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Research Article

Genogram and primary health care

Genograma e atenção primária à saúde

Genograma y atención primaria en salud

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Abstract

Introduction: The determinants of inequality in health and disease patterns of the population are linked to the social context in the municipality of Rio de Janeiro, Brazil. In Primary Health Care (PHC), the use of family approach tools, such as the genogram, proves to be an important instrument for recogwnizing the context and its networks of relationships to provide an understanding of the dimensions of health and disease processes. **Objective:** In this article, we aim to analyze the challenges and potentialities of using the genogram as a support tool in PHC. **Methods:** To achieve the proposed objective, interviews were conducted with health professionals in PHC in the municipality of Rio de Janeiro, in addition to a bibliographic review on the use of the genogram in similar contexts. The collected data were qualitatively analyzed. **Results:** According to the results, although the genogram is a valuable tool for understanding family dynamics and health and disease processes, there are significant challenges in its application, such as the lack of adequate training for professionals and the resistance of some families to share personal information. **Conclusions:** We conclude that, despite the challenges, the use of the genogram in PHC has great potential to improve the understanding of family contexts and, consequently, the quality of care. It is recommended to implement training programs for health professionals and to raise awareness among families about the importance of this tool.

Keywords: Genogram; Family; Family health; Primary Health Care.

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Resumo

Introdução: Os determinantes da desigualdade dos padrões de saúde e doença da população estão atrelados ao contexto social no cenário do município do Rio de Janeiro. Na Atenção Primária à Saúde (APS), o uso de ferramentas de abordagem familiar, como o genograma, mostra-se um importante instrumento do reconhecimento do contexto e de suas redes de relações para proporcionar uma leitura e compreensão das dimensões dos processos de saúde e doença. **Objetivo:** Este artigo tem como objetivo geral analisar os desafios e as potencialidades do uso do genograma como ferramenta de auxílio na APS. **Métodos:** Para alcançar o objetivo proposto, foram realizadas entrevistas com profissionais de saúde da APS no município do Rio de Janeiro, além de uma revisão bibliográfica sobre o uso do genograma em contextos similares. Os dados coletados foram analisados qualitativamente. **Resultados:** Os resultados indicam que, embora o genograma seja uma ferramenta valiosa para a compreensão das dinâmicas familiares e dos processos de saúde e doença, existem desafios significativos na sua aplicação, como a falta de treinamento adequado dos profissionais e a resistência de algumas famílias em compartilhar informações pessoais. **Conclusões:** Conclui-se que, apesar dos desafios, o uso do genograma na APS tem grande potencial para melhorar a compreensão dos contextos familiares e, consequentemente, a qualidade do atendimento. Recomenda-se a implementação de programas de capacitação para os profissionais de saúde e a sensibilização das famílias sobre a importância dessa ferramenta.

Palavras-chave: Genograma; Família; Saúde da família; Atenção Primária à Saúde.

Resumen

Introducción: Los determinantes de la desigualdad en los patrones de salud y enfermedad de la población están vinculados al contexto social en el municipio de Río de Janeiro. En la Atención Primaria de Salud (APS), el uso de herramientas de enfoque familiar, como el genograma, se muestra como un instrumento importante para reconocer el contexto y sus redes de relaciones, proporcionando una comprensión de las dimensiones de los procesos de salud y enfermedad. **Objetivo:** Este artículo tiene como objetivo analizar los desafíos y las potencialidades del uso del genograma como herramienta de ayuda en la APS. **Métodos:** Para alcanzar el objetivo propuesto, se realizaron entrevistas con profesionales de salud de la APS en el municipio de Río de Janeiro, además de una revisión bibliográfica sobre el uso del genograma en contextos similares. Los datos recopilados fueron analizados cualitativamente. **Resultados:** Los resultados indican que, aunque el genograma es una herramienta valiosa para comprender las dinámicas familiares y los procesos de salud y enfermedad, existen desafíos significativos en su aplicación, como la falta de capacitación adecuada de los profesionales y la resistencia de algunas familias a compartir información personal. **Conclusiones:** Se concluye que, a pesar de los desafíos, el uso del genograma en la APS tiene un gran potencial para mejorar la comprensión de los contextos familiares y, en consecuencia, la calidad de la atención. Se recomienda la implementación de programas de capacitación para los profesionales de salud y la sensibilización de las familias sobre la importancia de esta herramienta.

Palabras clave: Genograma; Familia; Salud familiar; Atención primaria de salud.

INTRODUCTION

Families can assist in the success or failure of treatments, in addition to the management and coping of the actions presented in the health care and disease process.[1]

The empirical experiences gained during my period of training and work in the public network were crucial for developing this article. The considerable gap between the need of the population, the provision and improvements in the public service draws attention and encourages the need to think about more effective care practices in Primary Health Care (PHC). The difficulties encountered, both structural and personal, in the everyday work showed me more clearly the need to intensify and expand the quality of care. Professionals with high demands, numerous patients, and precarious workplaces sometimes made the care delicate and tense, with little time and room for questions and reflections regarding the quality and deepening of family issues so relevant in supporting the treatment of diseases and maintaining healthy habits in the Family Health Strategy (FHS).

Through the genogram tool — as it is a device of extreme importance for gathering information relevant to the treatment and prevention of diseases and maintenance of family health in Primary Health Care in the family unit —, it is possible to obtain information that guides health professionals in choosing specific plans for the treatment of a disease and assist the family in facing their issues.

Primary Care

Primary Care (PC) in Brazil, for Mendes,[2] is marked by decentralization and capillarity. It should be the preferred support of users in the area in which they live and is the gateway to dialogue with the Health Care Network (*Rede de Atenção à Saúde* – RAS). The FHS, in this sense, has a person-centered type of care, encompassing family and community, in such a way that it must consider the diversity of the territory in which it resides, comprising culture, religion, and ethnicity. The FHS is composed of multiprofessional teams, and its care process is based on the relationship with the population. In the process of working in the FHS, focused on the care of users and their family, the historical and social context is greatly considered, as it helps to understand how the environment interferes in the dynamics of the users and their nuclear family.

According to Mendes,[2] the shift from individual-centered care to family-centered care was fundamental in health care. The focus on family-centered care directs clinical work to a population limited to a FHS team, within the specific territory, socially organized as enrolled families with their own classifications, for clinical care using family approach tools. PHC has its history in the Brazilian public health system marked by development cycles since the second decade of the 20th century, with the creation of Health Centers in the Public Health Unit until the formation of the Brazilian Unified Health System (SUS) in 1988, allowing the expansion of PHC. After several steps, including the implementation of the Family Health Program, PHC acquired a very relevant quantitative dimension, determining the Primary Health Care Cycle, which continues to this day.

Chapadeiro et al.[3] report that the inclusion of the family in public health policies, resulting from the interests of the State, civil society, and international organizations, in the 1980s, gained prominence. The understanding of public policy has gone through the concern of the State with the demands highlighted by society to tackle social issues. In the post-war period, in 1945, the family was not the focus of discussions of State health policies, which privileged the individual. This picture started to change in the last decades of the 20th century, when the family assumed the role of co-responsible for the development of individuals.

The issues surrounding the family institution and its functioning guide the context of the family structure, emphasizing the demands, relationships, interactions, roles, norms, and a range of relations of the participants of this nucleus, ratifying the complex nature of the family system. The study of this social group, due to the complexity of its relations, is an issue in the research work, because there are several family models, with different interaction patterns and behaviors, as reported by Bowen,[4] who defines family as a mixture of relational and emotional systems. Sousa et al.,[5] in turn, define this term as a nuclear set composed of people living in the same household, represented by a person in charge. Mendes,[2] on the other hand, considers the family as a complex social system, of relationships in constant transformation, based on life cycles and allied with internal elements, interchanging with the social context.

Family-centered care works with a perspective that includes it as a benchmark, placing it as an important and responsible part of the maintenance and health of the individual. Automatically considering systemic interventions, the family becomes the main provider of beliefs and rules of health-related behaviors. From the perspective of Nascimento et al.,[6] every relationship, especially the family, has conflicts and requires an understanding that encompasses the social, economic, and life cycle contexts in which the individual is inserted. Following the everyday life of a family clarifies many conflicting situations that affect the most varied health conditions of family members individually.

For Mendes,[2] the FHS clinic, within primary care, is directly related to the use of family approach tools, also known as *family health tools*. Stemming from Psychology and Sociology, they focus on the development of intimacy between professionals and families, providing greater understanding of that unique and complex nucleus. According to Borges et al.,[7] there is a need for studies on the work with the genogram in public health, and there is scientific relevance in the proposal to fill the gap in studies on the genogram, seeking to highlight what are the contributions of the tool to Primary Health Care, being able to collaborate to health practices and to the development of new strategies for promoting health.

The survey of articles evidenced gaps in studies on the practical application, barriers, and potentialities of the genogram, a tool that can be applied using electronic medical records and/or through graphic representations. The genogram can help overcome difficulties of relationship between professionals and users of the FHS, facilitating the treatment of the individual, and defining actions and plans related to investments of resources in the health center. The challenges and potentialities of the genogram use in PHC in the city of Rio de Janeiro can represent tools of great relevance in the FHS, in the treatment and prevention of diseases, and in the maintenance of health, considering the care of the individual in the family context and the influence that the family exerts on them.

For Talbot,[8] as highlighted in the literature review, the importance in working with families is centered on understanding the model constituted by the very family, that is, the knowledge of their habits, beliefs, and values. According to Franco et al., [9] there are special situations in patient-centered relationships, in their family context, that favor the health professional to develop necessary bonds with the user. Wagner et al.[10] report that the work with families is divided into stages and that the beginning takes place from the connection of the professional with the family, and communication between professionals and the family should be clear for the exchange of essential care information and better habits. From this perspective, the knowledge of local families becomes indispensable for gathering information on diagnosis, interventions, formulation of programs, and decisions close to the reality of that place, as families have the understanding of their strengths and weaknesses, their limitations and capabilities, and the resolution of most health problems, allied with the establishment and maintenance of the population base, is among some of the main functions of PHC.[1]

There are many potentialities highlighted by those who use the genogram, but difficulties are pointed out less. According to records of studies on the genogram, there are positive results of the use, but not the difficulties and limitations of the process. From the perspective of comprehensive health, Borges et al.[7] emphasize that the information obtained from it, such as the identification of the life aspects of the family group, helps in the assessment of mental health and in the decision on the intervention or prevention of the disease. Although it is more frequent to see the benefits of using the genogram in improving relationships between professionals and users, as observed by Athayde and Gil,[11] the difficulties in working with families using this tool are consistent. Borges et al.[7] report that professionals with a higher-level position, although knowing the genogram, have demonstrated limited knowledge for its efficient use. To implement its use in everyday practices of the FHS, it is necessary to invest in human and material resources.[11] The lack of knowledge of the resource of the genogram tool can make it difficult to use it in a productive way, especially if it is compared with the dimension of demands in the FHS.

History and family

At the beginning of modern times, as per Ariès,[12] the concern with education starts being taken into consideration. A real struggle against the disorder of medieval society by religious supporters initiates

a social mobilization, displaying the moral side of religion and recognizing the importance of education. A new phase begins: the phase of school. Free school becomes a controlled space, and religious orders, founded by Jesuits or Oratorians, have become orders dedicated to the education essentially aimed at children and young people, and no longer adults. The new form of education was transforming society. The family ceased to be an institution of private law to become an entity that shares goods and names, and assumed a moral, spiritual, and caring role for children and young people in the physical and emotional sense. The action of having a child began to inspire new feelings, and could be named "the modern feeling of the family." The traditional learning of the time was replaced with the transformed school, ruled by strong discipline and protected by justice and politics. Ariès[12] emphasizes the duty of parents to send their children from an early age to school, where they would become the apprentices of their own social construction. Together, family and school withdrew children from the adult society. In the 18th century, the family reorganized around the child, "the wall of private life." In this reorganization, the family began to distinguish itself in society, becoming more focused on living with its members. The household organization began to correspond with this new way of living, protected from the outside. The independence of the rooms was established, so that there were no more scattered beds, which were placed at the bedroom, with adequate spaces for personal hygiene. The spatialization of the rooms, which arose between the nobility and the bourgeoisie, was one of the greatest changes in the everyday life of the time.[12]

Bowen[4] describes family as "a combination of emotional and relational systems. The term 'emotional' refers to the way it expresses itself. The latter comprises communication, interaction, and other modalities of relation." Carter and McGoldrick[13] point out that external influences can intersect individuals and families through a series of stressful events. The family member, as an individual, is the result of genetic inheritance and experiences during their life, and can be characterized by their abilities and failures.

Family covers an entire four-generation emotional system, not limited to the nuclear family itself. They are emotional subsystems, always responding to past and current relationships and precipitating future ones. People cannot modify the fact that they are connected to the web of family ties through several generations. The family life cycle is divided into stages, referring to the movements of the members of a family: marriage, birth, raising children, departure of the children from the parents' house, retirement, and death. In each stage, there is a plot of roles for family members.[13] To deepen our understanding of family, we need to circumscribe the concept that covers the title "family" and observe it in its social context. Wright[14] highlights that the individual functioning of each participating member of the family group establishes the form of interaction of these participants, and that any significant change that affects each member individually may affect or reflect in the family group.

The family is categorized as a basic institution, as defined by Carvalho and Almeida[15], and has as its structure the relations of cultural and historical kinship. With the analysis of the multiple family configurations made in the Social Sciences, the family is the center of protection and socialization of its members, ensuring the sharing of the internal culture and also the connection between the individual and society. Only in contemporaneity, according to Alves et al.,[16] the notion of family acquired a new connotation as a multiple and complex institution. It is the oldest and most universal social institution, with a determining structure of the social roles of its participants, seeking alternation between power and benefits, conflicts and agreements. From the perspective of Alves et al.,[16] the harmonious institution that emerges in the social imaginary about family as a place destined to welcome and meet the needs of its members is far from the predominant type established in contemporaneity. For the authors, the social institution has a fixed structure with defined social roles, alternating balance between rights, duties, powers,

and dependencies. According to Chapadeiro et al.,[3] families are permeable to the external environment, being vertically influenced, through systems, or horizontally, through life cycles.

For Penteado,[17] new issues arise, many others reappear, and several others fail to make sense in the general picture of the changes processed in the family context, because, as unusual as certain expressions of the individual may seem to be within the group, or even the group in its entirety, they certainly mark the new styles or the different arrangements and updates of experiences already lived by other generations. Leonidas and Santos[18] point out that the family represents an interaction unit formed by subsystems characterized by psychological, physical, and biological aspects, configuring the larger group named family. All this complexity of family relationships can be used to understand and help in the treatment of diseases and maintenance of health. The work with families enriches the understanding of the individual, because this is considered a group with a unique body, with its specificities and particular functions of each microuniverse. However, these family models, within the multiplicity of patterns existing in the family context nowadays, do not represent the diversity of the family in Brazil.

Generational transmission

The entire process of generational transmission begins before the birth and conception of a child, as the whole idealization of the family already prepares this place that will be occupied by the baby who will be conceived.[19] The family group is the place for the creation and development of the individual within its context. According to Andolfi et al.,[20] the need for differentiation of the individual is confused with the need for cohesion with the group. Initially, the individual lives an indifference; then, they seek separation in an attempt to individuate themselves, so as to find their own identity. The family is responsible for the feeling of belonging and differentiation. The individual develops within these family relationships and, through the content that will be transmitted by the family, recognizes their place within this group.[21]

For Cerveny and Berthoud,[22] the transmission of interactional patterns appears in the context of the family system. Past generations are included and can be alternated in the transmission of these patterns. The authors point out that the current system of repetition of patterns of a family removes from the past what will be reproduced. In turn, Kaës[23] points out that the crucial points of psychic transmission are in the psychic place according to which individuals are led to think of themselves as subjects both of an inheritance and of deviation, which they assimilate in what they receive from the parents. The origin is that which escapes from us, of which we are absent, and of which we have no control in the very movement in which we are constituted in and by the desire of the other and, even more, of the other that precedes us. The result of the received inheritance and the individualization process is the sum for the formation of the individual, but it also belongs to a group. For the author, the psychic transmission revolves around the axis of intergenerational relations and implies the apprehension of the subject by more than one other, that is, the subject of the group is constituted as a subject of the unconscious, according to the functioning of the unconscious itself in the intrapsychic space and the requirement of psychic work imposed on the psyche, due to its connection with the intersubjective and its subordination to the arrangements from which the subject comes — the family, groups, institutions, masses.[23]

In the process of transmitting family values and myths, previous generations delegate to the members of the family system a role and a destiny, attributed by the constituted family rules. According to Boszormenyi-Nagy and Spark,[24] each family has its rules that are inherited throughout the family life cycle. The authors call this content “invisible loyalties,” because it permeates generations, often without being

explicitly named. For Wagner et al.,[10] the individual receives an idealization produced before their birth and ends up inserted in an existing story, making them captive of the inheritance received.

According to Bacal et al.,[25] the family becomes a means of transmitting life, first and last names, education, heritage, culture, education, and even profession. This process of transmission is essential for the construction of a person's identity. The content transmitted by family generations supports the continuity of the family group through time. The generational transmission becomes clear through the process of recurrence of the family patterns, establishing the continuity and duration of that family group. The family issue becomes more complex when it comes to transmitting the culture of parents and ancestors to children. At this point, the ingrained values are exposed and, consequently, confrontations arise more sharply. In addition to this context, the aggravation of contemporaneity emerges, with a scenario of more than one family structure, opening up space for new patterns to be copied and improved and for different situations to be assimilated.[17] Family rules exist and are indispensable to teach its members how to establish and solidify the relationship between them, the way they should express their emotions, what is allowed and what is forbidden, how to transmit the legacy of this family to the upcoming members and, lastly, how to belong to this unique family group. Conscious psychic transmission occurs through language and affection, and unconscious transmission occurs through the relationship between the subjects of the same group. The differentiation may be greater or lesser in relation to the group and will depend on the process of construction of the subjectivity of this individual. The process of differentiating ourselves from our origins can be painful and, sometimes, impossible. There is a tendency towards "sticking" ourselves to families and becoming equals to them, whether through the first name, last name, biological and genetic inheritances and, also, family inheritances loaded with information. The form of transmission becomes evident through the repetition of family patterns, and it is in this transmission of values that lies the survival and perpetuation of the family.[26]

Family relations and functions in the sociocultural context

Knowing a family means analyzing the scenario in which the family lives and the influences exerted by this context. People are the result of their genetic load and the environment. Carter and McGoldrick[13] claim that the influence of the closest family on the human being is categorized as vertical, expressed in the level of education of those belonging to that nucleus as a way of establishing a relationship. This same individual and their nuclear family are also under the influence of the extended family, specified as cousins, uncles, grandparents, great-grandparents, and all the other members that participate in the family. For the authors, the emotional system of the family expands up to four generations, as presented in Figure 1.[13]

The family network goes beyond domestic boundaries, and family relationships endure time through generations. Life cycles are important in building the identity of the individual. The initial formations of life cycles are phases, as defined by Fortes[27]: marriage, expansion with the birth of children, and decline marked with the departure of children for the formation of new nuclei. However, as explained by Peixoto,[28] the development of each family is more complex than described, as the stages of the cycles are not so clear nowadays. The social and economic settings helped in the process of little delimitation of the beginning and ending of the family cycles, making it difficult to establish limiting patterns.

The family, despite being anchored in the process of parenting, assumes different configurations, marking the passage through the stages, regardless of the formed structure. The restructuring after

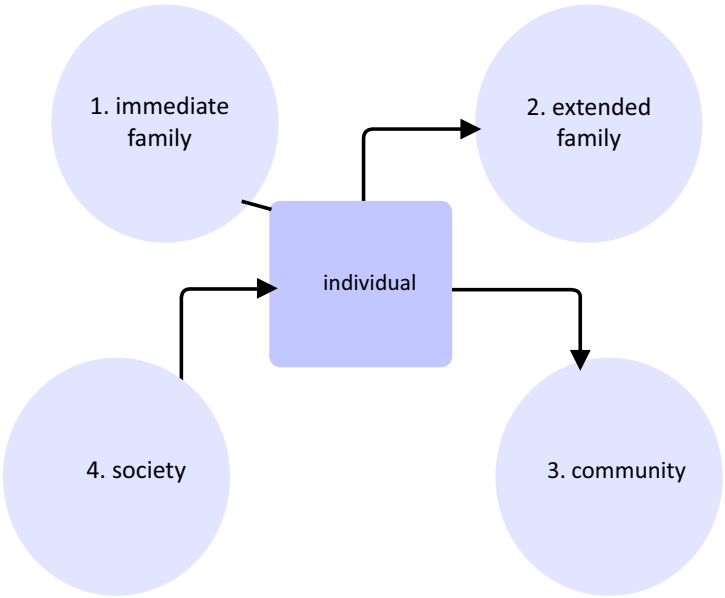


Figure 1. The individual and their influences.[13]

passing through each stage to maintain family stability is what marks the functional family development.[13] According to Walsh,[29] the family is a system that changes as time goes by. It goes through several phases, always changing, linked to the stages of life and connected in an intergenerational way. The stages of the family life cycle are divided into development stages, with predefined roles and functions, gathered in eight stages:

Stage I – phase in which the couple's life begins;
Stage II – period in which families have small children;
Stage III – families with preschoolers;
Stage IV – families with school-age children;
Stage V – families with teenagers;
Stage VI – families as a departure center;
Stage VII – middle-aged couples;
Stage VIII – families in old age[30].

Walsh[29] points out that the family life cycle and the impact it generates on the human being were not taken into consideration before. A broad perspective of this cycle provides data for health professionals to design the development of those belonging to the family group more precisely and with greater possibilities of healthy results. The importance of family ties and configurations is essential for understanding the role of the individual within that family. The adequacy of the current social context is also very relevant in understanding the family, because in addition to changes in the family cycle, the cultural social environment changes as well. What we deemed "normal" is no longer suitable and, in addition to the speed and amount of information, the parameters are more fluid, resulting in the relativity of standards for life cycles. The challenge of the family lies in this reorganization and search for stability to reach the new stages in the life cycle. When something is disrupted and the family context cannot bounce back by itself, there is a need for external participation. When looking for new solutions, the family is faced with several possibilities of configurations, and family approach tools belong to this context.

For Penteado,[26] the combination of individual, family, hereditary, and sociocultural factors forms the human being. Family/hereditary factors are related to the mechanisms of intrafamilial transmission, when they are mixed with the inheritances/transmissions by the biological pathway, such as genetic inheritance, as well as those resulting from relational patterns of family interaction, whose roots are in the history of the members of the same family and in the mechanisms of transgenerational family narrative construction. Finally, sociocultural factors are values and opinions socially shared that build and sustain the environment in which the individual lives. In this sense, they are decisive in the way of presenting oneself and interacting.

Primary care and family health

The concept of working with families takes place as specific and varied interventions during an indefinite period.[8] Gomes[30] reports that the importance of working with the family lies in the understanding of the model constituted by this family, including their habits, beliefs, and values. According to Franco et al.,[9] there are special situations in patient-centered relationships, within their family context, that provide the health professional with significant bonds with the user. These situations can be very rich and should be explored, such as the moment of enrollment, information on the family life cycle, family behavior in critical situations, and diseases present in the family context. For Wagner et al.,[10] the work with families is divided into steps, and the beginning is based on the connection of the professional with the family. After the first moment, the next step guides the objective evaluation of the issue, the functioning of the group, and the way the family works. Communication between professionals and the family should be clear for the exchange of essential care information and better habits.

The resolution of most health problems combined with the establishment and maintenance of the population base is among some of the main functions of PHC. In this context, the knowledge of local families becomes indispensable for gathering information on diagnosis, interventions, formulation of programs, and decisions close to the reality of that place, as the families have the understanding of their strengths and weaknesses, their limitations and capabilities.[1] McDonald et al.,[31] based on a concept of their own, point the user as co-responsible for the construction and maintenance of their care-related actions. Furthermore, the coordination of care is the articulation between sectors, services, and actions in health care and has distinct meaning for the participating actors, regardless of the region where it is carried out, provided that it is interconnected to the service provision.

The establishment and formation of the SUS are marked by national and international political and economic contexts until its current formation. Giovanella et al.[32] point out the assumptions and strategies related to the proposal for universal health coverage and the different conceptions of universality to pinpoint the experiences of countries with combinations of private and social insurance that do not exceed the strength of universal public health systems. Likewise, Rodrigues[33] addresses the context of the conception of health reform and the development of the SUS in the transition of Brazilian politics from militarism to democracy, and points out the political challenges for consolidating the system. Paim[34] talks about sectoral health systems and reforms, market-oriented trends, and obstacles in the development of the SUS. All of these authors contextualize the emergence and inauguration of the SUS, taking into account the political and economic changes in the process of establishing the system adopted in Brazil.

The organization of knowledge building and the implementation of practices and policy formulation in the health sector were carried out through multiple intertwined aspects. The provision of public services varied in the course of the historical context. According to Aguilera Campos et al.,[35] the implementation

of the permanent network of Health Centers (HC) in Brazil occurred before the constitution of the PHC field. Still according to the authors, Public Health (PH) initiatives were carried out with a philanthropic-like characteristic until the 1910s, through interventions in the environment, always focused on the collective, because there were no specific establishments. The first appropriate public places aimed to act in disease control and were intended to provide permanent assistance to the population. During this period, the government felt the need to set up a technical staff to cover new functions. In 1923, with the Carlos Chagas Reform, the National Department of Public Health (*Departamento Nacional de Saúde Pública* – DNSP) was created, with the attributions of promoting rural and urban sanitation, child, industrial, and professional hygiene, health supervision and surveillance of ports, and combating rural endemic diseases.[35]

A lot of effort was put into the topic of health development, but it was still far from achieving sufficient results for serving the population. According to the same authors, when the city of Rio de Janeiro became the capital of the state, in 1974, the Municipal Department of Health resurfaced, maintaining the principles and functions. In the period from 1979 to 1985, the implementation of an extensive policy on health services was initiated, inspired by the Alma-Ata Conference. The Integrated Health Actions of 1984 prompted municipal governments to review the role of a health service provider. Services were created under the name of Auxiliary Centers of Primary Health Care (*Unidades Auxiliares de Cuidados Primários à Saúde* – UACPS) and Municipal Centers of Primary Medical Care (*Unidades Municipais de Atendimento Médico Primário* –UMAMPS). This expansion of the primary care network highlighted the relevance of outpatient care. The decentralization of the SUS management, between 1988 and 1999, emphasized health promotion and disease prevention.[35]

The key proposal was the creation of the Family Health Program (*Programa Saúde da Família* – PSF) in 1993, initially aimed at populations of greater vulnerability. Gradually, due to successful experiences, there was an increase in the adherence of municipalities and popular support. The PSF started receiving special resources, facilitating its expansion, and the model became known as the Family Health Strategy (FHS), expanding the action of public health. According to Pinto and Giovanella,[36] the organization of PHC in Brazil, since 1994, has the FHS as a model of assistance, previously called PSF, intended to be the first contact of patients with the health system.

In order to achieve an integrated and effective result, the completeness of care is indispensable, as it circumvents the health needs of the system users. Fragmented care is one of the obstacles of poor quality of care, high costs, duplicities of information and diagnostic procedures, conflicting use of plans and therapeutic drugs, among others.[37] To ensure the coordination of care in a productive way, it is necessary to organize actions, such as the definition of shared goals for the health system, including the three levels — primary, secondary, and tertiary —; adequacy of payment schemes and allocation of resources; selection of communication tools among professionals; creation of a shared culture and leadership for teams; and strengthening PHC as the foundation of the system.[37]

Family health and family approach tools

In social terms, we can observe a set of important changes in society that are not under certain authoritarian and established standards when the limits of individual rights are exceeded. These social changes are also representatives of changes in family roles and strategies. The conceptions and evaluations of behaviors are changing, resulting in a diversification of family structures and roles, valuing the family group as a protector of individuals, detached from the traditional concept of family. Family transmissions

also rely on the surroundings, such as support networks, thus expanding the source of information and protection. These networks encompass relatives outside the nuclear family, neighborhood and the government, with education, care, and health systems, including the FHS, which represents a tentacle of public action.[38]

Advances in understanding the importance of family in the treatment of individuals have gained prominence, and the FHS is translated as a reorientation of the care model active in multiprofessional teams in health centers. The family health teams within the FHS are formed by professionals from different fields, characterized by multiprofessional teams, aiming at reorganizing primary health care in the country, as determined by the SUS. They are responsible for about 3,000 to 4,000 people, respecting the equity criteria and considering the vulnerability degree of the families. The teams are composed of general practitioners or specialists in Family Health, Family and Community physicians, nurses, nursing technicians, community agents, dentists, and oral health technicians.[38]

According to Hemfelt et al.,[39] it is paramount for health professionals to know the social aspect of the community related to that family under treatment, seeking to adapt the possibilities of support within the established social context, because, in this social spectrum to be mastered, there are the history of the community; social and local organization and movements; community leaders and representatives; public services available; schools; churches; leisure spaces; risk areas, among others. The domain of this information helps in understanding the context of the family, equipping the professional to understand the singularities of the process.

Emphasizing the family as the epicenter of the FHS, for Cecagno et al.,[40] it is interpreted by multiple definitions and concepts, also considered from different perspectives, which makes the work with the family group quite complex, that is, it requires dedication, attention, capabilities, and malleability to create a bond. Therefore, it is paramount to have knowledge of social issues. Fonseca[41] points out that there is a need to dive into the topic “what family is” to situate this group as a central focus of intervention. The intervention process in the family group demands questioning more refined strategies, which rely on contextual information of the group in its territory, in addition to the direct communication of the actors who are at the center of the intervention action with the specific population. The author states that, from a spatial perspective, kinship networks go beyond the blood connection, making family groups wider and more complex.

According to Starfield,[1] the family approach is one of the principles of PHC and guides the health team to know family members and their issues. The understanding of family health standards provides a relevant advance for the possible intervention contextualized in that group. Thus, family approach tools are effective and assist in working with families, because, through these tools, one can visualize family dynamics, intrafamilial relationships, and malfunctioning patterns, allowing pertinent and appropriate interventions for the moment. Getting to know the family is important for the evaluation and decision-making of the diagnosis and possible interventions connected to the reality of those social groups.

The goals of health systems are to optimize population health with knowledge of the causes of diseases and to minimize disparities between population groups, so that there are no groups more advantageous than others to access health services.[1] One of the characteristics of the FHS, according to Borges et al.,[7] is its strong role in the community, always taking into account the close work of the family and the social, economic, and political relations that permeate the history of the primary care user. In this sense, the use of the genogram, the focus of this article, is one of the contributing instruments for understanding the specific and current family context, allowing for greater access and knowledge of

relevant information about families, so that the health teams of the FHS follow up and make possible quality interventions within the care process.

For Chapadeiro et al.,[3] in the literature, we find some family approach tools used in the work with families in PHC, such as the Problem, Roles and Structures, Affect, Communication, Time in Life, Illnesses in Family, Coping with stress, Environment or ecology (PRACTICE), the Fundamental Interpersonal Relations Orientation (FIRO), the Family APGAR scale, network maps or ecomaps, and the genogram. As per Lacerda et al.,[42] the PRACTICE tool assists in family evaluation and possible interventions. The acronym PRACTICE stands for problem; roles and structure; affect; communication; time in life; illnesses in family; coping with stress; environment/ecology, whose translation to Brazilian Portuguese would be *problema; papéis e estrutura; afeto; comunicação; tempo no ciclo de vida; doenças na família; lidar com estresse e meio ambiente*, as illustrated in Chart 1. Within the context of family approach, the employed tools, such as PRACTICE, allow the discussion on the issues raised and possible solutions for the adaptation of family members to the presented situations.[43] The form of use includes family interviews with the aim of collecting information for possible interventions in the presented cases, including behavioral, medical, and relational data. For Fernandes and Curra,[44] PRACTICE is employed in more complex cases, being used to guide the evaluation of family functioning. It aims to solve problems by showing the various aspects that originate the presented issues.

Chart 1. Meaning of the acronym PRACTICE and its translation into Brazilian Portuguese.

P – Problem	*Problema apresentado*
R – Role and structure	*Papéis e estrutura*
A – Affect	*Afeto*
C – Communication	*Comunicação*
T – Time in life	*Tempo no ciclo de vida*
I – Illness in family	*Doenças na família, passadas e presentes*
C – Copping with stress	*Lidando com o estresse*
E – Environment or ecology	*Meio ambiente ou ecologia*

Source: Adaptation of the name of the tool, made by the author, based on the surveyed literature.

In turn, FIRO (Fundamental Interpersonal Relations Orientation) is used to evaluate the feelings of the members participating in the family group, to observe the everyday relations, and the relational experiences of the family members. It encompasses the understanding of everyday interactions, evaluation of changes in the family life cycle, marital changes, emergence and establishment of diseases, serious pathologies, and family members with terminal diseases. Family relationships are presented in the dimensions of intimacy, control, and inclusion, which can be seen as relationships of affection, power, and communication.[3]

According to Silva et al.,[45] the APGAR instrument was developed to estimate the level of functionality of a family, regardless of the life cycle stage of family members. It enables, through questionnaires, to identify dysfunctions in family systems and reorganize the balance of participating members. The acronym APGAR stands for *adaptation* — comprises family resources available in assistance —; *partnership* — refers to correspondence in family communications and problem-solving —; *growth* — related to the ease of changing roles and emotional development of the family —; *affection* — corresponds to emotional interactions and intimacy within the family group —*;* and *resolve* — related to the family determination,

decision, and problem-solving capacity. It is employed in clinical practice in FHS because it is a tool capable of facilitating the observation and analysis of family groups.

The genogram makes the graphic representation of the family by representing family members, relationship patterns and their diseases, and can expand to data pertinent to the family and the professional that applies it, enabling the reflection on family issues and ways of coping with possible problems.[3] For Mendes,[2] the use of family approach tools, such as the genogram, in the work of the teams can help in the perception of these professionals concerning the needs, pains, anxieties, demands, and potential of the families. Corroborating this perspective, Silva et al.[43] explain that health professionals, in the object of their care, understand the value of the family for the construction of care despite having a more person-centered practice.

As highlighted by Sarti,[46] the lack of focus on family and family approach tools, in the healthcare model and daily decision-making of the FHS, in addition to the lack of community awareness, opens up a harmful space that prevents actions around family-centered health and its context. Welcoming the family and its context, as well as the use of family approach tools as key in the formulation of actions, coping with diseases, and health care, are the basis of care in PHC.

Athayde and Gil[11] state that, in the process of creating a bond between family members and health professionals, the genogram plays an important role, because, for its development, it counts on the participation of the family, thus being a support instrument for FHS professionals. For Mello et al.,[47] the genogram expands the understanding of the family group, resulting in the expansion of forms of intervention. Thus, professionals of family health teams can assimilate relational patterns produced over generations, which are very influential in the health-disease process.

According to Machado et al.,[48] the formulation of the directions for the initiatives aimed at disease prevention and health promotion structured by professionals of the health teams are supported by the elements derived from making the genogram. The family has the opportunity to observe the members themselves as belonging to a larger group, responsible for the support process in the production and maintenance of diseases as well as in the promotion of health.

Support networks are relationships that connect groups, people, and institutions to a subject. For Camilo et al.,[49] these networks are paramount for the configuration and protection of the individual, because it has interpersonal relationships as essential for its survival, which directly act on the well-being and psycho-emotional aspects. The support networks are decisive for the subjects exposed to confrontations and complicated situations, achieving as a positive result the reduction of suffering as well as the foundation for tackling problems. It is worth emphasizing the importance of health professionals being the first ones able to identify vulnerable families with support needs.

Network maps or Ecomaps are the graphical representation of family members with all social systems that surround that family group. They represent the social network of the family and the complementary design of the genogram, comprising the relational structure and composition of the family and the interaction with the surrounding environment. All kinds of support of the family, such as churches, communities, neighbors, and family support, are used in its composition. Families that have more weakened connections between their members and the community require the care from the Family Health teams the most.[3]

The use of family approach tools, such as the genogram, in PHC supports and outlines the services, facilitating the relationship between the team and the professional and the user of the health system. The stories, ways of establishing relationships, and past experiences are the source of information for

understanding the functioning of the family group — which, in turn, provides the special elements, leading the FHS quality of care to a higher level, of greater attention and provision of care.[50]

The functions of PHC, according to Viegas,[51] are aimed at solving the health problems of the specific population of each territory, delimited with the coordination of multiprofessional health teams. Santos et al.[50] report that the quality of care of the health system user depends on the dynamics of understanding the family structure and its context. In this specific place, we find the most relevant information for understanding the family composition that carries the whole story capable of telling who the members of that group are. The use of family approach tools, such as the genogram, serves to understand the various interactions that are present in the relationships between those belonging to a nuclear family.

Genogram as a tool in Primary Health Care: deepening the knowledge

The term "familiogram" is best known in the medical field because it is used in several courses, including genetics, to identify hereditary problems. It is deemed an essential instrument in the family clinic. Other terms, such as "family tree" and "genogram," are also adopted in the fields of Psychology, Social Assistance, and Family Therapy to name the familiogram.[52] The choice for the term "genogram" in this study is due to my path in Psychology and Family Therapy, fields in which the term is more widespread than familiogram; however, both represent the same thing.

The family genogram, as previously explained, is a form of graphic representation of the family structure widely used in PHC. It can be considered as a tool that helps the family to express their issues and demands, because the physical, social, and emotional functioning of those belonging to the family group is interconnected.[53] In this tool, we observe the graphic map of the family, along with its pattern and history, according to McGoldrick and Gerson.[54] For Nichols and Schwartz,[55], in turn, this instrument has as its main function to organize family data and follow relational movements during the evaluation process. Used as a way of encouraging the family adherence to treatment, for McGoldrick and Gerson,[54] the genogram gathers the difficulties and possibilities of the participants, emphasizes the relational patterns, and identifies the extended family, in such a way that it can clarify the identification of the issue for which the family seeks treatment. It graphically represents the pattern and structure of the several types of family relationships. Thus, identifying the family structure and the existing pattern in the relationship is the basic characteristic of the genogram, pointing out the pathologies and frictions existing in the family group and mapping and expanding the knowledge of the family.[50]

As per Nichols and Schwartz,[55] its main function is to organize family data and follow relational movements during the evaluation process. McGoldrick and Shibusawa,[56] in turn, point out that the genogram is a structure for understanding the relational arrangement of the family in a simple and direct way. For Santos et al.,[50] the illness of an individual interferes in the family context, hence the importance of data collection in the patient's treatment. The tool provides access to specific information on the connection of the nuclear family and the environment in which the family lives, with particularities that would probably not have been accessed otherwise.

Athayde and Gil[11] point out that the participation of family members in the development of the genogram contributes to the creation of the bond between the health professional and the family, strengthening the relationship and enabling the work with the family that uses the health system. This participation in the development of the family structure allows health teams to know more deeply the patterns and relationships established during the transmission of generations that mark the process of family health-disease.

Consequently, this information facilitates directing actions and measures, as well as the risk assessment for implementing programs for prevention and support for families.[11] Machado et al.[48] emphasize that the perspective, from family representatives integrated into the context, of the family as a larger organism is only possible through the work of the genogram, and that the use of the genogram in Primary Health Care allows to observe and identify the current needs and enable relevant interventional actions, which can strengthen the vulnerabilities of that family group.[7]

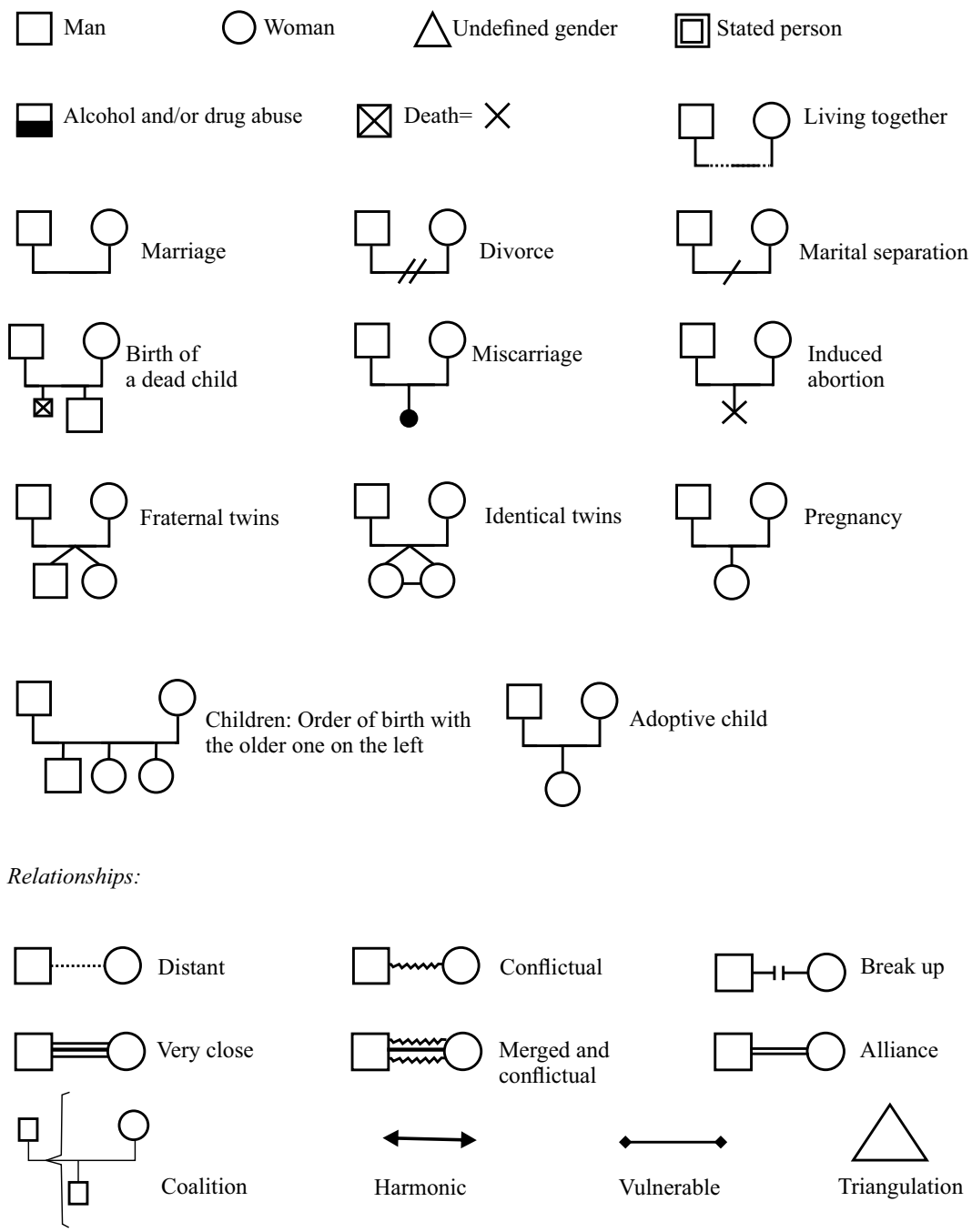


Figure 2. Caption of the genogram symbols.[18]

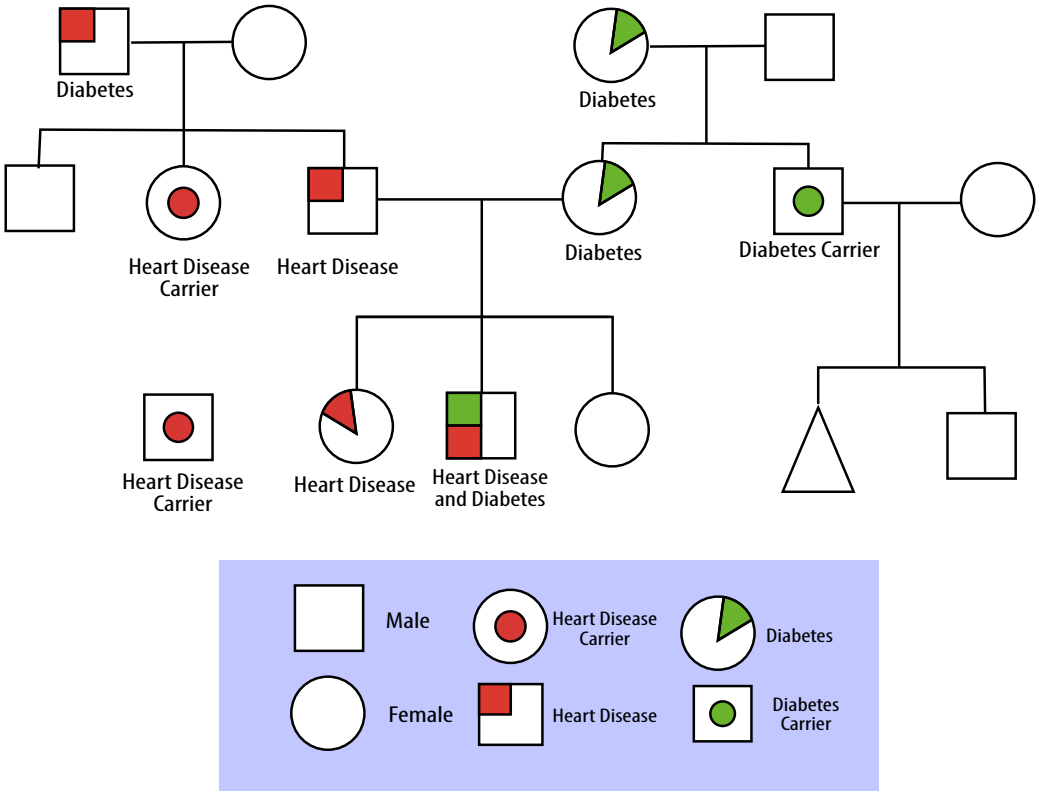


Figure 3. Example of a genogram mapping diabetes and heart disease.[57]

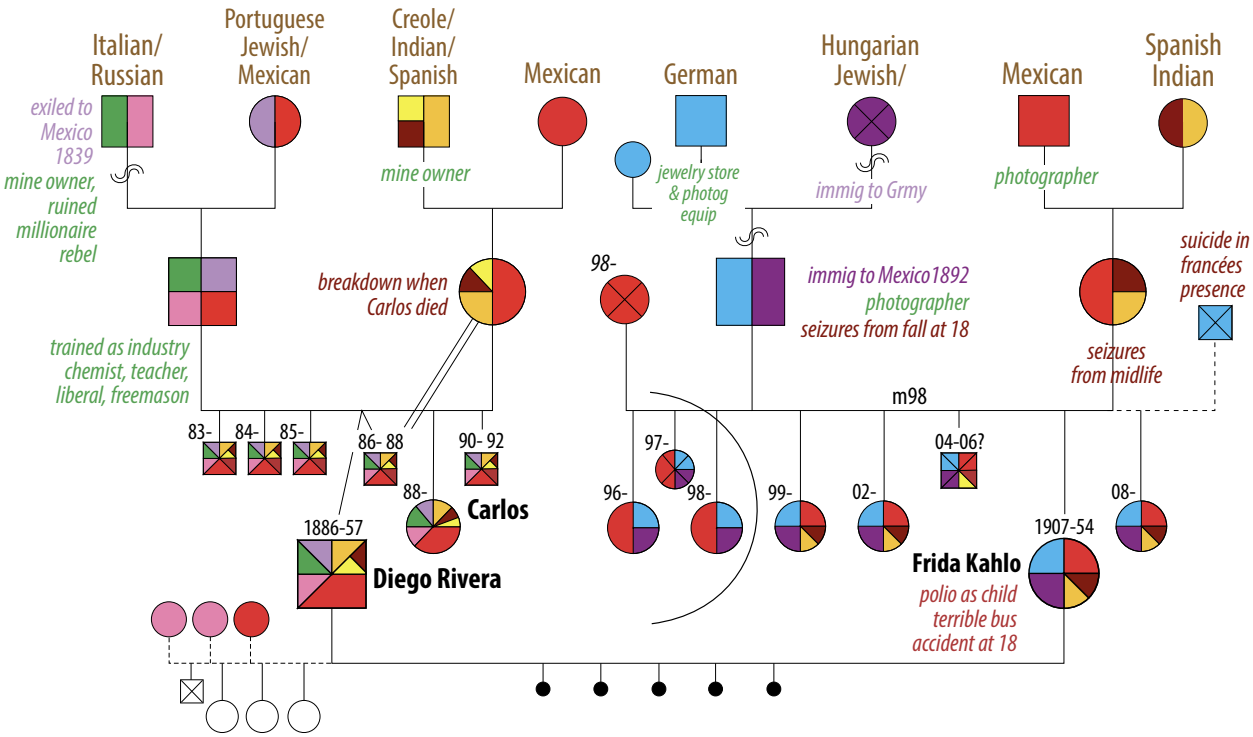
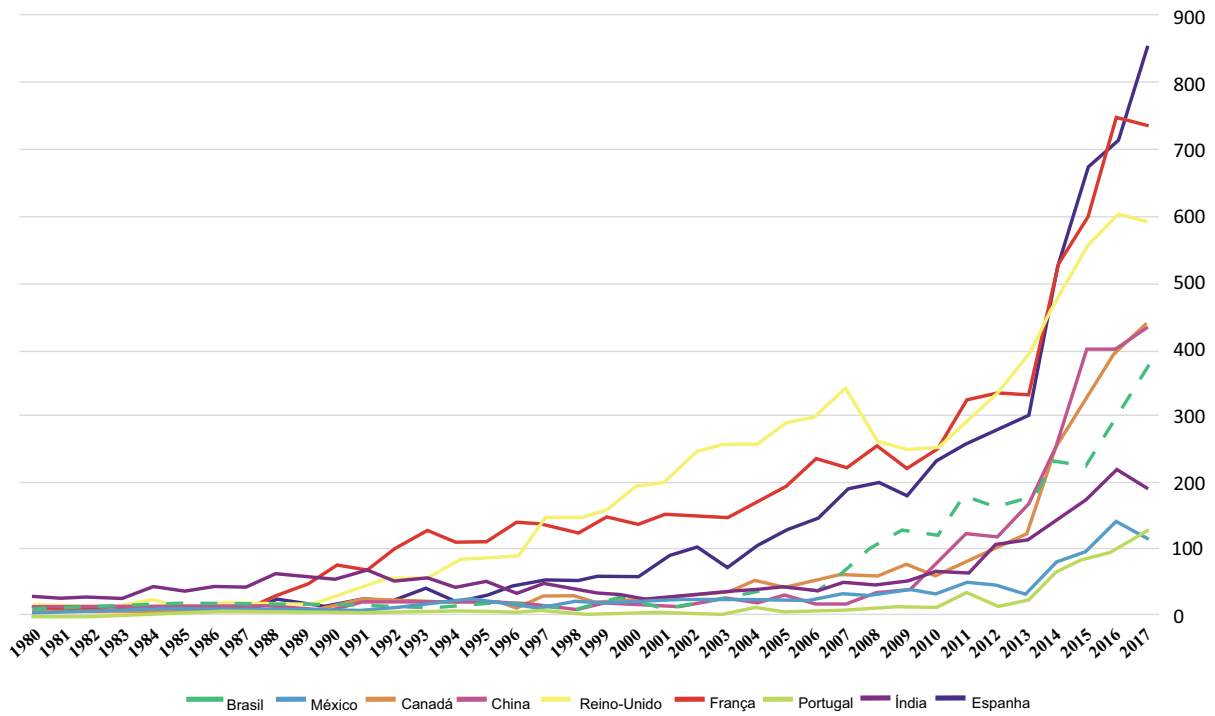


Figure 4. Example of a genogram of Frida Kahlo's family.[58]

Examples of genograms as illustrations are presented as follows: in Figure 2,[18] we show the captions and symbols used in the genogram design; in Figure 3,[57] we provide an example of a genogram mapping diseases; and finally, in Figure 4,[58] there is an example of family structure.

Considering these examples, every family relationship has its issues and should be looked at through lenses that see the life cycle with its social and economic contexts of the observed moment. Deepening the knowledge of the daily life of a family clarifies the conflicting situations that interfere with the health conditions of family members individually.[6] The work of family-centered care places as vital the maintenance and health of the individual in their family context because, systemically, the family is the main marker of beliefs and rules of behaviors directly linked to health.

For Macinko and Mendonça,[59] there is an increasing number of studies published, nationally and internationally, on the expansion of the FHS. According to the graph represented in Figure 5,[59] scientific publications significantly increased from 2007 to 2008, including in Brazil. This scenario also encompasses the growth of the FHS, with publications ordered with the terms PHC/Primary Care in Brazil growing after the implementation, in 2006, of the National Policy of Primary Care (*Política Nacional de Atenção Básica* – PNAB), as shown in Figure 5.



Note: Graph colored by the author.

Figure 5. Published articles including the terms “primary health care” or “primary care” in the title, by selected countries (1980–2017).[59]

The will to carry out the present research was supported by the need for studies on the work with the genogram in public health, as evidenced by Borges et al.[7] There is a gap in scientific publications whose authors aim at studying the genogram and its contributions as a tool in Primary Health Care. Moreover, according to the literature review, there are gaps in studies on the practical application, barrier, and potentiality of the genogram tool in the daily life of health professionals.

METHODS

This is a descriptive, cross-sectional, and quantitative/qualitative study. The field of study of Social Sciences is part of Collective Health as a component of great relevance, and it seeks to understand and interpret social phenomena from different interpretations of the fields of epistemology and varied methodology. According to Minayo et al.,[60] from the anthropological point of view, human beings have always been concerned with the knowledge of reality. Although the scientific field is permeated by contradictions and conflicts, science is the provider of current criteria and truths.

The objective of qualitative research, according to Proetti,[61] is the description and understanding of the phenomenon belonging to a specific context, without deepening in explanations, nor assumptions. The object of study of qualitative research lies at the origin of the facts and aims to show the results in a coherent and logical way. The investigated facts must be understood in the context in which they happen and, in this sense, qualitative research is also considered subjective research, referring to the idea of uniqueness and specificity of the observed subject.

Quantitative research focuses on numerical data, and qualitative research, on words. The quantitative method is conclusive, it quantifies a problem to understand its dimension through numbers. Quantitative research methods, overall, are used when it is intended to measure issues, such as habits, attitudes, opinions, and reactions, among others, of a specific environment through a sample collected to be statistically proved, but it may have qualitative indicators, as described by Günther.[62] In this study, the use of frequencies for the description and analysis of the obtained responses was highlighted.

This article was developed aiming at investigating the use of genogram in PHC, from the perspective of professors of the Institute of Medical Education (IDOMED) of Universidade Estácio de Sá (UNESA), in Rio de Janeiro, Brazil.

Study scenario

From the perspective of Lima,[63] Rio de Janeiro, a city with considerable population, brings together a vast network of services, especially hospital-related, coordinated by various governmental spheres. The municipal Primary Care network used to work based on the traditional care model. Only after 2009, according to Soranz,[64] there was an attempt to promote the reform, including the coordination of the network based on the logic of the integrated health territories, resulting in a large expansion of the Health Centers, solidifying the FHS model in Rio de Janeiro.

Being the second capital in terms of population in Brazil, Rio de Janeiro has a significant health services network coordinated by different government areas. Lima[63] points out that the managements, in the 1990s, were reluctant to reform the established traditional model to be replaced with the FHS model, and this scenario was intensified only in 2009, slowly and far behind other Brazilian states such as Minas Gerais and Santa Catarina.

PHC comprised the study scenario, more specifically from the perspective of professors of IDOMED, UNESA, the Medicine program, and preceptors of Health Centers of the municipality of Rio de Janeiro, who have an important role in public health experiences, in the following programmatic areas: 1.0 Centro, with 37% of the answers (nine respondents); 33.3% (eight respondents) preferred not to respond; 12.5% (three respondents) with more than one programmatic area; 2.2 Tijuca, with 8.3% (two respondents); 3.1 Manguinhos and Penha; and 2.1 Rocinha, Catete, and Copacabana, with 4.1% (one respondent each).

The scenario was chosen for presenting a relevant concentration of experienced and renowned professionals in the health area in the city of Rio de Janeiro, enabling to improve the research quality. The choice of study participants occurred through conversations about access to qualified people in terms of professional training and experience in health centers that could be available for the research. Their names were chosen according to the occupied positions, according to which they could have a greater range of other professionals, also qualified for the study. Thus, a greater number of participants was enabled, enriching the results.

For Mónico et al.,[65] the way of working in PHC in Rio de Janeiro is supported by a management structure shared between the Municipal Department of Health (*Secretaria Municipal de Saúde* – SMS) of Rio de Janeiro and Social Health Organizations (*Organizações Sociais de Saúde* – OSS), in order to serve SUS users with quality. According to Harzheim et al.,[66] the services that compose the Health Care Networks are formed in line with the demands of the local population, selected by the Family Health Teams. The primary health care professional must integrate the coordination of services with the care provided to the user through family orientation, community orientation, and cultural competence. The map of the programmatic areas of Rio de Janeiro in shown in Figure 6.[67]

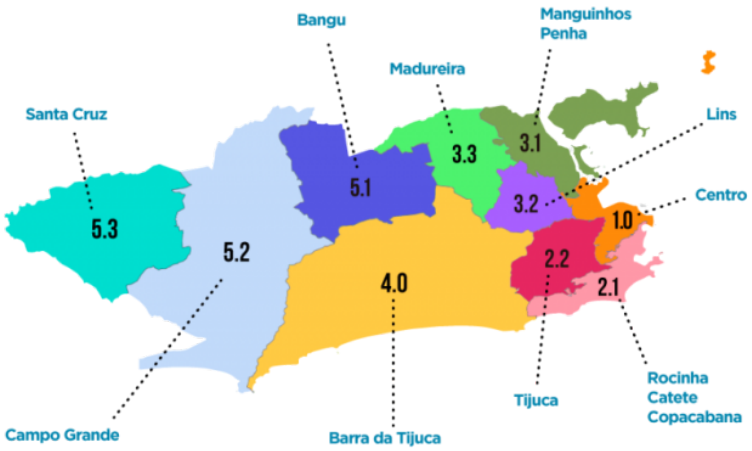


Figure 6. Map and caption of the programmatic areas of Rio de Janeiro.[67]

Data collection technique

For Mota,[68] although technology is extensively present in the lives of most people worldwide, besides serving as a support, there is still a certain resistance, perhaps even prejudice, in relation to its use in an academic and pedagogical way. The justification for the use of these technological tools lies in the possibility of opening new perspectives that provide an increase in participatory learning.

The use of technological tools for assisting studies and research causes practical changes in the collection and analysis of information. According to Santos et al.,[50] this daily change proved to be very significant for making processes faster and more sustainable. Education has been impacted by new technologies, and this impact changes the way people rethink strategies, projects, plans, communication, and methodology.

Considering that the constant changes in the world directly affect social relationships, for Castells,[69] technological advances promote a rupture of these relationships, thus changing the behavioral status through the large volume and speed of accessible information, directing the individual, expanding knowledge, and seeking different means of communication.

In this context, specifically in relation to data collection technologies available, Google Forms was chosen for this research, a Google Drive application that allows the editing of electronic forms to be launched on the Internet, facilitating research.

The idea of using a pilot instrument is supported by the definition of Mackey and Gass,[70] who define the pilot as a tool that presents itself on a small scale with the ability to present the methods chosen for the study.

In order to deepen the issues to be investigated, the employed methods were the survey of experiences through online interviews and the deepening in three stages: pilot[1] instrument, study instrument, instrument of validation of results and recommendations. The *pilot instrument* comprised the initial data collection for the formulation of questions for developing the study instrument based on the literature review. The *study instrument* was formulated based on the answers to the pilot instrument with the objective of selecting the relevant questions for collecting information directed to the topic of the research on the use of the genogram in Primary Care. The *instrument of validation of results and recommendations* emphasized the collected responses directed to the handling and use of the genogram tool in daily life and its importance, considering individual evaluation, as described in Chart 2.

The study participants were preceptors linked to IDOMED and the FHS in the city of Rio de Janeiro (RJ), with training in the field of health. The pilot instrument script was composed of guiding questions to achieve the proposed objective.

To this end, these were divided into six blocks that covered:

1. Insertion in PHC;
2. Sociodemographic data;
3. Use of the genogram in PHC;
4. Genogram in the health center;
5. Recommendations in PHC;
6. Possibility of interview for the instrument of validation of results and recommendations — for those who were willing to participate in this more in-depth stage.

For each of the blocks of guiding questions, answer options were formulated aligned with the reviewed literature. Thus, all options could be marked with more than one option, if necessary, and with a box for comments. The results of the data collected through the Google Forms questionnaire, provided in the research, were surveyed to verify some similarities with the literature review, while others showed discrepancy between the report and the handling in everyday practice.

Data processing

Phase 1 for developing the pilot instrument was conceived in the ICPD — Data Collection Instrument in Qualitative and Quantitative Research (*Instrumento de Coleta de Dados em Pesquisas Qualitativas e Quantitativas*) course, with the idea of standardizing, in a more concrete way, the body of research by a literature review. In Phase 2, for the of application of the pilot instrument, nine participants were

1 Pilot instrument applied to Primary Care peers, in the Seminar III course, with the objective of collecting observations for improving the final questionnaire.

chosen from different backgrounds, who work in Primary Care, in Family Clinics of the city of Rio de Janeiro, who were available to answer the pilot questionnaire, and who were taking the aforementioned course, being: two dentists; one nurse; and six family doctors, with the idea of structuring the possibility of research with the aid of experienced professionals in the field. Phase 3 focused on the formulation of the study instrument, based on the pilot instrument, considering the reported experiences and including the suggestions obtained from the participants.

Chart 2. Phases of the questionnaire application.

	Description	How it was carried out
Phase 1	Development of the pilot instrument based on aspects verified in the literature review.	The pilot instrument and its application were conceived and carried out within the ICPD – Data Collection Instruments in Qualitative and Quantitative Research course, with nine participants, namely: two dentists; one nurse; and six family doctors. It was developed based on the literature review. The idea was to structure the possibility of research with the aid of experienced professionals in the area providing their lived experiences.
Phase 2	Application of the pilot instrument to peers in Primary Care.	
Phase 3	Development of the study instrument based on the pilot instrument and suggestions.	Instrument review – Appendix 1 – Google Forms. Through the answers obtained in the pilot instrument, we structured the development of the study instrument using the experiences reported and the suggestions given by the participants of the previous phase.
Phase 4	Application directed to professors of Universidade Estácio de Sá – IDOMED/UNESA.	After approval by the Ethics Committee, the questionnaire was forwarded via institutional contacts (WhatsApp and e-mail) by preceptors of the selected units of Family Clinics in the city of Rio de Janeiro, with a presentation text and explanation, for three months. Study participants were selected by conversations on how to have access to the eligible participants, in terms of professional training and experience in the health centers, who were available to participate in the research. Their names were chosen according to the occupied positions, according to which they could have a greater range of other professionals, also qualified for the study. Thus, we would have a greater number of participants, enriching the results.
Phase 5	Survey of the results of the study instrument and development of the instrument of validation of responses and recommendations, based on significant criteria highlighted in the answers obtained from the previous phases.	Statements and questions were developed through the analysis of the results obtained from the previous steps, aimed at people who were available, through a specific question of the main instrument. The results of the previous phase were considered, with emphasis on the collected responses concerning the handling and use of the genogram tool in everyday life and its importance, according to individual evaluation, as well as the criteria defined by the answers to the open-ended questions.
Phase 6	Instrument of validation of responses and recommendations – application of a survey aimed at participants who were available to: I) validation of study results; II) survey of recommendations.	The survey was sent to participants who had registered their e-mails and contact details in the study instrument and availability to continue participating in the study, through a specific question in the questionnaire.
Phase 7	Analysis of the results obtained from the instrument of validation of responses and recommendations.	Investigation and categorization of the responses obtained from the instrument of validation of responses and recommendations and articulation of these responses with the literature review.

Source: Prepared by the author.

Subsequently (Phase 4), after approval of the Ethics Committee, the questionnaire was forwarded to the preceptor professors and coordinators of the selected units (Centro, Tijuca, Manguinhos, Penha, Rocinha, Catete, and Copacabana) of IDOMED/UNESA, via social media, such as e-mail and WhatsApp, with a presentation text and explanation, for three months. Study participants were chosen by conversations on access to eligible participants, in terms of professional training and experience in health centers, who would be available to participate in the research. Their names were chosen according to the occupied positions, aiming at having a greater range of other professionals, also qualified for the study. Thus, we would have a greater number of participants, enriching the results. Phase 5 included survey and categorization of the results, preparation of the step of the instrument of validation and recommendations based on the criteria selected through the importance highlighted in the obtained answers. The analysis of the results and the definition of the sample for the step of the instrument of validation of responses and recommendations considered the results of the previous step, with emphasis on the collected responses directed to the handling and use of the genogram tool in everyday life and its importance, according to individual evaluation. In turn, in Phase 6, the instrument of validation of responses and recommendations was sent to the participants who made themselves available through e-mails and contact information in the study instrument, for more in-depth answers. Finally, in Phase 7, the results obtained from the instrument of validation of responses and recommendations were analyzed, with survey and categorization of the obtained responses to articulate them with the literature review.

Ethical aspects

This project was developed based on the ethical principles for research involving human beings, as stated in CNS (National Health Council) Resolution No. 466/12. It was also based on CNS Resolution No. 510/2016, which determines specific ethical guidelines for the Human and Social Sciences. For the questionnaire/interview, it was necessary to pre-sign the Informed Consent Form, as per Appendix 2, supported by CNS Resolution No. 441/2011 of the Government of Rio de Janeiro, of the research subject who, in a clarified, free, and autonomous way, consents to participate in the research and interview. Field research began after the approval of the Ethics Committee, under CAAE (Certificate of Presentation for Ethical Consideration) No. 63514322.8.0000.5284 (attached), Opinion No. 5.721.542, and Research of Universidade Estácio de Sá. To preserve the identity of the participants, no personal data of possible identification were disclosed.

RESULTS AND DISCUSSION

The study participants were selected from the contacts of the preceptors of the health centers and professors of IDOMED/UNESA. This group of professionals has a capillarity position in the different scenarios of practices in which they work and would be able to have a more comprehensive view on the use of the genogram in PHC in the city of Rio de Janeiro, in addition to helping answer the guiding question of the study, as well as configuring a sample profile capable of directly contributing to the achievement of the study objectives. All respondents are health professionals working in the FHS and linked to IDOMED. There were 24 participants in total; 15 of them were available for the open-ended questions phase, and only four participated in the last stage.

The open-ended questions addressed the inclusion and recommendations for the insertion of the genogram in the curriculum of professional training; storage of the tool in everyday practice; work structure for the use of family approach tools; in-depth knowledge and practice of using the tool; and general recommendations.

The professionals participating in the instrument, as shown in Chart 3, were identified through the criteria of age; sex; professional training; specialization; time of professional practice; and working hours in Primary Care. We verified the highest number of responses among respondents aged 41 to 60 years, women, physicians with Master's degree, PhD and residency, with more than ten years of professional practice, and a 40-hour workload in primary care. According to Mendes,[2] the clinic in the FHS is directly related to the use of family approach tools from Psychology and Sociology, focusing on the development of intimacy between professionals and families, resulting in greater understanding of the family group.

Chart 3. Participants' profile.

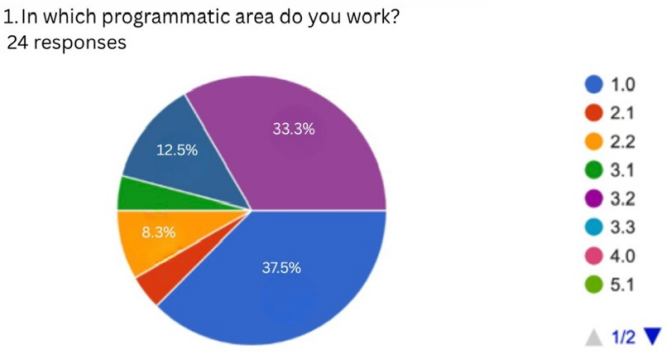
	Participants
Age (years)	8 – From 51 to 60 8 – From 41 to 50 6 – From 31 to 40 1 – From 61 to 65 1 – Over 66
Sex	18 – Women 7 – Men
Training	7 – Nurses 6 – Physicians 10 – Family and Community Physicians 1 – Cardiologists
Specialization	10 – Master's degree/PhD 8 – Residency 3 – Both 3 – Currently taking their Master's degree
Professional practice time (years)	17 – Over 10 6 – From 5 to 10 1 – From 3 to 5
Working hours in Primary Care (hours)	11 – 40 6 – 20 4 – 30

Source: Prepared by the author.

As demonstrated in Figure 7, the research participants were divided into the following programmatic areas: Nine (37.5%) in area 1.0; eight (33.3%) preferred not to respond; three (12.5%) in more than one area; two (8.3%) in area 2.2; one (4.2%) in area 3.1; and one (4.2%) in area 2.1.

Knowledge of the genogram tool

Regarding knowledge of the genogram, whether the tool is addressed in the syllabus of the attended university: 16 (66.7%) participants reported that the tool is addressed in the syllabus of the attended university; five (20.8%) did not have contact with the genogram through the syllabus of the attended university; and three (12.5%) did not respond (Chart 4).



Source: Prepared by the author.
Figure 7. Programmatic areas.

Chart 4. Genogram tool addressed in the course syllabus.

Description	Respondents	%
Yes	16	66.7
No	5	20.8
Did not respond	3	12.5

Source: Prepared by the author.

The importance of mapping the relation of learning family approach tools in training is relevant to identify possible difficulties in applying these tools when there is no familiarity and/or knowledge. According to the results, most respondents had prior knowledge of the tool, but even so, a percentage did not have direct contact with this type of support tool.

Applications and functions of the genogram: potentialities

The genogram, according to the research participants' perception, is deemed relevant in the identification and collection of information on the family composition, gathering vital and accurate data in relation to the form of organization, socialization, history, perception, structure, health, and adherence.

As per the following results, 23 (95.8%) respondents think that the applications and functions of the genogram help getting to know the family structure/dynamics; for 22 (91.7%) of them, the genogram serves to map the history of diseases and facilitates the visualization of the family structure; in turn, 20 (83.3%) respondents highlight the visualization of family disease; for 18 (75%), the genogram can improve family health; 15 (62.5%) belive that it helps preventing diseases; 14 (58.3%) respondents think the genogram can assist in the treatment; 13 (54.2%) of them believe it can increase treatment adherence; 12 (50%) reported that it helps getting to know the family's social network of support and investigating the disease causes; according to five (20.8%) respondents, it may help diagnosing diseases; and for one (4.2%) of them, the genogram assists in understanding the family dynamics.

The items "getting to know the family structure/dynamics" and "understanding the family dynamics" showed discrepancy in the responses for being similar. We can hypothesize the possibility of misformulation in the description, inducing the participant to confusion in the response (Chart 5).

Chart 5. Genogram applications/functions.

Description	Respondents	%
Getting to know the family structure/dynamics	23	95.8
Mapping the history of diseases	22	91.7
Facilitating the visualization of the family structure	22	91.7
Facilitating the visualization of family disease	20	83.3
Improving family health	18	75.0
Preventing diseases	15	62.5
Assisting in treatment	14	58.3
Increasing treatment adherence in the FHS	13	54.2
Getting to know the family's social network of support	12	50.0
Investigating causes of diseases	12	50.0
Diagnosing diseases	5	20.8
Understanding the family dynamics	1	4.2

Source: Prepared by the author.

The results confirm that the interviewees recognize the diversity of purposes for which the genogram tool can and should be applied. The diverse range of possibilities to be explored by the tool shows the versatility of combinations in its use both by the team of professionals and by users, resulting in the breadth of information collection for use in care initiatives aimed at the family and its individuals and the social group.

Getting to know the structure and family dynamics and its own way of functioning is the baseline of the conceptual framework of Family Health. The understanding of family health patterns, according to Starlfield,[71] provides a significant achievement for possible interventions in the specific family context, assuming the importance of knowing the group and its unique context for evaluation and decision-making for diagnosis and possible interventions related to the concrete reality of these social groups. It is a fact that social and family relationships also affect health and disease processes, as families have the power to intervene in the success or failure of treatments, as well as in the management of the structure, maintenance, and confrontation concerning the actions presented in the process of health care and disease.[1] The study reinforces this conception and ratifies this centrality with regard to the use of the family genogram approach tool in the context of encouraging improvements in public health services, aiming at assisting in the maintenance and treatment of diseases of users and family members. With strong action in the community, considering the close work with the family, the social, economic, and political relations that mark the history of the Primary Care user are one of the main characteristics of the FHS.[7]

Information made available by the genogram

Santos et al.,[50] point out that the illness of a person interferes in the family group, hence the relevance of data collection to the treatment. The family approach tool facilitates the access to specific information about the nuclear family, its connections, and the environment in which the family lives, with a refinement difficult to achieve otherwise.

The genogram graphically represents the structure and pattern of the various types of family relationships. Identifying the family structure and the existing pattern in the relationship are the basic characteristics of the genogram, pinpointing the diseases and difficulties existing in the family group, as well as mapping and expanding the knowledge of the family.[50] As per Machado et al.,[48] the perspective of individuals belonging to the family group as a larger organism only takes place by making the genogram.

For McGoldrick and Gerson,[54] the genogram is used as a facilitator for family adherence to treatment, pointing out the difficulties and possibilities of the participants, highlighting relational patterns, and identifying the extended family in a simple way. Furthermore, Athayde and Gil[11] point out that the participation of family members in designing the genogram influences the creation of the bond between health professionals and the family, thus strengthening the relationship. The joint development of the family structure, between the family and health professionals, allows teams to deepen their knowledge about the patterns and ways of establishing relationships instituted during the transmission of generations participating in the family health-disease.

According to the results presented in Chart 6, 22 (91.7%) respondents point out that the genogram enables to know the family structure, visualize the history of family diseases, and current diseases. For 20 (83.3%) of them, however, getting to know the family dynamics is the key aspect of the information made available by the tool. Speeding up information gathering and assisting in identifying aspects related to mental health were highlighted by 19 (79.2%) participants. For 18 (75.0%) of them, it helps in identifying social factors that interfere with family health. In addition, 17 (70.8%) people responded that it facilitates the interaction with the user, and 16 (66.7%) reported it improves family health. Preventing diseases and assisting in adherence to treatment were reported by 14 (58.3%) participants; in turn, assisting in and increasing the adherence to treatment were mentioned by 13 (54.2%) respondents. Another 12 (50.0%) answered that knowing the social support network is a facilitator. Assisting in referral was reported by 11 (45.8%) participants; investigating causes of diseases was highlighted by nine (37.5%); and diagnosing diseases was pointed out by seven (29.2%), although, to make a safe diagnosis, specific additional information is necessary for a professional opinion. For this reason, the option “diagnosing diseases” was not taken into account in the comments and recommendations, as the use of the genogram alone is insufficient to diagnose diseases. Lastly, none of the participants failed to answer the addressed items. The information made available by the use of the genogram tool is highlighted through the importance given by the interviewee according to the following order: visualizing and getting to know the family structure; visualizing the history of family diseases; knowing the family dynamics; speeding up information gathering; helping to identify aspects related to mental health; helping to identify social factors that interfere with family health; facilitating the interaction with the user; improving family health; preventing diseases; helping in treatment adherence and maintenance; knowing the social support network; helping in referral; investigating causes of diseases; and, finally, diagnosing diseases.

It is worth highlighting that the data collected from item 7.3 – *Applications and functions of the genogram: potentialities* and item 7.4 – *Information made available by the genogram* present similar answers because they are present in two types of questions, divided by the aforementioned items. These questions were asked for confirmation purposes regarding the functionality of the different attributions of the genogram tool. It is noteworthy that the response options of the study instrument derived from the literature review.

It is evident, for Athayde and Gil,[11] that the information retrieved from the genogram process helps to guide the measures and to assess risks for formulating programs of prevention and support for families. In turn, for Borges et al.,[7] the use of the genogram in Primary Health Care allows the observation and identification of the current needs and the promotion of appropriate intervention actions in families inserted in specific social contexts, consequently strengthening the family as a whole.

Chart 6. Information made available by the genogram/instrument trial.

Description	Respondents	%
Getting to know the family structure	22	91.7
Visualizing the history of family diseases	22	91.7
Visualizing the family structure	22	91.7
Visualizing family diseases	22	91.7
Getting to know the family dynamics	20	83.3
Speeding up information gathering	19	79.2
Assisting in identifying aspects related to mental health	19	79.2
Assisting in the identification of social factors that interfere with family health	18	75.0
Facilitating user interaction	17	70.8
Improving family health	16	66.7
Preventing diseases	14	58.3
Assisting in treatment adherence and maintenance	14	58.3
Assisting in treatment	13	54.2
Increasing treatment adherence in the FHS	13	54.2
Getting to know the social network of support	12	50.0
Assisting in referrals	11	45.8
Investigating causes of diseases	9	37.5
Diagnosing diseases	7	29.2

Source: Prepared by the author.

Contributions and benefits for providing care in the use of the genogram in Primary Health Care

The contributions of the genogram tool, according to the obtained results, reflect the importance given to the assistance in identifying aspects related to mental health, with 20 (83.3%) respondents; followed by 19 (79.2%) who highlighted the help in identifying social factors associated with family health. Assisting in treatment adherence and maintenance together with health centers is ranked at third place, with 15 (62.5%) respondents, with 11 (45.8%) participants pinpointing the assistance in referral to specialized health services (Chart 7).

Chart 7. Contributions of the genogram in health to work processes in Primary Health Care — assistance in prevention and treatment.

Description	Respondents	%
It can assist in identifying aspects related to mental health	20	83.3
It assists in identifying social factors related to family health	19	79.2
It assists in treatment adherence and maintenance along with health centers	15	62.5
It assists in referral to specialized health services	11	45.8

Source: Prepared by the author.

In the item concerning benefits in the use of the genogram, 22 (91.7%) of the study participants affirmatively answered as to the professional team; as for the applicator and health professional, there were 17 (70.8%) respondents; 15 (62.5%) pointed out benefits for the user; 14 (58.3%), for providing care; and one (4.2%) respondent pointed out benefits for academics (Chart 8).

Chart 8. Benefits of using the genogram for providing care.

Description	Respondents	%
Professional team	22	91.7
Applicator and health professional	17	70.8
User	15	62.5
Provision of care	14	58.3
Academics	1	4.2

Source: Prepared by the author.

The professional team, including the applicators of family approach tools, is the group of professionals responsible for the reception, welcoming, diagnosis, treatment, and referral of users, who, in turn, are the people belonging to the regional population who use the facilities and enjoy the benefits of the local health system. Health professionals, in charge of providing care, are not always those who serve the general population, and finally, the academics belong to the group of professionals in training who assist in processes related to the population using the local health system. All participants are important elements in the organization and operation of the health system altogether.

The contributions of the genogram to the health treatment and prevention in Primary Care, according to the obtained results, point to help in prevention and treatment with: possibility of identifying aspects related to mental health; identification of social factors related to family health; treatment adherence and maintenance; and referral to specialized services. The genogram is ratified as a powerful support tool in the development of the relationship with the user and in the amount and quality of information obtained from it, consistently enhancing the treatment of diseases and the maintenance of the population health.

Lines of care benefited by the genogram

The lines of care that can benefit from the use of the genogram tool are listed in order of importance as selected by the participants. Mental health is mentioned by 23 (95.8%) respondents, followed by hypertension, by 20 (83.3%), and alcoholism, by 19 (79.2%). Mental illness and obesity are considered together by 18 (75%) respondents, with 16 (66.7%) responses concerning tobacco smoking and eating disorders, as shown in the chart titled “Lines of care benefited by the genogram.” The specific choice of these lines of care was discussed, and we took into consideration, for example, the selection of common noncommunicable diseases, but not with the intention of disregarding other diseases (Chart 9).

Chart 9. Lines of care benefited by the genogram.

Noncommunicable diseases	Respondents	%
Mental health	23	95.8
Hypertension	20	83.3
Alcoholism	19	79.2
Mental illness	18	75.0
Obesity	18	75.0
Smoking habit	16	66.7
Eating disorders	16	66.7

Source: Prepared by the author.

Events of high magnitudes, such as disasters and emergencies, directly affect the human being, whether a health professional or not. The need for care and psychosocial care throughout crises and the constant maintenance of metal health are essential for the well-being of a population, whatever it may be. Mental health is defined by the World Health Organization (WHO)[72] as "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." We can expand it into a mental state in which individuals feel comfortable with themselves and have tools to deal with everyday issues in a healthy way.

As per Dantas,[73] the new coronavirus (COVID-19) pandemic clearly showed the dimension of the impact on mental health in the general population and health professionals, evidencing the need to strengthen the public network in terms of actions and services related to mental health, to enable the speed in the responses to the demands presented in an intense and rapid way. According to Borges et al.,[74] Brazil is in demographic and epidemiological transition related to the increase in the number of older adults, a phenomenon of population aging in which chronic diseases, such as hypertension, are more evident, representing a challenge for public health and for social protection initiatives.

Excess alcohol consumption, as well as smoking habit, are known to be major public health issues in Brazil. Functional limitations, mortality, and diseases resulting from alcohol and cigarette abuse cause high costs for the health system. Consequently, it is necessary to implement public policies in practice.[75] Strengthening these public policies could involve the use of family approach tools in the daily practice of public health care, ensuring an effective application also in the survey and prevention of alcoholism and smoking habits in the served families. For the Brazilian Ministry of Health,[38] health promotion is the process of empowering the community to control and improve health.

Mental illness is part of medical issues and is treatable, encompassing emotions and actions. For instance, for eating disorders, as well as obesity, according to Freire,[76] history is very important in understanding current social, political, and economic phenomena. The reflection on eating disorders throughout history shows the importance of the body and food for the human being, and helps to understand disorders in the ways of eating. Obesity can be seen in a wide and diverse way. There are many components that highlight the maintenance of obesity, but few explain it. We know the importance of genetic factors in obesity; however, psychosocial determinants affect families, hence the importance of family, social, and cultural perspectives.

The predisposing factors of eating disorders are categorized into individual, family/hereditary, and sociocultural. The individual factor highlights personality traits combined with psychiatric disorders, while the family/hereditary ones imply intrafamilial transmission mechanisms, when mixed with the inheritances/transmissions through the biological pathway, such as genetic inheritance, as well as those derived from relational patterns of family interaction, from the history of members of the same family, and in the mechanisms of transgenerational family narrative development. Genetic factors are important, but patterns of family interaction can be very meaningful in the transmission of eating disorders. Finally, sociocultural factors are socially shared values and conceptions.[26]

Other strategies for knowledge of family relationships

Through the questionnaire, we visualized other forms of knowledge of the family relationships used in the relation with users of FHS in the provision of care. According to the results, as shown in Chart 10, there was greater use of the ecomap, followed by the lifeline and family structure, which appeared in the sequence, Thrower's Circles, PRACTICE and, lastly, without demonstrated use, FIRO. The ecomap was highlighted by the respondents, evidencing the importance of this tool for the collection of information, compared to the other strategies listed. The other aforementioned tools, except for the FIRO, are also used as a strategy for knowledge of family relationships.

Chart 10. Other strategies for knowledge of family relationships.

Description	Respondents	%
Ecomap	12	50.0
Lifeline	3	12.5
Family structure	3	12.5
Thrower's Circles	2	8.3
PRACTICE	1	4.2
FIRO	0	0.0

Source: Prepared by the author.

Limits and challenges

Through the electronic questionnaire, we obtained a category of answers to the open-ended questions for the participants on the use of the genogram via electronic medical records, as described in Chart 11. In the category limits and/or difficulties in using the electronic medical record in relation to the genogram, we identified, through respondents' answers to the open-ended questions, three major categories that hinder the process of using the genogram tool in everyday practice such as technological, technical, and institutional limitations. Technological limitations refer to the ineffective functioning of the equipment, methods and processes available to facilitate human needs, while the technical limitations are linked to the use of procedures and the set of practical knowledge to achieve a specific objective. In institutional limitations, we address aspects of the organization order of institutional services and aspects of the work process. In Chart 11, the answers were categorized into technological, technical, and institutional limitations. According to the respondents, the technological limitations appear as a great obstacle to the use of the genogram tool in the daily practice of care in the FHS, but does not prevent the use of these tools, only limits the process in the number of appointments. In turn, technical limitations can be circumvented with alternative strategies using manual tools and physical storage. Institutional tools serve to aggregate the organizational capacity of services and the performance of tasks in everyday life, as long as they work in a productive way, and when they are not working, they are deemed as limitations.

From the respondents' report, we noticed that the limits and difficulties presented in the use of the electronic medical record, in relation to the genogram, point more consistently to the technological limitations as a structure, in the general context, to facilitate the introduction of data collected by the genogram tool, followed by technical limitations, such as lack of knowledge or interaction with the tool and, finally, lack of time during the working day in the everyday provision of care within institutional limitations.

FINAL CONSIDERATIONS AND RECOMMENDATIONS

Through the electronic questionnaire, we obtained a category of answers to the open-ended questions for the participants, volunteers of this stage, for broadening the analysis of the results to validate the answers and recommendations in the use of the genogram in Primary Care.

In the category "inclusion of the genogram in the curriculum of professional training," we identified that three participants answered yes, the genogram is included in the curriculum, while one respondent answered not having the genogram in the curriculum. The descriptions of the answers are shown in Chart 12.

Chart 11. Use of the genogram via electronic medical records.

Categories	Report
Technological limitations	"I don't know how to draw it on VITACARE."
	"I have doubts, but I think it's not available in the electronic medical record we currently use."
	"It facilitates the need to enter new information" (difficulty entering information in the electronic medical record in the current format).
	"I can't find it in the medical record." (the tool)
	"The electronic medical record doesn't allow entering the genogram and it doesn't provide the tool."
	"It has no specific field to draw it. With so many assignments, it's better to do it separately."
	"The system where I work has not been programmed to work with a genogram, so you can only respond to the adapted medical record."
	"Lack of standardization."
	"The medical record accepts attaching the genogram, but all steps depend on whether the medical record is working properly, on a computer that is running well, with good access to the Internet etc. Also, it's not easy to resume the visualization of the genogram. Sometimes, it takes time to load and you have to go to a different tab, little used in the routine."
	"I have doubts, but I believe it's not available in the electronic medical record we currently use."
	"I can't find the tab in the medical record."
	"There's a limit in the medical record."
	"There is no such function in PEC."
	"Some medical records don't accept it, or the time for doing so may interfere with attaching it."
	"The medical record doesn't register it."
Technical limitations	"I don't see other professionals adhering to it."
	"I don't use it in the computer."
	"I don't know how to use it in the electronic medical record."
	"I prefer to draw it together with the user and, in the impossibility of attaching it to the electronic record, I keep it in the file, but I fear that there's exposure of the person's information without me noticing it."
	"I don't know how to use it in the medical record. I prefer the paper."
	"I don't know how to enter the genogram."
	"I don't know how to use it in the electronic medical record."
	"I don't use electronic records."
Institutional limitations	"Lack of time." "Time issues."

VITACARE: Electronic medical record used in Family Clinics of Rio de Janeiro; PEC: Brazilian Citizen's Electronic Medical Record.
Source: Prepared by the author.

Chart 12. Recommendations for implementing the genogram in professional training.

Description of the report
"The genogram is part of the tools of the family and community physician and, as such, it should be included in the curriculum of the FCP"
"In the fourth-term course, all the tools of the family and community physician, including the genogram, are discussed with the students."
"It's part of the syllabus of the Family Health IV course."
"In the family approach and complex cases in Primary Health Care."

FCP: Family and community physician.
Source: Prepared by the author.

Regarding the importance of the implementation of the use of genogram in PHC in Rio de Janeiro, all participants answered that yes, they deem the implementation of the tool important, and the comments are described in Chart 13. The answers were categorized into data collection; user/family approach; assistance in prevention and treatment; and potential/importance of the tool in the FHS/PHC. According to the collected responses, we verified some of these restrictions explicitly, opening up space for new suggestions of implementations relevant to the improvement of the system in a comprehensive way. By listing the functionalities implemented and the functionalities provided for by e-SUS,[77] we can verify that making the receipt of information about the genogram tool easy is not provided for in the aforementioned actions. For this reason, we can infer the need to highlight this action in the recommendations.

Chart 13. Importance of implementing the use of the genogram in Primary Health Care in Rio de Janeiro.

Categories	Report
User/family approach	"Very important tool to work."
	"It's a tool that provides information quickly."
	"An important tool to getting to know the family dynamics."
	"Necessary for collecting information and approaching the patient."
	"It's a facilitating tool to know the family history."
	"Family structure issues."
	"It would be very interesting for it to be available in the electronic medical record."
	"The perception of the family as a whole is very important, and its relationships are part of the work of the FCP and of any other specialty."
	"I think it enables an overview of the family and its processes, beyond restricted biomedical aspects."
Assistance in prevention and treatment	"It may be more accurate in treatment."
	"It improves assistance to families."
	"It's very important to use the genogram for the comprehensive care of people in PHC."
	"It's about information that helps."
	"It improves the perception of the user's life."
Potentialities/ importance of the tool in the FHS/PHC	"It should be used in every health service, regardless of the State."
	"It helps monitoring teams."
	"It's an excellent tool."
	"It's an essential instrument for family-centered approach — a PHC feature."
	"It's of extreme importance, if health professionals know how to use it, in view of the wide diversity of possibilities for the low-complexity patient"
	"It's a tool of key importance."
	"It's a very powerful tool."
	"It's been applied, but it should be widely used."

FHS: Family Health Strategy; PHC: Primary Health Care; FCP: Family and community physician.
Source: Prepared by the author.

As for the digital tool provided by the SUS, according to Brazil,[77] e-SUS is an initiative to organize Primary Care information, in general, throughout the national territory, aligned with a larger proposal for restructuring the Health Information Systems of the Ministry of Health, from the perspective that the quality of information management is essential for the improvement of population care altogether. Like most electronic systems, e-SUS has its advantages and limitations, always requiring reformulations as needs change.[78]

In the “everyday practice in Primary Care” item, in the questionnaire of the instrument and validation of responses and recommendations, answers according to which storing the genogram physically or electronically would be deemed fundamental for its use and follow-up of the family dynamics showed that only one person does not deem the storage of information essential, whereas three respondents stated yes, they do consider the storage of information essential. Among the provided answers, it was emphasized that there are still physical records in some units, thus facilitating the manual storage of information in relation to the genogram (Chart 14).

Chart 14. Recommendations.

Recommendations	Description of the report
Form of storage of the genogram tool	“In practice, the storage is done physically, but it would be interesting to store it electronically.” “The ideal would be to have the medical record grouped by family and have the option to include the genogram made online, as letters and symbols would be easier to visualize.”
Facing the challenge of time management	“To complete it in the first appointment at the center or home visit.” “To employ a modified genogram proposal.”
Work structure	“To have a suitable virtual environment.” “A physical genogram form to allow entering it into the system later.” “Adequacy of the genogram tool to the easy-to-perform electronic medical record.”
Greater knowledge of the genogram	“Professional improvement.” “Permanent training.” “Awareness regarding the importance of using the tool.”
Input for team meetings	“Time of exchange between the team for the benefit of the patient.” “Understanding patterns and repetitions of family relationships.” “Assistance in the discussion of complex cases.”
Graphic representation	“Ease of access to the form with the caption of the main symbols.” “Empower teams for the application of the tool.” “Making it a common practice and facilitating the storage.”

Source: Prepared by the author.

The categories listed were selected aiming at investigating the importance of the inclusion of family approach tools in the training of health students for a better preparation in providing care to families and their individuals, consisting in a more intimate knowledge of tools such as the genogram. According to the reports, the technological support for the application and storage of family approach tools should improve, seeking to gather more information and facilitate the relationship with users, resulting in better provision of care and developments aimed at improving treatments.

The present study allowed us to recognize the existing institutional challenges for the full application of the family approach tool, the genogram, within the FHS, and its potentiality for use based on the reports of PHC professionals, focusing on the interviewees’ view on the use of the family approach tool.

To deepen the discussion on the challenges and potentialities of the use of the genogram tool, the main axis of the study valued the reports of professors of IDOMED/UNESA with the purpose of discussing the potentialities, possibilities, and difficulties of the tool in question. The fact that the genogram is not widely used by all respondents was not disregarded, including the deficiencies presented in the results, such as storage difficulty and impossibility of application. The importance of expanding its use as a tool during the training process and in the various spheres of care in Primary Care is noteworthy.

The technological and technical limitations observed in the collected responses, mentioned as the main concrete difficulties, point to poor work structure, such as the Internet and e-SUS program, in addition to the lack of more in-depth knowledge of the tool. Making the receipt of information on the genogram easier in the e-SUS digital tool, in the categorization of answers to open-ended questions of the questionnaire, is not provided for in the actions mentioned by the research respondents. For this reason, we can infer the need to emphasize this action also as a recommendation, always taking into account the limitations of the study and the experiences reported.

The challenges for the use of the genogram tool as an established daily practice were categorized through the reports described in the questionnaire. The results point to the main challenges, which are the storage system, instability, and slowness. All these responses evidence the need to adapt the system to support tools aiming to facilitate its use.

The potentialities of the tool insertion in FHS involves identifying aspects related to health and social factors that interfere with the health of the family, in addition to assisting in treatment adherence and maintenance and referral to specialized health services. From this perspective, we perceive that the understanding of the challenges and potentialities of use of family approach tools could help increase the handling of the tool more widely, thus contributing to facilitate the collection of data from the family group, access to non-apparent issues of families, perception of the family context, and support for diagnoses, both in the scope of treatments on a small scale and in public health, on a large scale.

The use of the genogram as an additional resource in the FHS is referred to as adequate and desired, but it presents restrictions in everyday practice. Other researchers also point out the potential of using family support tools, such as the genogram, but without the specific investigation of their use in everyday life. Several studies and articles on genogram were surveyed, but few indicate its versatility formally inserted in the basic handling of health professionals. In this sense, this study sought to contribute as an additional element in the production of knowledge concerning the practical use of the tool.

The SUS maintains an effort to meet the constantly-evolving demands of the population altogether. Promoting initiatives for improving the quality of care is paramount, welcoming any possibility that adds value to the system. In this sense, the inclusion of family support tools, such as the genogram, should be encouraged in the everyday use of health teams, as well as making the handling easier, including it in professional's training, and favoring data storage in a simple and fast way.

The foundation of family health relies on multidisciplinary team work, that is, according to the research data, the genogram is a relevant tool for a deeper analysis of family dynamics by the entire team, in such a way that we can infer the use of this tool as one of the recommendations for planning actions to improve family health in the provision of care and future social initiatives, as past and current family histories are the baseline for understanding the way the family group functions. Therefore, we obtained the main elements to investigate the quality of the FHS care.

We can go further, with the recommendation that municipal management could invest in improvements in technological tools, as well as in the organization of the service and work processes of the teams, so that the tool of the genogram was better applied and enhanced, contributing to making the principles of family health present in the practice of teams and users, resulting in a more comprehensive care.

The quality of care of the health system user is directly linked to the dynamics of understanding the family structure. The context of the family members comprises the most relevant information for understanding that group, and the use of specific tools can interpret the nuances existing in the relationships between those belonging to a nuclear family.

One of the principles of PHC is the family approach, which directs the health team to deepen the understanding of the family group and its issues, as the understanding of family patterns allows an intervention in the established dynamics. It is evident that family approach tools are accurate and assist in working with families, being able to visualize the dynamics, relationships, and patterns that work poorly, allowing possible interventions. For planning and decision-making, it is essential to know the family consistently, because the family has the power to favor or not the success of the treatments.

Although extremely well qualified by the participants, the genogram is not used in everyday practice, which makes this the main challenge identified by the study. Aspects of the training of health professionals can be improved to include theory and practice of tools, such as the genogram, in the curriculum.

All in all, we know that there is no perfect health system that can meet any and all of the population demands, but we can present better results with improvements in the quality of public services with simple and affordable tools, such as the genogram, by adding them to everyday life. Uncomplicated actions with significant results do not require high investments and result in positive returns to PHC. Improvements in prevention and health care, such as those provided by family approach tools, result in a reduction of future State spending by enabling the reduction of complications in the physical and mental health of the family and its members.

CONFLICT OF INTERESTS

Nothing to declare.

REFERENCES

1. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO, Ministério da Saúde; 2006.
2. Mendes EV. O cuidado das condições crônicas na atenção primária à saúde: o imperativo da consolidação da estratégia da saúde da família. Brasília: Organização Pan-Americana da Saúde; 2012.
3. Chapadeiro CA, Andrade HYSO, Araújo MRN. A família como foco da atenção primária à saúde. Belo Horizonte: Nescon/UFMG; 2011.
4. Bowen M. De la familia al individuo: la diferenciación del sí mismo en el sistema familiar. Barcelona: Paidós; 1991.
5. Sousa AN, Cielo AC, Gomes IC, Oliveira Júnior JG. Estratégia e-SUS AB: transformação digital na Atenção Básica do Brasil. In: Núcleo de Informação e Coordenação do Ponto BR, editor. Pesquisa sobre o uso das tecnologias de informação e comunicação nos estabelecimentos de saúde brasileiros. Brasília: TIC Saúde; 2018. p. 29-38, 2018.
6. Nascimento LC, Dantas IRO, Andrade RD, Mello DF. Genogram and ecomap: Brazilian nursing contributions. Texto Contexto Enferm. 2014;23(1):211-20. https://doi.org/10.1590/S0104-07072014000100025
7. Borges CD, Costa MM, Faria JG. Genograma e atenção básica à saúde: em busca da integralidade. Revista Psicologia Saúde. 2015;7(2):133-41.
8. Talbot Y. Assessing the single-parent family [Internet]. Can Fam Physician. 1985 [cited on Apr. 7, 2022]. Available at: https://www.academia.edu/62228321/Assessing_The_Single_Parent_Family
9. Franco TB, Bueno WS, Merhy EE. O acolhimento e os processos de trabalho em saúde: o caso de Betim, Minas Gerais, Brasil. Cad Saúde Pública. 1999;15(2):345-53. https://doi.org/10.1590/S0102-311X1999000200019
10. Wagner ABP, Wagner HL, Talbot Y, Oliveira E, Czeczko NG, Ribas CA, et al. Trabalhando com famílias em saúde da família. Revista de Medicina do Paraná. 1999;57(1/2):40-6.
11. Athayde ES, Gil CRR. Possibilidades do uso do Genograma no trabalho cotidiano dos médicos das equipes de saúde da família de Londrina. Revista Espaço Saúde. 2005;6(2):13-22.
12. Ariès P. História social da criança e da família. Rio de Janeiro: LTC-Livros Técnicos e Científicos; 1981.
13. Carter B, McGoldrick M. As mudanças no ciclo de vida familiar: uma estrutura para a terapia familiar. 2ª ed. Porto Alegre: Artmed; 1995.
14. Wright LM, Leahey M. Enfermeiras e famílias: guia para avaliação e intervenção na família. 2ª ed. São Paulo: Editora Roca; 2002.
15. Carvalho IMM, Almeida PH. Família e proteção social. São Paulo Perspec. 2003;17(2):109-22. https://doi.org/10.1590/S0102-88392003000200012

16. Alves JED, Cavenaghi SM, Barros LFW. A família DINC no Brasil: algumas características sociodemográficas. Rio de Janeiro: IBGE, Escola Nacional de Ciências Estatísticas; 2010.
17. Penteado PA. Construção social da maternidade. Rev Bras Ter Família. 2012;4(1):23-34. https://doi.org/10.60114/rbtf.v4i1.66
18. Leonidas C, Santos MA. Family relations in eating disorders: the Genogram as instrument of assessment. Ciênc Saúde Colet. 2015;20:1435-47. https://doi.org/10.1590/1413-81232015205.07802014
19. Bowen M. Family psychotherapy with schizophrenia in the hospital and private practice. In: Boszormenyi-Nagy I, Framo JL, editors. Intensive family therapy: theoretical and practical aspects. New York: Harper & Row; 1965. p. 213-43.
20. Andolfi M, Angelo C, Menghi P, Nicolo-Corigliano AM. Por trás da máscara familiar: um novo enfoque em terapia familiar. Porto Alegre: Artes Médicas; 1984.
21. Minuchin S, Fishman CH. Técnicas de terapia familiar. Porto Alegre: Artes Médicas; 1990.
22. Cerveny OC, Berthoud CME. Família e ciclo vital: nossa realidade em pesquisa. São Paulo: Casa do Psicólogo; 1997.
23. Kaës R. Transmissão da vida psíquica entre gerações. São Paulo: Casa do Psicólogo; 2001.
24. Boszormenyi-Nagy I, Spark GM. Lealtades invisibles: reciprocidad en terapia familiar intergeracional. Buenos Aires: Amorrotu; 2003.
25. Bacal MEA, Magalhães AS, Féres-Carneiro T. Transmissão geracional da profissão na família: repetição e diferenciação. Psico. 2014;45(4):454-62. https://doi.org/10.15448/1980-8623.2014.4.15344
26. Penteado P. Transtornos alimentares: transmissão geracional, obesidade e família. In: Damião DB, Moreira RC. Psicologia: um olhar na família. São Paulo: Editora Científica Digital; 2020. p. 138-47. https://doi.org/10.37885/200500245
27. Fortes M. The developmental cycle in domestic groups. In: Goody J, editor. Cambridge papers in Social Anthropology. Cambridge: Cambridge University Press; 1958. p. 53-91.
28. Peixoto CE. Aposentadoria: retorno ao trabalho e solidariedade familiar. In: Peixoto CE. Família e envelhecimento. Rio de Janeiro: FGV; 2004. p. 57-84.
29. Walsh F. Processos normativos da família: diversidade e complexidade. Porto Alegre: Artmed; 2016.
30. Gomes HS. Educação para família: uma proposta de trabalho preventivo. Rev Bras Cresc Des Hum. 1994;4(1):34-9. https://doi.org/10.7322/jhgd.37714
31. McDonald K, Schultz E, Albin L, Piñeda N, Lonhart J, Sundaram V, et al. Care coordination measures atlas. Rockville: Agency for Healthcare Research and Quality; 2011.
32. Giovanella L, Mendoza-Ruiz A, Pilar ACA, Rosa MC, Martins GB, Santos IS, et al. Sistema universal de saúde e cobertura universal: desvendando pressupostos e estratégias. Ciênc Saúde Colet. 2018;23:1763-76. https://doi.org/10.1590/1413-81232018236.05562018
33. Rodrigues PHA. Desafios políticos para a consolidação do Sistema Único de Saúde: uma abordagem histórica. Hist Ciênc Saúde Manguinhos. 2014;21(1):37-60. https://doi.org/10.1590/S0104-59702014000100003
34. Paim JS. Os sistemas universais de saúde e o futuro do Sistema Único de Saúde (SUS). Saúde Debate. 2020;43(n. esp.):15-28. https://doi.org/10.1590/0103-11042019S502
35. Aguilera Campos CE., Cohn A, Brandão AL. Trajetória histórica da organização sanitária da Cidade do Rio de Janeiro: 1916-2015. Cem anos de inovações e conquistas. Ciênc Saúde Colet. 2016;21(5):1351-64. https://doi.org/10.1590/1413-81232015215.00242016
36. Pinto LF, Giovanella L. Do Programa à Estratégia Saúde da Família: expansão do acesso e redução das internações por condições sensíveis à atenção básica (ICSAB). Ciênc Saúde Colet. 2018;23(6):1903-14. https://doi.org/10.1590/1413-81232018236.05592018
37. Nolte E., McKee M. Caring for people with chronic conditions. a health system perspective. Maidenhead: Open University Press/McGraw-Hill; 2008.
38. Brasil. Ministério da Saúde. Secretaria de Atenção Primária à Saúde. Estratégia Saúde da Família. Brasília: Ministério da Saúde; [s.d.] [cited on Mar. 6, 2022]. Available at: https://www.gov.br/saude/pt-br/composicao/saps/esf
39. Hemfelt R, Minirth F, Meier P. O amor é uma escolha: recuperação para relacionamentos codependentes. Nashville: Grandalfo Editores; 1989.
40. Cecagno S, Souza MD, Jardim VMR. Compreendendo o contexto familiar no processo saúde-doença. Acta Sci Health Sci. 2004;26(1):107-12.
41. Fonseca C. Concepções de família e práticas de intervenção: uma contribuição antropológica. Saúde Soc. 2005;14(2):50-9. https://doi.org/10.1590/S0104-12902005000200006
42. Lacerda MKS, Pereira ACA, Pereira MM, Teixeira RLOD, Veloso DCMD, Pimenta DR. Ferramentas de abordagem familiar: estudo de uma família cadastrada em uma equipe de estratégia saúde da família em Montes Claros, Minas Gerais, Brasil [Internet]. Revista de Iniciação Científica do UninCor. 2017;7(1):25-34 [cited on July 10, 2025]. Available at: http://periodicos.unincor.br/index.php/iniciacaocientifica/article/view/3984/3184
43. Silva MCLSR, Silva L, Bousso RS. A abordagem à família na Estratégia Saúde da Família: uma revisão integrativa da literatura. Rev Esc Enferm USP. 2011;45(5):1250-5. https://doi.org/10.1590/S0080-62342011000500031
44. Fernandes C, Curra L. Ferramentas de abordagem familiar. Porto Alegre: Artmed/Panamericana Editora; 2006.
45. Silva MJ, Victor JF, Mota FRN, Soares ES, Leite BMB, Oliveira ET. Analysis of psychometric properties of family APGAR with elderly in northeast Brazil. Esc Anna Nery. 2014;18(3):527-32. https://doi.org/10.5935/1414-8145.20140075

46. Sarti C. O lugar da família no Programa de Saúde da Família. In: Trad LAB, ed. Família contemporânea e saúde: significados, práticas e políticas públicas. Rio de Janeiro: Editora FIOCRUZ; 2010. p. 91-103.
47. Mello DF, Viera CS, Simpionato E, Biasoli-Alves ZMM, Nascimento LC. Genograma e ecomapa: possibilidades de utilização na estratégia de saúde da família. Rev Bras Cresc Desenv Hum. 2005;15(1):79-89.
48. Machado HB, Soprano ATB, Machado C, Lustosa ACP, Lima MH, Mota ACG. Identificação de riscos na família a partir do Genograma. Fam Saúde Desenv. 2005;7(2):149-57. https://doi.org/10.5380/fsd.v7i2.8042
49. Camilo LA, Couto LL, Barreto ACM, Santos ACS, Regazzi, ICR, Pinto LF. Family violence against children: approach to nursing through genogram and ecomapa. R Pesq Cuid Fundam Online. 2021;13:1554-60. https://doi.org/10.9789/2175-5361.rpcfo.v13.10443
50. Santos JAD, Cunha ND, Brito SMS, Brasil CHG. Ferramenta de abordagem familiar na atenção básica: um relato de caso. J Health Sci Inst. 2016;34(4):249-52.
51. Viegas AB. Possibilidades de uso de ferramentas de abordagem familiar na construção da SAE na APS: o genograma funcional [dissertação]. São Paulo: Universidade de São Paulo, Escola de Enfernagem; 2019.
52. Mejía Gómez D, Soto Soto MI, Molina de Uriza J, Ruiz Puiana CE. Salut familiar. Bogotá: ASCOFAME; 1990.
53. Wendt NC, Crepaldi MA. A utilização do Genograma como instrumento de coleta de dados na pesquisa qualitativa. Psicol Reflex Crít. 2008;21(2):302-10. https://doi.org/10.1590/S0102-79722008000200016
54. McGoldrick M, Gerson R. Genetogramas e o ciclo de vida familiar. In: Carter B, McGoldrick M, eds. As mudanças no ciclo de vida familiar. Uma estrutura para a terapia familiar. 2ª ed. Porto Alegre: Artes Médicas; 1995.
55. Nichols MP, Schwartz RC. Terapia familiar: conceitos e métodos. Porto Alegre: Artmed Editora; 2009.
56. McGoldrick M, Shibusawa T. The family life cycle. In: Walsh F, ed. Normal family processes: growing diversity and complexity. The Guilford Press; 2012. p. 375-98.
57. Git Mind. Doenças [Internet]. GitMind; 2022 [cited on Sept. 12, 2022]. Available at: https://gitmind.com/app/flowchart/v176rrz6af
58. The Multicultural Family Institute. Kahlo genogram [Internet]. Mult Cultural Family; 2022 [cited on Sept. 12, 2022]. Available at: https://multiculturalfamily.org/product/kahlo-genogram-downloadable-pdf/
59. Macinko J, Mendonça CS. Estratégia Saúde da Família, um forte modelo de Atenção Primária à Saúde que traz resultados. Saúde Debate. 2018;42(spe1):18-37. https://doi.org/10.1590/0103-11042018s102
60. Minayo S, Deslandes MC, Gomes RSF. Pesquisa social: teoria, método e criatividade. Petrópolis: Editora Vozes, 2011.
61. Proetti S. As pesquisas qualitativa e quantitativa como métodos de investigação científica: um estudo comparativo e objetivo. Revista Lumen. 2017;2(4). https://doi.org/10.32459/revistalumen.v2i4.60
62. Günther H. Pesquisa qualitativa versus pesquisa quantitativa: esta é a questão? Psic Teor Pesq. 2006;22(2):201-9. https://doi.org/10.1590/S0102-37722006000200010
63. Lima DMC. Estratégia Saúde da Família na cidade do RJ: desafios da atenção primária numa grande cidade [dissertação]. Rio de Janeiro: Fundação Oswaldo Cruz; 2014.
64. Soranz D. A reforma da atenção primária no Rio de Janeiro [Internet]. Rio de Janeiro: Prefeitura da Cidade do Rio de Janeiro; 2012 [cited on July 10, 2025]. Available at: https://subpav.org/download/prot/A_Reforma_da_APS_no_Rio_de_Janeiro_2009_2012.pdf
65. Mónico L, Alferes VR, Castro PA, Parreira PM. A observação participante enquanto metodologia de investigação qualitativa. Atas CIAIQ. 2017;724-33.
66. Harzheim E, Pinto LF, Hauser L, Soranz D. Avaliação dos usuários crianças e adultos quanto ao grau de orientação para Atenção Primária à Saúde na cidade do Rio de Janeiro, Brasil. Ciênc Saúde Colet. 2016;21(5):1399-408. https://doi.org/10.1590/1413-81232015215.26672015
67. PSE CARIOCA. Programa de saúde na escola [Internet]. 2018 [cited on June 1, 2023]. Available at: https://psecarioca.wordpress.com
68. Mota JS. Utilização do google forms na pesquisa acadêmica. Rev Humanid Inov. 2019;6(12):371-3.
69. Castells M. A sociedade em rede: a era da informação: economia, sociedade e cultura. 6ª ed. São Paulo: Paz e Terra; 2011.
70. Mackey A, Gass SM. Second language research: methodology and design. New York: Routledge; 2010.
71. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO, Ministério da Saúde; 2006.
72. Brasil. Ministério da Saúde. Saúde mental [Internet]. [cited on Dec. 10, 2024]. Available at: https://www.gov.br/saude/pt-br/assuntos/saude-de-a-a-z/s/saude-mental
73. Dantas ESO. Saúde mental dos profissionais de saúde no Brasil no contexto da pandemia por Covid-19. Interface (Botucatu). 2021;25(suppl 1):e200203. https://doi/10.15590/Interface.200203
74. Borges MM, Custódio LA, Cavalcante DF, Pereira AC, Carregaro RL. Custo direto de internações hospitalares por doenças crônicas não transmissíveis sensíveis à atenção primária em idosos. Ciênc Saúde Colet. 2023;28(1):231-42. https://doi.org/10.1590/1413-81232023281.08392022
75. Mangueira SO, Guimarães FJ, Mangueira JO, Fernandes AFC, Lopes MVO. Promoção da saúde e políticas públicas do álcool no Brasil: revisão integrativa da literatura. Psicol Soc. 2015;27(1):157-68. https://doi.org/10.1590/1807-03102015v27n1p157
76. Freire SD. Com açúcar, sem afeto. In: Del Priori M, Amantino M, eds. História do corpo no Brasil. São Paulo: Editora Unesp; 2011.
77. Brasil. Ministério da Saúde. Secretaria de Atenção Primária à Saúde. O que é o e-SUS APS? [Internet] .Brasília: Ministério da Saúde; 2022 [cited on Dec. 5, 2024]. Available at: https://sisaps.saude.gov.br/esus/

78. Postal L, Celuppi IC, Lima GS, Felisberto M, Lacerda TC, Wazlawick RS, et al. Sistema de agendamento online: uma ferramenta do PEC e-SUS APS para facilitar o acesso à Atenção Primária no Brasil. Ciênc Saúde Colet. 2021;26(6):2023-34. https://doi.org/10.1590/1413-81232021266.38072020