Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.7
DOI: 10.1590/1413-81232024297.03132024EN

THEMATIC ARTICLE

Social network of families involved in child neglect: building a multidimensional perspective

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Abstract *Neglect is one of the most frequently reported forms of violence against children and adolescents, although it has rarely been explored in national studies. In this light, the present study aimed to analyze the personal social network of families involved in negligence against children and adolescents. This work takes a qualitative approach, anchored in the Paradigm of Complexity, conducted with twenty families involved in negligence against children and adolescents in a municipality in the countryside of the state of São Paulo, Brazil. Data collection took place through minimal maps of the personal social network and semi-structured interviews in January 2021. The networks were limited, with little to no interaction among the different services and sectors, and were predominantly homogeneous. Because they have many weakened ties, they are relatively unsupportive, pointing out difficulties in access to work, education, and health. Due to the characteristics of the network, the complexity of the phenomenon of neglect was identified, in which elements condition and perpetuate experiences of absence and fragility. Interprofessional and intersectoral views and actions are requested and recommended.*

Key words *Domestic violence, Child abuse, Child, Adolescent, Family, Social support*

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Introduction

Violence, according to the World Health Organization (WHO), is defined as the intentional use of force or power, which can cause harm or risk of physical or psychological harm to a community, a group. or an individual[1]. Family neglect, one of several types of interpersonal violence, is more common among children and adolescents[2].

Child neglect is characterized by the failure to provide or carry out care provided to children and adolescents, which is related to failure to provide medical care, hygiene, and safe housing, as well as failure to guarantee protection against dangerous situations, such as coming in contact with people or environments that pose risks[3]. It is a type of violence with multiple factors, which are linked to individual characteristics and difficulties of the family; the sociocultural context in which the family finds itself; the lack of access to services and information that provide the means to provide adequate care for children; and the interaction of these factors, combining stressors in the family context with their capabilities and resources to respond to them[4].

In Brazil, this phenomenon is crossed by socioeconomic, structural, cultural, and especially gender and social class issues due to the fact that violence consists of a social, cyclical, and repetitive omission[5]. Such violence is linked to others, generally in a repetitive nature, and brings risks of health problems, including death[4]. The locus of these situations generally centers around the family as being responsible, and sometimes blamed, despite other elements[5]. Here, *family* is considered to be a flexible, complex, and non-isolated concept, giving space to multiplicity, which can include people with biological and blood ties, but also significant individuals with relationships of affection and care, such as people in the extended family, friends, and relatives involved in a child's "upbringing"[6].

In Brazil, the latest publication of the Atlas of Violence[7] shows that neglect affects around 52% of children aged 0 to 9 years. A significant increase was observed in reports of violence against this population, even before the COVID-19[8] pandemic. Global estimates of the incidence of neglect against children range from 20.6% to 29.4%, depending on the age group and the characteristics of neglect[3]. In national studies, this phenomenon is related to the element of gender, race, and economic condition, which is more present in male, brown, or black individuals, as well as in situations of poverty[9-11].

The context of interpersonal violence presents conditions and determinants involved in a multidimensionality of factors. However, the literature's views on negligence are still not very robust due to underreporting; therefore, this context requires an in-depth and contextualized analysis of the scenario of these phenomena, along with the actors directly involved in this process, from a perspective that seeks to contemplate all of these dimensions[2]. Meta-analysis brought an update of risk factors for child neglect. Most of the risks were related to the parental level, such as having a previous or current history of mental or physical illness; history of antisocial or criminal behavior, and experiences of violence in childhood. The study concluded that these parental factors are relevant in order to prevent and reduce neglect involving children and adolescents[3].

Considering the prevalence of neglect and the demand to consider it from new perspectives, American research estimated how protective factors can reduce neglect in situations of poverty. Participating mothers reported that perceived social support was associated with less physical neglect, in addition to moderating the association between poverty and physical neglect[12].

Therefore, considering the need to construct a multidimensional look at negligence and the continuing gaps, the following questions emerged: What personal ties are established by families involved in neglect against children and adolescents? What support network can they use to help care for their children? From the analysis of social networks, from which social support emerges, it is possible to take a look at the specificities of social relationships and, consequently, their effects on individual wellbeing and health[13]. It is understood that the personal social network can determine the points of anchorage and fragility that individuals have in their daily lives so that the occurrence of negligence can be revisited when we reveal the social scenarios in which they are inserted.

To answer the questions of this study, the Complexity Paradigm[14] is applied as a theoretical reference. This framework aims to understand the meaning of complex phenomena, characterized by instability, non-linearity, and the impossibility of being described in a finite number of steps and space of time. For the paradigm, phenomena, such as violence, do not have a single cause or consequence, but rather multidimensionalities that lead to their appearance. The different elements of this phenomenon remain in constant interaction, from which unknown properties may arise[14].

Therefore, the present study aimed to analyze the personal social network of families involved in neglect against children and adolescents.

Method

This study took a qualitative approach[15], anchored in the Complexity Paradigm[14]. The Consolidated Criteria for Reporting Qualitative Research (COREQ) instrument was used to guide the writing of the study.

This study was carried out in a municipality in the countryside of São Paulo, with an estimated population of 83,626 residents in 2020, with 19.7% of the population in the age range from zero to 18 years of age[16]. The specific location was a Guardianship Council (*Conselho Tutelar* – CT), which served an average of 9,461 people last year.

Data were collected in January 2021. The inclusion criteria were: being a family member of children and adolescents who were suspected or confirmed of a family negligence situation against them; a family being monitored in the CT; and being over 18 years of age. Families deprived of liberty and/or undergoing severe psychological distress were excluded.

Participants were nominated by the service based on the indicated inclusion criteria. All ethical aspects were preserved so that participants did not feel intimidated or accused of being negligent. It should be noted that at no point were participants who would be invited to participate in the research scored because they were suspected of neglecting children and adolescents, but the importance of giving them a voice to talk about what they considered caring or not caring for children and adolescents was highlighted. Subsequently, the responsible researcher first made contact via telephone, explaining the research objectives and, after obtaining the participant's consent, a face-to-face meeting was scheduled in a private room at the CT. In the face-to-face meeting, the informed consent form (ICF) was handed out, possible doubts the families had regarding the research were answered, and, after acceptance for participation, the interviews were conducted. Twenty family members were invited and all agreed to participate. After their consent, data collection began.

The data collection procedure used a sociodemographic characterization instrument, Minimum Maps of the Personal Social Network, and semi-structured interviews. This map[17] is represented by drawing a circle with four main quadrants, namely: family, friendships, school/work, and community relations (religion, sport, cinema, theater, clubs, squares, among others). In addition to these, another quadrant covered the relationship with health services. The quadrants are filled by two separate circles that indicated the intimacy of the relationships (the closer to the center, the more intimate), which were classified as intimate, social, or occasional. The ties, represented by specific colors or traits, were classified as significant, weakened, and broken or non-existent[17,18].

Concomitantly with the construction of the maps, semi-structured interviews[15] were conducted, guided by the following triggering questions: How do you perceive your support network? What more could be done to help your life and that of your family?

Data collection was organized and carried out by the first author of the study, a male nurse, Master's student at the time, supervised by his supervisor, the last author. The construction of the maps and interviews lasted an average of 40 minutes, with the maps drawn on A4 paper printed with their structure. The entire collection process was audio recorded using a cell phone application. To identify the maps and interviews, the letter P was used, initial for participant, and numbered in the sequence in which they were carried out.

Although data saturation[19] occurred in the 13th map and interview, based on elements that allowed for deeper answers to the study questions, we decided to continue the collection until the 20th participant. As the conversations were held in the CT itself, it was reinforced that it was a confidential approach, with a guarantee of non-identification and freedom to withdraw consent at any time, without compromising the monitoring carried out in the service.

To evaluate the maps, the recommended interpretation is based on the following criteria: size (number of institutional/personal ties established, with the network being classified as reduced, medium or expanded); density (quality of the ties observed in relation to the trace lines); distribution/composition (number of people or institutions located in each quadrant, where gaps and resources in the network are identified); dispersion (geographic distance between members and institutions); homogeneity or heterogeneity (characteristics of members and institutions in order to verify the diversity and similarities that make up the network)[17,18]. In addition to these characteristics, the functions of the network are

recognized: social companionship, emotional support, cognitive guidance and advice, regulation and social control, material help and services, and access to new contacts[18]. In this way, our study sought to highlight these characteristics and functions throughout the maps, as well as the presentation of statements that illustrated such findings, following a logic of inductive analysis[20], that is, based on the data, in conjunction with the Complexity Paradigm[14]. This description and analysis were carried out by the first two authors of the study and reviewed by the last author.

This study was approved by the Research Ethics Committee of the Federal University of São Carlos, logged under protocol no. 4.513.110 and Certificate of Presentation of Ethical Appreciation (CAAE) 39875420.8.0000.5504, and followed all the recommendations present in Resolutions 466/2012 and 510/2016 of the National Health Council.

Results

Twenty participants were interviewed, 18 women and two men, with an average age of 34.4 years. The youngest participant was 19 years old and the oldest participant was 48 years old. As for race, 17 declared themselves brown and three white. Half of these participants declared that they had not finished elementary school, four had completed elementary school, four had completed high school, and only one had graduated. Half of the participants had informal jobs, four were unemployed and six did not work. The profession of cleaning/daily laborer was recurrent in nine participants. Regarding religion, 15 reported being evangelical, four had no religion, and only one declared himself to be Catholic.

These interviewees were family members of children monitored by the CT, 18 were fathers/mothers, one was a brother, and one was an aunt. These families were reported and referred due to negligent situations, seven were reported through legal means (Public Prosecutor's Office), five via telephone (Crime Stoppers – *Disque Denúncia*), two through the city's schools, and one case through the Basic Health Unit (BHU). The other situations were notified directly to the CT through neighbors, family members, and third parties.

The family had between 2 and 11 people in the house, with an average of 3 people per household. The family configuration was multiple: in fifteen families there was the absence of the partner/father in daily interaction when caring for the children due to separation and/or a single mother, some declared the maternal grandparents present in the homes, others the presence of the child's aunt/uncles, and there was only one participant who stated that she lived only with her son.

The Minimum Maps of the participants' Personal Social Network showed reduced networks, as the number of established personal ties was low. Furthermore, they were outlined as homogeneous, denoting the minimal diversity of individuals and institutions. In addition to a few family members and friends, churches, and basic social protection services, such as the Social Reference Center (*Centro de Referência Social* – CRAS), predominantly appeared as institutions linked to the participants. The networks were not very dense, that is, with a large number of weakened, broken or non-existent links, revealing limited support for families. The distribution and makeup of the networks will be discussed in the presentation of each quadrant of the map, but gaps are highlighted in several sectors.

Network ties are dispersed and occasional, especially with institutions. Furthermore, the great geographic distance between the research participants and the services and sectors that make up the network of protection and guarantee of rights makes it impossible for the processes to be properly constructed. As an example, both the CT, the women's police station and the municipal police station are located far from the participants' neighborhoods. In Figure 1, four maps are presented that represent the networks of the participating families:

Participants expressed that the difficulty in establishing and strengthening ties was related to the lack of coordination between sectors, especially health, education, and CT, as explained in the following excerpt:

Oh, I... Nowadays the generation is more difficult, you know, more complicated, and my son, who is fifteen years old now, is a lot of work, hard work, you know, he was already hospitalized, you know, he was involved with drugs, you know, and he was always in the council, they never liked studying, it's a little difficult, you know, but I try to pass it on to them, right (P1, 41 years old).

For many participants, ties with family members were fragile and with social, non-intimate relationships, as identified in P4's map. There is an emphasis on significant ties with older children and with the mother (in this case, the

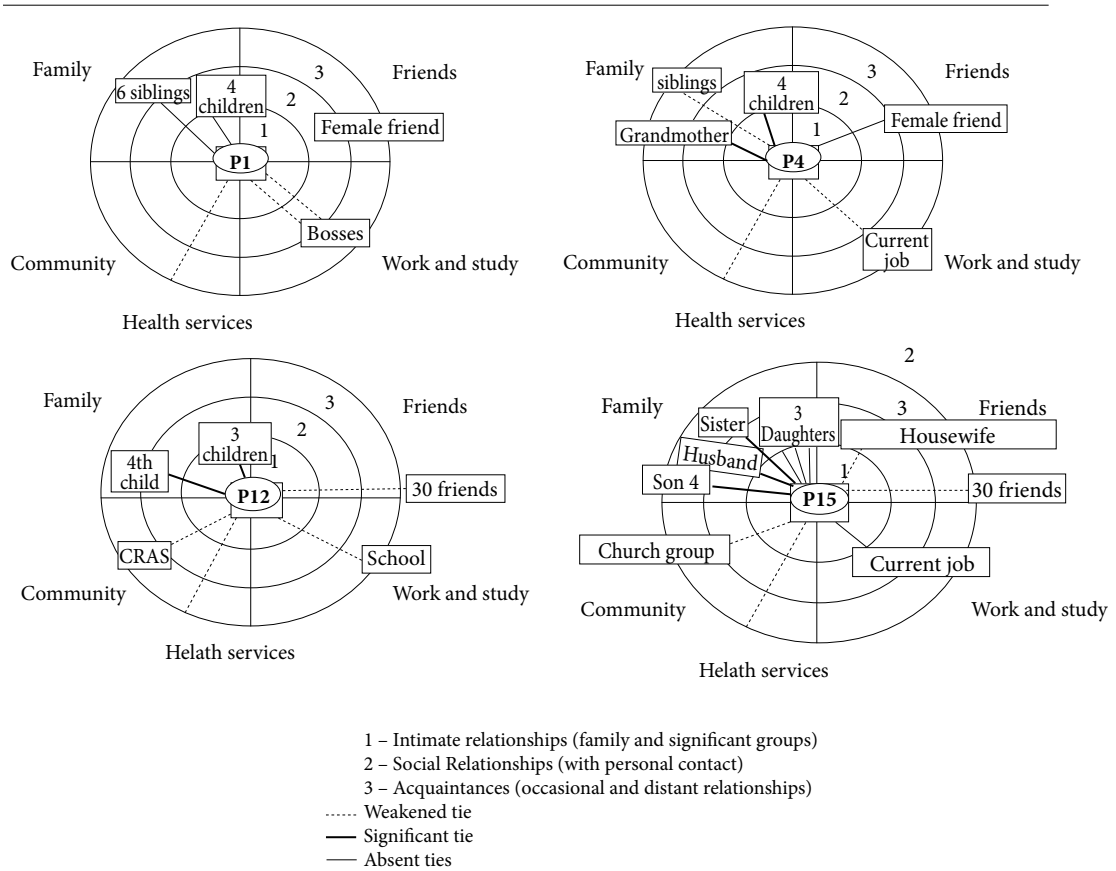

Figure 1. Minimal maps of the personal social network of participants 1, 4, 12, and 15.

Fonte: Autores.

grandmother of the children and adolescents, especially the mother). In the friendship relationships quadrant, it was evident that the number of friends is limited. In some situations, this network of friends and community was not supportive, but rather accusatory and in a police tone:

Ush... It's not just at home, there's a woman there who was my friend, she stays on the edge of the bar, the children are thrown into the street, the neighbor there these days grabs the child by the neck, I even started calling the CT [...] As they have already reported me for mistreatment, I also report them for mistreatment. And look, I didn't even treated them bad, hey, I didn't do it... (P10)

Regarding the work/study quadrant, participants demonstrated the absence of a formal registered employment relationship. Taking the P1 map as an example, there are two employment relationships not formally registered, as well as 70% of the research participants (n = 12). Work occupies an important field for the participants, since the absence of formal work relationships required the movement to seek more than an informal or seasonal insertion. There is predominantly more than one informal employment relationship per person, indicating the need for formalized relationships:

I already had a job before, which took up a lot of my time, you know, I go in in the morning and leave practically at night, I go in at nine in the morning and leave at eight-twenty at night, especially because I have one, that thing where I'm the breadwinnerand everything, so I have this responsibility, so I have, you know, it's this function, not this function, you know, I have this responsibility to assume, so I work for a long time, I try to do the best, it's obvious that there are times when we fail, right? There are times when we are tired, or stressed, you know? (P6, 33 years old).

In relation to the community/services, the experiences were related to the proximity of the church to family functioning, in a search for so-

cial company and emotional support, especially concerning the absence of other services in the network.

It's difficult, I'm trying to take him [son] to church, let's see what he wants, right, so where he worked with me, I always tell my husband that it's difficult for him to live there because of my daughters, you know, I have a ten year old daughter (P20, 26 years old)

Participants expressed the need to bring some services closer together, such as social and health care. In this sense, they explain both the absence of social companies and socio-emotional support, as well as the lack of support from the State in the face of their demands:

It's also the government's fault, the government doesn't help, the family is left unstructured, it's someone who is addicted to drugs, the father who doesn't provide food, the father who doesn't provide pension, the father who goes out with another woman, then the mother relapses. Also, they want to harm their children, they abandon their children, they go to a bar, they go down a wrong path, a drug path, and then it ends up like that, you know, this is negligence on the part of a father and a mother. Why leave a child lying around, then [...] The government had to pick it up, it had to help, and it also had to take control of it, right, because it's not just about letting go (P13, 44 years old).

Participants reported difficulties in accessing and continuing care in health services. They highlighted the precariousness of the approach to mental health, bringing the need for attention and care regarding the use of psychoactive substances and psychological suffering such as depressive disorders. Furthermore, due to their situations, actions are necessary to promote mental health:

Ah, I tell you no, because I've already hospitalized her four times, and each time I admit her, she comes back, but it gets worse and worse, you know, addictive stuff, you know, I give her a hard time, you know, because I lower my head and she wants to hit me, you know (P4, 39 years old).

I think there should be a vision for the mental health of the larger population, right, in every sense, it's just that not even in my case or in my mother's case, she ends up being negligent because she was abandoned when she was younger, she ended up getting involved in a relationship and then several factors came into play (P6, 33 years old).

Participants also demonstrated the need to strengthen ties. Among the concerns reported, the construction of a formal employment relationship emerged; returning to school to complete studies; closer ties with family members in occasional relationships; and the return of social activities, such as churches and CRAS.

Discussion

The maps and reports demonstrated diminished, homogeneous, less dense networks, with occasional and dispersed ties. The lack of articulation of services was highlighted, especially with difficulties in work, education, social welfare, and health care. In this sense, a lack of support emerges in the social, instrumental, and emotional spheres. Complexity brings the need for a perspective that considers the fabric of different elements for the emergence of a phenomenon[14]. In this study, it was revealed that all reported absences represented on social networks are linked to the emergence of family neglect against children and adolescents.

In this sense, the literature[21] proposes that the occurrence or not of neglect may be the result of the interaction of protective factors that the family has at its disposal, with its resources and capabilities for coping with adversities, as well as the stressors to which it is exposed. This aspect strongly dialogues with complexity, showing that the fabric of the neglect phenomenon is multidimensional[14]. Some stressors that appear in our study are reinforced in the scientific field, such as social vulnerability and the lack of State protection actions[21]; the geographic distance between the service and the place of residence; the weaknesses found in health services[22], and the weakened support network[23].

The results, illustrated in some sections, bring questions related to the lack of State support perceived by these families. In this regard, the present study shows that families in the Brazilian context tend to be held fully responsible for the care, or lack thereof, of their children, being blamed for their poverty and the survival strategies employed. It is understood that they are easy targets for reprisals, unlike society in general and public authorities[21]. These authors also pointed out the importance of not confusing negligence with the lack of material resources to provide the necessary care for children, as well as not failing to consider the negligence of the State when analyzing situations occurring within the family[21].

The absence of the State is also reflected in the difficulties encountered regarding the geographic distance between their residence and the location of the services offered, as well as the fragility of the care network for these families. Complexity seeks to reconnect the individual/species/societal dimensions of human survival, substantiating the so-called ethics of solidarity. In this sense, it brings the principle of autonomy-dependence[14], that is, it is understood that it is impossible for families to be fully responsible for the reality experienced – in this case, the situation of negligence. An example of this is discussed in the literature[22], when authors highlight that comprehensive care for children may not be available to all populations. According to these authors, geographic distance can result in decisions made by the family, for example, not to take the child to school due to the distance, as well as other unintentional situations related to difficulties in transporting to the location in question[22]. In other words, it is possible that geographic distance means, for families, a greater probability of breaking ties with the institutions in the network[22]. In this sense, it is necessary to coordinate services to guarantee comprehensive care and continuity of care for these families, including mobility services that promote the movement of families to the place of care, and for services to be decentralized and territorialized[24].

Regarding the weaknesses of the care network, in the literature, it is possible to find data that emphasize the lack of trust in professionals and health services that care for children, especially those with chronic conditions; difficulties in scheduling appointments; difficulties in accessing appropriate services and resolving health and illness situations; disjointed actions of health care services; and the lack of training, agility, and humanization in care[22,24]. These findings are similar to the results discussed here, since the participants in this study, in their statements, highlighted the difficulties encountered in accessing services and resolving health issues, especially mental health and substance abuse among their children.

Primary Health Care (PHC) plays a key role in the organization of healthcare networks and can strongly contribute to the construction of interprofessional and intersectoral care for these children, adolescents, and their families. The family is the focus of PHC, seeking to overcome the individual-centered biomedical model[25]. However, the existence of a health service does not necessarily imply access to it, as it is influenced by different factors, including geographic and financial[26]. Care networks imply social relationships and are therefore dynamic, aiming to guarantee access to health services[13]. Complex thinking thus proposes this paradigmatic change, from unidisciplinary to interdisciplinary and intersectoral[14] for care aimed at populations, in dialogue with the proposal of Health Care Networks present in Brazilian health policies but still distant from practices.

The data analyzed in this study also highlight the difficulties to access work, education, and income for this population. The literature corroborates these findings, showing that the main vulnerabilities of families caring for children were related to the lack of access to work and income. This aspect can result in poverty and the precariousness of the family's material resources to provide child care[21]. Another study estimated protective factors to diminish neglect in situations of poverty. The results showed that having part-time or full-time formal jobs were associated with lower occurrences of physical negligence[12].

Furthermore, socioeconomic conditions aggravate family conflicts and determine situations of violence. Some families in situations of poverty are often forced to bring their children to the job market early, removing them from the family and school environment, in turn weakening ties. Furthermore, this need for early entry into work activities can generate long-term consequences, such as dropping out of school[27].

The racial issue of the participants also stood out in the findings, with the majority being of a brown skin color. This determinant was seen in other national quantitative articles, in the states of Maranhão and Espírito Santo, as well as in a study that evaluated reports of violence against adolescents[9-11]. These studies highlighted that the black/brown race/color stratification involves greater exposure to violence and social inequalities, when compared to whites[9-11]. This evidence points to the need for a unique look at the intersectionality of race in understanding and practicing violence.

Another element found among the participants refers to stressors that have occurred throughout their lives and the repercussions on their mental health. One study[28], which analyzed the results of adverse childhood experiences in adulthood, described the appearance of anxious and depressive symptoms in adulthood. The same authors propose that access to mental health services and the perception of a strengthened support network can function as protective

factors against these symptoms[28], which are also related to the reproduction of the cycle of violence. Attention is drawn, therefore, to the importance of access to mental health services not only for children and adolescents, but also for their families, as well as the need to strengthen their support networks.

In addition, religiosity appears in the participants' reports, and here it is important to highlight that this aspect is already discussed in the literature as an important factor in coping with adversities and an increasing quality of life[29]. However, religion can also have negative aspects related to practices based on traditionalist beliefs that tend to reduce engagement in activities and treatments proposed by the institutions where people receive care, especially related to mental health issues[30]. One national integrative review, which aimed to describe scientific studies published in Brazil, demonstrated that national production on the subject is still lacking and is in the process of proving itself as an important research theme, especially as regards correlations between religiosity and violence[30].

Complex thinking explains that an object of study, here described as families in a context of neglect, is never isolated from its context[10]. This statement is in line with the discussion proposed here that what can be called negligence is often related to the context in which the family lives, and depends on the multiple interactions of the elements that can protect, such as one of the facets of the religious aspects mentioned above, or pose risks to the family, such as social vulnerability, the absence of a support network and support from the State, and the geographic distance from the services necessary for comprehensive care. In other words, the family context can influence behaviors that can be judged as negligent, but the behavior itself is not isolated and must be analyzed based on the various vulnerabilities to which the family is exposed.

Finally, our study highlights the relevance of this theme in the practices of healthcare professionals. One study showed that situations of violence require qualified and empathetic listening, promoting comprehensive care and involving the family. This demand requires a look at the family context and its risk and protective factors, in addition to extramural intersectoral actions, such as preventing situations of violence with educational actions, especially in schools, and the interaction with the protection network to resolve cases[31]. The very use of resources, such as the map of personal social networks, allows for an expanded view, understanding, and action, focused on the person and from a multidimensional perspective. In this aspect, complex thinking is once again called for, which proposes the integration of knowledge from various disciplines in order to understand and care for a given phenomenon[10].

This study does have limitations, especially related to the location. Due to the implication of CT, families could have given other answers if the research had been carried out in another environment, despite the ethical care taken. Furthermore, this study did not delve into the particularities of the participants, especially since most of them were single or divorced women.

Conclusion

The personal social networks of families involved in neglect against children and adolescents were diminished, with little to no coordination between the different services and sectors, which were predominantly homogeneous. Because they have many weakened ties, they are relatively unsupportive, pointing out difficulties in accessing work, education, and health. The complexity of the phenomenon of negligence is glimpsed, in which the elements condition and perpetuate experiences of absences and fragility, leading to the emergence of this phenomenon. Interprofessional and intersectoral perspectives and actions are requested and recommended.

Our study also brings contributions to collective health, namely the incorporation of instruments that allow us to approach the social support network of children, adolescents, and families involved in neglect so as to understand the complexity of their experiences and search for weaknesses or potential; the design of singular and continuous care, seeking to break situations of vulnerability; and the construction of a priori interprofessional and intersectoral care that strengthens links in the different services of the social protection network. It is a fact that PHC, as it is more directly present in the care and territory of this population, has in its hands the necessary technologies to promote a future life free from neglect and a precursor to healthy relationships. In the research area, this study recommends new approaches that revisit and reconsider the meanings of violence, especially family neglect, from the perspective of families, education, health, and social protection professionals.

Collaborations

FHO Sabino, MA Soares and DM Carlos: conception and design or data analysis and interpretation; write-up of the article or relevant critical review of the intellectual content; final approval of the version to be published; responsibility for all aspects of the text in ensuring the accuracy and integrity of any part of the work. API Pacheco, NVC Martinez, MR Françoloso: write-up of the article or relevant critical review of the intellectual content; final approval of the version to be published; responsibility for all aspects of the text in ensuring the accuracy and integrity of any part of the work.

Funding

Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES) – 001.

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Article submitted 05/05/2023
Approved 01/02/2024
Final version submitted 26/02/2024

Chief editors: Maria Cecília de Souza Minayo, Romeu Gomes, Antônio Augusto Moura da Silva