

COMMUNICATION BETWEEN THE NURSE AND THE MOTHER/FAMILY IN THE NURSING APPOINTMENT TO THE CHILD

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ABSTRACT

The objective was to analyze how the interpersonal communication of nurses favors or limits the autonomy of mothers/family in the care process during the nursing appointment to child. This is a qualitative study, conducted in four family health units of Cuiabá, Mato Grosso, between January and February 2012, with four nurses who did the appointments to the children in a programmatic way. The data were collected through participant observation of 21 nursing appointments. The data were analyzed through thematic content analysis, from which two categories emerged: "Ineffective communication between nurse and mother/family" and "Communication as a care tool". It can be inferred that the communication in the nursing appointment cannot have the control as a focus, but it must be adapted to each presented situation, having the mother/family in the center of this process, so they can express their knowledge, feelings and demands, besides of having an active participation.

Keywords: Child Care. Primary Health Care. Nursing. Health Communication. Professional-Patient Relations.

INTRODUCTION

The nurse, as a participant in the primary health care team, plays a relevant role in the execution of the political strategies directed to the child population⁽¹⁾, especially actions aimed at promoting their health. In this sense, an important tool to be used by this professional is the nursing appointment.

The nursing appointment in childcare is developed with a view to monitoring the growth and development and health conditions of the child, in which nurses' actions have a great impact in the prevention of diseases and health promotion⁽²⁾.

Among other aspects, the appointment should promote and encourage parents to offer satisfactory conditions so that the child can grow and develop properly. Thus, the nurse needs to pay special attention to the educational activities and the preparation of parents for the care of the children in their environment, stimulating them to participate in an active way, to make them autonomous individuals and empowered for the care of the children. For this purpose, the communication process must be mediated through dialogue, supported by a horizontal

relationship of listening, exchange, respect for values, knowledge, opinions and ways of being and doing of the other, based on trust, bonding and participation of the subject in the care process⁽³⁾.

However, it is observed that the activities carried out in the daily routine of primary health care are still centered on the perspective of the biomedical model, with prescriptive, imposing and vertical actions, dialogues without valuing the subject's knowledge, and therefore without the development of users' autonomy and empowerment to perform care⁽⁴⁻⁵⁾.

In order to break with the hegemony of this model, it is necessary to intensify health promotion actions in the daily life of services, to promote the autonomy of the people, so that together they can understand health as a result of the living conditions and that it needs interventions beyond curative practices⁽⁶⁾.

The interaction between the health worker with the user and participation of users in the construction of health knowledge are working tools that nurses can use to promote and maintain patients' health. Developing the autonomy of the subjects and fostering co-responsibility for health work helps forming a link between individual and team⁽⁷⁾.

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Given the above, communication as a capacity for dialogue between health workers and users is an essential tool to guide, inform, comfort and meet basic needs⁽⁸⁾, as well as to produce co-responsibility, resolution, quality care and clients' autonomy for the care.

Considering the importance of the autonomy of the mother/family for the promotion of child health and that the way the nurse communicates with this binomial can contribute positively for this process, this study aimed to analyze how the interpersonal communication of nurses favors or limits the autonomy of the mother/family in the appointment to the child.

METHODOLOGY

This is a descriptive, qualitative research that used the database of the Matrix Research "Evaluation of child care in the Basic Health Network of Cuiabá, MT, with emphasis on its organization, assistance and on nursing practices", developed by the Research Group on Child and Adolescent Health, Faculty of Nursing, Federal University of Mato Grosso.

The research was carried out in four family health units of Cuiabá, MT, chosen randomly by lot; each unit representing each administrative region of the city (North, South, East and West). Four nurses participated, one professional from each of the units selected for the research and who routinely developed the nursing appointment to the child. The criterion of choice for the child to participate in the study was being between 0-2 years of age, since the appointments for monitoring the child's growth and health status are more frequent in this period, as the great physical and psychic transformations occur in this age range, with intense growth and development. Therefore, nurses' actions have great impact for the promotion of children's health.

The data collection of the matrix research was performed in January and February of 2012 through the participant observation of 21 nursing appointments, in the selected units. This type of technique enables interaction, sharing and exchange of experience between the researcher, the observed subjects and the context. The observation was made by three researchers, one of whom took an active position during the

appointments and the other two were placed in the nursing office in strategic locations that made it possible to observe the environment, the nurse, the mother/family and the child, to capture the expressions, body position and, consequently, the interpretation of the meanings brought by these.

At each observation, the data were recorded in field diaries, one for each researcher, which provided three perspectives of the observed facts. The dialogs of the appointments were recorded in audio and this made possible the apprehension of details of the conversations, of the information transmitted, of the relation of the nurse with the mother/relatives, voice intonation, among other aspects.

In the present study, all 21 nursing appointments of the matrix research of the database were analyzed to answer the objectives of this research.

To analyze the dialogues of the observations of the nursing appointments, we used the Thematic Content Analysis method⁽⁹⁾. After several readings of the material, we selected the relevant data that could answer to the study objective. These were listed according to the most significant units of meaning present in the dialogues, and they defined the two thematic categories of the study: 1 - "Ineffective communication between nurses and mother/family", which was divided into two subcategories: "Imposing, vertical and non-participatory communication" and "Investigative communication that does not value mothers' demands"; and 2- "Communication as a care tool", with the following subcategories: "Participatory dialogues" and "Bonding, trust relation and support". For the discussion of the results, we used the published literature on the subject as reference⁽¹⁰⁻¹¹⁻¹²⁾.

This research complied with all the ethical precepts of Resolution 466/12 of the National Health Council and the study protocol was approved by a research ethics committee under protocol no. 850.754/CEP HJUM/2014. Before the beginning of the data collection, all research participants, that is, nurses and mothers/families, signed the Informed Consent Form.

RESULTS AND DISCUSSION

1. Ineffective communication between nurses and mother/family

So that the objectives of the nursing appointment to the child are met, the interaction between the professional/mother/family should be the central focus of the care process. Thus, for interaction to be effective, it needs to be sustained in horizontal dialogue, in participation in the care process, in **trust**, in **valuing doubts** and in **respecting the user**⁽³⁾. However, in this study, it was observed that the nurses' interaction with the mother/family, in several moments of the appointments, was based in imposing, authoritative and vertical communication, hindering the development of mothers' autonomy and personal abilities for child care.

Imposing, vertical and non-participatory communication

In order to actualize the relationship with individuals and their families, nurses need to use their communicative competences⁽¹⁰⁾. In this way, communication must be seen as a process that understands and shares messages, and that exerts influence on the behavior of the people involved. This influence shows that people are in constant interaction. In this interactional field, subjects perceive themselves, share the meaning of ideas, thoughts and purposes, changing or maintaining them, which allows them to set goals and visualize ways to achieve them⁽¹¹⁾.

The following dialogue clippings reflect a limited, authoritative and vertical communication in which the mother/family must comply with the actions/guidelines and the child is almost ignored in the care process:

Nurse: Is he taking two bottles? Mother: I'm giving him two or three, one in the morning, one in the afternoon and the other in the evening, before he sleeps. Nurse: It's the same as I told you before, he has a strong tendency to drop the breast, because the bottle...indeed, the child has a preference for the bottle, he gets confused about the nipple and the tip of the bottle. So, the guidance remains the same, it's EX-CLU-SI-VE breastfeeding {she speaks in an imposing tone, pronouncing each syllable separately, emphasizing the word}. So, my guidance is the same (Field diary, appointment 1).

The nurse, when attending a 3-month-old infant, makes technical and coercive orientations, as if

the mother was not part of the process and only had to comply with the nurse's orders. At no point did she bother to know how she felt about the situation, her needs as a mother/woman, not even sought to involve her in decision-making.

When attending an infant, the nurse questions about the situation of breastfeeding and after the information offered by the mother, she makes prescriptive guidelines, not considering the mother's experience with the breastfeeding process and not even seeks to involve her in the care process: *Nurse: Are you having trouble in breastfeeding? {The mother answers negatively} So, no bottle, no water, no tea! {She speaks in an imposing tone and with a firm, loud voice}. So, what are the recommendations? [...] Breastfeeding is the most important thing in the first months of the child's life. That's the aspect we most pick on mothers; it is what we most recommend. The mother has to breastfeed the child, because it strengthens, it nourishes, it makes the child to develop [...] So, during six months I hope you, young lady, breastfeed, and for this to happen she needs the support of everyone (Field diary, appointment 8).*

In the traditional clinical model, the communication between professional and user is limited, predominating the informative/investigative pattern, directed to complaint and to disease, excluding listening and dialogue, thus restricting the autonomy of the subjects for the care and the possibility of interaction between the knowledge of this dyad⁽⁵⁾. In the situation of the dialogues cut from the appointments, the nurse's attention focuses on breastfeeding, without considering neither the child nor the mother/family who experience the process.

Research that analyzed interpersonal relationships between health workers and pregnant adolescents in prenatal care at a public maternity hospital in the city of Rio de Janeiro identified reflections of the biomedical paradigm in health workers' speeches, characterized by the valorization of biological issues to the detriment of multidimensionality, besides mechanical and imposing conduction of communication. The conversations took place through vertical questions and answers and coercive conducts⁽⁴⁾.

The dialogue between the worker and the mother/family should be free of authority or prejudices, because vertical actions hinder the manifestation of subjectivities and the protagonism of the subjects. The health worker

must understand that power-dominating relationships are detrimental to communication with mothers. Communication should allow the exchange of ideas and knowledge and not devalue the care practiced by the mother/family:

The child is sitting on his mother's lap and lets the pacifier fall to the floor and his mother says: It fell, son. You cannot, only after washing it {talking to the child}. The nurse observes everything and talks: *Do he have a pacifier? Did not I tell you about the pacifier? Mother: Hun? {The mother laughs}. Nurse: Did not I tell you about the pacifier? {The nurse laughs, but continues to speak in an imposing tone} I'm going to give a tell off here. Try to remove this pacifier as soon as possible; otherwise you will suffer with that pacifier later. [...] And when it falls on the ground, he is going to crawl, when it falls to the ground, and he's going to get it, he'll put it in his mouth and you will not be looking? Mother: Truth. Nurse: He's going to have diarrhea, he's going to have this and that, he's going to have worms and you do not know why, it's because of the pacifier. Maybe he'll even have speech delay [...]* **(Field diary, appointment 4).**

So that a dialogue is effective and reduces vulnerabilities, the worker must be willing to exchange ideas with the mothers and not only judge their care attitudes. The worker also needs to help them reflect on the care for themselves and for their child and whether what is expected may or may not be included in this care, trying to understand the reasons and feelings that motivated them to make such a decision⁽¹³⁾.

In this sense, the guidelines for mothers should be based on an expanded view of the experiences of motherhood brought by them and on what they have as a life project. In view of this, women need to be considered autonomous and able to make their own decisions, and the worker must offer support, interact and share knowledge for the promotion and protection of the health of women and of their children⁽¹³⁾.

Mothers' decisions are motivated and influenced by their experiences and life context. However, it was observed in this study that certain actions/behaviors taken by nurses were based only on the expected standard of the ideal model of child care, without considering the reality, desires and

needs of the mother/family/child.

Investigative communication that does not value mothers' demands

The nurse needs to pay attention to the real health needs brought by the mother/family, and not disregard them or judge them from what they understand as necessary for the child. The clippings show an informative communication, with investigative standard⁽⁴⁻¹⁴⁾, and although they are focused on the complaint, they do not value the demands brought by the mothers.

The nurse starts the consultation asking about the health status of the child and even though the mother presents complaints, she continues the anamnesis without valuing the maternal report: Nurse: {She talks looking at the child.} *Is everything okay with him? Mother: Yes. But he's a little sick because of the teeth; two teeth are growing! Nurse: {She looks at the mother again and asks}: Did the syrup finish? {She is referring to ferrous sulfate}. Mother: It's over! Nurse: How are you giving it? Just to remember* **(Field diary, appointment 5).**

Nurse: Is everything okay with him? Mother: Yes. I just have the feeling that his gums are swollen and he has diarrhea. Nurse: He does not have any tooth, does he? Mother: No, but he has diarrhea. Nurse: Oh, it's probably because of the milk, okay? Mother: Is there something to put on, to improve the "itching" {irritation in the child's gums}? Nurse: I will not prescribe, but if you go to the pharmacy they will give you a medication for him to stay calm, but there are many physicians who say they do not need to take it **(Field diary, appointment 4).**

The literature shows that, from the perspective of child care, workers have not listened to the demands brought by the family⁽¹⁴⁾. In order to guarantee quality and effective care, the nurse must listen and value the demands brought by the family on the child's health, since the parents are excellent observers and their opinion, when respected and interpreted by the worker, can provide decision-making based on a broad vision of the child's health⁽¹⁴⁾.

Considering that each individual is unique, constituted of ethical values, behavioral patterns and social behaviors, and that this interferes directly in their way of communicating, it is necessary that during the appointment the nurse

recognizes this individuality and establishes a dialogue directed at the detected needs⁽¹⁵⁾.

In our work in primary care, it is observed that nurses still give little value to the personal relationship and adequate communication to the context of care, because it is restricted to the questioning of complaints and to issues advocated by ministerial protocols without considering the needs brought by the individual.

Thus, in order to conduct a proper communication during the nursing appointment, it is necessary that there is a change of focus and attitude by the nurse. In order to do this, the nurse must show interest, respect, cordiality and, above all, listen to the wishes, desires, demands and feelings of the user and their relatives, offering openness so that they can solve their doubts⁽¹⁶⁾.

A study that analyzed patients' perceptions about professional-client interpersonal communication showed that attentive listening and appreciation of the clients' experiences and doubts make them feel welcomed and safe⁽¹⁷⁾.

Through the communication established with the clients, the nurse knows their worldview, their way of thinking, feeling and acting, identifies the problems they experience, and can help them maintaining or recovering their health. The effective communication between the health worker and the user contributes to the resolution of education and health promotion actions⁽¹²⁾. In addition, when the nurse guarantees the active participation of the mother in the appointment and in the decision-making, there is an improvement in the clinical results, more adherence to the treatments and guidelines, and greater satisfaction⁽¹⁸⁾.

Adequate communication in health care is essential for promoting users' health and citizenship in primary care. However, for this to occur, it is necessary for practitioners to develop relevant skills, competencies and attitudes⁽¹²⁾.

In nursing care, when there is a dialogic communication, an environment of safety, trust and tranquility is created, because the difficulties encountered by the mother/family are heard and there is the construction of a therapeutic environment, aimed at reducing fears, offering help and overcoming difficult situations⁽¹⁴⁾.

The nursing appointment, as a space of interaction that favors the subjects' autonomy for

care, should be a space for nurses to demonstrate their interest in hearing and being heard. Thus, a basic aspect that this worker needs to be aware during appointments are the reports of the mother/family on the child's health, because even if discreet, this information can provide important clues about the real health needs of this child⁽¹⁴⁾.

2. Communication as a care tool

It was observed in this study that, in some moments of the appointments, the communication between nurses and the mothers/families favored the production of mothers' autonomy for the care, with horizontal dialogues that allowed the participation of the mother and the strengthening of the bond between nurse/mother/family, based on a relationship of trust and support.

Participatory dialogues

In some appointments, the nurse was empathic, with interested, understanding and attentive listening to the difficulties brought by the mothers, seeking together with them a solution to the demands presented:

The mother is insecure about child care and the nurse expresses interest in guiding and solving her doubts: *Mother: Can I leave her without socks or not? Nurse: It's hot in here, no problem, you can leave it. It's so hot in here that the child feels hot as we do. Mother: Yeah! Nurse: But you can observe, sometimes she will feel colder, but if it is hot and you see that her little foot is warm you can leave her without socks. Mother: It's sweating like that. Nurse: Yeah, if it's sweating, you take off the socks. She is already three months old, she is already "stronger"; she has created some "fat". Mother: Okay then. (Field diary, appointment 6).*

Mother: A. {Nurse's name}, I wanted to talk to you, because she's already going to start at nursery ... Nurse: {Nurse looks attentively at the mother and answers} Okay... Mother: I was talking with the principal about the food diet and schedules. But she {referring to the child} is not nursing anymore in the morning, at 9 o'clock in the morning. And she {referring to the day care principal} told me that at this time they give the breakfast, which is milk. So, as she does not nurse, I offer yogurt or other things ... Nurse:

Okay. Mother: Then she said I can take other things for her to eat; I need a prescription. Because then she will not nurse, right? Then she {referring to the child} needs eat, right? {Laughs} Can you make this prescription? Nurse: Yes, of course, we do it. **(Field diary, appointment 11).**

In order to promote practices that meet the real needs of the individual, it is indispensable that the latter participates autonomously in the nurse/user dialogue, be seen as the center of care and responsible for seeking adequate resources to promote their health⁽¹²⁾, in addition, health workers must develop accurate listening in relation to the needs of each individual⁽¹⁹⁾. From this perspective, the worker would act as facilitator and negotiator of the users-protagonists, who would be participants in the process of production of care.

We must also consider that through real dialogue, real interest in the other in the therapeutic encounter, the nurse can recognize the child's mother/family as a subject, empowering her to take care of the child with safety and autonomy⁽²⁰⁾.

In the perspective of this care, communication assumes new characteristics, since the professional, when listening and making oneself heard, starts to consider fundamental aspects of the child/family's life that were previously devalued or treated as secondary needs⁽²¹⁾.

Thus, acting in a dialogical relationship, where there is knowledge exchange, enables professionals to strip themselves of their technical knowledge and together with the user/family seek solutions to act as co-responsible for their health⁽³⁾. In this sense, open and frank dialogue favors the establishment of horizontal and symmetrical interactions between nurses and mothers, because it reduces the distance between them, building trust and freedom of expression.

Bonding, trust relation and support

The formation of bond between health workers and users is facilitated when the workers know how to listen complaints, because users feel valued and this increases their confidence in the worker. The individual feels that their rights as citizens are being respected when they receive quality care, in which they have space to speak, argue and choose⁽¹⁴⁻¹⁵⁾.

The following excerpts show some

manifestations that confirm the link between nurses and mothers/families:

Nurse: Oh my God, how different she is! The last time she came she was how many months? Mother: One year! Nurse: She's very different; her eye was bent, now it's different **(Field diary, appointment 3).**

Mother: Did you see how much he grew up? Nurse: It was a little baby when I saw him. It's been a while since I've seen him, the last time he was on month old, very small; he was a very little baby {speak in childish voice}. Now he's more like who? Mother: Like his father, he does not even look like me. Nurse: More or less, right ?! **(Field diary, appointment 4).**

The bond with the user is built gradually, from listening, talking, welcoming and respect. In the described situations, the fact that the nurse recognizes changes in the child's growth and development shows that she feels responsible for the child's health. This care attitude also influences the mother's view of the nurse, favoring the creation of an environment of trust and bonding. Gentle and educated behavior on the part of the health worker towards the user positively influences the establishment of bond, whereas the lack of confidence of users in the nurses is considered as a negative factor⁽¹⁹⁾.

Other key elements in the process of interaction between worker and user are trust and support. The nurse, when praising the mother for the care of the child and offering to help her, is taking an attitude that favors the approximation and development of mutual trust:

Nurse: [...] You're taking good care of her. Congratulations! Keep it up. Whenever you have doubts you can look for me, okay? And especially if you have no security, you can come and show me **(Field Diary, appointment 2).**

In another situation, the nurse makes herself available if the mother needs help: Nurse: Any questions? Mother: None. Nurse: That's fine, then. Whatever you need we're here. If we cannot solve it, we'll refer you. We'll help, okay? Mother: Thank you **(Field diary, appointment 14).**

In the relationship with the children's mothers, the nurse should demonstrate empathy and willingness to solve doubts, as well as to support fears and anxieties, establishing a relationship of trust and support and, consequently, promoting bonding⁽¹⁵⁾.

Dialogue, with mutual respect between health

worker and user contributes to satisfaction with the care received. A study that analyzed, among other aspects, the factors associated to the satisfaction of mothers with the care provided in primary care, in the city of Fortaleza, Ceará, showed that they considered as satisfactory the attendances in which the interpersonal relations focused on an interested communication between the health worker and the family, in which there was an understanding of the personal problems presented, equality in the form of care and answers to the doubts presented by the family about the child's health situation⁽²²⁾.

A resolute appointment is one that provides answers to the questions of the family and is based on a relationship of trust between the family and the nurse. In this sense, nurses' work in the family health strategy has been innovating health care, since this care model favors the construction of bonding and accountability with the individuals attended, as the worker becomes available, creates ties and welcomes the suffering of the population. Moreover, interaction with families and their members and the proximity to the user and to their different health needs favor the production of care in the perspective of comprehensiveness and humanization⁽¹⁾.

Although the results of the study presented here are part of a specific context and with a reduced number of participants, they can serve as a warning to nurses about the importance of interpersonal communication in childcare appointments, as well as contribute with

information for improving quality of care to the child, with a view to promoting their health.

FINAL CONSIDERATIONS

The dialogues captured in the nurses' appointments to the child revealed two types of communication between the nurse and the mother/family; the first focuses on imposing, directive, authoritarian and vertical dialogues, and the second was an investigative dialogue, which did not value mothers' complaints and demands, impairing the production of autonomy for care. On the other hand, the relationship with participatory dialogues, appreciation of mothers' doubts and expressions of support and trust were favorable to the development of autonomy for care.

Communication in the nursing appointment cannot be focused on control, but must be adapted to each situation, with the mother/family at the center of this process, so that they can express their knowledge, values, feelings and demands, besides participating actively. Communication between nurses and mothers/families should be seen as a central dimension of care and an intervention that promotes children's health.

The nursing appointment is an act of interaction, made up of actions and activities directed to the users and shared with them, supported by dialogue, listening, help, exchange, support, comfort and solving of doubts, permeated by sensitivity, appreciation and understanding of the other.

COMUNICAÇÃO DO ENFERMEIRO COM A MÃE/FAMÍLIA NA CONSULTA DE ENFERMAGEM À CRIANÇA

RESUMO

Objetivou-se analisar como a comunicação interpessoal dos enfermeiros favorece ou limita a autonomia das mães/família no processo de cuidado na consulta à criança. Estudo qualitativo, realizado em quatro unidades de saúde da família de Cuiabá, Mato Grosso, entre janeiro e fevereiro de 2012, com quatro enfermeiros que executavam a consulta à criança de forma programática. Os dados foram coletados por meio da observação participante de 21 consultas de enfermagem. Os dados foram analisados pela análise de conteúdo do tipo temática, da qual emergiu duas categorias: "Comunicação não efetiva entre enfermeiros e mãe/família" e "Comunicação como ferramenta de cuidado". Pode-se inferir que a comunicação na consulta de enfermagem não pode ter como foco o controle, mas deve ser adaptada a cada situação apresentada, tendo a mãe/família no centro desse processo, para que expresse seus conhecimentos, sentimentos e demandas, além de ter participação ativa.

Palavras-chave: Cuidado da Criança. Atenção Primária à Saúde. Enfermagem. Comunicação em Saúde. Relações Profissional-Paciente.

COMUNICACIÓN DEL ENFERMERO CON LA MADRE/FAMILIA EN LA CONSULTA DE ENFERMERÍA AL NIÑO

RESUMEN

El objetivo fue analizar cómo la comunicación interpersonal de los enfermeros favorece o limita la autonomía de madres/familia en el proceso de cuidado en la consulta al niño. Estudio cualitativo, realizado en cuatro unidades de salud de la familia de Cuiabá, Mato Grosso, Brasil, entre enero y febrero de 2012, con cuatro enfermeros que hacían la consulta al niño de forma programática. Los datos fueron recolectados por medio de la observación participante de 21 consultas de enfermería. Los datos fueron analizados por el análisis de contenido del tipo temático, del cual surgieron dos categorías: "Comunicación no efectiva entre enfermeros y madre/familia" y "Comunicación como herramienta de cuidado". Se puede deducir que la comunicación en la consulta de enfermería no puede tener como enfoque el control, pero debe ser adaptada a cada situación presentada, teniendo la madre/familia en el centro de este proceso, para que exprese sus conocimientos, sentimientos y demandas, además de tener participación activa.

Palabras clave: Cuidado del Niño. Atención Primaria de Salud. Enfermería. Comunicación en Salud. Relaciones Profesional-Paciente.

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