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REVISION ARTICLE

NATURE AND SOURCE OF CONFLICTS OF RELATIONSHIPS IN THE CONTEXT OF PEDIATRIC ONCOLOGY: AN INTEGRATIVE LITERATURE REVIEW

Fernanda Ribeiro Baptista Marques*
Marisol de Cassia Vidal Ferreira**
Adriana Maria Duarte***
Maria Magda Ferreira Gomes Balieiro****
Myriam Aparecida Mandetta*****

ABSTRACT
To identify the conflicts of relationships in the pediatric oncology context regarding its nature and source. Integrative literature review, in National Center for Biotechnology Information (PubMed), Cummulative Index to Nursing and Allied Health Literature (CINAHL), Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS) and Scientific Electronic Library Online (SciELO), in the last ten years, in English, Spanish and Portuguese. A Qualitative Content Analysis conducted data analysis. Seven types of conflicts were identified and three themes of sources of conflicts emerged: the professionals' difficulty in the involvement with the families and children; negative repercussions of hospitalization on the family functioning; lack of institutional politics of support to the families, professionals and children. The natures of conflict evidenced in this literature review were within the family and between staff and families. The sources of conflict were communication barriers and changes in family functioning. This synthesis can help health professionals to identify conflicts in practice.

Keywords: Pediatrics. Oncology. Conflicts. Patient care Team.

INTRODUCTION

When a family receives the news about cancer in one of its members, a change in its familiar functioning to meet the new demands of care occurs. As cancer is a disease associated with death, the family of a child expresses intensely its suffering. In this context, the family and the child are exposed to environments, physical and emotional stressful situations varying according to the organizational processes and the impact of the news at home[1].

To be adapted to this new way of "being a family", experiencing a disease that is currently considered a chronic disease, with prolonged and treatment evolution, it is necessary to reorganize the family, adapting routines and living with a new reality. This requires a family coping movement to overcome physical, emotional and relationship barriers, which sometimes are causes of conflict[2].

There is a movement of distance when the health care professional team are not prepared or encouraged to become involved and take care of families. This distance prejudice communication with the family and contribute to the intensification of vulnerability feeling[3].

Conflicts are natural and inherent in human beings, and they are classified as *functional* when promoting new ideas, positive and constructive changes - or *disfunctional*- when generating violence or is faced as an escape, removal and weakening by those who perceive it. This classification depends on how each person understands, manages and resolves it. Conflicts should be neither avoided nor eliminated, but managed effectively. There is no way to establish protocols for conflict resolution,

*Nurse. Post-graduate student. Escola Paulista de Enfermagem, Universidade Federal de São Paulo (UNIFESP). São Paulo (SP) Brazil. E-mail: fer.rbmarques@gmail.com
**Nurse, Hospital of the UNIFESP. São Paulo (SP) Brazil. E-mail: marisolvidalferreira@gmail.com
***Nurse. Post-graduate student. Escola Paulista de Enfermagem, UNIFESP. São Paulo (SP) Brazil. E-mail: adriana@mdlink.com.br
****Professor. Escola Paulista de Enfermagem, UNIFESP. São Paulo (SP) Brazil. E-mail: mmfgbalieiro#@unifesp.br
*****Professor. Escola Paulista de Enfermagem. UNIFESP. São Paulo (SP) Brazil. E-mail: mpettengill@unifesp.br

but there are mechanisms and tools that can be used to develop skills for mediation. Thus, it is necessary to understand the nature and sources of conflicts to detect how changes need to take place and what is needed in order to develop a consensus between the parties[4].

There are relational conflicts needing to be managed in daily pediatric oncology. However, it is necessary to know the magnitude of the problem in order to answer the central guiding question of the study: *what are the nature and sources of conflicts in pediatric oncology?* Thus, the aim of this study was to identify the relational conflicts in the pediatric oncology, as its nature and source.

METHOD

It was an integrative literature review. This method was used because it allows a more comprehensive understanding of a particular phenomenon or health problem, based on literature data. It supports decision-making in clinical practice and identifies gaps of knowledge to new researches[5].

The databases used for articles selection were: PubMed (National Center for Biotechnology Information), CINAHL (Cumulative Index to Nursing and Allied Health Literature) and LILACS (Literatura Latino-Americana e do Caribe em Ciências da Saúde); and SciELO (Scientific Electronic Library Online).

The key words used in PubMed and CINAHL were conflict, family, pediatrics, family conflict, medical oncology, patient care team, interpersonal relations; and for LILACS and SciELO the same words in Portuguese were used.

The research was conducted between February and March 2014. Inclusion criteria were: Portuguese, English and Spanish language publications addressing relational conflicts in pediatric oncology throughout treatment, with abstracts and text available in the selected bases, published between 2002 and 2013. Exclusion criteria were: theses and dissertations, book chapters and articles that addressed the conflicts in general contexts and adult cancer, review articles and articles related to the late effects of treatment.

After reading the titles there were 145 publications identified on the subject, 37 were repeated in different databases and in the descriptors associations. After reading the abstracts and full articles, 67 were excluded for not meeting the inclusion criteria. Thus, the sample consisted of 41 scientific articles.

For extracting data we used[6], an adapted instrument containing information about the author's identity, place of publication, purpose, method, results, conclusion and level of evidence. An electronic spreadsheet program (Microsoft® Office Excel® 2007) was used to organize and store data.

The identification of the nature of conflict was based on a previous study in which the conflicts detected were classified in three types: conflicts between professional and family, family conflicts, professional conflicts[7].

To identify the sources of conflicts a Qualitative Content Analysis was used[8]. At first, the results of each publication were read in full and codes representing the sources of conflict were extracted.

Each code was reviewed and grouped subsequently into subcategories and these into categories and themes as the meaning, the similarities and differences. Ethical principles were observed, respecting the copyright of the authors.

RESULT

From the analysis of 41 articles, the period of publication was distributed from 2002 to 2013, seven articles (17.16%) were from 2002 to 2004; 11 (26.8%) from 2005 to 2008; and 23 (56.1%) published between 2009 and 2013.

Most of studies, 32 (78.1%) were in English; 15 (36.6%) were conducted in the United States of America, six in Sweden (14.6%), three in Canada (7.3%), two in England (4.9%) and 6 in other countries (14.6)%, such as Australia, France, Holland, Japan, Italy and Trinidad and Tobago. Eight articles (19.5%) were in Portuguese, performed in Brazil and one (2.4%) in Spanish, in Spain.

The areas with the highest number of publications were nursing with 22 articles (53.8%), Medicine with nine (21.9%), Psychology with four (9.8%), Communication

with one (2.4%), social service with one (2, 4%). There were also together two publications in Medicine and Psychology (4.9%), one in Nursing and Psychology (2.4%) and one in Sociology and Physical Education (2.4%).

The methodological characteristics of the studies indicated that, qualitative research was the highest number with 24 (58.6%) studies, followed by quantitative 12 (29.3%), where one (2.4%) was an experimental design and 11 (26, 9%) quasi-experimental. There were also three case studies (7.3%), one experience report (2.4%) and one study with quantitative and qualitative design (2.4%).

The analysis of the nature of conflict identified seven types: *Conflicts between the professional and the institution*: authors emphasize the problems in the organization and the service structure as difficulties for children care and their families; *Personal conflicts of health professionals*: authors report the experienced personal dilemmas by members of the multidisciplinary team before the treatment and death of children in pediatric oncology; *Conflict between the professional and the family*: the conflicts identified are related to miscommunication, gaps in the dialogue between the members of the multidisciplinary team and the family, from the diagnosis until the end of treatment. *Family conflicts*: conflicts between family members about the care, communication and treatment. *Professional conflicts*: lack of communication between members of the multidisciplinary team and the difficulty in conducting collaborative work. *Conflicts between professionals and hospitalized children*: inadequate approach and disagreements in professional assistance to children during hospitalization; *Personal conflicts of families*: those conflicts of moral character experienced by parents, siblings and other family members during treatment of the child.

Each article analyzed was identified by a number and is presented in table 1 below.

Table 1. Distribution of articles by authors, title, year, journal and nature of conflict.

Autores	**Título**	**Ano /Revista**	**Natureza dos conflitos**
1. Duarte MLC, Noro A.	Humanization: a reading from the understanding of nursing professionals	2010 Rev Gaúcha Enferm	Professional and institution / professional
2. Stenmarker M, Palmérus K, Márky I.	Life satisfaction of Swedish pediatric oncologists: The role of personality, work-related aspects, and emotional distress.	2009 Pediatr Blood Cancer.	Professional and institution
3. Malta JDS, Schall VT, Modena CM.	The time of diagnosis and difficulties found by pediatric oncologists in the treatment of cancer in Belo Horizonte	2009 Rev bras cancerol	Professional and institution / Personal health professionals
4. Lazzarin M, Biondi A, Mauro SD.	Moral distress in nurses in oncology and hematology units	2012 Nursing Ethics	Professional and institution / Personal health professionals
5. Paro D, Paro J, Ferreira DLM.	The nurse and care in pediatric oncology	2005 Arq Ciênc Saúde	Professional and institution
6. Stenmarker M, Palmérus K, Márky I.	Stress-resilience capacity of pediatric oncologists: a Swedish nationwide and population-based study of motivation, emotional distress, and overall life satisfaction	2009 Pediatr Blood Cancer	Professional and institution
7. O'Shea ER, Shea J, Robert T, Cavanaugh C.	The needs of siblings of children: challenges for the specialty	2002 British Journal of Nursing	Professional and the institution / Personal health professionals

8. Stenmarker M, Hallberg U, Palmérus K, Márky I. B.	Being a messenger of life-threatening conditions: experiences of pediatric oncologists	2010 Pediatr Blood Cancer	Personal health professionals
9. Avanci BS, Carolindo FM Góes FGB, Netto NPC.	Palliative care to oncology child in the situation of live / die: the perspective of nursing care	2009 Esc Anna Nery Rev	Personal health professionals
10. Harrington AD, Kimball, TG Bean RA.	Families and childhood cancer: an exploration of the observations of a pediatric oncology treatment team	2009 Fam Syst Health	Personal health professionals
11. Rheingans JI. R J	Relationship between pediatric oncology nurses' management of patients' symptoms and job satisfaction	2008 J Pediatr Oncol Nurs	Personal health professionals
12. Holland D.	Teenager and young adult oncology: challenges for the specialty	2009 Pediatric nurse	Personal health professionals
13. Kersun L, Gyi L, Morrlson WE.	Training in difficult conversations: a national survey of pediatric hematology–oncology and pediatric critical care physicians	2009 J Palliat Med	Personal health professionals
14. Oppenheim D, Brugières L, Corradini N, Vivant F, Hartmann O.	An ethics dilemma: when parents and doctors disagree on the best treatment for the child	2004 Bull Cancer	Personal health professionals / Professional and family
15. Beane C; Auld L. British	Paediatric oncology research nursing: improving the service	2002 British Journal of Nursing	Professional and family
16. Zwaanswijk M, Tates K, Dulmen SV, Hoogerbrugge PM, Kamps WA, Beishuizen A, Bensing JM.	Communicating with child patients in pediatric oncology consultations: a vignette study on child patients', parents', and survivors' communication preferences	2011 Psycho-Oncology.	Professional and family
17. Klassmann J, Kochia KRA, Furukawa TS, Higarashi IH, Marcon SS	Experience of mothers of children with leukemia: feelings about home care	2008 Rev Esc Enferm	Professional and family / family
18. Miller VA, Nelson RM.	Factors related to voluntary parental decision-making in pediatric oncology	2012 Pediatrics	Professional and family / family
19. McCubbin M, Balling K, Possin P, Frierdich S, Bryne B.	Family resiliency in childhood cancer	2002 Fam Relat	Professional and family
20. Watt L, Dix D, Gulati S, Sung L, Klaassen RJ, Shaw NT, Klassen AF.	Family-centred care: a qualitative study of Chinese and South Asian immigrant parents' experiences of care in paediatric oncology	2011 Child Care Health	Professional and family
21. Clarke JN, Fletcher P. C J	Communication issues faced by parents who have a child diagnosed with cancer	2003 Pediatr Oncol Nurs	Professional and family
22. Blough CA,	Improving patient safety and	2007	Professional and

Walrath JM.	communication through care rounds in a pediatric oncology outpatient clinic	J Nurs Care Qual	family
23. Lock AL, Bodkyn C, Ali Z.	Parent perceptions of paediatric oncology services at the Eric Williams Medical Sciences Complex, Trinidad and Tobago	2012 West Indian Med J	Professional and family / professional
24. McKenna K, Collier J, Hewitt M, Blake H.	Parental involvement in paediatric cancer treatment decisions	2010 Eur J Cancer Care	Professional and family
25. Moore JB, Beckwitt AE.	Parents' reactions to conflict with health care providers	2003 West J Nurs Res	Professional and family
26. Linnard-Palmer L, Kools S.	Parents' refusal of medical treatment for cultural or religious beliefs: an ethnographic study of health care professionals' experiences	2005 J Pediatr Oncol Nurs	Professional and family
27. Streisand R, Kazak AE, Tercyak KP. P	Pediatric-specific parenting stress and family functioning in parents of children treated for cancer	2003 J Child Health Care	Professional and family / Family
28. Moore JB, Kordick MF.	Sources of conflict between families and health care professionals	2006 J Pediatr Oncol Nurs.	Professional and family
29. Gupta VB, Willert J, Pian M, Stein MT.	When disclosing a serious diagnosis to a minor conflicts with family values	2008 J Dev Behav Pediatr	Professional and family
30. Hall JA.	An exploratory study of communication, gender-role conflict, and social support of parents of children treated at children's hospital	2010 Psycho-Oncology	Family
31. Tomlinson D, Hendershot E, Bartels E, Maloney AM, Armstrong C, Wrathall G, Sung L.	Concordance between couples reporting their child's quality of life and their decision making in pediatric oncology palliative care	2011 J Pediatr Oncol Nurs	Family/ professional
32. Beck ARM; Lopes MHBM.	Caregivers of children with cancer: aspects of life affected by the caregiver activities	2007 Rev Bras Enferm	Family
33. Neil-Urban S, Jones JB.	Father-to-father support: fathers of children with cancer share their experience	2002 J Pediatr Oncol Nurs	Family
34. McGrath P.	Findings on the impact of treatment for childhood acute lymphoblastic leukaemia on family relationships	2001 Child Adolesc Social Work J	Family
35. Angelo M, Moreira PL, Rodrigues LMA.	Uncertainties on childhood cancer: understanding the mother's needs	2010 Esc Anna Nery Enferm	Family
36. Ozono S et al.	Psychological distress related to patterns of family functioning among Japanese childhood cancer survivors and their parents	2010 Psyco-Oncology	Family
37. Steffen BC, Castoldi L.	Surviving the Storm: the influence of oncological treatment of a child in the marital dynamics	2006 Psicol cienc prof.	Family
38. Velazquez RG ,Caraballo JMF ,	Experiences of children in pediatric units of the Hospital Virgen Macarena	2009 Indice Enferm	Family

Conde MDP , Albar MJM.			
39. Carlsson AA, Kihlgren M, Skeppner G, Sorlie V.	How physicians and nurses handle fear in children with cancer	2007 J Pediatr Oncol Nurs	Professional and hospitalized children
40. Hildenbrand AK, Clawson KJ, Alderfer MA, Marsac ML.	Coping with pediatric cancer: strategies employed by children and their parents to manage cancer-related stressors during treatment	2011 J Pediatr Oncol Nurs	Professional and hospitalized children
41. Nolbrisa M, Enska K, Hellstro AL.	Experience of siblings of chidren treated of cancer	2007 Eur J Oncol Nurs.	Professional and hospitalized children

Three representative themes were identified in the sources of the conflict, as follows:

1. Professional difficulties in engaging with families and children

In this subject the articles on difficulties perceived by professionals to relate to children and families and that generate conflicts in the hospitalization were grouped. There are six categories: *barriers in communication, differences in therapeutic planning, limited professional support offering to deal with families; non-acceptance of family participation in decision-making; limitations of professionals in the care of hospitalized children; unpreparedness of professionals to deal with difficult situations.*

Barriers in communication were the main obstacles highlighted in the studies and interfered with the effective establishment of link between professional and family. Such barriers are caused by failures in provision of information by professional and understanding of information by the families, who receive little guidance on the clinical condition of the child, the prognosis and the procedures to be performed [18, 21, 23, 26, 28, 41]. Parents need additional information in the transition from hospital care to home, but they are not always assisted [17]. Another element that contributes to the communication barrier is the use of technical language by the team [20, 21], together with little professional empathy with the family [17, 21] and the disengagement of the professional that triggers family dissatisfaction [1, 12, 15, 22].

Differences in therapeutic planning between the health team and the family involve disagreements about the treatment plan and the child´s prognosis. The authors report that the team and the family have different goals and expectations for the prognosis, which leads to the conflicts concerning the choice of therapy. When parents do not participate or receive information, they do not trust on the team [16, 25, 31].

Limited professional support offering to deal with families: in three articles, the authors report that during the hospitalization of the child, parents feel helpless, with little emotional and social support, both from the extended family as the institution, as well as professionals, who feel unable to help them in this experience. The precariousness of the institution affects resources including the mediation of conflicts that arise in relations between professionals and families [25, 35, 41].

Non-acceptance of family participation in decision-making: it derives from the reluctance of some professionals to accept and negotiate with the family their participation in care and decision-making. Thus there are few opportunities for the families to discuss together about the treatment and therapeutic interventions [16, 21]. In consequence families have difficulty making decisions, because they feel insecure and unprepared to express their will. Another element that contributes to family non-participation in care and decision-making is the prejudice of the professionals about gender, making difficult the permanence of parents and their participation in care, giving preference to the mother or others females on various allegations [20, 26, 29].

The category *limitations of professionals in the care of hospitalized children* refer to the distance between the team and the child, with an inadequate hospital environment to the children´s needs. In one article the conflict in the way the professionals deal with the fear of children during hospitalization and, during the procedures was identified, when professionals do not seek strategies to relieve the stress of the child, such as the use of therapeutic play and distraction techniques. In another study, the authors note the lack of physical infrastructure for the care of children´s needs which hinders the experience of the children, preventing them from wear their own clothing, in a poor environment resources as toys and outdoor space [38, 39].

The *unpreparedness of professionals to deal with difficult situations* occurs when the professional is faced with different situations and not does not feel qualified to address them, such as: giving difficult news to children/adolescents with cancer and their parents; take immediate and effective decisions; dealing with death and bereavement experience. Moreover, it is that a higher professional involvement with the child and family can be a distress generator factor and obstacle to decision-making [4-6, 9, 10, 13, 40].

2. Negative effects of hospitalization for family functioning

In this subject the articles referring to conflicts of family nature were grouped. The categories are related to: *changes in family life; difficulties in the mother's relationship with the children without the disease and difficulties of the siblings coping the disease.*

The category *changes in family life* describes the negative aspects of hospitalization contributing to changes in the family routine, the imposition of new routines, new family relationships, changes in the performance of parenteral and emotional destabilization functions. The conflicts between parents, described in four studies, are due to the division of tasks for providing care to the child with cancer. The differences in the roles, where the mother alone assumes responsibility for the child´s follow-up, while the father financially helps the family, has been the cause of crisis and even rupture of the family unit [10, 29, 31, 32].

Hospitalization triggers changes in family life and family functioning. There is a family movement to try to remain as before, but the changes occur quickly and the family sometimes needs to be separate [10, 19, 34].

Authors report that during the treatment of the child, both the father and the mother have high levels of stress and emotional imbalance [27, 29, 36, 37]. Many times the conflict between couples is marked by mutual charges, when one blames the other for the child's health condition, and the changes generated at home contribute to a rupture of the family unit [29, 37].

In addition, life, affection and couple sexuality become compromised by the lack of attention between them; because they have lack of time, no mood for sexual activities. Since there are different ways of looking at sexuality between genders, it is common for women to leave the external problems affecting the relationship more than men [21, 32].

Expending more time with the child consultations and hospitalizations, the mother delegates the care of other children to other extended family members, neighbors or acquaintances and prioritizes the sick child. Maternal feelings expressed in three studies show that lack of attention to children without the disease is experienced with grief and suffering by the mother, because, while she wants to accompany the sick child during treatment, she also want exercise her role as mothers of the other children [7, 17, 34].

Another evident aspect is the conflict relationship established between the mother and the sick child versus the parent and other children, caused by the stress of treatment and the hospital environment. The mother becomes agitated and nervous, unloading her ~~troubles~~ problems in her husband and other children, building a barrier between them [38].

The category of *difficulties of the siblings coping the disease* describes the personal conflicts of siblings fighting the disease in the family. Two articles that sought both to understand the experience of being the brother of a child/adolescent with cancer, as nurses opinions on the siblings needs of children with cancer [7, 38] were found. Siblings face conflicts of interest, have difficulty dividing attention of

parents and feel negatively affected when the brother needs more hospital than home treatment [42], expecting a normal routine [7]. They state that when a child. When a child has cancer, siblings' state that parents struggle to provide care to other children (siblings) and making them jealous and aside [7]. They feel excluded from the care of the sick child, as they are not informed about the disease, makes the treatment full of uncertainties and insecurities for them giving them uncertainties and insecurities about the treatment [7, 17, 34, 35]; reporting that they would like to receive more attention from the health team and learn more about the disease and the treatment of the sick brother [41].

3. Failure to support multidisciplinary team

In this theme, conflicts caused by difficulties of services in support to team members to perform their activities appeared, affecting the promotion of care centered in the patient and family.

In the current health care system, there are structural difficulties that compromise the care of children and adolescents with cancer. Among them, the small number of professionals specializing in pediatric oncology, contributing to delay in diagnosis, appropriate treatment and follow-up of this population [29]; short supply of specialized institutions for the care of this population [1].

The lack of trained nurses to perform their duties in pediatric oncology and the lack of psychological support services to assist them in engaging with the child with cancer and their families, generate trauma and feelings of powerlessness in these professionals [5].

A well-known frustration of many physicians is the gap between them and the patients and their families. Work overload, with little time to discuss the situation and provide information contribute to the conflict of these professionals with the institution [8, 41].

DISCUSSION

Studies have not exactly shown relational conflicts in pediatric oncology. Most publications deals with stress, family difficulties with the disease situation, tensions and anxieties that are potential to generate conflicts.

Communication is one of the ways to intervene in conflicts, providing a two-way channel: speaking and listening. It can be understood as a process of transcendence inherent to interpersonal relationships. The recognition of the other and of their autonomy becomes an important tool for communication and ethical behavior between the professional and the user of health services[9].

The family is responsible for the health of the child and, therefore, needs to know and understand what happens to the child during treatment. Improving communication between professionals, family and child, recognizing the individuality, the suffering and the reality of those involved, in addition to the biological aspects, it is essential for satisfaction of both of whom assist as to who is assisted[10].

The guidelines, information, clarifications, listening, respect the parent's right to inquire about the care provided to the child foster effective communication between interdisciplinary team, patient and family[11]. In addition, transmitting respect and consideration and providing appropriate information to the family allows them to expand the ability to cope with the situation, making reasoned and informed decisions regarding the recognition of the time when the curative therapy should be discontinued[4].

One strategy to help reducing relational conflicts is the negotiation, which facilitates the interaction between families and professionals improving the anxiety of parents and make them more secure and confident about the treatment and the children´s hospitalization. Thus, their application has advantage over personal initiatives than institutional, promoting the reduction of probable situations/conflict sources[4].

The negotiation implies mutual partnership and such process involves the sharing of power and responsibilities among the partners. Negotiating involves identifying the customer's perspective and professional, build consensus between them without actively negotiate a mutually satisfactory plan, favoring the patient and his family control and greater responsibility for their decisions. In this process, there is a

change of the professional role; it ceases to be a provider of specialized care to take a partnership with the client and his family improving the relationship between them[9].

SYNTHESIS CONCLUSION

The present review has highlighted the nature and sources of conflicts in the pediatric oncology, revealing the complexity of this subject. These findings can contribute to professionals in the identification of conflicts and their analysis for clinical practice.

Most of the time, conflicts are of domestic nature and between professionals and families. The difficulties of professional involvement with families and children; the negative effects of hospitalization for family functioning and the lack of support multidisciplinary team are identified as sources of conflicts.

It is important to develop researches for the understanding of the subject and advance towards the proposition of interventions to guide professionals in the mediation of conflicts.

NATUREZA E FONTE DE CONFLITOS RELACIONAIS NO CONTEXTO DA ONCOLOGIA PEDIÁTRICA: REVISÃO INTEGRATIVA DA LITERATURA

RESUMO

Identificar os conflitos relacionais no contexto da oncologia pediátrica quanto a sua natureza e fonte. Revisão integrativa da literatura nas bases PubMed (National Center for Biotechnology Information), CINAHL (Cummulative Index to Nursing and Allied Health Literature) e LILACS (Literatura Latino-Americana e do Caribe em Ciências da Saúde); e na Biblioteca Científica Eletrônica Online SciELO (Scientific Electronic Library Online), nos últimos dez anos, nas línguas inglesa, espanhola e portuguesa. Utilizou-se Análise Qualitativa de Conteúdo para guiar o processo analítico. Identificaram-se sete tipos de natureza dos conflitos e três temas referentes às fontes de conflitos: dificuldades dos profissionais no envolvimento com as famílias e as crianças; repercussões negativas da hospitalização para o funcionamento familiar; e insuficiência de suporte à equipe multiprofissional. Destacam-se como natureza de conflitos os do tipo intrafamiliares e entre profissionais e família; e como fonte de conflitos as barreiras na comunicação e as alterações familiares. A síntese do conhecimento pode auxiliar profissionais da saúde a identificar conflitos na prática clinica.

Palavras-chave: Pediatria. Oncologia. Conflito. Equipe de assistência ao paciente.

NATURALEZA Y FUENTE DE CONFLICTOS RELACIONALES EN EL CONTEXTO DE LA ONCOLOGÍA PEDIÁTRICA: REVISIÓN INTEGRADORA DE LA LITERATURA

RESUMEN

Identificar los conflictos relacionales en el contexto de la oncología pediátrica en cuanto a su naturaleza y fuente. Revisión integradora de la literatura en las bases PubMed (*National Center for Biotechnology Information*), CINAHL (*Cummulative Index to Nursing and Allied Health Literature*), y LILACS (*Literatura Latino-Americana e do Caribe em Ciências da Saúde*); y en la Biblioteca Científica Electrónica Online SciELO (*Scientific Electronic Library Online*), en los últimos diez años, en las lenguas inglesa, española y portuguesa. Se utilizó el Análisis Cualitativo de Contenido para orientar el proceso analítico. Se identificaron siete tipos referentes a la naturaleza de los conflictos y tres temas con relación a las fuentes de conflictos: dificultades de los profesionales en el envolvimiento con las familias y los niños; repercusiones negativas de la hospitalización para el funcionamiento familiar; y ausencia de soporte al equipo multiprofesional. Se destacan como naturaleza de conflictos los del tipo intrafamiliares y entre profesionales y familia, y como fuentes de conflicto las barreras de comunicación y los cambios familiares. La síntesis del conocimiento puede auxiliar a los profesionales de la salud a identificar conflictos en la práctica clínica**.**

Palabras clave: Pediatría. Oncología. Conflictos. Grupo de atención al paciente.

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Corresponding author: Fernanda Ribeiro Baptista Marques. Rua Napoleão de Barros, 754. CEP: 04024-002. São Paulo – São Paulo, Brasil. E- mail: fer.rbmarques@gmail.com.

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