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Family experiences and arrangements in the care and bodily practices in coronary patients

Experiências e arranjos familiares no cuidado e práticas corporais em coronariopatas

Mayara Cassimira Souza[1]
Jaqueline Teresinha Ferreira[1]

[1] Universidade Federal do Rio de Janeiro, Instituto de Estudos em Saúde Coletiva. Rio de Janeiro, RJ, Brasil.

Correspondence
Mayara Cassimira Souza
E-mail: mayaracassimira.sc@gmail.com

Abstract

Heart diseases facilitate the understanding of the meanings and interactions of individuals with the environment in which they live, interpret and experience their relationships. We sought to understand the relationship of coronary patients hospitalized in the pre and post-surgery periods with the care and bodily practices recommended and prescribed during their illness. The methodological procedures were based on qualitative research utilizing the ethnographic method, which uses participant observation and ethnographic interviews as techniques. The study was conducted at a federal cardiology hospital in the city of Rio de Janeiro, from September 2015 to February 2016. Sixteen adult patients (8 women and 8 men) with coronary artery disease, who were in the pre-surgery and immediate post-surgery periods of cardiac operation, were interviewed, and their routine was observed during hospitalization. The understanding of the experiences evidenced that, throughout the illness of these patients, there were frequent recommendations from health professionals regarding the practice of physical activity, specifically walking; and a diet restricted in sodium and fat. However, it was observed that the patients' experiences and family arrangements and rearrangements determine the social support for these bodily practices and are crucial in coping with the disease.

Keywords: Coronary patients. Care. Bodily practices. Social support.

Resumo

As doenças cardíacas facilitam a compreensão dos significados e interações dos indivíduos com o meio ao qual se inserem, interpretam e vivenciam suas relações. Buscou-se compreender a relação de coronariopatas internados no pré e pós-cirúrgico com o cuidado e as práticas corporais recomendadas e prescritas durante seu adoecimento. Os procedimentos metodológicos embasaram-se na pesquisa qualitativa com método etnográfico, utilizando como técnicas a observação participante e entrevistas etnográficas. A pesquisa foi realizada em um hospital federal de cardiologia da cidade do Rio de Janeiro, no período de setembro de 2015 a fevereiro de 2016. Foram entrevistados 16 pacientes adultos (8 mulheres e 8 homens), com coronariopatia, que se encontravam no período pré-operatório de cirurgia cardíaca e pós-operatório mediato e foi observada a rotina dos mesmos durante a internação. A compreensão das vivências evidenciou que, ao longo do adoecimento desses pacientes, houve recomendações frequentes dos profissionais de saúde quanto à prática de atividade física, em especifico a caminhada; e a alimentação, com base numa dieta restrita em sódio e gordura. No entanto, observou-se que as experiências e arranjos e rearranjos familiares dos pacientes determinam o apoio social para essas práticas corporais e são cruciais no enfrentamento da doença.

Palavras-chave: Coronariopatas. Cuidado. Práticas corporais. Apoio social.

Introduction

Family structures are addressed in several fields of knowledge, such as Anthropology, Social Sciences, Collective Health, among others. The traditional family nucleus (father, mother and children) remains as a reference in the popular imaginary, however, several family configurations are present in the Brazilian context.[1] In the perspective of understanding and expanding the horizons of family configurations perceived in the presented research, family is conceptualized "enquanto um processo de articulação de diferentes trajetórias de vida, que possuem um caminhar conjunto e a vivência de relações íntimas, um processo que se constrói a partir de várias relações, como classe, gênero, etnia e idade".[2]

Based on this concept, it is possible to understand how the new and different family arrangements and rearrangements that are established in daily life are addressed in studies about the organization and dynamics of the Brazilian family. There is a great diversity of these arrangements, e.g., large families with members diversified by gender, ethnicity and age; families of homosexual couples with children; rebuilt families living on the same land; families without blood connections; families with single mothers and fathers, among other possibilities. The look at the new family arrangements makes it impossible to consider the family as a unique model to be followed.

It is important, for this study, to highlight that "a família como instituição socializadora de seus membros é o espaço de proteção e cuidado onde as pessoas se unem pelo afeto ou por laços de parentesco, independente do arranjo familiar em que se organize".[3] Romanelli[4] emphasizes that studies concerning family arrangements today are fundamental to understanding the means by which families socialize and transmit their values and norms, since the forms of sociability experienced by family members occur in a differentiated, however, complementary way.

Thus, to look at the family at the present time is to understand it as a constantly changing social process, perceiving new family arrangements and not following a stereotyped and predefined view established in the socio-historical process as ideal, normal or structured.[5]

Faced with social changes and demands, such as technology, globalization, population growth, gender debates, among others, families go through adaptations. The forms of adaptation relate to the survival needs of present and future responsibilities, such as health care conditions.[6]

According to Carreira & Rodrigues,[7] the family is the largest provider of care in relation to family members with chronic diseases; thus, it deals daily with the frailties of elderly people affected by this disease. In these cases, the family is guiding the care of its members, playing a crucial role in the handling of family care at home.

In the context of chronic diseases, the positive factors of support and of social networks in behaviors contribute to their adjustment and management, as well as in the coexistence of patients with health services and professionals, in the adherence to treatment, improvement in quality of life, adoption of new lifestyles, and disease risk prevention.[8] However, social relations and support depend on what is happening in the social actors' lives, on conception and role attributed to gender, on marital status, on involved or absent family members (children, grandchildren, parents, etc.), on cultural, educational and political issues, and on the way in which family arrangements and the context as a whole work and are established.[9] Thus, family social support is a source of protection and maintenance of health, because the bonds established may strengthen health through the meanings experienced, perceived and shared in social relations. The family support network favors the patient's adherence to the habits and behaviors demanded to cope with the disease, generating a positive influence in their daily lives.[10,11]

In their various forms and intensity, networks are broad and singular. The way in which social support networks are established has repercussions on the possibilities of the patients' bodily experiences. After the diagnosis of the disease and its coping, the support network is crucial for the care and the bodily experiences, reflecting in the maintenance and recovery of the disease.

Methodology

The methodological procedures of this study are based on qualitative research utilizing an ethnographic method, which uses techniques such as participant observation and ethnographic interviews.[12] These instruments aim to mediate between theoretical and methodological frameworks and empirical reality.[13] Observation and interviewing are effective tools which allowed to research the chosen universe. The use of combined techniques sought to fill the gaps and make the information collection in the field more complete.[14]

The researcher went to a federal cardiology hospital of Rio de Janeiro to carry out the field research. The proposal was well accepted by the service coordinators, then the observations began in the hospital ward and in the beds where the coronary patients were. In this ward, the receptivity to the study also went well. The patients at first confused the researcher with a health professional in the sector, and gradually her identity and interest was clarified. All patients were willing to participate in the interviews because they liked to share their stories, their fears and their expectations.

During the field research, the field diary was extremely important, since it was intended for personal records and reflections, seeking to exercise a look at what was strange and familiar. However, it was crucial trying to understand what the field "asked for", "showed", "revealed" to allow the researcher to see new possibilities of knowledge of the research object. This is in accordance with what Dalmolin et al.[15] emphasized about the field leading us to paths previously unseen, opening new horizons, leading to diversified and more comprehensive procedures that were not planned beforehand. Thus, the understandings were not restricted to the individual's speeches and punctual observations, however, to the senses, experienced relations and bodily interactions perceived daily in the visits to the hospital.

The selection criteria of the research subjects were: patients with coronary diseases, adults, regardless of gender, who were hospitalized in the pre and post-surgery periods of cardiac operation, except for the patients in a severe state of recovery. Only those patients who agreed to participate in the study and who agreed with the Informed Consent Term were interviewed.

The research was performed at a federal cardiology hospital in the city of Rio de Janeiro, from September 2016 to February 2017. The observations were daily and were directed to the routine of the patients. The places for the observation were: the rooms of the beds, the corridors where the patients wander and the hall of the corridors that give access to the rooms, which has benches that favor socialization. The observed criteria were: their bodily practices in these spaces, the support of their family and friends for this and other relationships established between them and the professionals present in their daily lives. These places were rich in interactions among patients, companions and, occasionally, professionals.

Although the relationships with the patient's social support are the focus of this study, the interviews occurred only with the patient's presence in their beds. Sixteen adult patients were interviewed, including eight women and eight men, who were in the pre and post-surgery periods of cardiac operation. In addition to directing their hospital experiences, the questions were directed to the individual trajectories of patients facing the disease.

To assist in the development of this technique, the interviews were recorded with permission of the interviewees, which facilitated the conduction of the interview, since the recording captures in full and in all dimensions the interviewee's words, conditioning the quality of listening and favoring a deep analysis of it.[14] Subsequently, the recordings were carefully transcribed for analysis and interpretation.

Regarding the patients' profiles, the majority of the observed patients were between 60 and 75 years old and presented an acute heart problem. They live in different regions of the capital of Rio de Janeiro and in several cities in the state. Regarding the educational level of the patients, the majority studied until elementary school, only two went to a higher education institution and three were illiterate. The educational level was determined by access to schools, interference of localities, financial conditions and family values. Most patients stated that they did not have physical education at school. Concerning their occupations, most of the interviewed men was already retired, however, they continued to work until the disease affected them. As for the women, they were engaged in household chores in their own home or they worked in someone else's house.

The project followed the ethical precepts of the CNS Resolution no. 466/2012, and was submitted and approved by the Comitê de Ética de Pesquisa (CEP - Research Ethics Committee) of the Instituto de Estudos em Saúde Coletiva (Institute of Collective Health Studies) of the Universidade Federal do Rio de Janeiro (Federal University of Rio de Janeiro), under opinion number 1,863,965.

Results and Discussion

During the research, the absence of a single family model was noticeable, however, the prevalence of a referential nucleus (father, mother and children) was observed among couples and widowers above 60 years old. This public was married only once - "*we have been married for*

42 years" (Woman, 69 years, post-surgery). The interviewed widowers did not marry again and they always made references to their deceased spouse - "*it was in that year that I discovered the heart problem I had, because my, my husband died in January*" (Woman, 69 years, post-surgery).

Sarti[16] adds to this discussion of a male referential nucleus that today the idea of masculine authority based on the power of man in the family and on his role of mediator with the external world still persists. The family that does not follow this model is considered fragile before society for not having the presence of a man in the family who is the supplier of respect, of food and of housing.

Thus, in relation to the public above 60, reference and family origin follow a standard model, however, the family extensions and other configurations have succeeded throughout their lives. In some cases, the widowers went to live with their children - "*I am the one who lives with them*" (Woman, 78 years, post-surgery); "*I live with my daughter and her children*" (Man, 79 years, pre-surgery) - participating as a member of the family established by their children. Other couples, after raising their children, welcomed and raised little grandchildren - "*my daughter works, my 25-year-old granddaughter also works and there is my 3-year-old granddaughter who we take care of*" (Man, 65 years, post-surgery).

It is also possible to observe the return to the parents' home of unemployed adult children with or without children - "*she stays here all day, all the time, because she's not working [...]. She helps a lot at home*" (Woman, 69 years, post-surgery). In this age group, it was observed the configuration of families with single brothers, a 72-year-old woman chose not to marry and take care of her mother. With the death of her mother, she took care of her older brother, then her younger brother divorced and the three siblings started to live together, giving and offering social support to one another.

However, different family arrangements are seen among patients in the 50-60 age group. Divorced patients formed a family from a second or third marriage, with or without stepchildren - "o*h, let me tell you, I moved in with the girl. Then we separated. [...] that's okay, I spent some time alone, then I met another one, with that one I was twenty, twenty-five years. Now we separated, but my stepdaughter still comes to my home*" (Man, 50 years, post-surgery). Other divorced people have distanced themselves from the previous family and live only with their partners and their children; there are still unmarried and divorced people without family bonds, however, with bonds of friendship or of religious groups. For these patients, non-blood bonds are a source of care and protection, similar to those provided by kinship.

Moreover, family support in coping with the disease favors protection as it reduces the patient's social isolation and assists in decisions and care strategies.[17] The social support network has been reported at various times by patients:

> *There are a lot of people who take care of me. There's my husband, my 13-year-old granddaughter. See, honey?! It's my children, my daughter-in-law, my nieces and neighbors [...]. Thank God! Many people. I had enough people to accompany me... My children also forced me to walk and kept holding me (Woman, 65 years, post-surgery).*

> *My wife and my son have always stayed with me, my daughters too. Each one came to spend the night. I was practically at home. When I could get out it was with the daughter taking me somewhere. I can't drive any more. I was very tired (Man, 58 years, pre-surgery).*
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> *Full support! Even those who don't live at my house, nieces, children, everyone, friends, daughter-in-laws. I did nothing alone, my children carried me. Then I get angry, these annoying people "you can't eat that, you can't do that", oh, it's boring, my daughter says "mom, you can't do that". But, thank God, my family is like this, united (Woman, 61 years, post-surgery).*
>
> *On top of that, at home my grandchildren are the ones who carried me. And so they took me, down and up. I thought that it was very tiring for them (Man, 77 years, pre-surgery).*
>
> *No, it wasn't difficult (pre-surgery) because I had my wife (Man, 50 years, post-surgery).*

The patients' speeches were related to the direct assistance of family members, relatives and friends, with great appreciation of the care provided by them. Social support was referenced and correlated to care strategies for coping with the disease. Cardiopathy patients, before and after surgery, have severe bodily limitations; fatigue and recurring lack of air prevent locomotion and handling of their own body. Thus, patients become dependent on support for everyday activities (walking, sitting, eating, combing, bathing). Likewise, they need to get used to new eating practices and often to dietary restrictions, such as: reducing sodium, portions and fat intake, in addition to not being able to make their own daily food.

The various family arrangements and rearrangements have singular modes in the development of care strategies. The recommendations of health professionals, whether they are about physical activity or food, demand new daily organizations that may reverberate in all the support network of coronary patients.

Thus, the established support network is fundamental to the new routines, which include these bodily and food adaptations, and decisions about the treatment of possible practices to be or not adopted.

The imperative of the disease in family rearrangements

It is important to highlight that, in addition to the various family arrangements already established or not by kinship bonds, there are family rearrangements in the face of the disease, hospitalization and afterwards. Elsen et al.[18] report the obstacles, organizations and reorganizations during hospitalization and the daily life of the family before, during and after it, affecting to a lower or higher degree all family arrangements. There are families that may overcome the difficulties of hospitalization and organize a structure to accompany the person. As the chronic condition goes through its acute moments and there is a higher demand for care, the rearrangements in the family dynamics becomes increasingly necessary in order that it may provide essential needs that arise with autonomy loss.

Thus, discussions about social networks as support resources are also based on the bonds and interdependence among individuals. Family arrangements, with a higher prevalence in the families of lower classes, are manifested as a protective, affective, informational and assistance resource.[19]

Nevertheless, Souza[20] warns of the conflicts and ambiguities also involved in kinship relationships and in family arrangements. The family nucleus, as a group of coexistence, cooperation, division of responsibilities and obligations among its members, propitiates offering and receiving support and care. However, the lack of family bonds and care or conflict may undermine the health benefits. This may be seen in the report of a patient living alone and an elderly patient who looked after her elderly siblings:

> *There's no one, I have to do it. I cook my own food. And, I'm gaining weight. I can't, but there's no one, I'm alone, I live alone. And, there are times I can't do it, I have to stop, the tiredness is too much, it seems that I'm going to die. Walking about fifty meters, I have to stop three or four times to be able to breathe or else... There are times we do something and sit, then I sit still for a long time (Man, 50 years, post-surgery).*
>
> *My concern was with that sick brother and the older brother having to do everything, to make food, things like that. But then he passed away and then I needed to take care of the surgery. There's the older brother, I worry, he comes every day in the afternoon, currently only him, there is no one else who can come (Woman, 72 years, pre-surgery).*

The absence of family relationships perceived in the daily life of single patients does not favor a larger network of social support, causing them to create and adapt to coping strategies. The 50-year-old patient's strategy was to reduce the pacing of basic tasks. The 72-year-old lady waits for her older brother every afternoon, who always came at the same time and kept her company during visiting hours. Another single patient, 69 years old, who also lives alone, has received almost no visits. After the surgery, a friend accompanied him for three days, no more than that. His strategy was to stay as long as possible in the hospital. He came into conflict with the professionals, pointing out and showing which parts of his body were not well. Once, he approached the researcher and complained: "*they are claiming that I have to leave, but I already put my food down saying I'm not going there, I'm not going home like this, I'm not going to give a hard time there*".

Studies report that when patients do not have social support (family and/or friends), they tend to face greater difficulties in dealing with stress, compared to those who have social support. E.g., some studies about diseases and mortality in the elderly associate these factors to the absence of close relatives, such as spouse and children.[21] Therefore, the family support network represents a fundamental element in any stage of the life of the individual. Everyone needs some support, and family and community are natural places of protection and social insertion in informal social networks. In these places of interaction and mutual help, patients find in the family network, in the coexistence with neighbors, support for coping with difficulties that they encounter in their daily lives.[22]

The family structure as a nucleus composed by husband, wife and children generated a pattern of roles attributed to the figure of the woman and others to the figure of the man. These roles were historically delegated as a necessary condition for being a member of the family. To men, a centrality and authority toward the other members was delegated; to women, as wives and mothers, the subordination to the head of the family (man) and the assignments of housewife were delegated.[4] For the author:

> [...] a divisão sexual e etária do trabalho é um princípio fundamental que delimita posições e papéis diferenciados de acordo com o gênero e a idade dos componentes da unidade doméstica. Associadas a esse princípio, porém desfrutando de autonomia em relação a ele, as relações de autoridade e poder também se constituem como elementos ordenadores da cena doméstica, definindo para marido e esposa, para pais e filhos posições hierárquicas, direitos e deveres específicos, porém desiguais[4] (p. 74).

Scott[23] adds that gender differentiations are a historical product and social construction. These biological differences are appropriated and naturalized by the social group over time, permeating all areas of relationships involving men, women and power. This reveals in some studies the lack of reciprocity between the spouses in times of illness; women are confidants of husbands, however, they do not establish the same trust in them. Thus, husbands seek and have a greater return of support from their wives, and in turn women do not seek the same support or find it. This is due to the hierarchical system, which delegates and overlaps the role of man in society.[24]

In the hospital, most men over 65 years old with the right of having company had the support and were accompanied by their wives - "*my 'mermaid' is coming, we are always together*" (Man, 65 years, pre-surgery), however, not all women over 65 had the company of their husbands. Some married women were accompanied by daughters, daughters-in-law and sisters. In daily conversations with patients, they reported that they were concerned. The daughters, on the other hand, made an effort to provide care and attention to their mothers. One daughter told me: "*Because, what happens?! We are protective daughters, because my mother is protective. Then we get scared, right?!*" - emphasizing the meticulous care with the mother.

It is possible to observe that there are also conflicts among them, and that this directly relates to the role designated to the mother as "housewife" and caretaker, and the fear that she may lose that position.[25] There were complaints from both parts; the daughters reported obstacles and complaints from the mother in accepting the hierarchy and the way they cared; and the mothers lamented for not being able to maintain the daily care provided to the whole family.

These experiences are in line with studies in which women occupy the central place of the mother as responsible and provider of care, especially in cases of illness, since the role of caretaker, either of mother, daughter or wife, falls on her. Traditionally, her profile is to have a more frequent, more intense and more affective participation.[26] However, this female role attributed to the other woman in the hierarchical and generational scale brings repercussions and resistance to the new roles assigned to the care of others.

Summarizing, the role of daughters in this care process was observed. Among the researched patients, the care relationship between mothers and daughters was notorious, since they are central to the responsibility of care at this moment of illness of the family member. There is a role reversal: the mother, as caretaker, is taken care of; the daughter, who was taken care of, becomes the caretaker.

Nonetheless, this is not a simple process. Daughters feel that taking the role of home caretakers is a feminine obligation and a retribution for the protection and care offered by the mother to the family. This role could be taken by any relative, however, the daughters are the ones who take this position for themselves. It is a repetition of gender roles.[27] Nevertheless, mothers do not agree to give up this role. They resist accepting their daughters' recommendations, including physical activity. E.g., they insist on performing activities that are not recommended, such as climbing stairs, lifting weight, moving furniture, and walking alone.

These and other witnessed moments of the family dynamics reveal that the roles assigned to family members (father and mother) imply all phases of life and that in all of them there are social pressures that influence the behaviors approved by the whole, i.e., appropriate and expected roles at different ages, genders, civil status, etc.[28] When faced with certain age phases and moments of life, in this case, illness, we require adaptations, such as changes in self-concept and incorporation of new social roles.[29]

This change of roles is also noted in the statements of men about their activities. As reported above, men fully engaged themselves in the work to support their families, a part of which has always been away from home most of the time. In contrast, both wives who did not work and those who worked out of home exercised their domestic duties alone. With the beginning of the disease and its bodily restraints, men began to compose the daily life of the home and establish new roles in that environment. Thus, there are transformations in the familiar role of the man as being a provider, starting to be useful at home, helping in the housekeeping or running errands. Next are the speeches related to this.

> *Oh, I swept the yard, fed the animals. That sort of thing (Man, 65 years, post-surgery).*
>
> *I leave home to go to Tabuna, pay a bill, a rent. I go to Madureira to buy a lamp, a wire. I go back and forth (Male, 67, pre-surgery).*

> *You are an active person all the time, I was an active person 24/7, when I wasn't working out of home I was doing something at home. I was helping my wife. I cook, I wash, iron, I tidy the home. I lived alone a long time, so I learned to do all this. Mom taught me all these things when I was young (Man, 58 years, pre-surgery).*

Erbolato[28] stresses that social roles - socially determined forms of behavior - are reflections of social impositions; however, they allow people some flexibility in their manifestations. Once new roles have been established, styles of interaction with them are also adopted. This yearning of men for new functions has been opposed to a sense of worthlessness reported by them.

During the dialogues with a 58-year-old man waiting for surgery, he complained about the difficulties of not being able to do much. One day, when we greeted him, we asked how he was feeling and he replied, "*oh, it's a feeling of worthlessness. I feel useless, it's hard, honey*". We started to realize how this feeling prevailed in both genders and how it was reported in interviews. Next are the statements:

> *For me it wasn't, it's not being easy. Because I like to clean my house by moving the furniture, they are quirks that you have, see, I like to make my food, then I couldn't do it, I've been feeling a little useless. Now I'm accepting it, thank God, not at first. It was a little while. I wasn't upset with the disease, I wasn't revolted with the disease, I wasn't, I was sad that I couldn't do the things I liked to do (Woman, 61 years, post-surgery).*
>
> *So, I feel useless because I can't do anything, even so I still get up and wash the dishes and my legs are wobbling and I feel like I'm going to fall, things like that. So I feel useless, I start to cry then she comes and says: no, let me do it. I answer that I am useless and she says: You are not useless, you are sick and need to heal (Man, 58 years, pre-surgery).*
>
> *The roof tiles are broken and I can't do anything, change a lamp. My brother-in-law comes over and changes it. I can't climb a chair... I go up, look over there, when I look down, and I think I'will fall, then I don't go up. It's too boring, I can't do it. I didn't have the strength, I can't get anything because I'm afraid that I have no strength and I get tired. All I do is lie down and eat. 'Cause I can't do anything at all, and talking to the boys lying down (Man, 67 years, pre-surgery).*

Carvalho & Cidade[30] emphasize that it is widespread in society the idea that a person suffering from a heart problem, or having undergone surgery, becomes useless. This is reinforced to the extent that the family, through excessive zeal, may start treating the patient as an incapacitated person. Excessive care often limits patients' roles by restricting their functions. Women no longer participate in the organization and care of the home, in addition to renouncing the care of family members. Men stop working out of home and often do not have daily duties at home, where their obligations were restricted to repairs, which they can no longer perform. However, as described earlier, patients adapt and set new roles, according to their bodily possibilities.

Thus, family context represents a fundamental element for the support and intimacy of the different situations that patients face. The contemporary family has undergone transformations in relation to the emergence of new roles. This panorama demonstrates that family, despite changes in the face of various situations, remains an extremely important place to nurture affection and protection to patients.[31]

The importance of the support network in the management of the bodily practices of coronary patients

The support network is guiding and indispensable for the movement of the patients and their possibilities of bodily experiences in coping with the disease. In the patients' reports about bodily practices, it is possible to observe that, in addition to referring to the locations chosen or not for their extension (physical activity programs developed by the Family Health Support Centers, popular and outdoor gyms, private fitness centers, social programs and school physical education), they report the encouragement and assistance of family members in conducting physical activity and in the places for it. Next are the reports:

> *Oh sure! I even have a daughter who is a personal trainer, who likes and is a professional of physical activity. She would come at my home and pick me up, put me in the car, and bring me to the gym. She put me on the treadmill to walk. She carried me because I didn't go. She went there and picked me up. But that was not for long because it was up to me, I got better, started walking alone, it was my business to go and I didn't go (Man, 58 years, pre-surgery).*
>
> *No girl, I couldn't walk. They forced me (children and relatives), but I couldn't walk much. See? It took me some time to get up. I walked a little on the yard. I walked a little because I couldn't stand walking a lot (Woman, 65 years, post-surgery).*
>
> *They tell me to walk (children). They want to accompany me but I won't go [...] my daughter doesn't do it, she doesn't like anything, she has a gym in the building, but she doesn't go, because she doesn't like it, but she wants me to do it (laughs) (Woman, 78 years, post-surgery).*
>
> *After the ICU I walked with them, I didn't feel safe, then they (daughters) were letting me out, walk alone (Woman, 61 years, post-surgery).*

It is possible to observe that the family may support the medical prescriptions about physical activity, totally legitimizing them. This does not imply that these individuals practice physical activity routinely, which is intended for those who are sick. In that case, the whole family participates: "*They tell me to do it (physical activity). She (wife) doesn't go, now my boys go (gym)*" (Man, 67 years, pre-surgery).

However, relatives may also reject this prescription, by opposing medical guidelines for physical activities, in order to protect the patient:

> *They said that when I got home I could walk a little back and forth. Then my daughter didn't think it was good. My daughter thought I couldn't. Because I stayed there for five days on the tenth floor and from there I went home. My daughter said: no, you left the ICU five days ago, you can't walk. (Woman, 68 years old, post-surgery).*

Zaparoli and Mattar[32] stress that family is still an intermediary of the values that affect society, since it has always been a place of harmony, organization, mutual respect and development of affective bonds among its members. Sarti[16] emphasizes that in the family space one learns to order and give meaning to the acquired experiences, as well as to attribute meanings to the relations among individuals, being the privileged place for elaboration of the diverse lived experiences.

In the family context of coronary patients, affective values and bonds may be affirmed, restored or modified according to the uniqueness and complexity of family arrangements. In other words, the disease may imply the reaffirmation of family bonds or the need for new arrangements for the care of that patient. Thus, there is a need for the patient and the family to adapt or negotiate medical prescriptions according to these bonds, i.e., when prescriptions require care that does not fit family relationships, there is difficulty in following that prescription. This happens in the case of reliance on special diets or reliance of the patient on performing simple tasks such as hygiene or locomotion.

Changes in the family routine imposed by the disease bring impacts of structural social values built on gender, age, social roles and family organizations. Therefore, family rearrangements are necessary, reformulating social and functional roles of both the patient and caretakers, in order that the care strategies meet professional recommendations. These rearrangements depend on the lived experiences, such as solidarity, dependence, reciprocity, patience, overcoming and union shared or not within the family.

These values may be conflicting or aimed at the handling of strategies, depending on who they will represent. E.g., if the husband needs to perform domestic chores and take care of the patient, he may or may not adhere to them or partially perform them. On the other hand, if daughters, sisters, or other women who are close to the patient are involved in the execution of these tasks, this may represent the loss or affirmation of social and functional roles in the case of female patients.

Final considerations

In view of the statements, it is possible to observe recurrent aspects in the families in relation to the support for the practice of physical activity of the patients. In general, relatives, especially children, or more specifically daughters, recognize the need for the patient to walk. Patients report that their family members "tell" them to do it, however, they question the fact that they do not do it and do not like it either. The other aspect is the children's initiative to accompany and lead parents to physical activities, as well as the personal difficulties in the experience of adhering to it, such as: insecurity, lack of will and physical unwillingness to move.

The bodily practices lived or not by the cardiac patients have meanings and form conceptions that guide the way in which they were related to physical activities in the pre and post-surgery periods. On the other hand, health support networks influence the individuals' experience of bodily practices and may also determine how patients cope with the heart disease, i.e., how they will adhere or not to the recommended physical activity.

In the history of physical activity addressed by the patient, before and when living with the disease, the planned or prescribed bodily practices occurred randomly, i.e., without continuity. In dialogues with patients, it is noticeable that those who remained for a longer time evidenced the following reasons: friendship bonds, need for socialization, time available after raising children, death of the spouse and medical orientation - factors related to the referred network. Therefore, social support coming from family is crucial to the bodily practices of coronary patients.

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