The importance of using genograms for...



THE IMPORTANCE OF USING GENOGRAMS FOR UNDERSTANDING OF FAMILY DYNAMICS

A IMPORTÂNCIA DO USO DO GENOGRAMA PARA COMPREENSÃO DA DINÂMICA FAMILIAR LA IMPORTANCIA DEL USO DEL GENOGRAMA PARA LA COMPRENSIÓN DE LA DINÁMICA FAMILIAR

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ABSTRACT

Objective: to describe the experience of medical students in the use of genograms to understand family dynamics. **Method:** qualitative, descriptive case report study carried out by a medical student with a family group in a situation of social vulnerability during the horizontal module of Health Care II, with data collected through six home visits held every two weeks from February to May 2015 in João Pessoa-PB, Brazil. **Results:** the three-generation genogram of the family was constructed, including hereditary diseases, family structure type, socioeconomic data of the family members of the index patient, and a care plan was prepared aiming to improve the quality of life of the family. **Conclusion:** the construction of the genogram allowed a better understanding of the family dynamics, with creation of a link between users and the student, incorporating a vision beyond the biological perspective into the training of medical students. **Descriptors:** Primary Health Care; Medical Education; Home visit; Community Medicine; Humanization; Public Health.

RESUMO

Objetivo: descrever a experiência dos discentes de medicina na utilização do genograma para compreensão da dinâmica familiar. *Método*: estudo qualitativo, descritivo, do tipo relato de experiência, realizado por um estudante de medicina, com um grupo familiar em situação de vulnerabilidade social, durante o módulo horizontal de Atenção à Saúde II, sendo os dados coletados por meio de seis visitas domiciliares realizadas quinzenalmente de fevereiro a maio de 2015, em João Pessoa/PB, Brasil. *Resultados*: construiu-se o genograma familiar das três gerações da família acompanhada, constando-se doenças hereditárias, tipo de estrutura familiar, dados socioeconômicos dos integrantes da família do paciente índice e a produção de um plano de cuidado visando melhorar a qualidade de vida da família. *Conclusão*: a construção do genograma possibilitou uma melhor compreensão da dinâmica familiar com a produção de vínculo entre usuários e estudante, incorporando à formação dos acadêmicos de medicina uma visão para além do biologicismo. *Descritores*: Atenção Primária de Saúde; Educação Médica; Visita Domiciliar; Medicina Comunitária; Humanização; Saúde Pública.

RESUMEN

Objetivo: describir la experiencia de los estudiantes de medicina en la utilización del genograma para comprensión de la dinámica familiar. *Método*: estudio cualitativo, descriptivo, del tipo relato de experiencia, realizado por un estudiante de medicina, con un grupo familiar en situación de vulnerabilidad social, durante el módulo horizontal de Atención a la Salud II, siendo los datos recogidos por medio de seis visitas domiciliares realizadas quincenalmente de febrero a mayo de 2015, en João Pessoa/PB, Brasil. *Resultados*: se construyó el genograma familiar de las tres generaciones de la familia acompañada, constando enfermidades hereditarias, tipo de estructura familiar, datos socioeconómicos de los integrantes de la familia del paciente índice y la producción de un plano de cuidado visando mejorar la calidad de vida de la familia. *Conclusión*: la construcción del genograma posibilitó una mejor comprensión de la dinámica familiar con la producción de vínculo entre usuarios y estudiante, incorporando a la formación de los académicos de medicina una visión para más allá del biologicismo. *Descriptores*: Atención Primaria de Salud; Educación Médica; Visita Domiciliaria; Medicina de la Comunidad; Humanización; Salud Pública.

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INTRODUCTION

The Ministry of Health (MOH) is responsible for the implementation and organization of Primary Health Care (PHC) in the country. This health care model is the main strategy for reorienting and organizing health care according to the principles of the Unified Health System (SUS). PHC is represented mainly by the Family Health Strategy (FHS), which prioritizes health care actions at individual, family and community basis, in a continuous and integral way.¹

Team professionals should be able to solve individual and collective health problems in the space of the Family Health Unit (FHU) and when necessary, during home care, with actions to promote, prevent, diagnose, treat and rehabilitate health within the scope of PHC.²

The home approach to families allows knowing them and the possible dysfunctionalities that affect the biopsychosocial well-being of their components. Home visits help to reveal and assess more accurately some issues about the family structure. For example, in the case of a decompensated diabetic patient, professionals are able to contact all family members and visualize in loco their eating habits in order to contribute to the provision of the most adequate care measures.3

Some family assessment tools can be used as a strategy to assist health professionals in providing comprehensive care. Genograms, for example, allow an overview of the familiar structure and the identification of affective bonds, what is particularly relevant in the present study, with the record of information about the subjects of a family group and their relations spanning at least three generations. This tool helps in the understanding of several clinical problems in the family and the trajectory over time and generations. ⁴

The graphic representation of a genogram is intended to present the family by means of symbols pre-established in a family context. This is considered a clinical tool that assists the work of health professionals, especially in Primary Health Care. It is an instrument that works as a psychosocial "picture" of the patients and of their family context and their illness. ⁵⁻⁶

The use of genograms is based on the idea of the family history extrapolating its entire family context; thus, certain family patterns, either positive or negative, may be present and repeated over generations .⁷ Thus, the data collected through a carefully constructed family genogram help professionals to adopt

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strategies to identified risks, and design measures or programs in order to prevent and solve certain problems, considering specific situations of each family member, and the available and necessary resources of the family.

In this context, through their experience with health assessment tools, home visits and the process of creating bond with users, academics were able to grasp a broad understanding of the family dynamics, allowing the recognition of particularities of the family group followed-up; this experience is, in turn, important for their academic training.

OBJECTIVE

• To describe the experience of medical students with the use of a genogram to understand family dynamics.

MÉTHOD

This is a qualitative, descriptive case report study, carried out between February and May 2015 by students of the second semester of the Medicine Course of the School of Medical Sciences of Paraíba/FCM, during the horizontal module Health Care II. The study site was the area of action of a Family Health Unit in the municipality of João Pessoa/PB.

The students were separated in pairs and each pair was responsible for following-up a family. Data were collected through six home visits conducted biweekly medical by students, always accompanied Community Health Agent (CHA) responsible for each family. The families visited were previously chosen by the health team in a meeting with the professor responsible for the group. The criteria used to choose the families were vulnerability and situations that would require a closer follow-up by health professionals, where academics could use genograms as instrument to approach the family, and with that, draw a care plan with the health team to improve the quality of life of the monitored families.

Visits were always carried out with a previously established goal to be developed by the students. Thus, the first visit had the purpose of establishing a first contact with the family to initiate the bond. The second visit aimed to meet all members of the family. The third meeting consisted in the identification of the family type, vital cycle and functionality; and the fourth visit, aimed to build the family genogram. The fifth visit

had the purpose of mapping the necessary and available resources, aiming constructing a care plan. A farewell to the family was also prepared and carried out in a playful way; and the last visit consisted in the presentation of the family genogram to the family along with the health team of reference.

Family data collected during the visits provided the necessary information for preparation of the genogram. With these data, the academics built the genogram in the *Genopro* program, which, after elaboration, facilitated its understanding.

It is worth mentioning that because this is an case report and all the ethical precepts necessary for the development of this study were respected, there was no need to submit the study to the Research Ethics Committee.

RESULTS

The provider in the household and index patient was 69 years old, hypertensive, with history of two previous strokes, recurrent urinary infections, and denied Diabetes Mellitus (DM). The patient was bedridden by a paraplegia which he believed to be the result of a severe pain in the back that bothered him and he reported that when looking for a health service his complaint received little attention from the professionals of the unit. After some time, the pain began to increase and eventually caused his physical disability. The retired patient (with a former bricklayer and sugarcane cutter), widower, had 4 children.

The family group consists of the index patient, a granddaughter and her husband, and a lady (described only as a sister of the church, who had no relationship to the other members of the household). During the first visit, the user chosen for the development of the activity showed a strong religious belief of healing only by faith, a picture characterized as a psychiatric disorder by medical professionals, since he did not use to look for the Family Health Unit (FHU), did not take medicine or did any medical tests.

The genogram allowed the students to identify the fragilities present in that family, such as the violent death of the index patient's spouse and also the death of two of their children, showing that violence was frequent in that environment, and also the exodus of the others to big cities in search for better living conditions; the genogram also allowed to evaluate the presence of Diabetes Mellitus (DM) with limb amputation in the father and mother of the index patient, which put him at greater risk of developing such a

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condition and indicated the need for the Unit carry out a follow-up to prevent the progression to DM and its complications and to recognize the existing vulnerabilities.

Furthermore, the use of the tools enabled evaluation of the relations and functionality of the family group and the degree of care it received, besides perceiving care/caregiver relationship of dependence existing in that family group due to the physical limitations of the index patient that altered the routine of other family members. We also observed an attitude of distancing of all the siblings toward the patient, a conflict relation with his grandson, due to his involvement with illicitness.

Students classified the family group and life cycle phase as follows: the family group as extended or expanded, consisting of two generations in different phases of the life cycle in which the index patient is an elderly person, the children are already grown up and have already achieved independence, and the index patient is in the widowhood phase, and the other part of the family group was classified as a childless couple.

The tool used for evaluation of family functionality identified this particular family group as functional, for much negotiation with clear and direct communication and relations between all the individuals in the residence were observed, as well as a harmonious relationship between them. Even in moments of disagreement, all were willing to solve the problems.

The data collected during the period of home visits revealed a barrier between the user and the FHU team due to the characterization attributed by the index patient to the pathologies that affected him only as works of an evil being and works of witchcraft. Because of this belief, the patient refused most of medical treatments, making it difficult for him to use the health service. It was also possible to talk about the situation with other family members and to confirm that the church was a fundamental part of his life. His situation was fostered by his belief that his physical limitations would be cured only by faith in the supernatural, leading him to reject the treatments offered by health professionals.

DISCUSSION

The activities carried out by the students proved to be important for academic training from the moment they allowed a reflection and analysis of the difficulties to be faced when inserted in the Unified Health System

(SUS) in the scope of Primary Health Care. As Crevelim and Peduzzi argument, one of the great challenges faced by health teams is to build possibilities for the population to be integrated into the process of building team work.⁸

According to the literature consulted, it was observed that problems of family group are frequent. There is an important need to distinguish between mental illness expressions of religiosity. Indeed. Diagnostic and Statistical Manual of Mental Disorders presents a new diagnostic category denominated Religious or Spiritual Problem. Other data also enabled us to observe that the large number of recognizing the importance of religiosity for promotion of health care, a significant number of health professionals are not trained to deal with this issue. This has created a gap between the developed care and the knowledge on the importance that religion has in the life of patients.9

Throughout the process, the students perceived a distancing of the user from the Family Health Unit (FHU), and they sought to reestablish the link. This is an important tool for adequate and comprehensive care, as shown by Souza, Duarte, who reports that the link brings people together and allows for mutual involvement between subjects. The strengthening of the bond between the family health team and the user is of paramount importance, as it favors the production of care through a relationship of trust and sharing of commitments. Moreover, bond has a close relationship with the practice of care, since it fosters harmony, exchange of affections and coexistence that potentially rebuild autonomies. 10 This is an important activity in undergraduate training to enable future doctors to have the audacity and necessary competence to reestablish the bond of confidence with individuals, which is currently observed in the literature as one of the main challenges to be overcome by physicians.

We observed compatible data with studies showing that home visits performed by CHAs are not efficient enough and have low resolution and provide little clarification about the health promotion model. The CHA's questions are purely based on the biological point of view, focused only on the distribution of medical prescriptions, medicines, referrals, and requests for examinations among others, missing the main goal of prevention and health promotion.¹¹

We also observed that the CHA responsible for the family was unprepared when she

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described the patient as mentally ill without adequate diagnosis. This situation caused the home visits to be inefficient in many times, as the CHA gave little importance to the patients' complaints and to his needs, besides the fact that the visits were fast and did not solve the user's needs. These aspects weaken the bond in the construction of care. It is paramount that health professionals perform a qualified, welcoming listening, because this will facilitate the identification of the patient's problems. 12

The direct relationship with the challenges faced in care is a fundamental part of medical training, since this action is prospected in the Brazilian curricular guidelines for medical teaching. Teamwork and integral health care should guide the training of physicians. This way, it is up to the student to focus his training on a biopsychosocial model centered on a multiprofessional team to execute an efficient care plan.¹³

The application of instruments of family approach was of great importance to increase the knowledge and validate it as a resource in the bond with patient - his family, friends, relationships with people and with the community, with his religion and with the FHU.

At the end of each home visit, discussions and exchange of experiences with the other members of the activity were held in order to share the learning acquired during the visit so that all the involved ones were aware of the fragilities and challenges that each group faced and the different ways of exercising care according to the particularities of each group. This sharing of experiences was important in team meetings, in daily work, since they represent devices for the structuring, organization, information, and establishment of guidelines and a space for decision-making.¹⁴

The proposals of the module are an important way to enrich the teaching-learning process, allowing students to broaden their view of the patients' context and evaluate their family history, as well as highlighting the importance of the social and relationships in the health-disease process to provide individualized and humanized care, as well as facilitate the establishment of bond with the individuals with whom the professionals work.

The process of building the genogram sought to awaken a critical reflection in students on the importance of this fundamental tool for the practice of the medical science, especially in Primary Health Care, as it has been ratified in many studies in

which new forms of efficient increasing the contact between families and students are important to make future health professionals acquire maturity to conduct different situations of care.

At the end of the activities, the care plan the built by students based multidisciplinary model was presented to all the professionals of the unit with the purpose of assisting in the work of that health unit as a form of retribution to them and to the people who helped to construct the knowledge. Thus, the care plan was presented by each group of the activity. An individualized care plan is important for the reality of each family, and this highlights the importance of building individualized care plans, and stresses the need for a planning of care involving the families of people, especially of patients with chronic conditions, in different areas of health care, since the family directly experiences the confrontation of the chronic condition by the individual.15

present study In this context, the evidenced the students' view on the use of health tools and building of bond in the care process to understand family dynamics and its importance for academic training. The study has the limitation of having a qualitative approach, what makes it impossible to formulate hypotheses, since the approach seeks to analyze non-measurable Another limitation is the low number of national studies on the subject. Therefore, more studies are necessary, especially with quantitative nature, to allow a more complete evaluation.

CONCLUSSION

The experience of the students with the use of health tools for evaluation and approach to the family proved to be important for professional and academic training, as well as brought students closer to the challenges faced throughout the construction of care. The experience also enabled them to conduct the process going through all the stages of integral health care, from the creation of bond to the use of instruments for the construction of individualized and resolute care.

It is important to highlight the lack of preparedness of health professionals to conduct complex and particular situations that demand great dedication and persistence, being efficient to detect the fragilities and vulnerabilities of the group, but which showed little preparation during the problem solving process. There were great efforts of the students to reestablish the bond

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and trust in the behaviors proposed by the Health Unit and in the construction of a care plan that promoted a better quality of life of the family group.

The use of tools in the health field allowed the identification of fragilities, vulnerabilities, prevalent pathologies, and family functions, as well as exposed the causes that distanced the family from the care provided by the Health Unit. This detection is important to reestablish the link broken at some point.

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