CEREBROVASCULAR ACCIDENT IN THE AGED: CHANGES IN FAMILY RELATIONS

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Marques S, Rodrigues RAP, Kusumota L. Cerebrovascular accident in the aged: changes in family relations. Rev Latino-am Enfermagem 2006 maio-junho; 14(3):364-71.

The aims of this study were: to identify aged persons who were victims of Cerebrovascular Accident and received care at the Emergency Unit of a Public Hospital in Ribeirão Preto-SP, Brazil, and their respective families, as well as to identify the changes in family relations that occurred after the event. In order to identify these changes, the adapted Critical Incident Technique was used, while the analysis was based on the idea of Current of Thought. The sample consisted of 11 families, totaling 34 participants. The analysis of the consequences displayed the changes in family relations, which made up 13 subcategories, 5 of which were positive and 8 negative, totaling 58 alterations, 30 of which were positive and 28 negative. The study revealed the need to work with the family in order to identify changes and develop an action plan to favor the family's relations and adaptation to the demands, with a view to improving the living conditions of its members, including the aged person.

DESCRIPTORS: aged; cerebrovascular accident; family; nursing

EL ANCIANO TRAS ACCIDENTE CEREBROVASCULAR: ALTERACIONES EN EL RELACIONAMENTO FAMILIAR

Las finalidades de este estudio fueron las de identificar a los ancianos con diagnóstico médico de Accidente Cerebrovascular, atendidos en la Unidad de Emergencia de un Hospital Gubernamental de Ribeirão Preto-SP, Brasil, y a sus respectivas familias y también identificar las alteraciones en el relacionamiento familiar, que ocurrieron tras el evento. Fue utilizada la Técnica de Incidentes Críticos adaptada para identificar las alteraciones en el relacionamiento familiar ocurridas tras la enfermedad. Para el análisis, fue adoptada la reflexión del Camino del Pensamiento. La muestra fue compuesta por 11 familias, totalizando 34 participantes. El análisis de las consecuencias reveló las alteraciones en el relacionamiento familiar, que constituyeron 13 subcategorías, 5 positivas y 8 negativas, con un total de 58 alteraciones, siendo 30 positivas y 28 negativas. El estudio reveló la necesidad de trabajar con la familia para identificar las alteraciones y desarrollar un plan de acción que pueda favorecer las relaciones y la adaptación de la familia a las demandas, con vistas a mejorar las condiciones de vida de sus miembros, incluso el anciano.

DESCRIPTORES: anciano; accidente cerebrovascular; familia; enfermería

O IDOSO APÓS ACIDENTE VASCULAR CEREBRAL: ALTERAÇÕES NO RELACIONAMENTO FAMILIAR

Os objetivos deste estudo foram: identificar os idosos atendidos, na Unidade de Emergência de um hospital governamental do município de Ribeirão Preto-SP, com diagnóstico médico de acidente vascular cerebral, e suas respectivas famílias, bem como identificar as alterações, no relacionamento familiar, que ocorreram após o evento. Utilizou-se a Técnica de Incidentes Críticos adaptada para identificar as alterações no relacionamento familiar ocorridas após a doença e, para a análise, a reflexão do Caminho do Pensamento. A amostra constou de 11 famílias, totalizando 34 participantes. A análise das conseqüências revelou as alterações no relacionamento familiar, que constituíram 13 subcategorias, 5 positivas e 8 negativas, perfazendo o total de 58 alterações, sendo 30 positivas e 28 negativas. O estudo revelou a necessidade de trabalhar com a família para identificar as alterações e desenvolver um plano de ações que possa favorecer as relações e a adaptação da família às demandas, com vistas a melhorar as condições de vida de seus membros, inclusive o idoso.

DESCRITORES: idoso; acidente cerebrovascular; família; enfermagem

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INTRODUCTION

Cerebrovascular Accident (CVA) is one of the most prevailing neurological problems in the category of cardiovascular system diseases. It is the third most common cause of death in developed countries. Approximately 20% of patients who are victims of CVA die within one month; about 50% of survivors present permanent and considerable disabilities, needing care and supervision; the remaining 30% present neurological deficits, but are capable of leading an independent life[1].

After a period in hospital, aged victims of CVA can go back home with physical and emotional sequelae, which affect their functional capacity, independence and autonomy, and can also exert social and economic effects that invade all aspects of life. In general, when a functional decline occurs as a result of some pathological process, it is the family that gets involved in care aspects, supervision of responsibilities and direct care delivery.

Hospitals are reducing their clients' hospitalization period due to different factors, including health care costs. However, after hospitalization, aged persons' return home requires care and attention. The effects of this return on aged persons and their families can often be destructuring, as it demands the availability of space, a caregiver and, also, economic resources. Nevertheless, most elderly prefer to receive care at home.

Significant events in life, such as the appearance of a chronic disease, divorce, unemployment or death of a relative can bring about relevant transformations in the family system as a whole. These changes can affect the cognitive, affective or behavioral domains. However, an alteration in one of them causes an impact in the others. It is important for nurses who work with families to carefully observe and assess these aspects to enable them to identify changes and develop a nursing intervention plan that is capable of contributing to the achievement of a new balance in the family system.

The change in family structure is experienced as a disturbance in its system. Family systems aim to preserve their stability. An alteration is seen as a behavioral change, which may be accompanied by judgment or not and, thus, suggests an investigation of differences in family interaction patterns. Alteration and stability must be considered jointly[2].

Changes are constant in our social interactions and environment, but we often do not notice and get used to them. In families too, alterations constantly develop and nurses working in this context may be aware of this fact or not. This is the type of continuous or spontaneous alteration that happens in daily life and involves the stages of family and individual development[3].

Nurses should obtain families' active and responsible participation in care for dependent elderly. However, to achieve this, there is a need to invest in research and increasingly include families in health care.

Considering the relevance of this theme, this study aimed to identify aged persons who received care at the Emergency Unit of a Public Hospital in Ribeirão Preto-SP, Brazil, and were victims of (hemorrhagic or ischemic) Cerebrovascular Accident, whose first episode occurred in 2002, and their respective families, as well as to identify the changes in family relations that occurred after the CVA, using an adapted version of the Critical Incident Technique.

METHODOLOGY

We carried out a qualitative study. Data were collected by means of the Critical Incident Technique, with a view to identifying the changes in family relations that occurred after one family member became a victim of CVA.

The Critical Incident Technique covers a set of procedures to obtain direct observations of human behavior, stimulating its application to solve practical problems. The critical incident refers to an observable and complete human activity that permits making inductions and forecasts about who performs the activity. It should happen in situations in which the intention or objective of the person performing the activity is clear to the observer, and its results are systematically defined[4].

In summary, the technique involves asking an activity's agents for reports about situations they experienced. The researcher observes and analyzes these reports in view of a previously established objective.

Study participants were families who lived in Ribeirão Preto-SP and included an aged person of 60 years or older, who received care at the Emergency

Unit of the HCFMRP-USP, and was a victim of (hemorrhagic or ischemic) Cerebrovascular Accident, whose first episode occurred in 2002.

Families were selected in August 2003, after the study had been approved by the Research Ethics Committee at the University of São Paulo at Ribeirão Preto Medical School *Hospital das Clínicas*.

We asked the Hospital's Medical and Statistical Filing Service for a list of patients aged 60 or older, who were victims of CVA and had been attended at the Emergency Unit in 2002, their record number, address and phone number, totaling 109 aged persons. After this survey, we first contacted these persons' families to set a time for the interviews. The following exclusion criteria were adopted: patients who had died and patients who did not live in Ribeirão Preto. We interviewed 11 families, totaling 34 participants. The number of interviewed families was determined by the saturation point of answers.

Data were collected from August to November 2003. For the interviews, we used two data collection instruments with open and closed questions. The first was an identification questionnaire with social profile information: date and time of birth, gender, color, civil status, number of children, education level, profession/occupation, income (in minimum wages), address and telephone.

The second instrument was a questionnaire to: a) identify the elderly victim's family, containing: family composition, monthly income and religion of each member; b) identify changes in family relations after this events, using two questions elaborated to obtain the critical incidents: 1) Think of situations that happened after the elderly returned home, after the hospitalization period, because (s)he suffered the stroke. 2) Try to remember situations related to the elderly and the stroke, involving the family environment and its members, which you believe caused positive/negative alterations. Tell me about the situations, which persons were involved, what they did and what the result was. We first referred to positive alterations and then repeated the same question for negative alterations.

One of the researchers collected data at the families' homes, after a first contact by telephone and each participant's consent. Between two and three visits and an average of three phone contacts were realized for each family.

The reports of these situations were registered in the field diary and, at the end of each report, the text was read aloud to be validated by the interviewees. The researcher's observations were also registered.

The analysis was based on the idea of the Current of Thought, presented as "the possibility of technical realization related to communications in the health area"[5]. All collected material, including the meaning of social relations, was joined in the analysis to identify changes in family relations. In this study, we analyzed the consequences of the situations experienced by the family members.

In accordance with resolutions 196/96 and 251/97 by the National Health Council, this project was evaluated by the Research Ethics Committee at the University of São Paulo at Ribeirão Preto Medical School *Hospital das Clínicas*. It was approved in a meeting on 08/18/2003 as HCRP Process No 4700/2003.

RESULTS

The results will be presented in two steps, described below: a) Identification of Aged Persons Diagnosed as CVA and their Respective Families and b) Description of changes in family relations.

Identification of Aged Persons Diagnosed as CVA and their Respective Families

All aged persons were victims of CVA in 2002 and were attended at the at the Emergency Unit of the University of São Paulo at Ribeirão Preto Medical School *Hospital das Clínicas*.

Their ages ranged from 62 to 84 years, with a mean age of 73.4 years. Seven patients (63.6%) were men. Most (72.7%) CVA victims were married and three (27.3%) widowed. Five (45.4%) patients knew how to read and write, four (36.4%) had not finished primary education, one (9.1%) finished secondary education and one (9.1%) was illiterate.

As to profession/occupation, most participants were retired. Five (45.4%) earned one minimum wage per month, two (18.2%) one and a half minimum wages, one (9.1%) earned four minimum wages, one (9.1%) six minimum wages per month and two (18.2%) did not have their own income. What the medical diagnosis is concerned, 10 patients (90.9%) were victims of ischemic CVA, and only one (9.1%) of hemorrhagic CVA.

One family (9.1%) consisted of seven members, followed by three (27.3%) with six members, one (9.1%) with five members, two (18.2%) with four members, one (9.1%) with three members and three (27.3%) with two members. On the average, the 11 families consisted of 4.3 members.

In terms of family income, five (45.4%) families received between one and a half and two minimum wages, four (36.4%) between two and four minimum wages, two (18.2%) between four and six and only one (9.1%) received nine minimum wages per month. At the time of research, the minimum wage in Brazil was R$240.

What religion is concerned, in eight (72.7%) families, all members of the family nucleus were Catholic; in one (9.1%), the aged person was a Spiritist, the wife Adventist and the daughter and grandchildren Catholic; in one family, (9.1%), the elderly and his wife were Catholic and their grandchildren Evangelic and, in another one (9,1%), the aged woman, her son-in-law and two granddaughters were Catholic, her daughter was Spiritist and one granddaughter was Buddhist.

Description of Changes in Family Relations

The analysis of the consequences revealed a number of changes in family relations. These constituted 13 subcategories, five positive and eight negative, totaling 58 changes, 30 positive and 28 negative, in accordance with the family members' reports (Table 1).

Table 1 – Category of change in family relations and respective subcategories, with a positive or negative reference, extracted from the reports of relatives of aged persons diagnosed as CVA - Ribeirão Preto, 2003

ALTERATION	SUBCATEGORIES			
	POSITIVE	Nº	NEGATIVE	Nº
Family Relation N=58	Collaboration from relatives to take care of the aged person.	7	Worsened the aged person's relation with family members.	11
	Improved relation among family members.	12	Increased the aged person's aggressiveness towards his wife.	5
	Support from relatives to decide about treatment.	4	Lack of collaboration from relatives to take care of the aged person.	4
	Collaboration from neighbors and friends.	6	Changed the composition of the family nucleus.	2
	Increased the wife's decision power.	1	Charges due to decision making about treatment.	1
			Children asking their father to dedicate more attention to their mother with CVA.	1
			Marriage after the CVA.	1
			Distancing from neighbors and friends.	3
TOTAL		**30**		**28**

DISCUSSION

The 11 elderly persons' average age was 73.4 years and 63.6% were men. These data are similar to a study[6] on health conditions among persons aged 60 or older in the city of São Paulo, carried out through self-referred assessment. This research observed higher incidence levels of CVA among elderly men over 75, accompanied by a larger amount of sequelae.

Most male victims were married, and most female victims widowed. Among the men, the condition of being married favors care delivery by their families.

In terms of education, a majority of participants knew how to read and write, followed by those who had not finished primary education, with four years of study at most. This is in accordance with the Brazilian reality, where most elderly alive did not have the opportunity to learn how to read and write[7]. Low education levels can contribute to the appearance of the disease, as this fact, associated with socioeconomic and cultural factors, can difficult awareness about health care needs across a person's life, adherence to treatment and to the maintenance of a healthy lifestyle that limits the effects of risk factors[8].

What profession/occupation is concerned, 81.8% were retired, while the other participants did not have any own income and depended on their partner. As a result of this condition, most elderly needed help from their relatives to complement their low income. This was aggravated even more when the appearance of the disease led to increased expenses.

Most participants (90.9%) were victims of ischemic CVA, and only 9.1% of the hemorrhagic type. This is probably due to the high lethality of hemorrhagic CVA[6].

On the average, the families consisted of 4.3 members. In most of them, two or more generations lived together, characterizing multigenerational

households. This fact can create the need for a family arrangement to cope with the situation of having a sick and dependent elderly at home.

We found that most families survived on a monthly family income of about one and a half to two minimum wages, that some members were unemployed and that the parent affected by the disease could not work. Hence, some relatives mentioned the lack of resources to buy food, drugs and disposable diapers, as well as to rent care equipment, among others.

When all members of the family nucleus had the same religion, this was mostly Catholic. In some cases, members in one and the same family mentioned different religions, including Evangelic, Spiritist, Buddhist and Adventist. This mixture did not affect their mutual relations. When questioned, all relatives indicated respect for each other's religion. Evangelicals regularly went to church, while most Catholic family members attended services more sporadically. We found that the disease recovered persons' link with religion, indicated as a possibility of hope to recover from the health problems resulting from chronic disease.

The analysis of the consequences of CVA and the situations it produced revealed changes in family relations. The concept of family relation is linked with connections and/or co-living among family members or persons they find significant. In this study, we look at changes in the domestic environment of the aged person victim of CVA.

For elderly persons, the family is fundamentally important for solidarity and protection, as well as affective relations permeating the family dynamics. When the disease appears, besides breaking the family's organic balance, interferences occur in other levels of life, mainly in co-living with close relatives[9]. Hence, a disease like CVA, which can produce sequelae in one of the family members, favors disorganization and changes balance and pre-established interaction patterns. Promoting harmony and understanding among its members is paramount for the reorganization of the family system.

For people to live together, there is a need for an interpersonal relation among family members, with one understanding the other. This is not an easy task, as interpreting other persons' behavior and acknowledging differences sometimes leads to preoccupations, disagreements and difficulties in relations[10]. The same author adds that communication is an important strategy to approximate people, and that dialogue is fundamental in family relations.

The most relevant changes for the positive subcategories refer to collaboration for care, improved relations among family members, relatives' support in decision processes and collaboration from neighbors and friends.

Most families mentioned that the family caregiver received both informal and formal support to help in care activities. Wives, daughters and grandchildren assumed the responsibility for direct care.

Two families received support at their homes from a hospital's home visit team, which guided care activities. Relatives described this experience as positive, due to the fact that it made caregivers feel more secure to handle care situations.

The duties imposed by care for the elderly changed family relations. This gave both caregivers and the aged persons the opportunity to obtain new perceptions of themselves and the others, as the care process implies a set of actions that involve attitudes, feelings and commitments.

The greater proximity as a result of care activities stimulated improved relations among relatives, including the aged. Family 4's mother indicated that most children met more frequently and, besides taking care for their father, they also took care of each other. They were concerned about not leaving the care responsibility with one single person and the presence of affection and understanding was clear.

In 54.5% of families, relatives started to dedicate more attention to the elderly, that is, wives, in-laws, children, grandchildren and great grandchildren spent more time with them, talking, watching TV and accompanying leisure activities, among others. Manifestations of harmonious family relations contribution to the aged persons' emotional comfort[11].

The cognitive and motor deficits that affect victims of CVA bring about a large-scale redistribution of family roles. The victims' decision power is considerably impaired and, often, what remains is the illusion that they are still making decisions. In family 7, before the disease, the aged man was autonomous, in spite of alcoholism and even without assuming family revenues. After the CVA, decision power passed to the wife, who assessed the situation as positive, as family organization changed in several ways.

Families 1, 5 and 8 experienced situations related to the responsibility of deciding about the realization of surgical procedures in the elderly, as well as about withdrawing the nasogastric catheter and the start of oral diet. With respect to these procedures, we perceived the importance of all relatives' participation in the decision process, as cohesion made them feel more secure about their final attitude towards intervention.

Some participants mentioned collaboration by neighbors and friends, related to transport, security, company for the elderly when caregivers were absent and support in emergency situations.

In family 3, the daughter indicated the family's tight relation with the closes neighbors, who offered help for some needs. The elderly wife in family 5 spent part of the day alone at home with her aged husband and could also count on neighbors in case of emergency.

It is natural for relatives to cultivate and invest in friendship systems, including outside the family. Some individuals consider friends as people with whom they develop significant and more profound relations. Co-living with these persons can happen in the neighborhood, work environment and school, among other social institutions. The relevance of relations with neighbors and friends was evidenced in terms of their collaboration with daily problems, making the relatives responsible for the aged feel supported and secure.

As to negative subcategories of changes, these included worse relations between the aged person and relatives, increased aggressiveness between the aged and his wife, lack of collaboration for care and distancing from neighbors due to the elderly persons' bad mood.

Elderly persons in families 2 and 7 had a drinking habit, which seriously impaired their relation with relatives before the CVA. Alcoholism can distort or destroy families' self-confidence and self-esteem. Family members can isolate an alcoholic relative and keep only limited contacts with him/her[12].

In family 2, the wife told that her aged husband had a conflicting relation with her and his children, even before the CVA. She also added that, at the time of the interview, he had been even more aggressive and that, during care, he insulted her, spitted on her face and had already tried to physically attack her. She attributed this behavior to the fact that "he is naturally bad-tempered", did not accept to depend on her for body care and financial matters, among other forms of dependence. The same person also had a conflicting relation with his children, grandchildren, in-laws and brothers.

The wife in family 7 mentioned that her aged husband offended both herself and her daughters psychologically and physically. This violence or mistreatment is a complex public health problem, originated in the interaction among biological, social, cultural, economic and political factors[13]. The oldest daughter felt revolted by her father's violent attitudes towards the family in the past, and this fact interfered in daily care. This responsibility was assumed by the mother, who also went out to work to sustain the family.

The conflicting relations described above dated back to situations before the occurrence of the CVA, however, with a considerable increase after the disease. The wife in family 2 indicated that neighbors and friends no longer visited their house due to the aged person's bad mood and aggressive behavior.

The lack of collaboration for care can produce conflicts among relatives, as the desire to help cannot solely depend on one single person.

In family 3, the daughter told about conflicts between brothers due to the division of care responsibilities. In an attempt to transfer the aged women to her sister's home, her brother-in-law did not accept. As a result, the aged woman returned to her original home and caregiver. In this case, one sister could not decrease the other's overload due to her husband's opposition to take the aged woman into his home.

Family reports revealed various other impediments to collaboration. The most common ones were external work, obligations towards husband and children and angriness and grudges against the aged person.

Family relations are relevant in terms of love, affection, respect and values, as they contribute to healthy aging[14]. These authors also highlight that, in case of health problems, the relation with significant persons and their co-living can help the elderly to cope with and adapt to the instabilities of the disease.

Developing and looking for friendships and close relations is essential when people need one another. Interdependent and complementary relations, characterized by mutual help when needed, generate the support of security and comfort, relevant for survival and paramount in old age[15].

Disorganization, due to the lack of control on the situation produced by chronic disease and aggravated by the family's own life history, makes relatives look for reorganization to achieve a balance, using strategies that can guarantee coping with these situations, with a view to continuing the family's trajectory.

Nursing professionals need to acknowledge and value each family's efforts and potential, using what is positive to give the required support. Families must be encouraged and supported to reorganize and balance the family system by looking into its own daily demands and challenges. This attitude can strengthen and enable the family to attend to the aged person's care needs, as well as to administer the situation all relatives are going through with less suffering and disagreements.

FINAL CONSIDERATIONS

Cerebrovascular accident can cause a range of neurological deficits that produce sequelae, affecting the victims' self-care performance and life maintenance. Besides physical consequences, psychological and social functions also change, exposing family structure, development and functioning.

In the family sphere, family reports demonstrated changes resulting from the disease process, associated with losses due to aging, attributing positive or negative references. These alterations influenced and were influenced by family relations and the families' context itself.

Aged persons' living and co-living in continuous care processes is permeated by feelings of tiredness, stress, exhaustion, but sometimes also by welcoming, affection and tenderness. Care and tiredness as a result of the care process are human conditions that require reflection and support to the care-giving family.

Changes emerged from the situations produced by the chronic disease and aggravated by the family's own life history. They received positive or negative connotations from the perspectives of relatives who were going through the disease process of aged persons who were victims of CVA, presenting sequelae and decreased functional capacity and thus needed help to perform basic and instrumental activities of daily living.

Family dynamics can influence one or more of its members positive or negatively. Multidisciplinary teams can favor families' relations and adaptation to the demands. Nurses who do not know the family structure should not value its difficulties with a view to solving problems.

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Recebido em: 2.2.2005
Aprovado em: 1º.2.2006