



## USE OF FAMILY APPROACH TOOLS IN THE FAMILY HEALTH STRATEGY

### *Aplicação de ferramentas de abordagem familiar na Estratégia Saúde da Família*

### *Aplicación de herramientas del abordaje familiar de la Estrategia de Salud de la Familia*

#### **Vanessa Cristiane Araújo Oliveira**

State University of Montes Claros (*Universidade Estadual de Montes Claros - UNIMONTES*) - Montes Claros (MG) - Brazil

#### **Suzane Fonseca Oliveira**

State University of Montes Claros (*Universidade Estadual de Montes Claros - UNIMONTES*) - Montes Claros (MG) - Brazil

#### **Patrícia Helena Costa Mendes**

State University of Montes Claros (*Universidade Estadual de Montes Claros - UNIMONTES*) - Montes Claros (MG) - Brazil

#### **Aline Soares Figueiredo dos Santos**

State University of Montes Claros (*Universidade Estadual de Montes Claros - UNIMONTES*) - Montes Claros (MG) - Brazil

#### ABSTRACT

**Objective:** To describe the experience of the use of family approach tools after diagnosis of mouth cancer in one of its members. **Data synthesis:** Qualitative descriptive case study carried out in the first half of 2014 in a Family Health Strategy in Montes Claros, Minas Gerais, Brazil. Family approach tools were used to identify family structure and the ability to cope with the disease. This approach allowed us to know the family, monitor the treatment of the patient with mouth cancer and establish a trustful relationship between the family and the healthcare team, highlighting its importance in supporting families with diseases that are difficult to manage. **Conclusion:** The use of family approach tools allowed us to know the life context of the people involved, monitor the results of the sick patient and establish a bond and a trustful relationship between the family and the healthcare team.

**Descriptors:** Primary Health Care; Family Health Strategy; Case Studies.

#### RESUMO

**Objetivo:** Descrever a experiência da aplicação de ferramentas de abordagem familiar após diagnóstico de câncer de boca em um de seus membros. **Síntese dos dados:** Estudo de caso descritivo, desenvolvido com abordagem qualitativa, realizado no primeiro semestre de 2014, em uma Estratégia Saúde da Família, em Montes Claros, Minas Gerais, Brasil. Para o reconhecimento da estrutura familiar e da capacidade de enfrentamento da doença, foram aplicadas ferramentas de abordagem familiar. Essa abordagem permitiu conhecer a família, acompanhar o tratamento da paciente portadora de câncer de boca e estabelecer uma relação de confiança entre a família e a equipe de saúde, constatando sua importância no apoio às famílias com enfermidades de difícil manejo. **Conclusão:** A utilização das ferramentas de abordagem familiar permitiu conhecer o contexto de vida dos envolvidos, acompanhar os resultados do tratamento da paciente enferma, criar vínculo e estabelecer uma relação de confiança entre família e equipe de saúde.

**Descritores:** Atenção Primária à Saúde; Estratégia Saúde da Família; Estudos de Casos.

#### RESUMEN

**Objetivo:** Describir la experiencia de la aplicación de herramientas de abordaje familiar después del diagnóstico de cáncer de boca y uno de los miembros de la familia. **Síntesis de los datos:** Estudio de caso descriptivo desarrollado con un abordaje cualitativo en el primero periodo de 2014 en una Estrategia de Salud de la Familia de Montes Claros, Minas Gerais, Brasil. Para el reconocimiento de la estructura familiar y de la capacidad de afrontamiento de la enfermedad fueron aplicadas herramientas de abordaje familiar. Ese abordaje ha permitido conocer la familia, hacer el seguimiento del tratamiento de la paciente portadora de cáncer de boca y establecer una relación de confianza entre la familia y el equipo de salud señalando su importancia para el apoyo de las familias con enfermedades de manejo difícil. **Conclusión:** La utilización de las herramientas de abordaje familiar ha permitido el conocimiento del contexto de la vida de los involucrados, hacer el seguimiento de los resultados del tratamiento de la paciente enferma, crear vínculos y establecer una relación de confianza entre la familia y el equipo de salud.

**Descritores:** Atención Primaria de Salud; Estrategia de Salud Familiar; Estudios de Casos.



## INTRODUCTION

The family approach is an important health care strategy used in primary care. It is essential for understanding the family structure, identifying weaknesses and limitations, and it is useful to understand how the family functions in the face of problems, illnesses and difficult situations<sup>(1)</sup>.

Family medicine relies on sufficient understanding of the biopsychosocial aspects of its members. In this context, the family is considered the most important aspect of patients' social environment<sup>(1,2)</sup>.

The family is a universal model of living and can be understood as a space in which the first sense of belonging, identity and connection is experienced. It is still appreciated as a dynamic unit in which there is the gathering of people who may or may not live in the same household and are united by consanguineous bonds, affectivity or interest<sup>(3,4)</sup>.

Although there have been many possible variations in the definition, functioning, and configuration of families over time, they continue to be the basic means through which an individual relates to the world and must be considered a research dimension for understanding how individuals live in their real context of life<sup>(5)</sup>.

Knowledge about the family provides the context for the assessment of patients' health problems and helps to isolate the probability of several diagnoses, favoring the decision regarding appropriate intervention<sup>(6)</sup>.

In this regard, the Ministry of Health recommends family approach tools which are specific and basic strategies to be used in primary care. Therefore, health professionals should be able to use these tools. These tools include the family interview, the genogram, FIRO (Fundamental Interpersonal Relations Orientations) and PRACTICE, which represents the acronym of the following English terms: presenting problem, roles and structure, affect, communication, time of life cycle, illness in family, coping with stress, and ecology (environment, support network)<sup>(4,5)</sup>.

The family-centered approach requires a change in the practice of health teams and has been implemented along with the Family Health Strategy (*Estratégia Saúde da Família – ESF*) since 1994, promoting personalized interventions over time based on the understanding of the family structure<sup>(7)</sup>.

In this context, Primary Health Care (PHC) is characterized by the family-centered care, which requires understanding of its dynamics and interaction to meet its needs<sup>(8)</sup>; the family is considered the basic locus of action and represents the most appropriate point of health care in the approach to the family facing complex situations or diseases which are difficult to cope with<sup>(9)</sup>. The multidisciplinary health teams are aware of the reality of the families under their responsibility through the recording, monitoring and identification of their characteristics and bonding, which is an essential point for the approach and for possible interventions and necessary negotiations<sup>(2,9)</sup>.

In professional practice, the family is the center of care and is apprehended given its physical and social environment, which enable health teams to gain an expanded understanding of the health/disease process. Therefore, by focusing on the approach to the family as a whole, and not only on the sick family member, the view of a comprehensive health care is broadened, with actions extended to the collective and with the organization of preventive group practices.

Given that, the present study aimed to describe the experience of the use of family approach tools after diagnosis of mouth cancer in one of its members.

## DATA SYNTHESIS

This is a qualitative descriptive case study<sup>(10)</sup> carried out in the first semester of 2014 in a Family Health Care center of Montes Claros, a city in the state of Minas Gerais, in Southeastern Brazil. The Health Care Center comprises three family health teams (II, III and IV). Team III is responsible for the monitoring of about 600 families and was chosen because it is the team that carries out the monthly monitoring of the health situation of the family analyzed<sup>(11)</sup>.

The study of this family began with a demand generated from a home visit requested by the health care worker for a family that presented altered family dynamics due to one sick member who presented with oral cavity injury, walking difficulties and memory loss. Data were collected during home visits to the index patient (who generated the demand) in order to get to know the family, follow the treatment and verify how the family functioned and coped with the current health conditions.

In order to understand the family structure, which was understood as the number of people living in the household and their respective functions (for example, the fact that the parents are alive or not, divorced, separated or sharing housing with other partners, among other characteristics, such as their ability to cope with this situation)<sup>(12)</sup>, family approach tools were used to provide support to the family in the incorporation of autonomy. This was a preponderant factor that has proved indispensable in the approach model used by health professionals in the provision of home care.

The autonomy and identity of the family must be respected, otherwise care will become inauthentic. Professionals must be well prepared for conflicts, interactions and dysfunctions that are part of the family universe<sup>(3)</sup>. They must therefore gain the confidence of the family and listen more than talk.

Importantly, health professionals should know each member of the family to identify the functions and roles of each one, thus providing comprehensive care and often rescuing the family's functionality and extracting the disease. In the practice of health workers, communication is the main working tool; therefore, they must pay attention to whether the message passed or received is being properly understood. In addition, transgenerationality must be considered, i.e., one must observe the nuclear and trigenerational families (grandparents, parents and children), evaluating patterns of repetition, secrets and rituals that may be rooted across generations<sup>(12)</sup>. Another important aspect is that professionals must remember that individual care includes embracing and respecting the family, their values and their beliefs.

Thus, we used the family approach tools that best fitted in the present study and that complement each other and overlap in some moments. They are: the family interview, the genogram, FIRO and PRACTICE<sup>(4,5)</sup>.

In order to carry out the family interview, professionals initially need to correlate the family life cycle stage to the person's and family's problem, and at the same time identify the stages of family development and the tasks to be performed according to each stage<sup>(7)</sup>. Therefore, it is at this moment that the repercussion of the diagnosis of the disease in all aspects of the patient's life is evaluated. Next, it is relevant to identify the patient's knowledge about the disease and the expectations of the circumstances, as well as to diagnose the type of family that emerges in the face of the problem and its dynamics of functioning<sup>(3)</sup>. The stages of the family life cycle are permeated with crises, which may or may not be predictable and may occur at any stage of development.

The classification of the stages of the life cycle used consists of six stages<sup>(13)</sup>: single youth, family without children, family with children, family with adolescents, family in the middle of life, family in the late stage of life/aging. As the family is composed of several members at different stages of their individual development, the stages are not lived in isolation. There are juxtapositions of stages, leading to expressive conflicts for the passage from one stage to another.

The genogram is a tool for the graphical representation of the family. It describes family members, the types of relationships between them and their main morbidities. Data such as occupation, habits, levels of education, among others, can be added according to the professional's objective and important data about the family. It is, therefore, a diagram in which the family structure is represented<sup>(14)</sup>.

FIRO<sup>(7)</sup> allows the identification of three categories (inclusion, control and intimacy), making it possible to evaluate the feelings of each family member in the daily life experiences. Inclusion ("inside or outside") refers to the interaction within the family, its organization and bonding. It allows one to know who is inside and who is outside the family context. The control ("top or bottom") refers to the power within the family itself. It identifies those who exercise the dominant control, the reactive power (which is developed by who presents opposite reactions to the dominant) and the collaborative power (which is represented by the one who divides the influences between the members). Intimacy ("close or distant") refers to the way in which feelings and interpersonal exchanges, vulnerabilities and strengths are shared<sup>(7)</sup>.

The PRACTICE model can be used in complex situations in which it is necessary to evaluate the functioning of the family and to understand the problem, allowing effective and resolute interventions to be developed<sup>(5)</sup>.

The information obtained through the data collection and the family approach strategies allowed to study the case of a family and to develop a plan of care with the possible and necessary interventions to be carried out with it.

The present research was approved by the Research Ethics Committee of the State University of Montes Claros (*Universidade Estadual de Montes Claros - UNIMONTES*) under Approval No. 572.244, and all family members who agreed to participate in the study received a detailed explanation of its purpose and objective and signed the Free Informed Consent Form for Participation in Scientific Study. Participants were given fictitious names to protect their names and remain anonymous.

Through the family interview, we identified that the family analyzed is composed of three members: the index patient, Salete, a lady who has mouth cancer, her sister, Silvia, and her niece Margarida.

Salete, 63 years old, female, *parda* (mixed-race Brazilian), single, lives in her own house with her sister Silvia (64 years old), who is a widow, and her niece Margarida (46 years old), who is also single.

Salete's sister said that before becoming sick she worked at home as an artisan in the production of embroidery, fabric paintings and crochet. With the installation of systemic changes, she kept working, but no longer with the same quantity and quality as before.

As for the previous history of Salete, the family said that the patient had an active life, was a smoker and alcoholic and, because of a love mismatch, intensified these life habits. After her mother's death, which occurred four years ago, she moved into Silvia's and Margarida's house. During the home visit, Salete already presented cognitive deficit and total dependence for basic activities of daily living (BADL) and instrumental activities of daily living (IADL).

According to family members, and a neurologist's assessment, this cognitive deficit presented by Salete occurred as a consequence of the abusive use of alcohol. Among the behavioral factors favorable to health and functionality, authors report an increase in adequate physical activity, use of healthy food, smoking and alcohol withdrawal, and adequate use of medications<sup>(15)</sup>.

An individual's independence is understood as the ability to perform activities of daily living and to live in community with some or no help from others. It includes functional capacity and contributes to autonomy. Independence enables individuals to cultivate actions concerning their dispositions about how one should live according to their principles and priorities<sup>(16)</sup>.

In a study carried out with older people, 15.2% of the participants requested help for at least one BADL, and 35.2% of the older people needed help for at least one IADL. Almost all of the older people analyzed were exclusively adapted to factors intrinsic to their difficulties in BADL<sup>(17)</sup>.

Maintaining autonomy and independence during the aging process is essential for individuals. As people age, their quality of life is surely determined by their ability to maintain autonomy and independence<sup>(16)</sup>. Autonomy is the ability to make personal decisions about how to live daily depending on your priorities. Independence is the ability to perform functions related to daily life with some or no help from others<sup>(16,17)</sup>.

After the home visits by the family health professionals (physician, nurse and dentist-surgeon), the patient was referred to a reference center and diagnosed with Broders' grade II squamous cell carcinoma in the oral cavity. The tomographic examination showed a solid expansive lesion at the base of the tongue, extending from the tonsillar to the pharyngeal region. The head and neck surgeon proposed surgical intervention with total removal of the lesion. However, surgical excision of the lesion would lead to loss of speech. The family's doubt was whether this proposed treatment would really be the most coherent for the situation, since the patient presented cognitive deficit and total dependence for basic and instrumental activities of daily living and the surgery could make communication between the caregivers and the patient even more difficult.

After planning the treatment indicated by the oncologist, one of the caregivers sought information about the advantages and disadvantages of each available treatment, sought help from the health team in search for information on each modality proposed by the head and neck surgeon responsible for the case and, after explanations made by the oncologist, the family opted for the alternative treatment, that is, chemotherapy and radiation therapy, respecting the autonomy of the family.

It is known that working with families requires the incorporation of a "relational" technology based on the humanist approach and developed through an understanding of the systemic functioning of the family and the application of the patient-centered clinical method<sup>(14,18)</sup>. This requires professionals to have a differentiated attitude based on respect, ethics and commitment to the families for which they are responsible<sup>(19)</sup>.

Although each family requires specific attention and approach from the health team according to the problem faced and based on peculiarities of their life context, studies on family-oriented techniques recommend specific and effective resources that guide the practice of health professionals in the work with families<sup>(2,5,9)</sup>.

The family life cycle<sup>(5,20)</sup> in which the family was found was that of aging members, and the health professionals involved understood the dynamics of the family and their experiences regarding diseases and conditions related to the aging process that require adaptations in life routine.

Figure 1 shows a broad view of the family analyzed by means of the graphical representation of the Genogram.

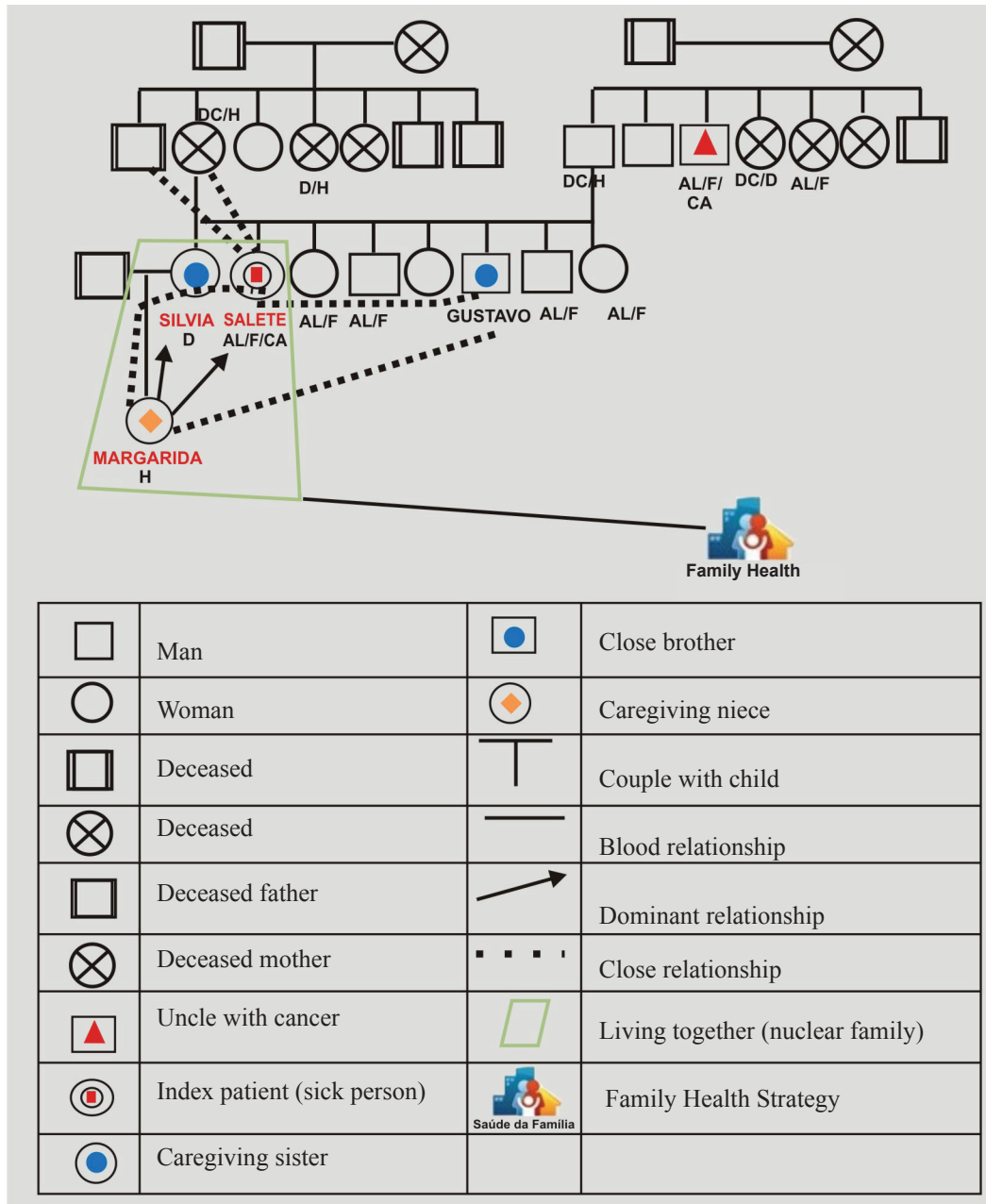


Figure 1 - Genogram of the analyzed family.

Note: CA: mouth cancer; S: smoking; ALC: alcoholism; HT: hypertension; D: diabetes; HD: heart disease.

The father (deceased) was cardiopathic and the mother presented several pathologies and died of cardiac complications. Still with regard to Salete’s family health history, we found that she had a paternal uncle who died of mouth cancer.

A pattern of occurrence and repetition of the main health problems of those involved can be identified. The main pathologies involved were diabetes, hypertension and cardiopathy. In addition, it is possible to verify the prevalence of alcoholics and smokers, and it is also worth mentioning the family history of mouth cancer.

The patient’s sister, Sílvia, had diabetes and accepted well the treatments proposed by the health team. She performed her basic activities of daily living normally, took care of the housework, and cultivated plants and made crochet work in her leisure time. As for the other Salete’s siblings, she had seven more siblings, and only two did not drink alcohol and did not smoke.

The nuclear family is represented by an extended family type with two generations<sup>(12)</sup>, which maintain a close relationship between its members, who have the health service as their main support network.

The relationship between individual and family health is evident: if, on the one hand, disorders and interactions are part of the family context, directly interfering with the health of their members, on the other hand, when one member becomes sick, it directly affects the stages of the family life cycle and the family needs to organize itself to care for the sick member. Prolonged/definitive situations of sickness may lead family members to seek resources to support the situation outside the family<sup>(20)</sup>.

Thus, it is important, based on the family structure, to identify important data to understand family functionality, that is, the “strong” and “weak” points of the family for home care, how the family can cooperate and how the professional should help the family for better care<sup>(21)</sup>. Thus, in this family, sisterhood, represented by Sílvia, was considered a “strength” as she is the sister and also caregiver. She said that she was always very close to the patient, and at that time, due to her current state of health, they always slept together to meet their needs in a timely manner.

In addition to the information obtained through the genogram, FIRO was also used to allow the professional to know the family structure, their power relations and feelings exchanges in addition to working as a facilitator of interaction among family members, clarifying their doubts on the pathology and its progression, and informing about the available treatment alternatives<sup>(22)</sup>.

The family involved in the study was composed of a sister, who played the dominant control role in the relations within the nuclear family, but who maintained a close and affective relationship. Her relationship with the other family members was distant, except with one member who is very involved with the disease that affected the index patient.

It was noted that the caregivers Sílvia and Margarida occupied much of their time with Salete and were, for now, organized in the process of care, since they divided their household tasks. Despite this, Margarida had made it clear that she would seek help from the patient’s siblings at any time if they felt overwhelmed.

Regarding the organization and division of tasks, the results of the present study contradict other approaches carried out by other authors in their studies<sup>(5,9)</sup> who found work overload and functions attributed only to the member who exercises the power relations within the family. In another study, it was possible to verify family conflicts and to identify reports of work overload among those involved<sup>(8)</sup>.

According to the caregivers, Salete did not know that she was being treated for cancer. She was not included in family decisions and was not involved in decisions about her treatment. Sílvia and Margarida thought she would not understand because of the cognitive deficit she presented. They also mentioned that the patient’s disease did not interfere with the performance of their roles, since they both took care of Salete very well, offering all the support she needed and always showing affection and protection.

It was noted that the power relations were represented by Margarida, who, in turn, influenced Sílvia. The two women were involved in decisions regarding the disease and contributed to the final decision regarding the type of treatment they thought was most convenient, since Salete’s siblings did not participate in the decisions on the case, nor did they comply with their roles as siblings, because they did not provide care to the patient nor gave support to their sister and niece.

As previously mentioned, only one of the patient’s siblings assisted in the treatment of Salete. The other siblings only said that whatever was decided by Sílvia and Margarida could be done. Margarida said that she shared her emotions with the others, but mentioned that she was reluctant to demonstrate the feelings related to the dissatisfaction with the patient’s siblings regarding their lack of commitment to the situation. These reports demonstrate “weaknesses” in the family functionality. They believed that with the onset of the disease, these family members became more distant. According to them, for fear of being sought to assist them and the patient.

In order to evaluate the way the family is organized to cope with serious diseases and conditions, some studies have successfully used the PRACTICE tool<sup>(2,5,9)</sup>. This family approach tool was also applied to the family, and the result obtained, likewise in other studies, allowed to assist the family according to its peculiarities in coping with the disease, strengthening ties with the health team and respecting the opinion of those involved in the treatment. The results are as follows:

P - Problem: Total dependence for basic and instrumental activities. Change in family dynamics due to treatment and interruption of family leisure due to Salete’s restrictions. R - Roles: Sílvia took care of Salete, of the house and accompanied Salete in the treatment. Margaret took care of Salete, of the bureaucratic questions and accompanied Salete in the treatment. Brother Gustavo transferred Salete whenever she needed. The other siblings did not participate. A - Affect: There was no change in affective relationships within the family because of the problem presented. C - Communication: Communication was satisfactory between Salete, Sílvia, Margarida and brother Gustavo, who assisted in resolving problems between them, but it was unsatisfactory among the siblings who preferred to stay away. T - Time in life: Family aging and facing the inclusion of a serious disease that affected one of its members. They need to negotiate roles among their members in the face of the current situation. I - Illness: The sister reported that they never faced similar problems and that they needed the mobilization of the family for resolution. C - Coping with stress: Sílvia and Margarida sought support from each other, from Brother Gustavo and from the Family Health Team. Sílvia and Margarida chose not to seek the rest of the family to avoid conflicts. And, finally, E - Environment/ecology: The family lived in their own home, with favorable socioeconomic conditions, had good relationships with the neighbors, but seldom sought help when needed. In the case of diseases, they used the Family Health Strategy through appointments at the health care center. The family attended the Catholic church assiduously and had financial resources from a retirement, a pension and real estate business.

The PRACTICE model<sup>(2,5)</sup> was a complementary tool that facilitated the evaluation of Salete’s family, providing information on how to conduct this case specifically. This tool made it possible to understand the dynamics of the family regarding the problem presented by the index patient. It was possible to note that, in this family context, there was no change in roles, but

there was a change in the family dynamics due to the current dependence to perform basic activities of daily living due to the health condition of the index patient.

The authors<sup>(2,5,9,21)</sup> who advocate for the use of this resource are unanimous in affirming that in order to interact in contexts of this nature, health professionals need to see beyond the user, that is, they need to see the whole family as it is an essential part of care and is involved in the maintenance of family relationships and the health of its members. Thus, professionals need to see the family as a link between the treatment and the patient<sup>(22)</sup>.

One of the main care techniques employed in the family approach was the observation caregivers' and the health team' understanding. It was noted initially that both Margarida and Sílvia were well informed and questioned the professionals involved, allowing an effective communication in the process of approach. In addition, it was noted that Margarida and Sílvia were responsible for home maintenance and decision making.

The family had as an auxiliary resource the health team, which was composed of professionals who provided multidisciplinary care to offer greater support to the patient and the family. During the visits made to monitor Salete, professionals addressed the absence of the other brothers in the assistance in her treatment.

In the present study, the family approach allowed the bonding between the health team and the family. The application of the available tools allowed to know the context in which the participants were inserted and the family relations in their daily life, facilitating access and providing greater assistance by the health team.

This experience allowed researchers to interact with the family and suggest the distribution of tasks for each family member in addition to providing guidelines to the caregivers regarding the management of the sick patient. The caregivers chose not to bring the whole family together to negotiate roles in the patient care strategy, as proposed by the team. In this regard, the team respected the opinion and limits pointed out by those involved because working with a family approach requires the building of a relationship of trust between professional and patient and respect for their beliefs, their demands and the autonomy of those involved<sup>(16,23)</sup>. In this regard, the caregivers mentioned that whenever they faced problems they tried to solve them among themselves, thus demonstrating patterns of repetition and usual rituals of the family in relation to specific situations.

The Family Health Strategy consists of a health service able to intervene in situations such as the one described in the case study presented herein, since it is the health care that is inserted in the social, economic and cultural environment of the individual and that addresses the determinants of the health process while encouraging the bonding between the team and the family/community. In this regard, the study allowed researchers to interact with the family, identify their needs and provide a follow-up of the development of this family by primary care professionals, strengthening their social support network. Such bonding has made the multidisciplinary health team become the reference of care for the family in the imminence of health problems, contributing to the achievement of the quality of life and health promotion of those involved. Caring for a sick family member is a challenge and has a great impact on the family, which needs to adapt and enhance their abilities. It is thus the responsibility of the multidisciplinary health team to recognize the difficulties and to assist in the organization of the roles of each member as well as in the adoption of coping strategies.

## CONCLUSION

The experience of the application of family approach tools allowed to verify and reinforce that a sick family member changes the family dynamics and that the support from the health team to the family affected by a difficult disease can minimize these changes. It also allowed to know the life context of those involved, to follow the results of the treatment of the sick patient, to create a bond and establish a relationship of trust between the family and the health team. It is important to emphasize the importance of health professionals in respecting the autonomy of the patient and/or the family as for the type of treatment to be followed.

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**Mailing address:**

Vanessa Cristiane Araújo Oliveira  
Universidade Estadual de Montes Claros - UNIMONTES  
Av. Dr. Ruy Braga, s/n  
Bairro: Vila Mauriceia  
CEP: 39401-089 - Montes Claros - MG - Brasil.  
E-mail: [araújodonto@gmail.com](mailto:araújodonto@gmail.com)