



THE ORGANIZATION OF FAMILY RESILIENCE TOWARD THE RISK OF DEATH IN THE HOSPITAL CONTEXT

A ORGANIZAÇÃO DA RESILIÊNCIA FAMILIAR FRENTE AO RISCO DE MORTE NO CONTEXTO HOSPITALAR

LA ORGANIZACIÓN DE LA RESILIENCIA FAMILIAR FRENTE AL RIESGO DE MUERTE EN EL CONTEXTO HOSPITALARIO

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ABSTRACT

Objective: to uncover the resilience of the family system that faces the hospitalization of a member at risk of death in the hospital environment. **Method:** qualitative, descriptive-exploratory study, carried out in a public hospital with eight families facing the risk of death. The collection involved the technique of theme-drawing-text and semi-structured interview, with data analyzed using the technique of Discourse of the Collective Subject. **Results:** evidenced five axes regarding feelings and factors of resilience evidenced: family crisis; personal approval in caring; family support; spiritual support and physical support. **Conclusion:** the process of resilience ensures the functional strengthening of the family system, modulating the consequences of the death-dying process for the reconstruction of new ways of overcoming. **Descriptors:** Resilience; Family; Death; Care.

RESUMO

Objetivo: desvelar a resiliência do sistema familiar que enfrenta a hospitalização de um membro em risco de morte no ambiente hospitalar. **Método:** estudo qualitativo, descritivo-exploratório, realizado num hospital público com oito famílias em enfrentamento do risco de morte. A coleta envolveu a técnica do tema-desenho-texto e entrevista semiestruturada, com dados analisados a partir da técnica do Discurso do Sujeito Coletivo. **Resultados:** evidenciaram cinco eixos referentes aos sentimentos e fatores de resiliência: crise familiar; aprovação pessoal em cuidar; apoio familiar; apoio espiritual e apoio físico. **Conclusão:** o processo da resiliência assegura o fortalecimento funcional do sistema familiar, modulando as consequências advindas do processo de morte-morrer para a reconstrução de novos caminhos geradores de superação. **Descritores:** Resiliência; Família; Morte; Cuidado.

RESUMEN

Objetivo: desvelar la resiliencia del sistema familiar que enfrenta la hospitalización de un miembro en riesgo de muerte en el ambiente hospitalario. **Método:** estudio cualitativo, descriptivo-exploratorio, realizado en un hospital público con ocho familias en enfrentamiento del riesgo de muerte. La recolección envolvió la técnica del tema-dibujo-texto y entrevista semiestructurada, con datos analizados a partir de la técnica del Discurso del Sujeto Colectivo. **Resultados:** evidenciaron cinco ejes referentes a los sentimientos y factores de resiliencia evidenciados: crisis familiar; aprobación personal en el cuidado; apoyo familiar; apoyo espiritual y apoyo físico. **Conclusión:** el proceso de la resiliencia asegura el fortalecimiento funcional del sistema familiar, modulando las consecuencias provenientes del proceso de muerte-morir para la reconstrucción de nuevos caminos generadores de superación. **Descriptores:** Resiliencia; Familia; Muerte; Cuidado.

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INTRODUCTION

The family represents the contact with people who share experiences, affection, union and protection, assuming the meaning of safe harbor. Above all, it symbolizes the place where you go when complicated situations appear, as it is a source of hope and immediate support. Thus, the family system is also responsible for material and psychological support in times of crisis,¹ as in disease, and in situations of risk or death.

Concerning this reality, concerns about the construction of this study emerged from the experience of the extension project "Multidisciplinary Grouping of Acolhimento: action of teaching-research-extension applied to care of the family in the hospital context", linked to the Federal University of Bahia, Campus Anísio Teixeira. This experience revealed a reduced tolerance of the multiprofessional to the family, emphasized by the verticalization of the assistance to the hospitalized patient, focusing on the diagnoses and pharmacological treatments, living up to the biomedical model and forgetting the care attentive to the family that, in turn, is an indispensable part of the process of caring for human dying.

In order to meet this need, the systemic view enables the family to be considered as a functional unit, a living and open system, due to the established interaction with the outside, influencing and being influenced by factors external to its structure, in constant interaction, that appropriate regulatory mechanisms in order to return the organization of the dynamics of the system, in the face of an adverse situation.²

Among these mechanisms, resilience is present and expressed as something dynamic, making what the individual who is being exposed to adversity faces it and adapts positively. The subject, who behaves as a resilient person seeks to overcome adversity and go beyond that moment of mishap.³ In this way, it translates the capacity of an individual or group to leave an adverse situation free of trauma, with a renewing force, implying in a adaptation to the hazard.

In this perspective, the protection factors are activated, in order to establish the management of adversity, providing emotional support to the family, providing strategies and skills that facilitate the confrontation of adverse situations, with the function of minimizing the impact of the risk, changing its meaning, danger and exposure to the individual's involvement, contributing to the reduction of negative risk reactions and

maintaining self-esteem, as well as providing opportunities to reverse the effects of the stress generated during the death-dying process.⁴

In view of the above, it is evident the relevance of the theme chosen, in view of this being an expanding area that still demands new research that can add knowledge and contribute to the adoption of new methodologies and strategies of care and welcome to the family that lives the death and dying in the hospital environment, an assertion that emerges from a review of literature on the subject. In this way, the problem of this study arises: how does the family system's resilience to the hospitalization process of the loved one at risk of death develop?

OBJECTIVES

- To uncover the resilience of the family system facing hospitalization of a member at risk of death;
- To know family mobilizing feelings in facing death and dying;
- To identify regulatory mechanisms for resilient coping with this system.

METHOD

Qualitative, descriptive-exploratory study. The research scenario consisted of a local public reference hospital in the interior of Bahia, specifically in its medical and surgical clinic units.

The subjects were eight relatives who accompanied patients at risk of death, chosen by non-probabilistic sampling and delimited by data saturation. It covered drawing-text-theme multitechniques, directed to the first specific objective, to know the mobilizing feelings of the family in coping with death and to die, and semi-structured interview, directed to the second specific objective: to identify regulatory mechanisms for resilient coping with the family system.

The design was chosen to access the subjective expression of family members, providing less elaborate revelations than those from the interview. For its accomplishment, the following material was made available: color pencils with 12 colors, graphite pencil, rubber, white drawing sheet A4 size. The stimulus to the drawing was: what is your strongest feeling right now? After the conclusion of the drawing, the subject was invited to the explanation of his art and later attribution of a title, being such information recorded and transcribed later. The text and

title are used to anchor the image, adding resources to your analysis and interpretation, from your speech.⁵ The semi-structured interview involved the questions: How is this experience for your family?; You have had to make adaptations (a) - the patient? Talk a little about it; What are the sources of support for you at this time?; How do you perceive the health team in this challenge?; What can the health team do to contribute to your well-being at this time?

The collection was carried out in a room of two months (July and August 2015), in private room of said hospital, being recorded the reports of the participants in apparatus mp4, which were transcribed and analyzed by the technique of the Discourse of the Collective Subject, that identifies Central Ideas (CI),

Axis 1: Family crisis

which guide the grouping of respective key expressions, originating Collective Subject Discourses (CSD), that is, the first person singular, representing the collective, translating a whole social eloquence. ⁶ The study complied with the formal national and international regulations governing human research.

The research project was approved by the Ethics and Research Committee of the Federal University of Bahia, Campus Anísio Teixeira, CAAE n °: 41300815.3.0000.5556.

RESULTS

The results comprise five axes, in the direction of unveiling the resilience of the family system that faces the hospitalization of a member at risk of death.



Figure 1. Pain. Vitória da Conquista (BA), Brazil, 2015.

The whole family is suffering and worried, we have no more joy, just thinking about her problem. We lose a parent has little time, so, this whole situation of having a family member hospitalized here affects us psychologically. It is distressing because you can not see a solution, you have nothing to do, you are only remedying, so, this drawing here is my face and my tears, it is pain that I am feeling, sadness. It's very difficult, every night I go to sleep crying, I miss home, to see my mother recovered, if I had, at least, my brothers here would be stronger, it's not easy to go through all this again, I'm in a bad mood, there I

get a headache, that whole thing. (CSD 1)

Axis 2: Personal approval in caring

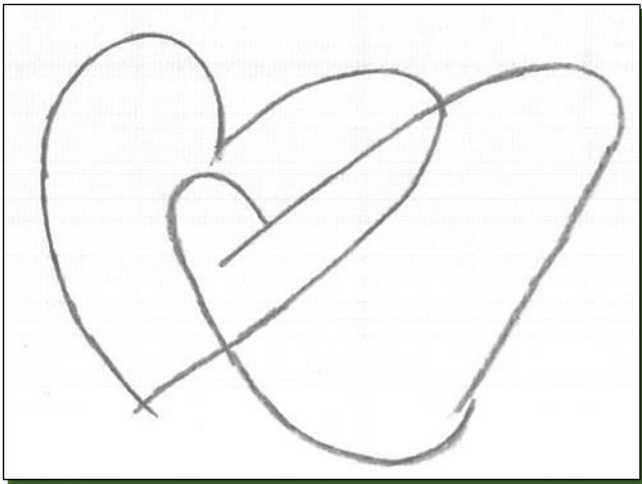


Figure 2. Donation. Vitória da Conquista (BA), Brazil, 2015.

I come and stay with him out of love and commit myself to the heart and the feeling in this gift. For me, it is not a sacrifice, because it is a happiness when his picture improves. So, all this, if it is not for the love of the patient, the brother, the loved one, does not do any good, because we would not be available, but this strength comes from the love that one feels for the other, for the whole family. (CSD 2)

Axis 3: Family support

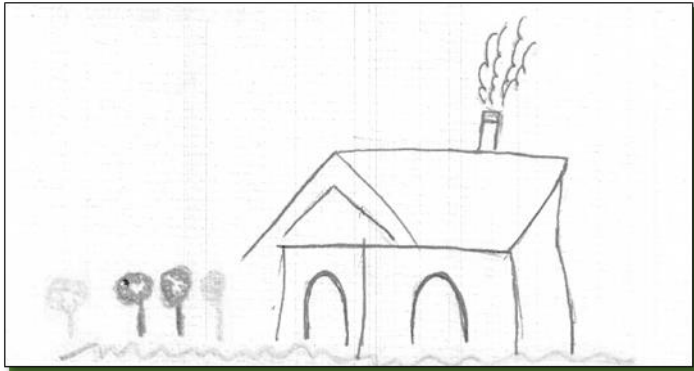


Figure 3. The home. Vitória da Conquista (BA), Brazil, 2015.

Surely, our family is the greatest support: my brothers, my children, my daughter-in-law, my son-in-law, who are all that we have of most important in life. The family is the base and we try to support each other, because we need to have the strength and unity to care for him, so, we are always supporting each other, I do not charge, but they are always with me. It's not a sacrifice, it's for love, they give up everything and we're always together. My brother came, the aunts came from São Paulo now to visit her, give a support, we have other relatives here, they are all in a prayer chain, the union is still more and the love is also, they do what they are to reach and become stronger. (CSD 3)

Axis 4: Spiritual support

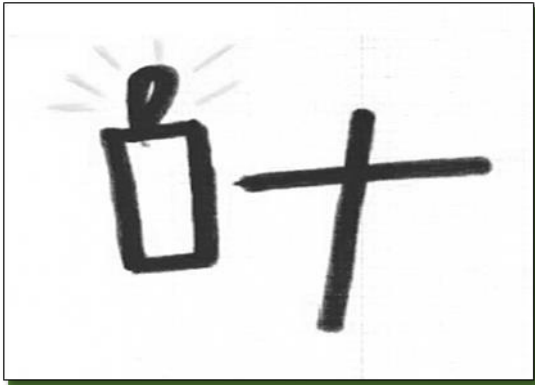


Figure 4. Hope, faith and light. Vitória da Conquista (BA), Brazil, 2015.

It has been said to us that her picture does not have much expectation of improvement, so, I thought of the candle as a sign of light and hope and the cross in a sign of faith, because we never lose faith, and at that moment, it becomes unshakeable. The feeling now is of hope in God, because one thing we can not lose is faith, belief in improvement, recovery.
(CSD 4)

Axis 5: Physical support

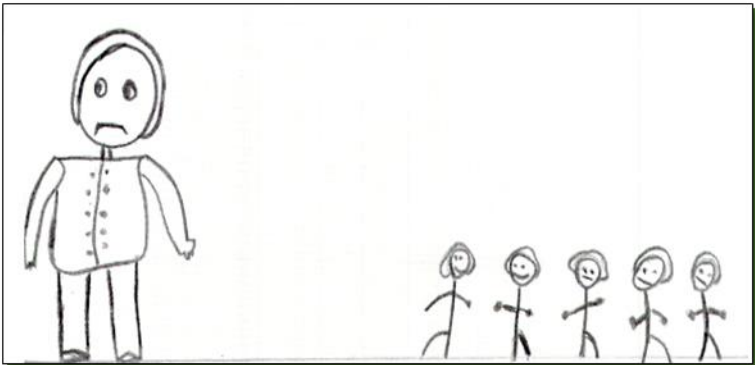


Figure 5. Insulation. Vitória da Conquista (BA), Brazil, 2015.

What is bad is to be here alone. I asked for a license at the school where I work to stay here with her, I already missed two days of classes in college, and tomorrow I need to go because, if I miss another class of this discipline, the teacher will disapprove me. I have two brothers who can not stay during the day, they stay the night taking turns, those who can always come, I had to stay Monday, Tuesday, Wednesday and Thursday, four days, it's difficult, so, I drew myself here disheveled, because has neither how to pack, nor anything.
(CSD 5)

DISCUSSION

♦ Axis 1: Family crisis

The first finding makes reference to the family mismatch at the moment in which this family is faced with the hospitalization of the entity at risk of death, situation which is responsible for making it vulnerable to feelings of uncertainty regarding the possibility of loss and separation.

In this perspective, the family submitted to the hospitalization experience of a member faces the imbalance of its dynamics and functioning, being conditioned to feelings

such as: sadness, worry, anguish, despair, constant fear of loss and loss itself (death). It is worth emphasizing that, in addition, there is a breakdown of the bond between the entity and the family, which contributes to the genesis of a greater emotional uncontrollability and shaking of the family system.⁸

In this sense, the risk of death, that emerges during hospitalization, causes complex changes in the family context, as well as changes in mood and increased anxiety of these companions when they experience hospitalization. Therefore, the need for

greater approximation between professionals and family members, so that, they can mitigate the negative effects of this moment.⁹

Thus, the family happens to be considered as a functional unit in constant interaction and appropriates regulatory mechanisms, in order to return the organization and homeostasis of the system dynamics. Among these, resilience is present and expressed as something dynamic, making the individual, who is exposed to adversity, face it and adapt positively.²⁻³

In this context, social interaction and caring for the family against death and dying emerge as protection and resilience factors, minimizing negative and dysfunctional effects of the family system through risk, while at the same time providing a better personal response to adversity.¹⁰

Faced with this understanding, the health team needs to work with affection, words of comfort that can motivate the other, while the professional must listen and show solidarity, both with the patient, and with their extension, contributing to attenuate the feelings of insecurity, distress and anxiety of the companions.¹¹

In this way, the subsequent axes evidence resilience factors signaled by these families that start from a situation of suffering and crisis discussed in this first axis.

♦ Axis 2: Personal approval in caring

As expressed in the narrative and drawing presented in Axis 2 of the results, the commitment to caring for the other is mobilized by the satisfaction of giving in to the proximal care of the loved one, contributing with comfortable conditions for the protection and the defense of the loved one's life.

The interaction with the other means that there is an exchange of experiences about the way of caring, as well as the strengthening of the family members in the situation experienced, through compassion, trust and intersubjectivity in the recovery of the hospitalized member, manifestos as a measure to promote development and personal fulfillment, from the moment it promotes change of attitude and individual values, as well as the expression of feelings such as solidarity, love and empathy.⁸

Therefore, family resilience is reinforced by the dynamics and functioning assumed in defense and protection of the system in the face of an adverse event. Then, the system strengthens itself through its own structure, which undergoes transformation and positive growth during difficult times. Families

become more ingenious to overcome the adversities of the moment, becoming more resilient to face the difficulties and strengthening their bonds.¹² In this way, giving oneself to the care of the other emerges as a strategy that guarantees the strengthening of the bond between the and thus contributes to the development of the resilience of the family system in crisis.

• Axis 3: Family support

The speech, reinforced by the respective design to Axis 3, illustrates the support of the family network, which is reinforced and requested during adversity, as a means of ensuring that its dynamics and functionality are not completely fragmented.

The totality of the family is more than the sum of each one of its members, emphasizing that the family can not be understood studying only each individual separately. The family, when undergoing a process of change on the part of one of the members, affects the whole system. For example: a father, who had a coronary problem, affected his whole family; he was not able to stay active due to illness, his mother had to work full time to meet the family expenses, and the daughters moved closer to offering emotional support to adversity. Faced with these problems, the family is able to create its own mechanisms to provide a balance between the change and the disturbance caused in the system, in a continued search for stability to face the changes of its system.²

In this way, family resilience is present as an effective dynamic and adaptive process to overcoming adverse situations, in order to restructure the routine of family members and provide personal empowerment.^{3,12} Therefore, family support becomes indispensable to provide the integrity and cohesion between the members, ensuring greater comfort in this process. With equal relevance, the practice of spirituality also contributes to this moment being softened.

♦ Axis 4: Spiritual support

From the narrative and drawing referring to Axis 4, we can see the relationship between spirituality and hope for a positive result in relation to the hospitalization of the entity - the cure. It is known that the disease is a source of suffering and anguish for the individual, but, also, a moment to unveil the possibility in search of meanings, meanings and to review situations, in order to understand the lived experience, key process that establishes the resilience, since the belief in something sacred gives them strength

and hope, figured on the cross and on the candle.

Thus, spirituality brings with it the capacity to alleviate the suffering that perpetuates within the family system, in addition to boosting positive energies during the moment of hospitalization. When spirituality is part of the most intimate beliefs of these individuals, it becomes comforting to the situations of suffering to which they are exposed. The belief in something superior, independent of religion, motivates the caregiver's self-confidence and the yearning for recovery of the health of the loved one expresses in this process.¹³

As a consequence, faith brings with it the strength necessary for individuals and families to feel empowered against the feelings experienced in the disease. The cultivation of faith must therefore be perceived, welcomed and encouraged by the professional without reference to his or her own religious beliefs, but in an acceptance interaction capable of providing a better understanding of the lived moment¹⁴ besides being listed as a factor of protection and recovery of health status. In this way, spirituality is shown as strategy chosen by the family as a source of resilience.

♦ Axis 5: Physical support

The speech corresponding to this Axis 5 highlights the organization of the family, within its possibilities, around the care provided to the entity. The pathological process and the hospitalization contribute with new events within the family context. Among these, the reorganization of schedules, tasks, relaying among family members and co-responsibility are necessary, in order to guarantee the integral continuity of care and the division of the physical effort demanded throughout this process, contributing to minimize the pressure resulting from the event.

In this sense, the care delivery to the sick family member appears as an event favorable to the development of the resilience of the situation, representing protective elements that facilitate the care of the family member, while at the same time helping to preserve the physical and emotional health of the other family members during the disease process.⁴

Therefore, the family member becomes vulnerable to changes in their daily lives, since the activities previously performed are replaced by the responsibilities that arise during the hospitalization of their loved one. By witnessing the family member's suffering and experiencing this new routine in an uncomfortable and stressful environment, the

accompanying member has his health altered as he is under stress and anxiety.¹⁵

Faced with this troubled hospital environment, it is necessary for the health team to intervene in a more humanized and welcoming way, in understanding the needs and desires experienced there, in order to maintain a closer bond with the members of this patient's family system. The importance of valuing the need to accommodate this family is fundamental in the perspective of care directed toward emotional support.¹⁶

Therefore, it is important for the health team to know and understand the family dynamics in the face of the risk of loss of a hospitalized loved one, from a care behavior to the whole family system in their interactions in directing their resilience.

CONCLUSION

The study made it possible to reach the general objective, by revealing the resilience of the family system that faces the hospitalization of a member at risk of death, through the specific objectives: to know the family's mobilizing feelings in facing death and dying; and to identify regulatory mechanisms for resilient coping with this system. The feelings permeated by perceptions of crisis and maladjustment, rising to contentment and satisfaction in caring for and donating to the sick loved one. On the other hand, the regulatory mechanisms have been mobilized from sources of support, family, spiritual and physical. Thus, the work allowed us to conjecture that the availability of looking at the suffering, to the crisis that the disease installs, added to the commitment-satisfaction of the family in caring and the multiple supports essential for the development of resilient processes.

Research and care strategies (concomitant) have shown that death in the family context causes profound changes in the family's relationships with the sick person, in the family's relationship with their non-ill members, and especially in their relatives in relation to life values. It is these changes, through adjustments, reorganizations and adaptations proper to each family unit, that produce a dynamic state of equilibrium, constitutive, buy excellence, of the processes of resilience. This study has proved to be relevant, but recognizes the need for more investments under other methodological approaches in the subject matter.

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