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ALCOHOLISM AND FAMILY RELATIONS: A CASE STUDY WITH THE APPLICATION OF THE CALGARY MODEL

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ABSTRACT

Alcoholism is considered a public health problem, because it has consequences for society. In this aspect, the study aimed to identify the implications and repercussions of alcoholism on family relationships according to the Calgary Family Assessment Model. This is an exploratory descriptive research of the type of case study, carried out by master's students with the family of an alcoholic subject, accompanied by the Family Health Strategy, Sobral - CE in May 2016. The Calgary Model was used as a reference methodological approach to the family approach. Data collection was done through a semi-structured interview and field diary. The use of the referential contributed to a better understanding of the Primary Care team in the family health-illness process, promoting the definition of actions capable of promoting health. It also allowed for an approximation of the family dynamics, providing integral assistance and proposing interventions to improve the quality of life, considering the uniqueness of the individuals, families and communities.

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INTRODUCTION

Alcoholism is considered a public health problem, since its consumption has consequences for society, either in the family, community or for the user who is dependent on the substance. Harmful use of alcohol is one of the highest-impact risk factors for morbidity, mortality, and disability worldwide, and appears to be related to 3.3 million deaths each year, and nearly 6% of all-cause deaths attributed to alcohol in whole or in part (WHO, 2014). In Brazil, the frequency of consumption of alcoholic beverages by the population has been increasing in recent years, with some peculiarities according to each region of the country, in relation to consumption pattern, gender, age group, socioeconomic class and type of consumption and the type of alcoholic drink consumed (GARCIA; FREITAS, 2013).

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The consumption of alcohol and other drugs, with the exception of tobacco, account for 12% of all serious mental disorders in the population over 12 years in Brazil, and the impact of alcohol is ten times higher when compared to all illicit drugs. The dependence of alcohol, being configured as a public health problem, deserves attention of the social and sanitary network. Disorders of alcohol use, abuse and dependence can lead to crises and penalizing family members, contributing to interpersonal conflicts, domestic violence, abuse, parental inadequacy, child neglect, separation, divorce, financial distress, and clinical illness (AZEVEDO; MIRANDA, 2010). A study carried out at the Socio-Alcoholic and Other Drug Psychosocial Center (CAPS-AD) in Sobral, Ceará, Brazil, in 2013, shows the relationship between the losses associated with chemical dependence and problems in the family environment, in which 31.3% of the cases had family problems such as disagreements, frustration, emotional exhaustion, lack of credibility and distrust in the family

(OLIVEIRA *et al*., 2013). In this context, the assistance provided by the Family Health Strategy (FHS), as a coordinator of the Health Care Network (HCN), can articulate its points of attention in the search of offering integral and continuous attention to the condition of the health-disease-care-rehabilitation process of this user, at the primary, secondary and tertiary level, to offer a promotional, preventive, curative, care, rehabilitation and palliative care (MENDES, 2010). From this issue and the intervention process developed within the subject of Integral Family Health Care of the Professional Masters in Family Health, the purpose of this study is to report the implications and repercussions of alcoholism in family relationships in the light of the Calgary Model.

MATERIALS AND METHODS

A case study, developed with a family of an alcoholic subject, accompanied by the team of the Family Health Strategy - FHS, in the neighborhood of Centro, Sobral - Ceará - Brazil, in May 2016. This study was carried out at the home of the selected participant due to the importance and necessity of collective intervention. A semi-structured interview and field diary was used. The Calgary Family Assessment Model was used as a theoretical-methodological reference, because it allows the family to understand its multidimensionality, evaluating its organization. The model integrates the structural, developmental and functional dimension, divided into categories and subcategories and guides the use of the genogram and ecomap (family relationship and social system). The evaluation can take place in a space that enables a good communication between nurses and family members, also allowing health professionals to know their structure, relationships and identify their needs, performing a comprehensive evaluation, in partnership with its members, proposing assistance interventions for improving the quality of life (FIGUEIREDO; MARTINS, 2010). The structural dimension comprises the family structure, affective bond between its members in comparison with the external subjects and the familiar relations. Three aspects of family structure can be examined readily: internal elements such as family composition, gender, sexual orientation, birth order, subsystems, and limits. External elements: extended family and broader systems and context such as ethnicity, race, social class, religion and environment (SILVA; BOUSSO; GALERA, 2009). In order to delineate such aspects, the genogram that is the elaboration of the family tree was used, being used as a technique of clinical evaluation of the families, in which the interview is a significant part and the communication that occurs between the professional and the family can be understood as a process involving social interaction, recovery of memories and development of self-care. It provides demographic information, functional position, resources and critical events in the family dynamics (HERTH, 1989). The development dimension was delineated by the eco-map, offering an expanded view of the family and its support structure, and portrays the relationship between the family and the world, showing the link between its members and the community resources, helping to evaluate the available supports and its use by this. It is considered a representation of the relations with other subjects and with institutions of the family context, allowing a visualization of the main relations that it has with the territory (BOUSSO; ÂNGELO, 2001). And the functional dimension refers to the way family members interact.

Two aspects can be explored: instrumental functioning, which refers to the activities of everyday life, and expressive functioning, which relate to the styles of communication, problem solving, roles, beliefs, rules and alliances (FORNAZIER; SIQUEIRA, 2006). The study is in compliance with Resolution No. 466/2012 of the National Health Council (NHC). In order to guarantee the anonymity of the participants, they were identified with flower codenames: Carnation, Rose, Delfin, Sunflower, Genistra, Hydrangea, Daisy, Carrot Flower, Eremurus, Orchids, Calla Lily, Falaenópolis, Gardenia, Jasmine, Gloriosa, Anthurium, Chrysanthemum and Lily.

RESULTS AND DISCUSSIONS

The case

It was considered relevant, to know the family dynamics of Mr. Carnation, for a comprehensive care as recommended by the guidelines that permeate the Unified Health System (UHS). The family dynamics is described in Figure 1. The team identified the problem of the family consisting of Mr. Carnation, ex-market salesperson, 58, alcoholic and unemployed. Accompanied by the Family Health Strategy - FHS and the Center for Psychosocial Care Alcohol and Other Drugs (CAPS-AD), with diagnosis of mental disorders, due to alcohol use. Married to Mrs. Rose, a 57-year-old woman with systemic arterial hypertension (SAH) and insulin-dependent diabetes mellitus, a public market trader, working in the coffee industry, assisted by her daughter Hydrangea, who is married to Genistra and has a son of 12 years. The income of the house comes from the work of Mrs. Rose of approximately a minimum salary. The couple lives in a rented house, with their daughter Daisy and a five-month-old granddaughter named Flower, and her other son, Jasmin. Mr. Carnation has a conflicting relationship with his 27-year-old son, Jasmin, who does not accept his father's life situation, disrespects him and attacks him verbally. Jasmin is diagnosed of moderate mental deficiency, has been accompanied by CAPS for some time, without drug therapy, is currently discharged and receives government benefit. His girlfriend is pregnant and the couple each reside in their parents' house.

Daisy is 36 years old, bisexual, does not work, living with her mother's income Mrs, Rose, has a five-month-old daughter with a boyfriend Carrot Flower, a drug user who frequents his house sporadically. Mrs. Rose has decompensated diabetes with hyperglycemic peaks and does not adhere to diet, does not practice physical activity and has an extensive work day, besides assuming the responsibility of the family shows suffering and concern about the alcohol use of the husband and the marital situation of his other son 34-year-old Calla lily, also an alcoholic, married to Gardenia. Calla lily has already suffered a serious accident and has a history of attempted suicide. The couple has two seven-year-old and five-year-old sons and another eight-year-old son from another of Calla lily's relationships. A fact that shook Mrs Rose passed away a year after her daughter Sunflower, 38, from breast cancer. There was a very strong friendship and complicity between the two. Sunflower helped the mother in the care of the father Carnation. He left a daughter named Chrysanthemum of 22 years who has stable union with Anthurium, who has depressive symptoms and when there is conflict with the husband, he returns to his grandmother's house. The couple has a seven-month-old baby.

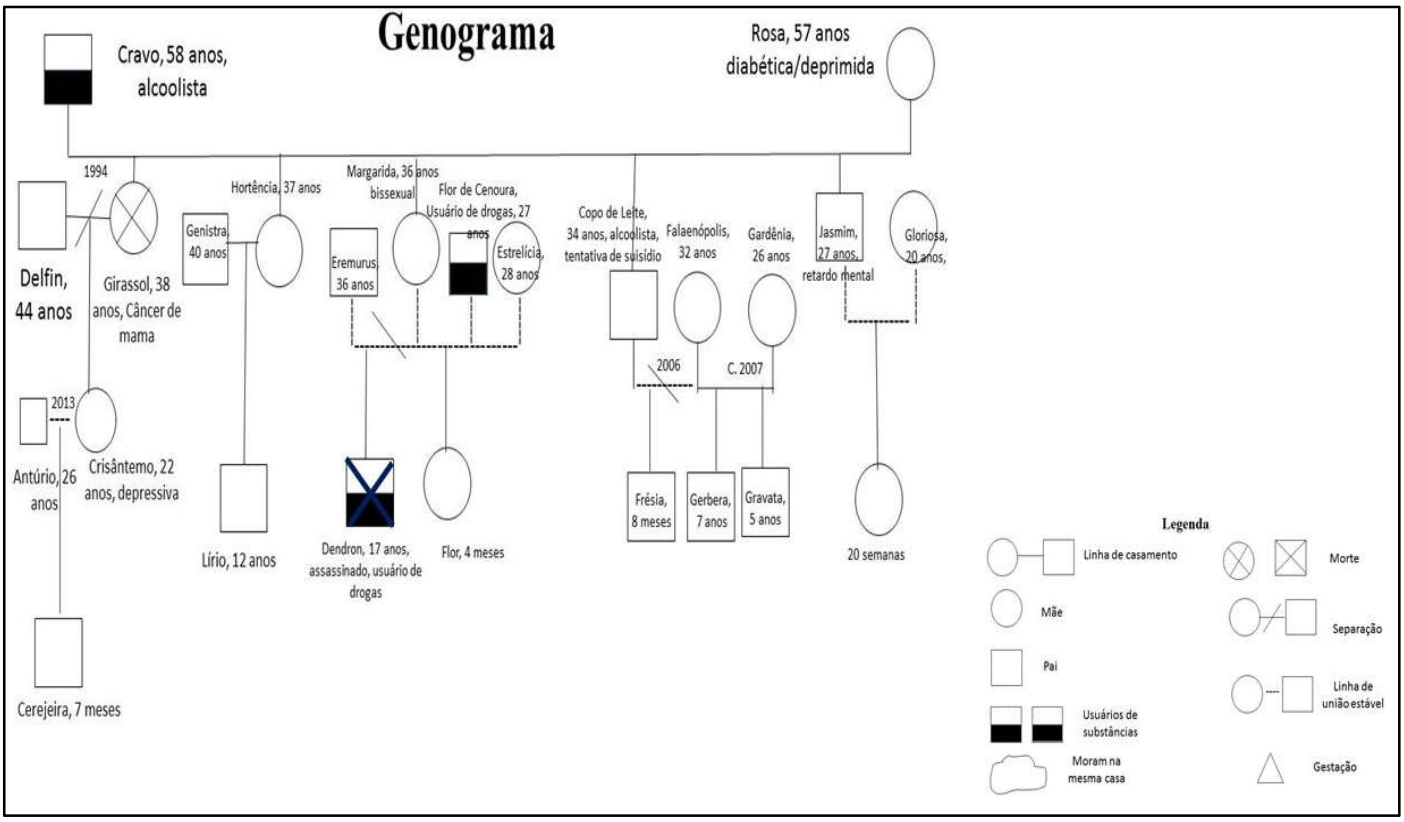

Figure 1. Mr. Carnation's genogram

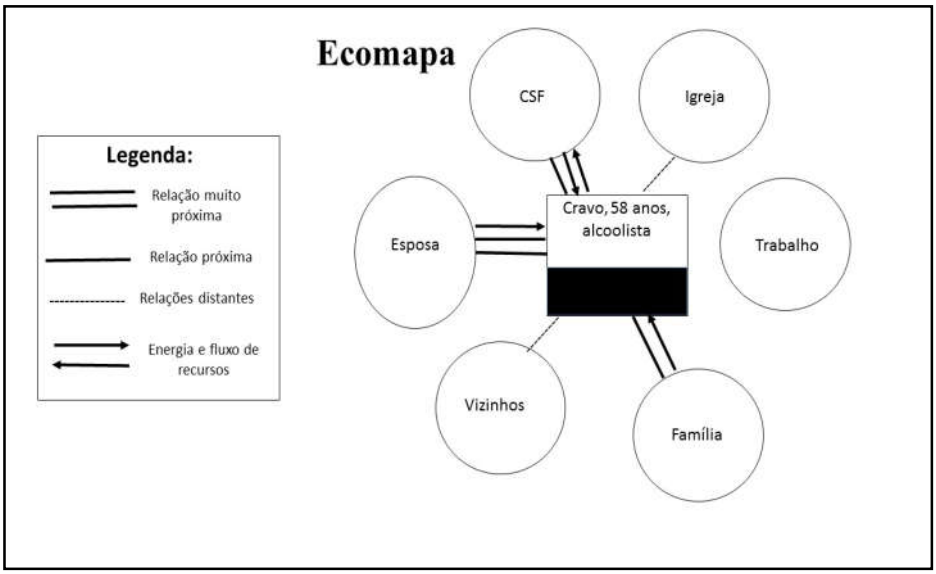

Figure 2. Mr Carnation's ecomap

In this way, we identify important biopsychosocial outcomes in Mr. Carnation's family, requiring attention and support. The category of development refers to the progressive transformation of family history during the phases of the life cycle: its history, the course of life, family growth, birth, death (Silva, Bousso & Galaira, 2009). Below is the structure of the ecomap, Figure 2.

Affected Needs and Care Practices

From the results presented in the previous category, it was possible to identify some needs for the family members under study:

Mrs Rose: She presents irregular use of her medication, absence of healthy eating, is anxious and worried about her husband's situation. In view of the needs identified, Mrs Rose was guided and referred to the therapeutic groups of the Family Health Center as the walking, Mental Health and Nutrition groups. I also directed the daughter Daisy who was more proactive in taking care of her mother, such as monitoring the medication administration and encouraging her to follow a proper diet. Clarified on the consequences related to hypertension and decompensated diabetes. Through a dialogue with the multidisciplinary team of the Family Health Strategy, we realized the need for referrals to Endocrinologist, Cardiologist, Psychologist and Nutritionist, which was carried out, considering the therapeutic itinerary of this, with a return

to the minimum team for longitudinality of care. It was possible to perceive for Mr. Carnation, family conflicts and frequent use of alcohol, since the family does not accept the behavior of Mr. Carnation triggering many conflicts. Faced with the story of his son Jasmin not to accept his father's drinking, often attacking him, driving him out of the house. Provided clarification on the problems that are linked to the use of alcohol and questioning about the desire to abandon alcohol dependence, he reported not having the strength to stop, reporting an earlier contact with the Alcoholics Anonymous (AA) group, without success, for not liking it. With the willingness to help him, he agreed with the team a therapeutic plan in conjunction with the CAPS-AD and also carried out intersectoral action with the AA, requesting a visit to the home of a representative of the group to attempt to raise awareness and rescue. The family thus requires support in the face of the imbalances arising from the emotional distress arising from the difficulty of the relationship and family problems related to the breakdown of the father and son bond. The need for help was perceived to account for the weaknesses and ruptures of the family bond and the resizing of roles that the situation imposes on the family. It is necessary to pay attention to this family that increases the possibilities of a better coexistence.

Mrs Rose shows sadness when referring to the grandson Dendron and the daughter Sunflower, leading to discouragement, low self-esteem, easy crying, depressed. Shared with the health team the need for the insertion of the lady in the coexistence group existing in the health unit, as well as massage therapy, being performed as alternative support and emotional support. He also has an exhaustive working day, with more than 12 hours, and when he arrives at his residence, he will still carry out the domestic activities and prepare some food for sale the following day. In the family of Mr. Carnation, we see the importance of the wife figure as an important emotional and financial support for this and all the members of this family, showing suffering and overload of work and responsibility. It represents the emotional support that sustains the whole family, which has been weakened by the overload of work and emotional support. Carvalho (1998) states that female-headed households are largely associated with situations of economic vulnerability, since women are the providers, besides assuming household functions and caring for their children and husband. The overload of roles assumed by women in the face of the social, economic and violence difficulties experienced by them exposed a perverse aspect of women's condition, highlighting, on the one hand, low self-esteem, frustrations, fears and longings and, on the other hand, courage and perseverance in the struggle for survival. In this assumption, it is indispensable that the health team observes the needs of the family involved with the subject in question, since this in addition to having their needs, causes pain and suffering for those involved in their family nucleus. Understanding the importance of providing support to the family of the subject under study because it understands the family as a fundamental role in the constitution of the subjects, being important in the determination and organization of the personality, besides significantly influencing the individual behavior through actions and educational measures taken within the family (PRATTA, 2003). The health team has been carrying out some family interventions, however, on time. Therefore, the multidisciplinary and multidisciplinary team was worked out and a longitudinal care was agreed upon, with the following actions: a unique therapeutic plan taking into account the social risks present in this family, with intersectoral actions with the social service, community unit of the health unit and CAPS-AD, in addition to follow-up with the above-mentioned health professionals. According to Alvarez et al., (2012), the CAPS-AD work in the whole territorial area of reference and consists of decentralizing the assistance promoting social and intersectoral articulation, seeking to strengthen the ties between the field of mental health and the community. Oliveira et.al, (2015) points out that the approach to chemical dependents needs to be multidisciplinary and integrated, with care that goes beyond clinical pharmacological treatment, referring as essential the psychosocial approaches aimed at the client and his family, including support groups and support as a care strategy. The basic health network presents itself as a gateway to the health system and represents the initial site that the family seeks help, and it is essential to be prepared to recognize its needs in order to implement actions whose interest is to benefit the family structure and achieve the recovery of the subject (FORNAZIER; SIQUEIRA, 2006). Therefore, the FHS was developed with the objective of strengthening the ties of commitment among health professionals, educators, managers and users of health services, being configured in interdisciplinary and intersectoral attention. In this way, professionals working in basic care must understand and act on the determinants of the health-disease-care process. This implies realizing a union of knowledges to be used in the definition of the care of subjects and their families (LOCH-NECKEL, 2009).

At this juncture, the National Health Promotion Policy identifies as one of the topics identified as priorities, addressing alcohol and other drug abuse, emphasizing the importance of promoting, articulating and mobilizing actions to reduce alcohol and other abusive consumption drugs, with co-responsibility and autonomy of the population, including educational, legislative, economic, environmental, cultural and social actions (BRASIL, 2014). Therefore, basic care services should be sensitive to these actions, so that they can dialogue with the other points of the networks in order to develop comprehensive care for the subject and his / her relatives.

The understanding of alcoholism within the family can help in the breakdown of beliefs, prejudices and overcoming the denial of the problem, enabling the development of an individualized plan of care, with educational interventions and counseling, in order to provide conditions that result in the reformulation of the lifestyle and a better reinsertion of the user into society (FORNAZIER; SIQUEIRA, 2006). Another important factor is that because alcohol is a licit drug, it causes people to have a perception of normality, without realizing when they are in abusive use and need for help. Oliveira et al. (2014) notes that alcohol can be considered sociable and lawful and unfortunately it is where it all begins. The economic value that circulates of taxes for Brazil is relevant, which prevents the construction of effective policies to reduce consumption. It was evidenced that the intervention was directed to the key subject and his / her relatives to the actions that sought to promote health in the search for self-care, strengthening it to a co-responsibility for actions that fostered interdisciplinary work, considering the needs of those involved. According to the Ministry of Health, the view about the use of alcohol becomes an exercise of coproduction of knowledge and subjectivity in the relationship of the worker with the user, it is necessary to create a dialogical space that thinks the alcoholic character as the one who has life for

besides the stigma it carries, understanding that the humanization of health practices affirms the singularity as a slogan for their actions (BRASIL, 2010). The production of the health care of a family could be approached by the health professionals, within a theoretical framework that made it possible to visualize, understand and intervene in the needs of the subject and their relatives, in the search for the care and production of their health, being able to articulate the points of the health care network. It was also noticed the relevance of using a theoretical framework that directed the approach to this family, making it possible to share this intervention with the family health team.

Conclusion

The evaluation of the family using MCAF allowed the family dynamics to be approached, provide assistance in the perspective of integral care, and verify that it is possible, in partnership with the health team and its members, to propose interventions to improve the quality of life , helping them to find solutions to deal with the difficulties of everyday life. In this scope, it becomes necessary the multidisciplinary work seeking the integration of health care networks. It is believed that caring for the alcoholic client and his / her family requires adherence of dialogical and constructive knowledge and practices so that the subjects can exercise autonomy in health care, therefore the MCAF can be an ally in the relationship of a care closer to the needs and increase the professional, subject and family bond.

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