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DOCENCIA - INVESTIGACIÓN

When the communication is harmful in the encounter between health professional and family of hospitalized child

Quando a comunicação é nociva no encontro entre profissional e família da criança hospitalizada

Cuando la comunicación es nociva en el encuentro entre profesional y familia del niño hospitalizado

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Palavras-chave: Comunicação; Enfermagem; Relações profissional-família; Saúde da família

Palabras Clave: Comunicación; Enfermería; Relaciones Profesional-Familia; Salud de la Familia.

ABSTRACT

Introduction: Identify harmful effects of communication between health professionals and families of hospitalized children.

Methods: Descriptive exploratory research. Data were collected during sessions of a Support Group to Parents and Family (SGPF) through recording on digital media, and analyzed using a procedure known as "boxes" which began of pre-defined categories, in this case, typical forms of communication and the elements that characterize them. It had been part of group sessions individuals who agreed to be part of the study, signing the Informed Consent Form and who met the following inclusion criteria: age of 18 years old or over and belong to a family of a hospitalized child in Pediatric Inpatient Unit investigated in the period of data collection.

Results: The analysis of the material resulted in the proposition of categories: "Meeting in an impersonal way and purely technical", "Orders and moral lessons" and "Contradictory Messages".

Conclusions: Fear, uncertainty, stress and anxiety, identified in the speeches of the group participants, indicate harmful effects with respect to the use or non-use, communication, and suggest that the behavior of some professionals is grounded in the biomedical model of health care assistance.

RESUMO

Introdução: Identificar os efeitos nocivos da comunicação entre profissionais de saúde e famílias de crianças hospitalizadas.

Metodologia: Pesquisa descritiva exploratória. Os dados foram coletados durante as sessões de um Grupo de Apoio para Pais e Família (GRAPF) por meio de gravação em mídia digital, e analisados por meio de um processo conhecido como "caixas" em que se parte de categorias pré-definidas, no caso, formas típicas de comunicação e os elementos que as caracterizam. Participaram das sessões do grupo indivíduos que concordaram em participar do estudo, assinando o Termo de Consentimento Livre e que preencheram os seguintes critérios de inclusão: idade de 18 anos ou mais e pertencer a uma família de uma criança hospitalizada na Unidade de Internação Pediátrica investigada no período de coleta de dados.
Resultados: A análise do material resultou na proposição das categorias: “Atender de modo impessoal e puramente técnico”, “Ordens e lições de moral” e “Mensagens contraditórias”.

Conclusões: Medo, incertezas, estresse e ansiedade, identificados nas falas dos participantes do grupo, indicam efeitos nocivos em relação ao uso, ou não uso, da comunicação, e sugerem que o comportamento de alguns profissionais está alicerçado no modelo biomédico assistencial de atenção à saúde.

RESUMEN

Introducción: Identificar los efectos dañinos de la comunicación entre los profesionales de la salud y las familias de los niños hospitalizados.

Métodos: Estudio exploratorio descriptivo. Los datos fueron recolectados durante las sesiones de un Grupo de Apoyo para Padres y Familia (GRAPF) por grabación digital, y se analizaron a través de un proceso conocido como "cajas" en que se parte de categorías pre-definidas, en el caso, formas típicas de comunicación y los elementos que los caracterizan. Participaron en las sesiones de grupo individuos que aceptaron participar en el estudio mediante la firma del consentimiento informado y que cumplían los siguientes criterios de inclusión: edad mayor de 18 años y pertenecer a una familia de un niño hospitalizado en la Unidad de Hospitalización Pediátrica investigado en período de recolecta de datos.

Resultados: El análisis de los datos dio lugar a la propuesta de las categorías: "Atender de modo impersonal y puramente técnico", "Órdenes y lecciones morales " y "Mensajes contradictorios".

Conclusiones: El miedo, la incertidumbre, el estrés y la ansiedad, identificados en las declaraciones de los participantes del grupo, indican efectos perjudiciales con respecto al uso o no uso de la comunicación, y sugieren que el comportamiento de algunos profesionales se basa en el modelo biomédico de atención de salud.

INTRODUCTION

Communication is a resource that enables, professionals, to establish interpersonal relationships with individuals, helping them in their recovery and overcoming trauma situations. Thus, through it, conditions are created for the nursing team be able to make effective changes, in an attempt to improve the situation experienced by their customers[(1)].

However, not always the communication is used in a way that favors building a positive relationship between health professionals and family. Furthermore, in relation to nursing care in pediatrics, researches show that the health team usually does not consider the family in its work plan, getting their actions directed, exclusively, to child's

illness[2-3]. Thus, the family and the child are not assisted on their needs and not perceived as a whole, going, virtually, unnoticed the emotional aspects, the insecurities, the doubts of children and their families.

This situation indicates losses in communication/interaction between families and health professionals, since they still focus their attention on technical care, with little or none concern with a family[3].

However, from the perspective of humanized care, the dialogue is indispensable tool in building the relationship between the health care team and a family. The lack of communication, respect, empathy, attention and generosity, impairs communication/interaction and contributes to an impersonal and inhuman assistance[4-5].

Studies with families are essential to produce evidence that, somehow, allow changes in the way to meet their needs and improve the quality of care[3,6]. Knowing the needs to better understand the issues that are limiting an effective and affected communication towards the family of the hospitalized child, from the state of the art about the topic, was what we set out to develop this research, aimed at identifying harmful effects of communication between health professionals and families in the process of experiencing the situation of having a hospitalized child.

METHODOLOGY

Descriptive research based on data produced during sessions of a Support Group to Parents and Family (SGPF); of the type open, namely, allowed the entry of new members in all meetings and participate in a session did not imply an obligation to attend other sessions; homogeneous in relation to its participants, since all the people invited to this activity had in common the experience of having a child of the family hospitalized in Pediatric Inpatient Unit/PIU, and with the aim at providing support, user embracement and information to families of hospitalized children.

The SGPF was coordinated by two nurses and, in its organization, supervised and conduct by a nurse specialist in Group Dynamics and another with experience in caring for family members of people admitted to the Intensive Care Unit.

The research was conducted in a PIU in a Hospital School located in Goiania - Goias, Brazil, in the period from February to July, 2010. The PIU in question has two blocks of admissions: the Pediatric Clinic (PC) and the Neonatal Intensive Care Unit (NICU). The PC has 20 beds with an average daily occupancy of twelve beds. The NICU has 10 beds for the care of newborns in intensive care (NB) and, almost always, has full occupancy of beds.

It had been part of group sessions individuals who agreed to be part of the study, signing the Informed Consent Form and who met the following inclusion criteria: age of 18 years old or over and belong to a family of a hospitalized child in PIU investigated in the period of data collection.

There were analyzed in this study twelve group sessions, which were recorded on digital media and later transcribed by the group coordinator and, to ensure the confidentiality of identity and avoid exposure and embarrassment of the subjects, in the presentation of results, the relatives were identified by the letter F followed by a

number (1 to 34 - total family members who participated in the study) and the letter G followed by the number of the encounter that this relative was present.

Data were analyzed using the thematic analysis of Bardin[7], specifically, the procedure for distribution of content by "boxes". This process requires the analysis to be made from pre-defined categories, which in this case were the typical forms of communication[8] and the elements that characterize them. The detailed analytical procedure was carried out beginning with the transcription of the recordings of the group sessions, followed by pre-analysis, then in-depth analyses by carefully reading and understanding, in order to identify the elements that characterize the typical forms of communication.

This study was designed and developed, following the recommendations of the Ministerial Order 196/96 of the National Health Council and approved by a Human and Animal Research Ethics Committee, located in Goiania - Goias, Brazil (protocol 153/2009).

RESULTS AND DISCUSSION

In total, 34 relatives participated in the sessions SGPF. The number of people in each session ranged from three to seven, with an average of 4.7 per meeting. Participants were primarily mothers (23, 67.6%), uncles (5, 14.7%), grandparents (4, 11.8%) and fathers (2, 5.9%) of hospitalized children.

The material analysis resulted in the proposition of the categories: "Providing care in an impersonal and purely technical way", "Orders and moral lessons" and "Contradictory Messages", which helped to understand the repercussions caused by improper posture and conduct of health professionals during the experiences lived by a family during the child's hospitalization.

It is important to emphasize that communication is a creative act, there is not only one agent sender or receiver, but an exchange between individuals that constitute a system of interaction and reaction, namely, a reciprocal process that promotes changes in the way of feeling, thinking and acting of the persons involved[1]. It is an indispensable resource for establishing nursing care[3,9-10].

Thus, some forms of communication have harmful results, causing undesirable side effects[8], which helps to accentuate the suffering of families that live with a hospitalized child, as will be presented in the following categories.

Providing care in an Impersonal and Purely Technical way

The construction of a cordial relationship between the health team, the family and the child, is extremely important to the well being of the family[1,11]. The cold, impersonal and purely technical conduct, in the service, contradicts any assumption of a humane and therapeutic assistance. When the health professional does not interact/establishes communication with the person whom the professional is listening to, viewing one as an object, the beneficial action of this relationship becomes extremely limited[8].

Therefore, therapeutic communication, namely, one that does not prejudice, that does not cause damage, is essential in the professional/family encounter[8], since these clients have difficulty in dealing with suffering and need guidance about the state of

health of child and support[12-14].

When professionals assume vertical posture, in relation to the demands of the family, without much effort to interact and establish effectively communication, they feel ignored and marginalized because, besides feeling powerless against the child's illness, they do not even know the actual clinical condition of the child[11]:

> *[...] They had [health professionals] a little meeting, in the room, then talked, talked, talked and talked and walked away! And then, I got lost! Because he asked nothing, said nothing (F25G10).*

> *[...] spoke thus: "Doctor, I wanted," she did not let me finish speaking, "no, we just say something about newborns in the late afternoon." If you do not reach them and talk like "Doctor, is he okay?" They do not say anything (F7G1).*

> *For me, the most difficult is when they [health professionals] know something and do not comment, do not tell us! [...] The results of the tests, they did not tell me! Then I'm like, "is it something serious?". They know and do not tell us. So, we get anxious, not knowing what it's going on. I would prefer that, they change it, you know (F9G12).*

The statements show that, in general, the action of ignoring the right of the family to be heard and to receive information related to the diagnosis, clinical features and evolution of child, compromises the physical and mental well-being of the family, increase their anxiety and stress, and results in losses in communication/interaction between professional/client.

Reports of the families indicate that the posture assumed, by health professionals, not only compromises the communication but also the humanization of the care. Therapeutic interventions in health depend on the professional interest of involving and believing that his presence is as important as the technical procedures that he or she performs[1].

Studies[3,5,8] indicate that the harmful communication between the health team and the family makes them feel unimportant, corroborating to the emergence of conflicts and tensions that result in psychic suffering.

This behavior also contributes to the blocking of communication channels. In this scenario the family feel constrained uncomfortable and without freedom to express the most significant experiences. This situation weakens significantly the quality of care[8]:

> *[...] because if I will talk to them [health professionals], and they I don't know what. [...]It is bad even for my baby. [...] I'm terrified (G1F12).*

> *[...] I do not complain of what I see, because I'm scared, because I'm not here all day. I'm afraid the person [health professionals] retaliating my son. Doing something to my son after I leave here (G2F7).*

We realized that to meet the family, in a impersonal and purely technical way, the health professionals trigger experiences and destabilizing experiences, intensifying the suffering of the family in the event of having/living with a hospitalized child. This posture makes the family fantasize negative situations and, even, be afraid of health

professionals.

Recent studies[11,15] also point out that the lack of approximation between professional and family makes that they, many times, even experiencing moments of dissatisfaction, subject to conditions imposed by the health team, because of their fears of reprisals for the child.

It is essential to humanize the care to children and their families, but, for this, it is necessary to go beyond the performance of technical procedures and the offer of advanced technologies. Humanization, in view of the family, is a complex set of attitudes motivated by an ethical, humanitarian, social and holistic thinking[16].

In the context of humanization of the care, it is a choice of the health professional, whether be responsible to provide emotional support to the family for them to find the strength to overcome the situation of having and living with a hospitalized child. So one must compromise to provide a moment of one's day to listen to the complaints and difficulties of the family, and meet the need for information, emotional support and training for child care[4,17].

Orders and Moral Lessons

Moral lessons consist of making moral judgments or judgments regarding customer behaviors that clash with the values or way of thinking of the health professional. Commonly, the messages are conveyed with tone of criticism, disapproval or irony[8]:

> *[...] when I came to pump out the milk, there was a day that I got so upset that it barely skirt. The nurse came in and said: "Mom, are you not ashamed of pumping out just this little bit of milk, don't you?" Like this. Then I felt that bad thing. [...] So, from that day to now, I couldn't be cheerful to pump out milk. (F7G1).*

> *I told her I had faith, so, that the baby would come out from there. But, she [health professional] said that [starts crying]. [...] I had to think about the other possibility, which was for me not to have faith. That day I responded poorly to her. I left there crying. Then, I went and told her get away from me, that she was disturbing me, that besides not helping me, she was stressing me. Then, that day was gone for me (F12G4).*

The statements show how much suffering is, for the family, be criticized or be called attention improperly or, even, unfairly. The exemplified situations of the statements of the health team, instead of helping to reduce stress, anxiety and suffering of the family, produce harmful effects, becoming one of the main sources of promoting destabilizing experiences. The health team should support and contribute to reduce the suffering of these people, through attitudes that demonstrate attention and take responsibility for what they communicate to people[4,18].

A research conducted with families of hospitalized children in Pediatric Intensive Care Unit[15], showed that the families have their conditions of vulnerability intensified, since the interactions are, in most cases, negative, due to the hostile environment caused by the real and imagined threats, of health professionals who have the power upon the child and the rupture that the family suffers in its structure.
When working with families of hospitalized children to make judgments or give values, is a form of harmful communication since, commonly, this posture causes reactions of

irritation and anger, and can cause blockages, resistance and compromise significantly the health of the family[8].

The vulnerability of the family is manifested by the divergences between family and health team, caused by the distance between these people. Health professionals remain distant from the family, treating them in a strictly professional way, relating only during visits and providing information that, not always, really answers the doubts of the family[15].

We note that an environment of family embracement and the availability to provide information and establish effective communication provide a pillar that sustain a good professional/client interaction, and promote a positive emotional climate in the realization of nursing care.

A study carried out to identify if nurses were aware of the harmful effects of nonverbal communication in contact with patients and families, showed that professionals perceive and acknowledge their inadequacies[19]. So, the problem is, to recognize and polish their knowledge about the importance of a therapeutic relationship and put it into practice.

In this scenario is important to emphasize that health professionals should not only be a performer of technical care, but to understand the importance of their role as facilitators of the hospitalization experience, both for the child as for his or her family[4].

Contradictory messages

By contradictory message we understand the simultaneous presence of discrepant information. It is harmful because it causes confusion, difficulty of discrimination, besides doubt and anxiety[8].

Research conducted with terminal patients indicates that effective communication between health professionals/patient/family, favors planning of care and improves the quality of care for these people, however, misinformation can compromise the satisfaction with the care received and the preparation for the end of life[20].

In the reports it is possible to identify contradictory messages, as the information comes to the family in a distorted manner, corroborating to their suffering and anxiety:

Commonly, in health institutions, the dilution of responsibilities, the lack of rapport between team members and the lack of effective leadership, that coordinates and integrates these professionals, increase expressively the incidence of contradictory messages between professional/professional and professional/client, corroborating to situations of confusion and insecurity[8].

A study conducted with parents of children with chronic illness[12], showed that ineffective communication can also compromise the health of the child, since, in many cases, the family reproduces only the information received from professionals without, really, understanding them. Thus, their knowledge about the disease and treatment is not enough, what can trigger obstacles for the family to feel able to care for the child.

Yet, the children stand out, as a positive aspect of the way professional nurses treat their parents and the relationship achieved between them. They consider the

relationship of sympathy, or antipathy, perceived in certain situations. The concept that children have the quality of nursing care is conditioned to the relation of the people of this team with their parents or significant adults[21].

Another aspect that should be considered, by the health team, is the co-participation of the child in the care process, as a recent study[21] showed that, at times, professionals are directed only to mothers forgetting that children also understand what is said. Thus, it is important to accentuate that established communication with the children has an essential role in mediating their experiences and ideas that elaborate on the health/disease process. In this sense, it is also important that the child is respected as an individual and as part of the professional and family interaction.

From this perspective, it is evident that the action of informing should be part of the daily practice of nursing professional allowing the family and the child feel cared and, to reduce the anxiety standard of these people[3,12], providing quality care, minimizing the chances of harmful actions related to communication/interaction between family, child and health team.

Ignoring the Client Problem

When fleeing away and avoiding the problem of the hospitalized child family, the professional signals difficulty of defining his ability to work and the fear of not being able to help the client. In these situations, commonly, the family feels no freedom to express what is the most relevant. Therefore, this form of communication has as result the difficulty of bonding among professional/family[8]:

> *[...] I needed someone to talk, to understand me, to give me some advice. To help me (G6F1).*
>
> *[...] only until then nobody ever sat down to talk to me (F25G10).*

It is important to emphasize that the family suffer when the health professional assumes a rigid, inflexible posture, with little or none demonstration of compassion and respect for their pain[3].

For parents, the hospital environment is a place frighteningly unknown and they feel insecure to expose their doubts, fears and, also, feel excluded from conversations held by health professionals in relation to child health, as these, commonly, use a language that is not understood by the family[13]. Developing communication skills is fundamental to health professionals, since they must know the meaning of the messages sent by the patient to, then, develop a care plan appropriate to meet the real demands of their clients[1,22], favoring the humanization of care[23].

Considering that the family live destabilizing experiences that put them in a situation of constant psychological distress[24], health professionals should reflect about their practices and reorganize their work processes aiming at team work, where actions are interdependent and complementary[2,6,25], focusing humanized care to binomial child-family.

The family feel embraced when perceive that, besides the care given to the child, the professional also demonstrates attention to the family, establishing a relationship of exchange, support and respect[3,26].

So is impossible, to health professionals, take any action in assisting the human being without resorting to interpersonal and communication skills and, it is not enough for the professional to use only verbal communication, he or she must be attentive to nonverbal signals emitted during the interaction with the patient[19].

It is essential, in the care process, to understand the other as holistic human being. In this regard, it is noted that health professionals should turn to the things themselves, for their experiences lived by the family, because that attitude will unveil the world and corroborate to the construction of care practices based on respect, attention and solicitude[8].

Thus, to achieve a truly humanized assistance to binomial child-family, it is needed to invest in changes in professional education, providing to the student the opportunity to focus his attention in these clients and the way to manage the PIU, in order to move the assistance guided on the biomedical model, for assistance grounded in relationships and human potential[27].

CONCLUSION

The results of this research indicate that communication can be a therapeutic or harmful resource in the context of health care. Thus, it can be used to benefit the family of the hospitalized child and help them in the living/overcoming of difficult times or it can compromise further their physical and mental health, providing traumatic and destabilizing moments.

In the reports of the participants of the SGPF it was possible to identify several needs presented by the family, such as receiving information about diagnosis and clinical status of the child, maintain dialogue/interact with the health team and receive attention and respect.

Fear, uncertainty, stress and anxiety, identified in the speeches of the group participants indicate harmful effects with respect to the use, or non-use, of communication and suggest that the behavior of some of the professionals of the researched PIU is still rooted in the biomedical model of health care, in which enhances the biological treatment, the cure. This position contributes to that it cannot be offered care centered in the child and in his family and to a fragmented assistance, reflecting insecurity and dissatisfaction among relatives.

It called out our attention the choice made, by health professionals, to be absent towards the needs of family, namely, not attend/care/listen/communicate/share. We emphasize that, for us, choose to “not do" is also an action that, by the way, compromise much of the physical and mental health of the family. This behavior leads us to a dehumanized care, the commodification and objectification of the family and its demands.

However it is worth considering that most health professionals do not receive academic training directed to work with families and situations that require interpersonal skills. In this sense it is important that undergraduate programs, in the health field, include the study of family care in their curriculum, providing opportunities for undergraduates to work with these clients, in order to understand the complexity and the need to include it in their care plans.

We believe that the results of this research can contribute to highlight to health professionals the importance of value the family in the hospital environment and make communication a therapeutic strategy to assist the child and his or her family, encouraging the processes of confrontation and overcoming the situation of having and living together with a hospitalized child.

This attitude can help professionals understand the context in which the disease occurred and the mechanisms of each person for facing it. Additionally, it enters the family life and looks through the eyes of those who live the experience, not only as a spectator, it allows the professional to understand the true impact of the disease on the family dynamics and it raises awareness of the value of human experience and compassion for the pain of the other.

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