



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

CHRONIC DISEASE AND ACTIONS OF CARE TO THE RELATIVE DOENÇA CRÔNICA E AÇÕES DE CUIDADO DO FAMILIAR ENFERMEDAD CRÓNICA Y LAS ACCIONES DE CUIDADO DEL FAMILIAR

Carolina Kroeker Kroeger Siemens¹, Maria de Fátima Mantovani², Mariluci Alves Maftum³, Elis Martins Ulbrich⁴

ABSTRACT

Objective: identifying actions of care that family members for chronically ill perform for themselves and relating it to their profile, their knowledge about the risk factors and their feelings. **Method:** a descriptive study with a quantitative approach conducted with 98 family members of patients at a hospital in Curitiba/Parana, through interview form, and analyzed with the software Statistica, version 8.0. The research had its project approved by the Research Ethics Committee, CAAE 0241.0.208.091-10. **Results:** among family members, 28% have changed their habits after diagnosis of SAH or hospitalization of the patient, while 72% have not changed it. Significant association was found between changes in habit with the profile variables: gender, education, income, and feelings of worry, sadness, fear and denial. **Conclusion:** promoting adult health care through actions configured in the field of research in order to prevent the onset of Chronic Diseases. **Descriptors:** Chronic Disease; The Adult Health; Risk Factors.

RESUMO

Objetivo: identificar as ações de cuidados que os familiares de doentes crônicos executam para si e relacioná-las com seu perfil, seu conhecimento sobre os fatores de risco e seus sentimentos. **Método:** estudo descritivo de abordagem quantitativa com 98 familiares de pacientes internados num hospital em Curitiba/PR, mediante formulário de entrevista, e analisados com o programa Statistica versão 8.0. A pesquisa teve o projeto aprovado pelo Comitê de Ética em Pesquisa, CAAE 0241.0.208.091-10. **Resultados:** entre os familiares, 28% mudaram seus hábitos após o diagnóstico de HAS ou internação do paciente, enquanto que 72% não os mudaram. Associação significativa foi encontrada entre mudanças de hábito com as variáveis de perfil: sexo, grau de instrução, renda, e sentimentos de preocupação, tristeza, medo e negação. **Conclusão:** a promoção da saúde do adulto através de ações de cuidado configura-se em campo de investigação a fim de prevenir o aparecimento das Doenças Crônicas. **Descritores:** Doença Crônica; Saúde Do Adulto; Fatores de Risco.

RESUMEN

Objetivo: identificar las acciones de cuidados que los familiares de enfermos crónicos prestan para si y relacionarlos con su perfil, su conocimiento sobre los factores de riesgo y sus sentimientos. **Método:** un estudio descriptivo con enfoque cuantitativo con 98 miembros de la familia de los pacientes en un hospital de Curitiba/Paraná, a través de formulario de entrevista, y se analizaron con el software Statistica, versión 8.0. La investigación fue aprobada por el Comité de Ética de Investigación, CAAE 0241.0.208.091-10. **Resultados:** entre los miembros de la familia, 28% han cambiado sus hábitos tras el diagnóstico de HSA o la hospitalización del paciente, mientras que 72% no los han cambiado. Se observó asociación significativa entre los cambios en el hábito con las variables de perfil: género, la educación, los ingresos, y los sentimientos de preocupación, tristeza, miedo y negación. **Conclusión:** la promoción de la atención de salud para adultos a través de acciones configuradas en el campo de la investigación con el fin de prevenir la aparición de enfermedades crónicas. **Descriptores:** Enfermedades Crónicas; La Salud del Adulto; Factores de riesgo.

¹Nurse, Master of Nursing, Federal University of Paraná / UFPR. Curitiba (PR), Brazil. Email: carolina_k2@hotmail.com; ²Nurse, Doctorate in Nursing, Federal University of Paraná / UFPR. Curitiba (PR), Brazil. Email: mantovan@ufpr.br; ³Nurse, Doctorate in Nursing, Federal University of Paraná / UFPR. Curitiba (PR), Brazil. Email: maftum@ufpr.br; ⁴Nurse, Doctoral student of Nursing, Federal University of Paraná / UFPR. Curitiba (PR), Brazil. Email: lilaulbrich@yahoo.com.br



INTRODUCTION

Chronic Noncommunicable Diseases (NCDs), according to the World Health Organization (WHO), are responsible for 63,5% of all deaths in the world, four times more when compared to infectious and parasitic diseases (15,3%), and the highest percentage corresponds to cardiovascular disease, resulting in 30,5% of deaths.¹ This occurs due to urbanization, which resulted in changes in lifestyle and habits of the people, and the demographic transition that is happening in Brazil since the 1960s.²

Habits and lifestyle are responsible for part of morbidity and mortality in adults, but its modification is not easily obtained, since it requires the elimination of some pleasurable situations, already incorporated into daily life and sometimes socially supported, such as smoking or ingesting alcoholic beverage. However, changing these habits can generate significant change in the quality and life expectancy.³

Needs to be adjusted for the adoption of a healthy lifestyle habits cause structural changes in everyday family dynamics; so, the family is participating in the co-responsibility for health and the complications of chronic illness of its members. In this context the presence of a chronic disease affects not only the patient, but extends to their family environment.⁴ A family of chronic disease carrier undergoes a process of maladjustment in its structure and functions, since goes to have to adapt its family dynamics to new needs and activities related to treatment and patient support, and tend to increase as there is the evolution of the disease.⁵

When a member is affected by some disease, the search for solutions begins in the family. Facing a problem related to a critical health event, family life tends to undergo changes with this new situation, which turns out to involve all members⁽⁴⁾, since the family constitutes a social environment in which the individuals who interact in it are able to make it or not conducive to health, generating conditions of health or disease, being subject to the same habits, customs and beliefs.⁶ When the positive aspects are stronger and weaker negative, preventive action can be achieved. As society parents are key influencers/educators, they should be the first to adopt healthy habits, and to encourage their children to adopt them.⁷

These aspects are often relegated to the background in hospital nursing practice, because although socialize daily with chronic disease and impact of the individual's life, the

concerns of these professionals are usually restricted to issues of illness and treatment.

When considering these aspects, one should reflect on how each of its members take care when experiences a complication of chronic disease that culminates in the hospital. Thus, the question that guided this research was: What care that the family of chronic ill done to you?

Care actions discussed here are the changes in lifestyle and preventive activities, and chronic disease was considered systemic arterial hypertension (SAH), its epidemiological magnitude, whose prevalence in Brazil, according to estimates based on data obtained from some population studies, leads them to believe that it affects approximately one quarter of the population.⁸

OBJECTIVE

- Identifying the actions of care that family members of chronically ill perform for themselves and associate them with their profile, knowledge about the risk factors of hypertension and feelings in relation to this disease.

METHOD

Article drawn from the dissertation << *Chronic Illness and Care Actions of the Relative: grants for nursing* >>, presented at the Federal University of Paraná/UFPR. Curitiba (PR), Brazil, in 2011.

Quantitative study, descriptive developed 14 units of a University Hospital located in Curitiba, Paraná. The sample was a convenience gem with 98 family members of patients who presented as one of the admission diagnoses Hypertension, aged between 18 and 59 years old, who coexisted with the same or had kinship with it.

Data collection was from March to May 2011, upon interview form, previously tested, including questions relating to the identification of participants, knowledge about the disease of the relative, feelings towards it, and habits and care related to the disease of its relative.

Data were organized in Microsoft Excel 2010 spreadsheet, and as a measure of quality control, has been validated typing 20% of interview forms. After this step, were analyzed with the computer program Statistica version 8.0, and used the Chi-square with $p < 0.05$.

The research project was submitted to the Research Ethics Committee of the Department of Health Sciences, Federal University of Paraná, and approved at the meeting on

September 22, 2010, under the record CEP/SD: 1011.136.10.09 and CAAE: 0241.0 .208.091-10.

RESULTS

Regarding the sociodemographic aspects of the family, 75% were above 30 years old, 67% were female and 68% were married. It was observed that 44% of the relatives initiated and / or completed primary education, 57%

had family income of 1-3 minimum wages and two-thirds (66%) were Catholic.

Regarding care actions identified by changes of habits, 28% of families responded that changed after the diagnosis of SAH or hospitalization of the patient-family (Table 1). Of the 98 respondents, 24% said they changed their habit at diagnosis of the patient and 11% said they changed their habit at the time of patient hospitalization.

Table 1. Careful actions of participants by category (n = 27). Curitiba-PR, 2011.

Categories *	1	2	3	4	HA	Total
Avoids salt	-	26%	22%	52%	-	100%
Does physical exercises	33%	41%	8%	7%	11%	100%
Stopped smoking	11%	-	-	4%	85%	100%
Avoids fried foods	7%	37%	19%	30%	7%	100%
Takes care of the weight	19%	22%	19%	33%	7%	100%
Avoids alcohol in large quantity	7%	-	4%	22%	67%	100%
Avoids getting stressed	15%	63%	11%	11%	-	100%
Performs medical consultation	30%	30%	7%	22%	11%	100%
Performs blood pressure examination	19%	33%	19%	22%	7%	100%

Legends: *1 - never; 2 - a few times / sometimes; 3 - many times; 4 - always; HA - previous habit.

The evident changes were: salt reduction (74%), the control of body weight (52%) and the decrease of fried food in the diet (49%). Already the less corporate habits were the practice of physical exercise (74%), conducting medical consultations (60%) and stress management (78%).

To assess the relationship between change in habits at diagnosis and profile variables such as age, religion and kinship, the results showed no statistical significance. However, gender (p = 0.024), the level of education (p = 0,026) and income (p = 0,043) were significantly associated with the change of habit when the diagnosis of hypertension in the patient occurs. Thus, there was a higher chance of changing habit at diagnosis of hypertension relative among women, individuals with higher levels of education and higher income level (Table 2).

Table 2. Evaluation of association between variables and the change of habit in the diagnosis (n = 98). Curitiba-PR, 2011.

Profile variable	Change of habit in the diagnosis		P value
	No	Yes	
Gender			
Female	70%	30%	
Male	91%	9%	0,024
Schooling			
Until the elementary school	89%	11%	
High School	71%	29%	
Higher/Graduate	60%	40%	0,026
Income (minimum wages)			
Until 1	80%	20%	
1 to 3	84%	16%	
3 or more	59%	41%	0,043

The relationship between feelings and habit change, and the relationship between knowledge of risk factors for hypertension and

habit change at the time of diagnosis, were not statistically significant.

Regarding the relationship between variables of profile and of change of habit

when relocation no statistical significance was found. Likewise, knowledge of risk factors is not associated with changes in habits during the hospitalization of the relative.

However, according to Table 3, the feelings of concern ($p = 0,014$), fear ($p = 0,001$), rejection ($p = 0,029$) and sadness ($p = 0,027$) significantly increase the chance of habit change occurs when the hospitalization.

Table 3. Evaluation of association between feelings and change of habit in the internment (n = 98). Curitiba-PR, 2011.

Feelings	Change of habit in the time of hospitalization		P value
	Não	Sim	
Worry			
No	100%	-	0,014
Yes	83%	17%	
Fear			
No	97%	3%	0,001
Yes	74%	26%	
No acceptance			
No	91%	9%	0,029
Yes	57%	43%	
Sadness			
No	93%	7%	0,027
Yes	72%	28%	

The reasons why 72% of respondents have not changed their habits, even after HBP diagnosis of a family member or his hospitalization, were 53% already had a healthy lifestyle; 31% said it would make no difference if they changed habits; 14% gave several reasons; 11% did not know that his family and patients had hypertension; 11% tried to change their habits, but failed; 11% would not mind having the same disease; 6% of respondents did not know the habits of the link with hypertension; and 6% said they will have SAH anyway, because it is genetic.

DISCUSSION

When discussing about care actions performed by 28% of the relatives, there is the reduced physical activity, despite the advantages in quality of life and morbidity and mortality that it provides profile. The prevalence of physical inactivity in Brazil is quite high. In a study with a sample of 1.935 people, the proportion of subjects with score 0 physical activity per week was 10% among men and 11% among women and 29% of the population studied had insufficient level of physical activity. However there is the difficulty experienced by research subjects to estimate and quantify physical activity and accurately determine what would be a normal/routine week. Another limitation is considered a dimension of leisure, or includes work-related activities, travel and home services.⁹

Regarding alcohol consumption, 67% said they had not the habit, and 22% said they always avoided the alcohol after diagnosis of hypertension in the family. Alcohol is a toxic substance that can contribute to the occurrence of hypertension,

hypertriglyceridemia, non-insulin diabetes, cancer, liver disease, encephalopathy, among others. Alcoholism is a major social pathology, but the direct questioning about the habit of drinking alcohol causes discomfort; social discrimination implied by this question.¹⁰ It is believed that this may have influenced participants' responses.

Regarding stress, only 11% were able to avoid it altogether after diagnosis or hospitalization of the patient. It is difficult to address this issue with family members of a patient admitted because, even though the stress of the risk factors for hypertension, both the chronically ill and families face challenges associated with new roles that affect their social, financial and their physical capabilities.¹¹

As for regular medical consultations, 30% do not even performed after diagnosis or hospitalization of the patient. Realizes the lack of preventive care by relatives, a fact that can be corroborated with a study among nursing students, people who are connected to the area of health, and that still reveal that his search for medical care arises only happens when some health problem.¹²

The changing habits of these relatives, or lack thereof, relates to the valuation of their own health, and this involves making decisions on how to live, assuming responsibilities as the behaviors and attitudes which determine the quality of life.¹²

A study that sought to identify the preventive measures, but of health complications in the presence of chronic disease nurses showed that they adhere to treatment, and that there was a change in lifestyle to tackle the disease. Regarding the changes in his life after the diagnosis of



chronic illness, 44.83% relate to the physical realm, such as weight control, and 20.69% reported behavioral changes, such as waiver of certain professional goals and reducing involvement with the patient. Thus, the nurses changed their habits and made changes at work that worsened their maladies. Only 13.8% said they had not made any change.¹³

Thus, the percentage of hypertensive patients who have changed their habits in the above study is greater than that found in this study among family members, but one must take into consideration that are health professionals, and so it follows that they have a greater knowledge about disease. In addition, most families in this study are not hypertensive and therefore their adherence to preventive measures can be considered less attractive.

A statistically significant association between change of habit at diagnosis of hypertension patient and gender of the participant corroborates with a study that investigated health behavior among college students and their gender differences. Found that male students had higher risk behaviors for health. In turn, women, in general, had lower frequencies of risk behaviors such as alcohol consumption, use of tobacco and illicit drugs, firearms and involvement in physical fights. Men and women have different health behaviors.¹⁴

As for schooling, this has recently been described as one of the most important socio-demographic variables in the study of smoking. In population studies, the prevalence of smoking has been higher among people of low and middle school, but found a survey in which the majority of respondents had completed their secondary education, an above-Brazilian population in general educational level. This fact can be explained by the finding that smokers who seek support to quit smoking are those with greater access to information in general, especially in regard to health care (including all concepts of prevention).¹⁵

Taking the above into account, this would also explain the fact that the level of education influences the changing habits of family contact with a sick member, causing them to seek disease prevention.

Income level and health status variables are correlated, both because of increases in first provide greater access to goods and health services that reflect improvements in the health status of individuals, as the gain in productivity and income propitiated by health improvements of the individual.¹⁶ It can be inferred that a higher level of income leads to

greater search for information on health services on prevention of disease, allowing/enabling change their habits.

Noteworthy is also the associations between change of habit when relocation and feelings worry, fear, rejection and sadness. Family caregivers are dedicated to caring for feeling love, compassion and concern for the patient. They strive to be good about themselves to provide the patient with one member of minimizing their suffering.¹⁷

Thus, this sense of concern appears in the literature to address the family worried about his patients, or patients themselves. There was no feeling of health-related family that led him to change his habits, as revealed in our research concern.

The look of fear that the family has in relation to chronic disease was addressed in a study that showed that this fear when there is a genetic risk, often leads these individuals to change their behaviors and habits, passing by the adoption of a healthy life. Fear can promote an unconditional adherence to preventive practices and medical recommendations, which corroborates our research, this feeling caused families to change their habits to avoid the suffering of SAH.¹⁸

The aspect of denial is discussed in a study that deals with "knowing or not knowing" when there is a genetic risk involved, raising the problem of denial as defense or escape. People seek not a way to discover the truth about themselves because they think they are not emotionally prepared to bear the psychic pain that this same awareness involves.¹⁹

The denial was present this research and led family to change their habits after admission the patient. It is inferred that this may mean that the family did not accept this situation of chronic disease, encouraging him to avoid it.

The reasons cited for the lack of change in lifestyle or concern with this aspect may be associated with chronicity of hypertension, or the disease is asymptomatic, which requires special concern in relation to preventive therapeutic actions. Habits and lifestyles are responsible for much of the morbidity and mortality in adults. The modification of these is not easily obtained because demand abolition of some pleasurable situations already incorporated into daily life and some times socially supported. However, the change of habits can generate significant change in the quality and life expectancy.³

Another reason for the difficulty of modifying habits found in the literature is that the implementation of preventive measures is



often limited by low motivation or lack of resources for adoption of these standards healthier.²⁰ It can also result from a lack of time to feed adequately care for themselves physically and aesthetically, for the sake of work. Commitments with the estimated work as priority impede the primacy of self-care in some cases.¹²

Regarding the aspect of healthy lifestyle, which was the main reason cited by the group for not deem it necessary to change their habits (53%), we stress the fact that the participants of this research to know the risk factors for chronic disease, can somehow have influenced the answers about their habits, since the tendency is to answer what is right, not necessarily what actually practice.²¹

For the four people who said they will develop hypertension regardless of their lifestyle, when communicating to someone that a genetic predisposition to a disease, which was identified to be said, is that there is no certainty of getting the disease, since other factors besides heredity may hinder or aid the onset of disease. The individual only has a risk factor and the fact that this predisposition be detected gives you the advantage to prevent. May be better guarded than someone who does not have this gene, and allows the individual trigger strategies to maximize the free time of disease.¹⁸

CONCLUSION

It was found that 28% of families have changed their habits, which were considered actions of care, depending on the diagnosis of SAH of the patient (24%) or its subsequent hospitalization (11 percent). In relation to the actions of care delivered by the interviewees, the changes refer mainly to avoid salt, take care of the weight and avoid fried foods. Already in relation to those habits that haven't had a lot of grip, are the practice of physical exercises, stress and medical consultation.

In assessing the relationship between change of habit when diagnosed and profile variables, there was association with females, individuals with higher education and higher income level. However, there was no significant association with the sentiments expressed by the participants, or with his knowledge at the time of diagnosis.

In assessing the change of habit when the hospitalization the results indicated that there is no association with the profile and awareness of the risk factors of SAH. However, feelings of worry, fear, rejection and sorrow were associated with statistical significance on the change of habit when hospitalization occurs.

Among the reasons why respondents have not changed their habits, even after the diagnosis of Hypertension of a family member or your hospital stay are: believe that have a healthy lifestyle; It wouldn't matter if would change their habits; not knowing that his family had patient HAS; Unable to change their habits; not knowing the connection habits with this disease; or develop it anyway, for she be genetic.

The research aimed at adult health promotion through actions of the health care field is configured for research to be explored by different approaches and their extension to other hospitals and other chronic diseases, in order to prevent or postpone the onset of these, which leads to a better individual and collective quality of life, even in the midst of the complexity of the inequalities of the Brazilian population.

REFERENCES

1. World Health Organization. Global Health. Observatory Data Repository. Mortality and burden of disease. Mortality and morbidity, 2008. WHO regions. Summary: Deaths (000s) by cause, in WHO Regions (a), estimates for 2008 [Internet]. 2008 [cited 2014 Feb 18]. Available from: URL: <http://apps.who.int/ghodata/?vid=10012>
2. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Doenças crônicas não transmissíveis [Internet]. Brasília; 2010 [cited 2011 Oct 28]. Available from: http://portal.saude.gov.br/portal/saude/profissional/visualizar_texto.cfm?idtxt=31877&janela=1
3. Schmidt MI, Duncan BB. Promoção da Saúde do Adulto e Prevenção de Doenças Crônicas. In: Duncan BB, Schmidt MI, Giugliani ERJ, editores. Medicina ambulatorial: condutas de atenção primária baseadas em evidências. 4th ed. Porto Alegre: Artmed; 2013. p. 530-42.
4. Althoff CR, Renck LI, Sakae SVSS. Famílias de crianças que necessitam de cuidados especiais: o impacto sobre a vida familiar. Fam Saúde Desenv. 2005; 7(3): 221-9.
5. Marques DKA, Nascimento EP, Cruz DSM, Lacerda ORM, Souza IVB, Collet N. Family's experience of living with a child's chronic renal disease. J Nurs UFPE on line [internet]. 2012 [cited 2011 Oct 26]; 6(6):1338-45. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/2513/pdf_1237
6. Melo EM, Silva RM, Fernandes AFC. O relacionamento familiar após a mastectomia: um enfoque no modo de interdependência de



Roy. Rev Bras Cancerologia. 2005; 51(3): 219-25.

7. Santos ZMSA, Caetano JA, Moreira FGA. Atuação dos pais na prevenção da hipertensão arterial: uma tecnologia educativa em saúde. Ciênc Saúde Coletiva [Internet]. 2011 [cited 2011 Oct 18]; 16(11): 4385-94. Available from: <http://www.scielo.br/pdf/csc/v16n11/a11v16n11.pdf>

8. Brasil. Ministério da Saúde. Inquérito Domiciliar. Hipertensão Arterial [Internet]. 2010 [citado 2010 nov 03]. Available from: <http://www.inca.gov.br/inquerito/docs/hipertensaoarterial.pdf>

9. Lopes JA, Longo GZ, Peres KG, Boing AF, Arruda MP. Fatores associados à atividade física insuficiente em adultos: estudo de base populacional no sul do Brasil. Rev Bras Epidemiol [Internet]. 2010 [cited 2011 Oct 17];13(4):689-98. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1415-790X201000400013&lang=pt

10. Bloch KV. Fatores de Risco Cardiovasculares e para o Diabetes Mellitus. In: Lessa I, editora. O Adulto Brasileiro e as Doenças da Modernidade: epidemiologia das doenças crônicas não-transmissíveis. São Paulo - Rio de Janeiro: Ed. Hucitec Abrasco; 1998. p. 43-72.

11. Simonetti JP, Ferreira JC. Estratégias de coping desenvolvidas por cuidadores de idosos portadores de doença crônica. Rev Esc Enferm USP. 2008; 42(1): 19-25.

12. Brandão ES, Santos I, Cavalcanti ACD, Santana RF, Queluci GC, Azevedo SL. Uma sociopoética do autocuidado: comportamento de estudantes de enfermagem visando à promoção da saúde. Rev Gaúcha Enferm. 2009; 30(2): 280-8.

13. Teixeira RC, Mantovani MF. Enfermeiros com doença crônica: as relações com o adoecimento, a prevenção e o processo de trabalho. Rev Esc Enferm USP [Internet]. 2009 [cited 2011 Oct 12];43(2):415-21. Available from:

http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342009000200022&tlng=pt

14. Colares V, Franca C, Gonzalez E. Condutas de Saúde entre Universitários: diferenças entre gêneros. Cad Saúde Pública [Internet]. 2009 [cited 2011 Oct 21]; 25(3): 521-8. Available from: <http://www.scielo.org/pdf/csp/v25n3/07.pdf>

15. Santos SR, Gonçalves MS, Leitão Filho FSS, Jardim JR. Perfil dos Fumantes que procuram um Centro de Cessação de Tabagismo. J Bras Pneumol [Internet]. 2008 [cited 2011 Oct 21];34(9):695-701. Available from:

http://www.scielo.br/scielo.php?pid=S1806-37132008000900010&script=sci_arttext&tlng=en

16. Neri MC, Soares WL. Estimando o Impacto da Renda na Saúde através de programas de transferência de renda aos idosos de baixa renda no Brasil. Cad Saúde Pública [Internet]. 2007 [cited 2011 Oct 21]; 23(8): 1845-56. Available from:

<http://www.scielo.org/pdf/csp/v23n8/11.pdf>

17. Volpato FS, Santos GRS. Pacientes oncológicos: um olhar sobre as dificuldades vivenciadas pelos familiares cuidadores. Imaginário - USP [Internet]. 2007 [cited 2011 Oct 28];13(14):511-44. Available from: <http://www.revistasusp.sibi.usp.br/pdf/ima/v13n14/v13n14a24.pdf>

18. Mendes FRP. A gestão quotidiana da herança indesejada: um estudo sociológico sobre o risco genético de câncer hereditário. Acta Sci Health Sci. 2006; 28(1): 1-11.

19. Flemming M, Lopes A. Saber ou não Saber: dinâmica e impasses psicológicos na doença genética. Rev Portug Psicossomática [Internet]. 2000 [cited 2011 Oct 28];2(1):33-40. Available from:

<http://redalyc.uaemex.mx/redalyc/pdf/287/28720104.pdf>

20. Duncan BB, Schmidt MI, Foppa M. Intervenções Preventivas no Adulto. In: Duncan BB, Schmidt MI, Giugliani ERJ, editores. Medicina ambulatorial: condutas de atenção primária baseadas em evidências. 3rd ed. Porto Alegre: Artmed; 2004. p. 495-7.

21. Machado LRC, Car MR. Dialética do modo de vida de portadores de hipertensão arterial: o objetivo e subjetivo. Rev Esc Enferm USP [Internet]. 2007 [cited 2011 Oct 28];41(4):573-80. Available from:

http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342007000400006&lng=en&nrm=iso&tlng=pt



Submission: 2014/02/26
Accepted: 2014/06/21
Publishing: 2014/10/01

Corresponding Address

Carolina Kroeker Kroeger Siemens
Rua Itupava, 330, Ap. 04
Alto da Rua XV
CEP 80045-140 – Curitiba (PR), Brazil