The foundation of care: Family Health Program teams dealing with domestic violence situations[1]

A construção do cuidado: o atendimento às situações de violência doméstica por equipes de Saúde da Família

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Abstract

As violence has proved to be an important public health issue, it has stimulated scientific production and the development of public policies. The objective of the present article is to understand the care strategies developed by Family Health Program Teams in Diadema to handle domestic violence situations. A qualitative analysis approach of selected cases identified by the teams as "difficult", "typical" and "successful" was adopted. Two Family Health Program teams and different professionals from the intersectoral network were interviewed. Organizing services according to the Family Health Strategy guidelines has shown to be a facilitating factor to develop care strategies to handle domestic violence. Professionals identified different kinds of violence in the assisted families, but the actions of the teams focused mainly on the child abuse related situations. Violence against women in general was not taken into account by the teams, which shows different degrees of "visibility" among the various types of violence. Strategies included actions to promote deeper bonds with the family, cases monitoring and biomedical aspects evaluation, as well as more acute actions such as mandatory hospitalization. The strategies developed alternate from a prescriptive perspectivel to one more centered in the concept of Care, during the interaction with the families and regarding their needs. The community health agents and NASF professionals were the main protagonists in these cases, articulating practical and technical knowledge.

Keywords: Domestic Violence; Child Abuse; Violence against Women; Primary Health Care.

Resumo

A violência tem se constituído importante objeto da saúde pública, tanto na produção científica como na elaboração de políticas públicas. O presente artigo tem como objetivo analisar as estratégias de cuidado construídas por equipes de saúde da família frente a situações de violência doméstica. Optou-se por uma abordagem qualitativa feita pela análise de casos traçadores identificados pelas equipes como "difíceis", "típicos" e "bem-sucedidos". Foram entrevistadas duas equipes de saúde da família e profissionais de diferentes serviços da rede intersetorial. Os resultados mostraram que a organização do serviço a partir das diretrizes da Estratégia de Saúde da Família propiciou condições favoráveis para o enfrentamento da violência doméstica. Os profissionais identificaram diferentes tipos de violência nas famílias atendidas, mas as ações das equipes voltaram-se prioritariamente para as situações de maus-tratos contra a criança. A violência contra a mulher em geral não foi tomada como objeto da equipe, demonstrando diferentes graus de "visibilidade" entre as violências. As estratégias incluíram ações de vinculação à família, de monitoramento dos casos e avaliação dos aspectos biomédicos, mas também ações incisivas, como a internação compulsória. As estratégias construídas alternam-se entre uma perspectiva prescritiva e outra centrada na ideia de cuidado, no diálogo com as famílias e suas necessidades. Os agentes comunitários de saúde e os profissionais do NASF foram os principais protagonistas nesses atendimentos, numa articulação entre o saber prático e técnico.

Palavras-chave: Violência Doméstica; Maus-Tratos Infantis; Violência contra a Mulher; Atenção Primária à Saúde.

Introduction

Domestic violence as a public health object in Brazil

Domestic violence and its repercussions on the health of children, adolescents and women has been the object of countless studies in the field of public health, showing that it is a highly prevalent phenomenon with great impact on physical and mental health. Research on violence in Brazil using population samples has found prevalence of severe physical violence[2] committed by mothers or fathers against children and adolescents of between 8.2% and 10.2% in Duque de Caxias/RJ; 10.3% in Embu/SP and from 14.5% to 16.3% in Rio de Janeiro/RJ (Assis et al., 2009). Between 27.2% and 33.7% of Brazilian women claim to have suffered physical violence at least once in their lives (Schraiber et al., 2005).

There are significant peculiarities in constructing strategies to deal with domestic violence. Data show that the attacks largely occur within the home and the rate of recurrence is high, characterizing it not as an isolated event but as an experience of long duration.

Analyzing the problem from a systematic, longitudinal perspective indicates that in families in which violent relationships are established, there is a cycle in the roles of aggressor and victim. It is worth highlighting that this cycle and the use of violence has diverse socio-cultural meanings, involving both gender and roles and powers constructed hierarchically by one of the members. Violence becomes the method of resolving conflicts within the family, shared by the different members, affecting them all, albeit in different ways.

The impact of domestic violence on health has been studied by countless researchers, covering not only physical and psychological injury but also risk of death (Schraiber et al., 2005; Assis e Avanci, 2004; Assis et al., 2009; Brasil, 2001). Exposure to violence has been shown to be an important risk factor in mental health problems (Paula et al., 2008). Studies show the relationship between domestic violence against the female and the mental health of her

2 The category severe attacks used in this study includes kicks, punches or bites, hitting with an object, slapping, burning any part of the body and threats or actual use of weapons against the child or the adolescent (Avanci and Assis, 2004).

children, as the attacks suffered affect her ability to care for different family members (Levendosky and Graham-Bermann, 2001; Durand et al., 2011).

The term "domestic violence" was used in this study as it was deemed to be more all-embracing than "family violence", including attacks committed by other individuals within the domestic space as well as attacks between members of the same family (Brasil, 2001), covering different forms of domestic violence (against women, children and adolescents), irrespective of its nature (physical, psychological, sexual, deprivation or neglect).

Dealing with situations of domestic violence in the context of primary care

Research conducted on basic care when faced with domestic violence in the ambit of primary care emphasizes the challenges and dilemmas posed in constructing integrated care.

Various studies have highlighted health care professionals' fragile and limited preparation for dealing with situations of violent, including their concept of violence and its causes, the actions developed (or not) and the relationship established with the family and other actors in the inter-sectoral network.

Violence is frequently associated with "poverty" and "broken families" (Andrade et al., 2011; Nunes et al., 2008) or with "pathological" characteristics of the victim or the aggressor (Santos, 2005), demonstrating a superficial understanding of cultural, historical and social aspects. The teams' actions showed a tendency to "medicalize" violence, with prescriptive and interventionist attitudes towards the family (Nunes et al., 2008).

Other research shows that professionals not uncommonly adopt an attitude of omission when faced with such cases, not accepting them as an object of their work. The teams' actions, then, take on an ad hoc and emergency character. In cases of violence against children and adolescents, professionals only complain to the Guardianship Court in the cases considered to be most serious. Fear of suffering reprisals from the family/community, uncertainty regarding the guardians' actions and fear of breaking ties constructed with the families are the main justifications for the low number of reports made (Andrade et al., 2011; Kiss and Schraiber, 2011; Ramos and Silva, 2011; Cavalcanti and Minayo, 2004; Santos, 2005).

Theoretical-conceptual contributions for thinking about violence and health care practices

Choosing care as the analytical lens used in this text expresses the effort made to listen to the day-to-day experience of the teams' practices in contrast (or resistance) to the usual strategies of a bio-political approach, that is, centered around medicalizing disciplinary control of populations and bodies (Foucault, 1985).

In academic output, the concept of care has been used by different authors. It has been linked with integrality and, this, is understood as health care practices that exceed an exclusively bio-medical perspective and pay attention to social, cultural and subjective aspects, focusing on the relationship between the health care professional and the used (Pinheiro and Guizardi, 2004). Moreover, integrated care should be capable of articulating care with a view to prevention, overcoming fragmentation with the care proposal being shared within the team (Pinheiro and Mattos, 2001).

According to Merhy (2002), the act of giving care assumes a change from the "centralized procedure" care model to a "user centered" care model, with the guiding principal being defending the user's life. In other words, care leads to practice that has the user's health as its main objective, viewing the user as a subject, understanding it as an amplification of the "technical reserve" for dealing with life's challenges, and not taking diagnoses and the biological aspects of falling ill as central.

On this issue: understanding health as a topic of life, a subject for all humans; having to do with the stock of resources available to continue living in the best way possible. This approach has something to do with the happiness project, with ways of being. The best way possible varies for each person and also over time and among societies. As health is all of this, it is clear that, to produce it, nourish it, make it possible, many elements are needed: good connections, life projects, chances to carry out these projects, chances to experience wins and losses, to face – without falling apart – the difficulties, frustra-

tions and disconnections that are also part of life (Feuerwerker, 2013).

Care is also considered part of life. With arrangements that differ over time and according to different ways of life, care also has to do with solidarity, support, producing life. The topic is not exclusively one of health. It is a topic of human concern involving constructing a fabric of relationships and connections that form life.

Caring for health, then, is a topic for all living beings, not only for health care professionals. This is a necessary consideration for us to know that, in this terrain, that of caring for health, users, their families and a variety of others are active participants, with their own guidelines, possibilities and impossibilities, often unknown to us. This is also a production with multiple meanings (Feuerwerker, 2013).

For this reason, health care presupposes a connection between the health care professional and the user, characterized as an intercessory relationship capable of articulating different visions – that of the professional (technological-scientific know-how, clinical experience, values) and that of the user (their life projects, desires, personal experience), producing treatment projects based on this composition (Merhy, 2002). It is this dialogical dimension that exists in the idea of health care that was of particular use throughout this research.

Ayres (2005) revisited the concept of "care" based on different readings of working in health care. Recovering the work of Heidegger, Foucault and modern critics of health care work in collective health, the author points out four different readings of the concept: care as an ontological category, as a genealogical category, as a critical category and as a reconstructive category.

The ontological category revives the concept of care based on the work of Heidegger, reminding us that care means we are implicated, responsible for a specific project and acting in function of this. Caring for someone, then, implicates us with the other and with their life project, taking this project as a guiding element in health care practices.

Care as a genealogical category reports the social historical synthesis of Foucault's (1997) idea of "self-care". This author shows us how care was historically constituted as a labor, a set of knowledge and care techniques able to be systematized, learned and practiced through interpersonal relationships. Care contains a technological aspect, the importance of which, in regard to social practice, has been gradually consolidated.

Care as a critical category deals with issues already approached here in the contributions of Merhy (2002) and of Pinheiro and Guizardi (2004) on the topic. The critical perspective was introduced from the perception of a crisis in the area of health, expressed by the contradiction between the growth of advanced technology (and its intense valorization) and its limits and problems.

Different authors point out the dual unfolding of this crisis. The first concerns the consequences related to care provided and how it is out of step with users' needs and wants (Ayres, 2000, 2004a, 2005; Pinheiro and Mattos, 2001, 2004). The second refers to the effects of this crisis for health care professionals, made explicit in the crisis of confidence in health care professionals, in the toughness of interventions and marked by the abandonment of the reflexive, critical and interactive perspective that composes working in health care. In this context, adopting successful technical and seeking appropriate technology are frequently seen, in and of themselves, as synonymous of good practice (Schraiber, 2011).

The reconstructive reading, proposed by Ayres (2005), combines the existential dimension of the concept of care and criticism of actual health care practices. It is proposed that the concept be used in terms of changing health care practices, so as to organize the technological and care provision based on the user's wants and projects, through open and productive dialogue, in an articulation between technical knowhow, based on scientific and technological knowledge, and practical wisdom, based on experience of falling ill and patient, and doctor, expectations, in a shared care intervention project. In other words, as the author says: care is health care practice articulating "successful technologies" and "practical success".

The practical wisdom that exists in care requires a negotiated decision, constructed on negotiation between the professional's knowledge (technical

and practical) and the user's perspective, their knowledge about themselves and their lives, wants and projects for happiness. "It is assumed that health is not only the objective, [...] but also a way of 'being in the world'. As such, the use, or not, of certain technologies, the development, or not, of new technologies comes to be understood as one more decision among others [...] an essential exercise of human autonomy" (Ayres, 2000, p. 120).

Valuing the practical wisdom that makes up care does not mean denying technology (technological knowledge, instruments and examinations) or its importance in health care, but rather using it in a critical and reflexive way, inquiring into its convenience with regards a specific situation (Schraiber, 2011).

In relation to violence, it could be said that practical wisdom and the relational, dialogic portion of working in health take on a central role, as they are essential elements for the team in their contact with the families. If we consider any relationship that reduces another to the condition of an object as violent (Chauí, 2002), the teams actions when faced with situations of mistreatment cannot be translated into a purely prescriptive attitude. The association – made by Ayres (2000) between care and exercising autonomy and by Merhy between care and enriching existential territories – takes on new meanings in this context: practices that result in non-violent ways of relating, thus forming a counterpoint to the day-to-day violence experienced by the families.

Analyzing primary care professionals' actions when faced with violent situations requires a definition of what primary care we are talking about, as there is a great diversity of care models and technological-care arrangements. The Family Health Strategy option is based on the expansion of this model in this country and on its characteristics, enabling the health care teams to get closer to the community. Our assumption was that this closeness could facilitate identifying cases and encourage the teams to develop strategies for this problem.

The aim of this article is to analyze the care strategies created by the family health teams when faced with situations of domestic violence against children and adolescents.

Diadema (SP) was chosen as the field of research because of the investments made by the municipality in structuring and consolidating the FHS and a care network for victims of violence. The definition of participating primary health care unit was produced adopting the length of time the family health teams had been established in their current configuration (compete teams) and the professionals' involvement with the topic of violence (participating in training and network meetings) as criteria.

Methodology

The care provided to the user was analyzed based on tracking cases. This method enabled us to evaluate the work of the health team by mapping the trajectory of a case based on different sources and points of view. The assumption is that in-depth analysis of a specific case – that may be one type of problem or a pathology -, by reconstructing the history of care may shed light on how the work and production of care is organized by the team, indicated in the criticisms and possibilities created by professionals and users. (Kessner et al., 1973; Silva, 2010; Merhy and Feuerwerker, 2008; Feuerwerker and Merhy, 2011).

The data were collected using semi-structured group interviews in three stages: 1) interviews with the two family health teams, psychologist and social worker in the primary health unit; 2) interviews with professionals from other services who participated in the cases (Social Care Referral Center (CREAS), Guardian Council and school); and 3) document analysis (medical records, reports from different services, among others). Eight meetings took place in the PCU, one at the Guidance Council, one in the CREAS and one in the local school, totaling eleven interviews with 27 participants.

The cases to be tracked were chosen by the health teams themselves, based on situations of domestic violence against children and adolescents that they had attended. They were requested to select: a) a "successful" case, b) a case considered "difficult" and c) a "typical" case, in other words, of the type they most frequently encounter in their day-to-day work. The script used was based on the teams' production, including listing the types of violence identified by the professionals, the actions and professionals in-

volved in dealing with them and the way in which the actions and inter-sectoral articulations constructed were defined. We also approached the criteria used by the teams to classify cases and suggestions made by professionals to qualify how care was provided in situations of violence.

The interviews were recorded and transcribed. Five cases were selected and analyzed, systemized using flowcharts that enabled the care provided to the user to be shown graphically. To construct the flowcharts, we used the tool proposed by Merhy (1997), using it to describe the set of actions offered to the family in the violent situation, including provision of different services in addition to health care, from the inter-sectoral network.

Participants authorized the use of their data, signing an informed consent form. The research was approved by the University's Ethics Committee.[3]

Results

When the "complaint" is violence: the strategies, knowledge and meaning of the teams' practice

Observation of the proposed care in each of the cases and of the way they were defined indicated that the primary care organized by the Family Health Strategy provides favorable conditions for constructing practices aimed at dealing with domestic violence.

Team meetings, home visits to get closer to the families and, above all, the community health agents' knowledge of the family dynamic and the territory were widely used in the care strategies analyzed.

In contrast to the results obtained by Andrade et al. (2011), we observed that in the teams studied, situations of violence against children or adolescents were viewed as an object of the teams' work. Analysis of the flowcharts enabled five types of case management strategies, combined in different ways in each situation studied, to be identified: 1) closeness and support strategies; 2) monitoring and control strategies; 3) health assessment and treatment; 4) articulation in the network; 5) legal/medical (hospitalization or refuge).

It stands out that, in the majority of cases analyzed, care was provided at the user's request, in two cases the community recognized and used the primary care unit as a reference for dealing with the situation of domestic violence against children and adults.

Team meetings with the participation of a social worker and/or psychologist were indicated as the main spaces for defining care strategies, a way of integrating the visions of different professionals, but also a strategy for protecting the team, a way of sharing responsibilities and recognizing the emotional aspects the situations of violence aroused in the professionals. This datum may indicate an effort to counteract the centrality of biomedical knowledge and fragmentation of care.

All of the professionals on the team participated in producing care in at least one of the cases; there was, however, a clear predominance in actions be community health agents, social workers and psychologists, showing the most frequent approaches drawn on to deal with violence by these family health teams.

The situation of violence invited the health care professionals to construct new ways of getting closer to the users, of understanding their lives, their family and social networks, the vulnerabilities and protective aspects in each case. The family's socio-relational diagnostic comes to weigh heavily in defining the team's work, while the knowledge of the psychologist, the social assistants and community health agents took central place.

It may be that the disconnections that the medical-social topics provoke in the teams' habitual functioning bring with them the possibility of important experiences in consolidating multi-professional work and for experiencing work that can bring the team closer to exercising practical wisdom in the search for successful practice that is not restricted to technical success (Ayres, 2000, 2001, 2004b; Schraiber, 2011).

The community health agent was indicated as a fundamental actor in defining and validating the actions planned by the team, in contrast to the results found by Ramos and Silva (2011). This professional's

3 Approved by the Research Ethics Committee of the School of Public Health, Universidade de São Paulo in the 4ª/11 session on 13/05/2011. OF COEP/193/11.

knowledge of the family and community's day-to-day life was constantly drawn on. In the cases analyzed, the agents played different roles: they alerted the teams to risks or probable failures of planned actions; functioned as "conflict mediator" between professionals and community residents; and helped the team to choose the best tool (consultation or home visit) to identify possible "allies" in the family of the neighborhood (who spends more time with the child?) Who does the adolescent listen to most?).

Monitoring the cases and the effects of the proposed interventions on the families' day-to-day life was also a role primarily played by community health agents, put into effect through home visits and, often, through information from neighbors and other relatives. This work is possibly the most tense and delicate, given that the community health agent is frequently identified as responsible for reports in situations of mistreatment.

The teams indicated that the participation of professionals from the Family Health Support Center (psychologists and social workers) in case meetings was an important differential, making them more flexible and able to solve problems. This differential occurs due to the possibility of providing actions specific to the center and its professionals (a psychological assessment, for example) as well as the sharing of knowledge and activities, giving the professionals from the family health care team more assurance to take on certain actions.

The psychologist and the social worker often worked together to manage the studied cases and demonstrated different ways of sharing their knowledge and practice. The psychologist mainly contributed by participating in meetings and providing specific actions, as well as sharing in the discussion and reflection of the cases. The social worker also acted together with the community health agents in home visits, meetings with other services from the intersectoral network and coordinating adolescent groups.

Doctors, nurses and nursing technicians were the professional's whose participation was most discrete in dealing with the violent situations studied. Medical consultations were used specifically to evaluate general state of health and in looking for possible hepatitis and HIV infections, strategies consisting almost exclusively of assessment and treatment, as described above. The nurses acted as a link with the team, and also facilitated communication between professionals.

It is interesting to note that, although the doctors, nurses and nursing technicians were those least involved in directly caring for users in situations of violence, in some cases they were the professionals who saw the patients most often, as many of these families had fragile linked with the PHU, often using it exclusively to meet spontaneous demand. Care, then, remained ad hoc and no notes were found in the medical records suggesting that these opportunities were used to create links with the patient and to build a more longitudinal care, showing the contradictions still existing between the care offered and proposed integrality Pinheiro and Mattos, 2001, 2003; Pinheiro and Guizardi, 2004). In other words, we observed limited action on the part of doctors, nurses and nursing technicians in getting close to and managing these situations, despite having contact with the families on various occasions, highlighted as an aspect to be better exploited by the teams.

An important challenge is to avoid reproducing the "referral" model, which has contributed little to taking increased responsibility and knowledge and practice in the teams themselves, within the PHU. It was observed that the NASF professionals' were concerned with valuing case discussion and developments with the entire family health team. On the other hand, joint interventions were mainly conducted with the social worker and the community health workers, there being few occasions on which joint actions were proposed with doctors, nurses and nursing technicians. It is appropriate, here, to reflect on the organization of the services' actions, reinforcing the gap between social and biomedical aspects of specialisms, thus distancing them from the logic of integrated care and impoverishing care.

The different case management strategies were made manifest through actions within the PHU, including medical consultations, laboratory examinations, home visits by community health agents, social workers, nurses and nursing technicians, dentist appointments and individual and family care from social workers, psychological consultations and educational groups with adolescents.

The provision of actions, "the treatment project", was formulated on a case by case basis, taking into consideration their uniqueness, including the risk to which the child or adolescent was exposed (of falling ill, of physical harm), to social and family networks available and the professionals' information and perceptions concerning the families - including subjective aspects involved in such readings.

A relevant aspect is the feeling of responsibility for the families, manifested at various moments in the interviews. The effects of defining reference teams for specific outlined territories, with the aim of making the professionals more responsible, were shown in these teams' practice.

The effort to "fence in the case" - the term used by the professionals themselves - translates into both concern with closely monitoring the family and the progress of proposed actions and also the effort made in monitoring the participation of other services from the inter-sectoral care network, based on agreements made.

The multiple meanings given to the terms ("fence in the case", "have a look at") used to characterize the teams' responsibilities open up the possibility to reflect on the various meanings that may (and do) occupy professionals' practice and the care model pervading the cases analyzed.

Checking the frequency of attendances and hospitalization in the emergency rooms are good examples of "prescriptive" care, while controlling "the bodies" and the families in the bio-political sense, denounced by Foucault (1985), as previously mentioned, are monitoring strategies and checking hospitalizations.

On the other hand, there is also concern with preserving and strengthening links with the families, in increasing dialogue with users and the projects, as well as between professionals involved, in the sense of reconstructive care proposed by Ayres (2005) and of user centrality proposed by Merhy (2002). Making frequent appointments with relatives and with the adolescents themselves, effort in agreeing on possible changes (in the sense of damage reduction) with the adolescents and their mothers, structuring adolescent groups with the aim of exchanging experiences or social networks are examples of attempts to change health practices and the health care professional-user relationship, characterizing strategies of closeness and support.

The ambivalence between the users' "defense of life model" and the "controlling life and bodies" model present in the health field are thus alive in these professionals' practice.

(In)Visibility of domestic violence

The five cases selected show the variety of situations of domestic violence encountered by the team, as can be seen in Table 1.

Table 1 - Cases analyzed, as classified by the teams, suspected aggressor and type of violence identified, Diadema, 2011

Case and identification	FHS	Classification if the cases	Type of violence against the child/adolescent	Suspected aggressor	Domestic violence against other family members
Case 1 - Isabel	A	"in progress"	Sexual violence – domestic (suspected)	Father	Violence against wife
Case 2 - Alisson	A	"difficult, very difficult"	Physical violence and neglect – domestic	Mother	History of domestic physical and sexual violence in childhood – mother
Case 3 - Karina	B	"difficult"	Neglect (?) Sexual violence – domestic (?)*	Neighbor	Violence against the elderly - neglect and physical violence; neglect of other children
Case 4 - João and Sandro	B	"typical"	Neglect – domestic	Mother	Violence against wife
Case 5 - José Fernando	B	"successful "	Neglect, physical violence– domestic	Mother, sister	Suicide (mother)

* The classification "domestic violence" does not properly apply to the case, since the relationship between the teenagers and the offender did not include living in a domestic environment. Yet the case was chosen by the team considering the proximity and the relationship of trust between the two before the assault. We prefer to keep the material of this analyzed case.

The cases chosen by the teams include different types of violence against children and adolescents (neglect, physical assault and sexual abuse). They also demonstrate the coexistence – in many cases – of domestic violence involving other family members, whom the professionals also identified and named.

The approaches were shown to be centered on dealing with and protecting the children and, not uncommonly, other forms of violence – especially violence against women – remained on the margin of the actions initially drawn up. Violence against the elderly and children/adolescents was that which most frequently appeared as a previous object of team actions, especially in situations of neglect of health care and feeding.

Violence against women, as present in the families in question, remained an almost invisible phenomenon – for the professionals, for family members and even for the abused women themselves, as shown by Schraiber et al. (2006).

Gender issues and their impact on health care professionals' practice are a topic which is still not highly valued in research, and the results of this study suggest the need to look at them more in-depth. In the cases analyzed, from the team's view of the women, especially the mothers. Their suffering and health needs frequently seemed to take second place. Activities aimed at protecting and supporting female victims of violence were only conducted in which the severity of the attacks placed her life and that of her children at risk.

On the other hand, actions developed to deal with neglect, in which the mother was identified as the "aggressor", were those in which the greatest number of services were involved or which triggered tougher interventions on the part of the team. In other words, these situations aroused a strong feeling within the team that "something needed to be done". The relationship between neglecting the child and abuse of the mother, as described by Levendosky and Graham-Bermann (2001), were not valued by the professionals in the cases analyzed.

Thus, we suggest that gender issues and, in particular, social values related to maternity may be an important element in understanding the teams' choices in these cases, meriting deeper reflection.

"Difficult", "successful" and "typical": the challenges facing the health care teams

The complexity of situations of domestic violence pose ethical-philosophical and practical challenges for health care professionals, experienced daily in each case dealt with.

The former returns us to ethical issues connected with recognizing and respecting the autonomy of the subjects and the health care professionals' role in situations involving risk to others or to themselves.

The term "difficult" – criterion used in choosing tracking cases – was used by the family health care teams to describe cases in which the actions and changes suggested by the teams and the users' wants and behavior and reached an impasse, placing them at risk of harm to their health. In situations of domestic violence, individual choices, the organization of the case and the family's routine and drug abuse had strong repercussions on the health and life of the whole family.

The dilemma reflects into the decision to "do something" or "preserve the links with the family", in other words, choose to take more radical action which could eventually lead to the family members being separated, or choose actions to get closer to, support and guide the family. The choice, more than a position taken at a specific moment of care, accompanied the professionals involved, reappearing with each new piece of information on the case. It is interesting to note that making this decision is the sole responsibility of the professionals, showing that defining care strategies is not seen as something shared (and negotiated) with the users and their family, as proposed by Ayres (2005) and Merhy (2002).

Identifying "successful" cases proved to be a challenge for the professionals, showing different readings of what "success" means in this context.

> *I see it like this: the PTS (Single Treatment Project) aims to have final goals. But it shouldn't have final goals. It should ascend. We can be successful at this: we climb towards a partial goal. But I think it's difficult to reach the end* [...] (Doctor – team A).

> *When we make an action plan and the person follows it, meets all the goals we set. As if it was a diagnosis. Making a diagnosis, an action plan and*

the person follows it, wants to help too. Because there's no point in us just guiding, guiding, guiding and the person not understanding. The patient has a part to play (Nurse – team A).

I think the case is successful, because contacts were made, the girls... She did her bit. The (health) center's part was very successful [...] (Nursing technician– Team A).

Yes, because that's the meaning of the work, taking the acute moment (of violence), when the situation is really bad, and try to change it in some way... it changes minimally, there could be a thousand other issues, but if it manages to protect a (family) member just a little bit better, it's successful [...] (Psychologist– CREAS).

In a case deemed to be "successful", this was one of the elements mentioned by the team: knowing when to take a more radical measure at the moment in which the adolescent was at imminent risk and having an appropriate inter-sectoral response. "Success" depends on the relationship between the team's professionals and other services in the network, so as to guarantee the agreed actions in dealing with the case.

It is interesting to note that the "successful" case was the one involving the greatest closeness between the team and the adolescent's family. Refuge was provided at the family's request, considering the possibilities and their knowledge of the adolescent, the territory and the risks he was at. This aspect, however, was not valued as an element of the strategy's success by the team.

The professionals viewed success as technical success, obtained through professionals' actions (Ayres, 2000; Schraiber, 2011). User autonomy, wants and choices are still viewed as a problem for the work of the team, often mentioned as causing the care to fail. Thus, practical success as discussed by Ayres (2000), that is, the use of technical knowledge in dialogue with users and their projects, was not identified as an element of success in care strategies by health care professionals.

Viewing the subjects' autonomy as a strength (not as an obstacle) and enabling user participation in drawing up their "treatment projects" are perhaps the main challenges facing teams. Without this element of shared production, the risk of being unsuccessful is greatly increased (Merhy and Feuerwerker, 2008).

Another challenge is dealing with the interconnection of situations of domestic violence, drug use and drug dealing. According to the teams, in a "typical" situation, there is a significant connection between domestic violence against children and adolescents, increasing the child's vulnerability (by spending more time on the street), exposure to drug use and involvement in crime, forming a vicious circle.

Closeness between the health team and the community allows a long-term relationship with the families to develop, enabling them to witness the trajectories of the children and adolescents in the neighborhood. Domestic violence and, especially, the perpetuation of the community's vulnerability is described by the professionals as a source of anguish, desperation and outrage.

Advances in dealing with care in violent situations are highlighted by the team, even considering the aforementioned difficulties. The main one concerns the primary health care unit's place in the community in relation to these topics, recognized and used as a sheltering space.

That's what I think is great about this unit and about our work. The people have it as a reference (cries)... The fact that someone can turn up and say: "I'm not good". That's great. We don't know what it is for someone to come to a center and to be welcomed. [...] *But they (the users) know that when they come here there will be the technicians, the nurse, the doctor, the agents. Someone will receive them, talk with them. This is really great and I think that's what we've built here. I myself am very happy when people say this* [...] (Social worker – PHU).

The professionals see it as a great victory that they have become a reference in a community that, traditionally, was socially excluded. In the midst of contradictions, the dilemmas, the practices of control or in the dialogues it was possible to observe involvement and a sense of responsibility towards the families. In other words, signs of ontological care of which Ayres (2005) spoke, or of intercessor care (Merhy and Feuerwerker, 2008).

Final considerations

The research proposal was to conduct a qualitative analysis, enabling reflections and notes, to be evaluated by managers and professionals from the inter-sectoral network and investigated in more depth in future research.

Data on the prevalence of situations of domestic violence and, above all, the feelings and dilemmas observed indicate that this is a problem difficult to leave on the margins of permanent education proposals aimed at professionals working in primary care. The proximity with territories and their way of life mean that domestic violence is a frequent topic in the work of health care teams. The lack of preparation on the part of professionals emphasizes feelings of fear, anguish and impotence and exposes both professionals and families to the consequences of inappropriate actions or those incapable of solving the problem.

The results indicate that approaching the topic should not be limited to a conceptual awareness of types of violence and signs that can be observed by the teams. They show an obvious need for space in which to reflect on practice, based on specific cases dealt with by the teams, using the dilemmas, subjective aspects and ethics that permeate the act of drawing up actions to be taken. Spaces that allow a multi-professional reading of the situation through teamwork, with shared decisions and constant re-evaluation of decisions made.

Another aspect of particular important in qualifying the work – and not solely in situations of violence, but for any health care work – is that of promoting reflection on health care within the team as an exercise in autonomy, and including negotiation with users as a fundamental element in drawing up treatment projects. The professionals' concept of autonomy and user participation in care is an issue meriting further studies that may contribute to advances in achieving integrated, user-centered care.

The concept of gender and its influence on health care professionals' practice is another topic to be further explored in other research. In the cases analyzed, it appeared to us to be essential in order to understand the visibility and invisibility of types of violence, the actions taken and their meaning, the feelings aroused in the teams, strongly influencing the strategies constructed.

The results presented here privilege the analysis of technological arrangements and the strategies constructed within and by the family health team actors involved, the knowledge used and the ways of spaces in which the actions were defined and implemented. Dealing with situations of domestic violence, however, requires an inter-sectoral approach, the construction of which assumes its own micro-policy, with the participation of other actors and knowledge in the composition of the care. The focus of this study was not to analyze these inter-sectoral relationships, but the data found suggest significant differences between services: different views of the families, different expectations and understandings of their own role and that of other services in dealing with the cases. We end by pointing out the challenge of constructing research that values the multiple voices of the diverse subjects of the family and of the service user population.

Authors' collaboration

Moreira conducted the field work and re-wrote the initial text of the article. Martins, Feuerwerker, and Schraiber contributed to the discussion and reviewing the article.

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