometimes in the hospital as well, and the shared experience contribute to the development of a feeling of closeness and unity, and the bonds of friendship and camaraderie may be maintained even after the treatment phase ends. The house remained a reference place to stay when it was necessary to return to the oncology service. People who met during this period continued to be present in some way, as well as the experience and intensity.

I like to stop here when I come, I get along well with the owner (halfway house coordinator). I do everything I need to in the hospital and then I leaving. When I return, I come back here. We get along well with everyone here, those who we did chemo together. Now we meet and even remember the good days we spent together (F5 P).

One person was hospitalized with leukemia, the same leukemia I had. His mother came to the pension and we developed a very strong friendship ... And, unfortunately, her son died. That shakes you up ... Some days they were there. We always think that everyone will get better. I think that way ... It gives me hope, you know? This problem of ours is serious, but there are worse scenarios. So, the strength, the will must always be greater. And so is life, every day is new. We get very shocked! (F1 P).

When staying in the halfway house and, in that context, interact with themselves, with others and with the events related to the disease process, the person defines the situation, interprets the experience, gives meaning to the experience and acts in relation to it⁽¹³⁾. Clinical improvement, optimism, the joy of each one influences the group. In this logic, hopelessness, sadness or death of one of the house guests is reflected in the other. Thus, considering the symbolic interaction process, the families identified by the fact of being at home and suffering due to something they have in common, they interpret the experience and act with solidarity, in a reciprocal manner. Thus, each person, the family and the group that there is hosted strengthen one another.

Suffering and others' difficulties contribute to values, beliefs, and personal attitudes and those of rural families to be reviewed and re-signified. From the experience, the ability to put yourself in the other's situation becomes developed and, therefore, the sensitivity to identify how to help and act accordingly. In this interactional context, rural

families redefine their situation and, based on this definition realize they can be useful to others, working cooperatively and collaboratively with others.

In sharing the illness, rural families staying in halfway houses exercise generosity, flexibility and share what they know and what they have. Thus, reciprocity, as presented in this course of action, strengthens both the helper and the person who is helped and, in living with the pain of others, they resignify their own pain.

■ FINAL CONSIDERATIONS

From the themes that emerged in the study, it was possible to seize the that experience of rural families who remain in halfway houses is the result of the movement undertaken in the search for specialized cancer treatment. For families, living in this space is an experience marked by the need to adapt to a context other than rural, with specific rules and routines, discomforts and confrontations before the characteristics of the urban culture and the experiences of other families in a situation of illness, but essential for the completion of treatment.

To understand the experience of families who turn to hosting in halfway houses contributes to seizing the resources that the rural family accesses in the management and coping process of falling ill from cancer, and how this experience affects the families of the stock. Thus, it may represent a contribution to Nursing at the time it raises a reflection on the social support to people who are ill, and in this case, aggravated by the withdrawal from their cultural scene, which is the rural world.

Whereas experience of rural families, in some respects, may resemble what is experienced by families from urban contexts that also remain in halfway houses, we need studies that explore this perspective, since approaches that include halfway houses as a space for care in situations of illness are still incipient in the specialized literature and constitute a limitation to this study. Thus, the results presented here can be considered representative of the sample and the context in which the research was conducted, and it is important to hold further studies to confirm and further analyze them.

It should be noted that this study contributes to nursing knowledge, increasing the prospect of professional interaction and enabling the approach to this population to support and strengthen family integrity, developing humane, comprehensive and affordable care, guided by the principles of care centered on the family and in accordance to what is recommended by SUS and the Health Care National Humanization Policy.

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