Doi: 10.4025/psicolestud.v22i4.35849

COMMUNICATION BETWEEN HEALTH TEAM, FAMILY AND CHILDREN IN BURNING UNITS

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ABSTRACT. The main purpose of this article was to comprehend the process of communication between the health team, the family, and the child in a Burning Unit. This is a descriptive explanatory study with qualitative nature counting with 12 professionals from a health team of different areas of acting. It was used the half-structured interview, and all the data was analyzed through thematic categorical analysis with the Atlas.ti 7 Software. The data allowed the construction of the category – The communication in hospital context – and subcategories – communication between health team, family, child and its facilitators and diffusers. When it comes to the communication with a child, the information is transmitted clear and straight through dialogue and activities. And, with the familiar caregivers occurs in daily conversations verifying the proper moment, and the way of which they comprehend the receiving information. It was identified facilitators: the family's interest and participation, the possibility in the use of informative materials, the gradual pass through of information. However, the instruction's degree and the family's guilt integrate the diffusers elements. Health professionals are attentive to the different ways of transmitting information, and giving the challenges related to the difficulties of communication, it is necessary to reflect about strategies to attend the necessities of the child and the family in the burning unit, as to promote the reception of demands which will be identified during the hospitalization period.

Keywords: Communication team-family; health team; hospitalized children; burning unit.

COMUNICAÇÃO ENTRE EQUIPE DE SAÚDE, FAMÍLIA, CRIANÇA EM UNIDADE DE QUEIMADOS

RESUMO. Este artigo objetivou compreender o processo de comunicação entre equipe de saúde-família-criança em uma unidade de queimados. Trata-se de um estudo exploratório descritivo de natureza qualitativa com 12 profissionais de uma equipe de saúde de diferentes áreas de atuação. Utilizou-se a entrevista semiestruturada e os dados foram analisados mediante análise categorial temática com o software Atlas.ti 7. Os dados possibilitaram a construção da categoria - A comunicação no contexto hospitalar – e subcategorias - comunicação entre equipe de saúde, família, criança e seus elementos facilitadores e dificultadores. Na comunicação com a criança, as informações são transmitidas de maneira clara e direta por meio do diálogo e do brincar. E com o familiar cuidador ocorre nas conversas diárias a fim de verificar o momento adequado e a maneira pela qual este compreende as informações recebidas. Foram identificados elementos facilitadores: o interesse e a participação do familiar, a possibilidade de utilização de materiais informativos e o repasse gradativo das informações. Por outro lado, o grau de instrução e os sentimentos de culpa dos familiares integram os elementos dificultadores. Os profissionais de saúde estão atentos às diferentes formas de transmissão de informações, e diante dos desafios inerentes às dificuldades de comunicação, é necessário refletir sobre estratégias para atender às necessidades da criança e família na unidade de queimados, para promover acolhimento das demandas que serão identificadas durante o período de hospitalização.

Palavras-chave: Comunicação equipe-família; equipe de saúde; crianças hospitalizadas; unidade de queimados.

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COMUNICACIÓN DEL EQUIPO DE SALUD, FAMILIA Y NIÑOS EN UNIDAD DE QUEMADOS

RESUMEN. En este artículo se tuvo por objetivo comprender el proceso de comunicación entre equipo de salud familia-niño en una unidad de quemados. Se trata de un estudio exploratorio descriptivo de naturaleza cualitativa con 12 profesionales de un equipo de salud de diferentes áreas de actuación. Se utilizó la entrevista semiestructurada y los datos analizados mediante análisis categorial temático con software Atlas. Ti 7. Los datos posibilitaron la construcción de la categoría – La comunicación en contexto hospitalario - subcategorías – comunicación entre equipo de salud familia, niño y sus elementos facilitadores y dificultadores. En comunicación con niños las informaciones son transmitidas de manera clara y directa por intermedio del diálogo y del jugar. Y con el familiar cuidador ocurren las conversaciones diarias verificando el momento adecuado y de manera por la cual este comprende las informaciones recibidas. Se identificaron elementos facilitadores: el interés y participación del familiar, la posibilidad de utilización de materiales informativos, y el repase gradual de las informaciones. Por otro lado, el grado de instrucción y los sentimientos de culpa de los familiares integran los elementos dificultadores. Los profesionales de la salud están atentos a las diferentes formas de transmisión de informaciones, y delante de los desafíos inherentes a las dificultades de comunicación, es necesario reflexionar sobre estrategias para atender las necesidades de los niños y sus familias en la unidad de quemados, para promover acogida de las demandas que serán identificadas durante el período de hospitalización.

Palabras-clave: Comunicación equipo-familia; equipo de salud; niños hospitalizados; unidad de quemados.

Introduction

The burn represents a lesion in the skin and its internal structures caused by external agents, such as fire, electric shock, chemicals, and is classified according to extension and depth (Lima-Júnior, Novaes, Piccolo & Serra, 2008). The depth of the burn will determine the severity, specifically in 1st, 2nd and 3rd degree, the last two being the most serious; and as to the extent of the affected area, it presents variations between small, medium and large area burned.

It is a type of injury that breaks the overall defense mechanisms, present in the whole skin, transforming it into a rich culture medium of bacteria, among other invading agents and causers of fungal and viral infections. Infections are responsible for the deepening of the lesions and consequent increase in hospitalization time and hospital costs, besides being responsible for more than 70% of the deaths (Lemos et al., 2004).

As for the occurrence of burns in children, accidents are attributed to lapses in attention, domestic dangers and the peculiarity of the child regarding mobility (Pickett, Streight, Simpson & Brison, 2003). The environment of the house that is most conducive to the accident is the kitchen, source of heat and existence of superheated liquids (Tse et al., 2006). Faced with these, it is possible to emphasize that regardless of these variables, burn represents a traumatic situation for all involved, child and family.

The trauma from the burn is experienced by the child even after the hospitalization period, due to difficulties to return to activities, changes in family dynamics, and the adaptation process (McGarry et al., 2014). For this reason, the psychological intervention performed during the hospitalization phase of the child has shown positive results, for example, the development of skills for pain management (Azevêdo & Santos, 2011). In relation to the family caregiver, the situation is similar due to the psychological suffering, alteration in the emotional state, changes in family relationships (Oliveira, Fonseca, Leite, & Santos, 2015); and the occurrence of post-traumatic stress symptoms (Bakker, Van Loey, Van Son, & Van der Heijden, 2010). Initially, these relatives experience panic reactions, and during the hospitalization process, feelings of guilt, especially those who witnessed the event that caused burns (McGarry et al., 2014). It is verified that there is shared suffering between child and family, and in this way, the health team's attention to the child and family in the Burn Unit represents something that makes it possible to minimize the psychological repercussions coming from the treatment of burns.

In the case of children with burns, the initial treatment, besides considering the anatomical and physiological characteristics, should value the experience of fear, pain and uncertainties, since this initial contact and actions provided by the health team will significantly influence the clinical progression and the prognosis (Oliveira & Serra, 2004). The authors highlight the importance of transmitting information

to the child during the dressing, with clear explanations, besides allowing some participation of the child during the treatment.

The participation of the child and family, when not limited to the rights and duties, with actions that involve it throughout the hospitalization process, results in the reduction of psychological distress, with the possibility of promoting the development of the child in an environment considered by many only hostile (Milanesi, Collet, Oliveira & Vieira, 2006; Sabatés & Borba, 2005). It is possible to infer that to involve the different subjects in all the stages inherent to the period of hospitalization, the welcome represents a basic strategy to identify the needs of the child and family.

Welcoming refers to a strategy of the National Humanization Policy, which emphasizes the ethical commitment of the health professional regarding listening attentively to the needs and demands experienced by people in the process of illness (Brazil, 2013). In this sense, welcoming is an important aspect of the communication process, since it enables the construction of links and support networks among all those involved.

The welcome aimed at the family in a personalized way allows the understanding and coping of their pain, problems, and ways of living (Crepaldi & Varella, 2000). In this sense, in order to carry out the welcome, the health team needs to be aware of the effects of hospitalization in families: disorganization of the family routine, absence of the mother in the home, marital conflicts, tension and concern for the sick child, worries about failing to work to provide more effective assistance. In view of the above, it is evident that when the health team identifies the repercussions of child hospitalization and values contact, dialogue, and different forms of interaction, this allows the inclusion of the child and the family caregiver in the communication process.

Communication here is understood as a fluid and multifaceted complex of numerous modes of behavior (verbal, tonal, postural, contextual), which in its entirety conditions the meaning of all other modes (Watzlawick, Beavin & Jackson, 1967).

Regarding aspects related to studies on communication, in scientific production, researchers have investigated the perspective of the health professional about the transmission of bad news (Gonçalves et al., 2015), namely: communication between pediatrician, child and accompanying person (McGarry et al., 2014); between parents, nurses and physicians (Fisher & Broome, 2011); and specifically the forms and character of communication between parents and pediatricians (Francisco, Queirós, Casimiro, Conde, & Brito, 2012); and between parents and nurses about information on pain management (Hong, Murphy, & Connolly, 2008). The thoughts of children and parents about the information received during the hospitalization period (Sabatés & Borba, 2005); the communication between doctor, pediatric patient, and family from the perspective of the child (Gabarra & Crepaldi, 2011); and the effects of the transmission of information on the surgical preparation according to the caregivers (Broering & Crepaldi, 2011), were investigated. Such studies have shown that the welcome is associated with the communication strategy used by the health team.

In the Pediatric Intensive Care Unit, communication has also been the object of study, since communication between the nursing team and the child was investigated (Dorociaki & Dyniewicz, 2000); between the health team and the hospitalized child's family (Nieweglowski & Moré, 2008); and another study focusing on intervention, for example, through a training program for nurses, physicians and psychologists with the aim of developing communication with family caregivers (Ammentorp, Kofoed, & Laulund, 2011).

There is a consensus in these studies regarding the importance attributed to the communication process due to the contributions to the child, family and health team, considering that the dialogue makes it possible to clarify information, collective participation in actions, and the reduction of anxiety experienced by all involved. It is possible to verify that these studies present different approaches, since some emphasize the communicative forms from the perspective of the child, the familiar caregiver, or the health team. As for health professionals, some studies direct attention to nursing staff and physicians (Dorociaki & Dyniewicz, 2000; Francisco, Queirós, Casimiro, Conde, & Brito, 2012; Souza & Oliveira, 2010), for this reason , there is a need to conduct research with different health professionals who work with hospitalized children, and therefore, this study is specifically directed to the team of a pediatric unit of children suffering from burns.

In the specialized literature, the study on the health team of children's burn unit was explored in a research, which identified the contributions of dialogue and social interaction from the child's play (Azevêdo, 2013). And to broaden the studies, the analysis of the communication between health team, family and child, allows us to understand how the processing of the information supply occurs in this environment marked by suffering and pain, so that it is possible to reflect on the ways of establishing and to improve a welcoming dialogue between the different social actors in the hospital context, and thus to promote the autonomy of all those involved. In the scientific sphere, the research related to this theme makes it possible to initiate a study area on communication in Burn Unit to contribute to the development of health care planning interventions to identify and analyze the different aspects that involve communication and transmission of information.

In view of this contextualization, this research aimed to understand how communication is processed, with a view to understanding the transmission of information, between team-family-child in Burn Unit.

Method

This is a qualitative research that had the participation of 12 professionals of the health team who work in the Burn Unit (BU) of a Children's Hospital in the south of Brazil, responsible for the treatment of children with burns. As inclusion criteria, professionals from the following specialties were considered: nursing, physiotherapy, psychology and medicine, with more than six months of practice, and who accepted to participate in the interview. Professionals with time less than six months of work were excluded from the sample, because it was sought to know those who were familiar with the routines of the sector.

As for the schooling of the participants interviewed, one held a master's degree, four had complete higher education, one had incomplete higher education and six had secondary education. The average years of service in the Burn Unit was approximately six years, with four professionals working for a period exceeding 10 years: 12, 15, 17 and 21 years of service.

The data collection was performed through a semi-structured interview consisting of questions that served as a guide to obtain the reports. The interview guideline was elaborated according to the objectives of the research and its contents referred to the types of burns, severity, recovery time, necessary care for the recovery and invasive procedures performed by the health team. It also dealt with psychological aspects involving the family and the child, and the importance of family support to the burned child. The semi-structured interview was audio recorded and later transcribed.

The work was approved by the Committee on Ethics in Research on Human Beings of the children's hospital where it was held, and by the Ethics Committee on Ethics in Research of the University that hosted it (Opinion 37156014.9.3001.5361). The professionals were invited to participate in the interview, individually, after signing the Free and Informed Consent Form (FICF). All were interviewed in the hospital's facilities, according to the availability and schedule established by the professional to dedicate to the moment of the interview.

For better organization, integration and analysis of data, it was used the software Atlas/ti 7 -– a computer application designed for the qualitative analysis of data from texts, images or sound records. Data from the semi-structured interview were analyzed according to theme/ category-based content analysis techniques (Bardin, 2011). The data were inserted in the Atlas ti 7, then it was tried to verify the words that stood out to be named of thematic elements, to later identify the category and subcategory.

Results

The results were grouped into categories, subcategories and elements of analysis, presented below in Table 1:

Table 1
Category "Communication in the hospital context", its subcategory and elements of analysis

Category	Subcategory	Thematic elements
1. Communication in the hospital context	1.1 Communication between health tem and child	1.1.1 Talking 1.1.2 With the help of parents 1.1.3 Playing 1.1.4 With empathy 1.1.5 With affection 1.1.6 Entertaining 1.1.7 Through bond
	1.2 Communication between health team and family caregiver	1.2.1 In daily conversations 1.2.2 With empathy 1.2. 3 Politely 1.2.4 Avoiding clashes 1.2.5 In due course
	1.3 Factors that facilitate communication	1.3.1 Participation – interest by the family member 1.3.2 The way of expressing themselves 1.3.3 Information material 1.3.4 Gradual transmission
	1.4 Factors that hinder communication	1.4.1 Difficulty in understanding: drug use and level of education 1.4.2 Sense of guilt Use of technical terms

The category **communication in the hospital context** was subdivided into four subcategories: communication between health team and child, communication between health team and family caregiver, and factors that facilitate and hinder communication. The sub-category **communication between health team and child** presents the health team's testimonials regarding the strategies used by these professionals to transmit important contents about burn treatment to the child.

The professionals considered that the communication should be carried out talking and joking during the accomplishment of the procedures. They also pointed out the importance of distraction, something that gives the child a change in focus from the stressful situation. For the transmission of information, they indicated that the accompanying persons are considered intermediaries and facilitators of this process. They emphasized that information is transmitted through empathy in conversations in the daily routine, as can be seen in the following reports:

> *I try to explain to the child everything I am going to do, regardless of whether he or she will understand it or not. Because, something, at least, the child absorbs. So, if I am going to bath, I say: Auntie is going to bath you, then change the dressing and put a clean one; it will scratch the boo-boo a little, but let us wash it to not catch a bug. So you can explain to a child what you are going to do. A 3-year-old child already understands what a bug is. She does not understand what a bacterium is, what an infection is, but she knows what a bug is (...). I think dialogue, conversation, is very important with the child, regardless of age (E2).*[2]

[2] Interviewees will be designated by the letter "E" followed by the participant's number.

> *(...)You have to take into account the age. If the child is small, like this one here that is seven months old, there is not much to do. You have to play and rely on his/her parents' help. The child only cries, it is difficult. But the older ones, I get them to participate in the treatment. I explain to them what is happening, the reason of that bath, the importance to avoid infection. I also ask them collaboration to be hygienic and not to touch the dressing. I explain that it is a treatment that requires care of everyone and to do nothing without the authorization of the team. So I keep talking to the patient during the procedures (E7).*

Based on the above reports, it is verified that these professionals seek to present the set of information regarding the current moment experienced by the child, and consider the characteristics of the child, namely, age, and ability to understand the information that is received. This is done through the use of a simple and accessible language to convey information about treatment. In the perception of professionals, in daily conversations and through play, it is possible to transmit the information to the child in a gradual way, so that it is possible to minimize the emotional impact. In addition to the transfer of knowledge, the conversations and plays aim at distraction, in order to divert the focus from the situation, which is sometimes experienced by the child in a stressful way.

Respondents reported that with children under three years of age, communication is limited to the smile, joke, and gentleness in managing the affected area, which also occurs through the help of family members. For children above 3 years of age, professionals explain the procedures counting on the help of the child in the treatment process, with attention to hygiene and care with the integrity of the dressings. Empathy is a key element in the communication process, as professionals E4, E6, E8 and E9 considered that putting themselves in the place of a crying child is fundamental, not only for being a child but for being a child who sometimes presents seventy percent of the body burned. According to professionals, crying is translated as a form of communication and should be welcomed.

Once the child is suffering, regardless his/her age during the treatment; the family member plays the role of intermediary in the communication process, as considered E5, E6, E7, E11 and E12. Communication does not follow a previously established pattern and will depend on the severity of the burn, the interest of the family member, and the degree of family openness and understanding of what is happening.

The subcategory **communication between health team and relative caregiver** presents the reports of the health team about the strategies used by the professionals to transmit to the accompany persons important contents about the treatment of the burn, besides guiding them as to the importance of their active role with the child. In the testimonies, the health team considered the need to be attentive when exposing information, so that this exposure is carried out with education and empathy, putting themselves in the place of the other, with a view to foster welcome and avoid conflicts. They considered that we should wait for the right moment for the transmission of information in daily conversations, which should happen gradually and with patience, insofar as the procedures are carried out, according to the following reports:

> *(...) we have to respect the moment of the family. We talk a lot, of course, when the relative opens up to it. Talking with patience day by day and gradually, we explain the procedures, the routines, and so on (E9).*

> *(...)So I go to them and I say: look ... parents or mother, 'This is my shift, I'm here to take care of your child and whatever you need, come and talk to me first'... and I'll make myself available. I ask their names and make room to familiarization. And then things flow well (E8).*

Professionals reported the importance of waiting for the right moment for the transmission of information, considering the period of crisis that the family is facing, the amount and complexity of information to be passed on, and the possibility of understanding by the family member. The professionals pointed out that the fact of being available promotes familiarity and facilitates communication.

The E6 professional pointed out that one of the strategies used to establish effective communication is to let the accompanying person to unload or even attack them, because *"letting them boss us around, draining a little of us, avoids confusion."* According to this professional, some accompanying family

members are considered to be *"difficult to relate"*, so it is important to establish strategies for establishing fluid communication.

Another professional interviewed pointed out that the personal introduction and explanation about the specialty that he exercises represents something that contributes to know, besides the name of the family member and the child, where they reside and other details for familiarization. Next, it was emphasized that in the first contact, they try to explain about the changes of professionals by work shifts, some routines of the unit with the purpose of promoting the welcome of the family.

The subcategory, **factors that facilitate communication** addresses the elements that facilitate the transmission of information performed by the health team for children and accompanying persons. The professionals considered that the gradual transfer of information is one of the elements that facilitate the transmission of content about the treatment. This is done considering the moment of the accompanying family member, in order to inform what is necessary regarding the treatment stage, since no attempt to transmit information will be effective in moments of great stress, usually present in the first days.

According to the professionals, another element facilitator of the communication referred to the possibility of using informative materials for children, which would contain content on the types of burns, treatment, length of hospitalization and general guidelines, however, this material is not found available at the Burn Unit. The way to communicate calmly, with education, and through a simple language that considers and values the sociodemographic characteristics of the family member is a facilitating element, since it provides a moment of welcome and empathy on the part of the professional. The professionals recognized that the interest and participation of the family member in the treatment is a facilitating element in the transmission of information, according to the following reports:

> *(...)as we go through the procedures, it facilitates when they participate because then we can explain what we are doing. It is a lot of information and we explain it in the course of the treatment (...) it facilitates communication when they participate, they ask, they are interested (E1).*

> *(...)So the important thing is that you can, regardless of technical terms, language, explain to the family what is happening to that child. Explaining with regard to wounds, for example, why it is white on the skin. Knowing to tell them what a third degree burn is, because for persons who have no study, by saying third degree they will not understand. You will have to say: this is because the cloth/tissue is all burned, it will have to be removed. Therefore, the way that you express yourself will help a lot in the contact. So I do not think it's too hard to pass on to them what's going on. What exists is the correct way of speaking, in order to facilitate the dialogue with the family (E2).*

According to the reports presented above there are strategies used in the communication process, for example, the way to express the content in a simple way; and once the relative participates in the performance of the procedures, the right moment for the communication process is established, because what is communicated simultaneously is being performed in practice.

Other testimonials complement the results of this category, such as the reports of professionals E2, E4 and E8, who considered the need for informative materials, such as banners, graphs and booklets, highlighting the types of burns and healthy attitudes the post-treatment . For the professionals, these materials would be available at the reception of the unit for periodic consultation by the family caregiver, so that the caregiver could develop interest in knowing the information, and in case of doubts, the members of the team would be the mediators in the process of clarification.

The professionals emphasized in their reports that the way to express themselves should be based on dialogue without using technical terms, and with a friendly and educated tone of voice. There will be a distance between what is communicated and what was understood, if the professional does not place himself within the cultural and understanding level of the relative, pointed out in their reports the professionals E2, E3, E4, E5, E8 and E9.

The results also pointed out that the interest of the family members was highlighted, because their questionings raise information that could go unnoticed, since the communication about about the procedures does not follow a sequential or content pattern. Interest should not be limited in knowing the moment to discharge or on routine issues, but they should be interested about the treatment, which will enable them to participate in the procedures and develop the necessary knowledge the situation of the

child. Participating with interest in actions in partnership with the health team is an element that helps communication (E1, E3, E7, E11, E12).

The subcategory **factors that hinder communication** refers to the elements that interfere in the transmission of information carried out by the health team. The interviewees reported that the use of technical terms is one of the elements that hinder the transmission of information. This practice, coupled with the element sense of guilt, makes communication on aspects relating to the treatment even more difficult. The professionals reported that the difficulty of understanding, due to the low level of schooling and, in some cases, the use of drugs, is another obstacle, according to the following report:

> *We have to assess the level of understanding of each of them to see how we will address them. There are families that do not present a very good understanding, or are angry (...). And schooling hinders a lot. They have difficulty in understanding the treatment when the level of schooling is low (E7).*

> *(...) not everyone understands what we explain. We talk, but they are not very aware. For example, there is a mother here who is addicted to cocaine, and has even made her two-year-old son addicted who wants to suck all the time. He is addicted, too. And then for such a mother, it does not help much to try to explain things. She is drugged, and we have already told her to stop breastfeeding, but she breastfeeds to keep him quiet (E4).*

The reports above highlight the difficulty of communication about the treatment, specifically referring to accompanying family members who present low level of education, which makes it difficult to assimilate the information. In addition to the educational level, the professionals interviewed reported that in cases where accompanying family members are users of drugs, such as alcohol and cocaine, this has consequences on cognitive skills, and subsequently interferes with understanding the information. This generated in the health professional a certain nonconformity with the situation of the relative, and thus the health team diminishes the contacts that are made (E4).

Other professionals expressed their opinion on the theme as follows: five professionals considered that because of the low level of schooling or drug use, information such as the need to keep the same dressing for up to five days without the need to replace it, is not understood or is misinterpreted by the accompanying person, who considers a negligence of the professional not to change the dressing with daily frequency, according to E2, E4, E5, E9 and E12.

Such a condition is aggravated when technical terms are used in the act of informing, which requires, for example, to replace terms such as third-degree burn by the skin is deeply burned. The interviewed professionals emphasized the importance of using terms accessible to the understanding of the accompanying family member. Technical terms should only be used with family members who demonstrate the ability to understand and contextualize technical information (E2, E4).

The professionals reported that the feeling of guilt of the family member interferes negatively in the assimilation of what is communicated, since the accompanying person is inaccessible to listening. On the other hand, when the communication is assimilated, the feeling of guilt is intensified by the belief that the child will feel more pain, especially in the balneotherapy procedure, which makes it difficult to receive the information due to the lack of acceptance of the treatment that will be performed (E5, E10, E12).

Discussion

The communication between health team and hospitalized child represents a theme analyzed in the scientific studies (Dorociaki & Dyniewicz, 2000; Gabarra & Crepaldi, 2011; Gonçalves et al., 2015; Souza & Oliveira, 2010), and what has been verified is the interest of investigating the reports of the child and health professionals. In the study by Gabarra and Crepaldi (2011), it was verified that the communication of the team with children aged five to six years is carried out in an indirect way, and with those aged seven to thirteen years, occurs directly. The children emphasized that the health team prioritizes communication with their relatives, and this demonstrates the desire of the children to establish a dialogue with professionals to know the information regarding their current situation experienced in the hospital.

Another study clearly presents this demand, since health professionals emphasized that nonverbal communication is used more frequently through facial expressions, but the team considered that playing

and telling stories contributes to establishing verbal communication (Dorociaki & Dyniewicz, 2000). In the pediatric burn unit, a health team considered that playing represents a useful resource for the establishment of dialogues, and this presents contributions, for example: social interaction, adherence to treatment, and child recovery (Azevêdo, 2013). These results regarding the use of play in the communication between health team and child are congruent with the reports obtained in the present research, since children claim for a direct communication even in the face of information that generates suffering. Thus, playing in the context of child hospitalization allows the child to understand the reality experienced and develop strategies for coping with situations, considering that the playful action contributes to the establishment of communication, in the management of traumatic events, and in the construction and strengthening of bonds between the child, the family and the health team.

Specifically, in communicating bad news, health professionals used the discussion of diagnosis, prognosis, and guidance on the invasive procedures that children would undergo, however only some information was transmitted (Gonçalves et al., 2015). For the professionals, the decision whether or not to inform the child will depend on specific variables, for example, the emotional state, age, schooling, and child-doctor relationship.

In the scientific production, it was identified that the pediatricians during the clinical examination established communication, but children could not understand the information that was transmitted (Souza & Oliveira, 2010). Thus, keeping focus on the forms of communication with gradual transmission of information, and verifying if the child was able to understand the content transmitted, represent strategies that contribute to the communication process, something that is carried out by the health team in the Burn Unit. Thus, the results obtained are divergent from the studies pointed out, as the team from the Burn Unit presents the child with the information they deem necessary, through different forms referring to direct conversation and playing.

Given this context, a study pointed out the importance of informing the child about all aspects of the hospital environment, even in cases of simple surgery and short stay in the hospital (Machado, Jesus, & Filgueiras 2008). The child who has been previously prepared for surgery will become a collaborator in the treatment when perceiving the need and benefits, even if this represents a possibly traumatic situation, a priori. Family caregivers evaluated the effects of the pre-surgical psychological preparation performed on their children, and the results showed greater contributions, namely improvement in sleep, reduction of anxiety, clarification about surgery, in children who received verbal information and used playful instruments , when compared to the group of children who received information exclusively through verbal communication (Broering & Crepaldi, 2011).

The team at the Burn Unit initially considers the child's experience, and to this end, uses empathy; and then transmits the information in a direct manner, adapting the use of words, according to the child's age and understanding, considering that there is an integration of verbal expressions, nonverbal expressions, and valuation of play. Possibly, the professionals develop a sensitivity to the hospitalization situation for burn treatment, and consider the uniqueness and the experience of the child and his/her family.

Investment in communication and emphasis on family needs represent the central point for developing interpersonal relationships and achieving positive outcomes in the interactions that are developed (Fisher & Broome, 2011). This demonstrates that a perspective of the communication focused on the demands of the family makes possible the use of actions of integrality of the assistance of the Brazilian health policy, the welcome, which is consistent with the results obtained in the Burn Unit.

In this sense, Murakami and Campos (2011) pointed out that actions in nursing, for example, should not be centralized only in the presented pathology, a condition in which the nurse is only a performer of technical care to the patient, but, on the contrary, they should exercise their role as a facilitator of the hospitalization experience, providing a less traumatic treatment for the child and his/her accompanying person, most often the mother figure.

According to health professionals, the participation of the family member caregiver was a facilitator in the communication process. Research by Gomes and Oliveira (2012) showed that families feel moved to care for the child when they are encouraged, educated and instrumented for this purpose through the mediation of health professionals. For example, information on medical procedures, diagnosis, and prognosis is a key part of adherence to the treatment and subsequent recovery by the child and family

member. The information transmitted by the health professionals promotes the reduction of possible negative symptoms, which occurs through the clarification with the transfer of information and welcome of this relative.

Góes and Cava (2009), in their studies, demonstrated that the health professional performs his actions based on the biological model of the process of health and disease, with transmission of knowledge from the one who owns the knowledge, with little valuation to the knowledge of families and their social reality. On the other hand, the professionals of the Burn Unit are concerned to communicate in the best possible way, in addition to not being attentive to the purely biological aspects, because the empathetic contact established and the respect to the moment experienced by the relative represents a humanized strategy of care.

Positive results were identified after the participation of nurses, doctors and psychologists in a training that had the objective of developing skills of communication with the relatives of hospitalized children. The experimental study investigated the team's communication before and after the intervention, which was possible to indicate that the levels of family satisfaction were higher after the team performed the training, since the caregivers perceived that they were understood and the information presented was regarded as sufficient (Ammentorp, Kofoed, & Laulund, 2011). However, in the Intensive Care Unit, the need for health professionals to develop different ways to establish communication (verbal and non-verbal) was identified, as it was verified that the relatives valued the way in which the transmission of information is performed (Nieweglowski & Moré, 2008). The research indicated that the health professionals were more attentive to the technical procedures performed in the hospital, because they had few skills of communication and development of interpersonal relationship.

The transmission of information from the health team to the accompanying person requires the professional certain skill and emotional balance, given the circumstances of the hospitalization. In the first contact, the family member presents emotional instability with a strong sense of guilt, anger, and is usually resistant to contact. Another facilitator was the possibility of using educational materials, for example, a booklet available in the sector to help communication with the family member.

The literature shows positive effects when these materials are used, because in a research nurses constructed and shared leaflets with information about pain evaluation in pediatrics, and the relatives emphasized that this form of communication allowed to know the procedures that are performed, and at the same time to clarify questions and participate in child care actions (Hong, Murphy, & Connolly, 2008). Parents, supported by information, are the main responsible for passing on and clarifying children's doubts (Sabatés & Borba, 2005).

In relation to the elements that interfere in the communication process, difficulty of understanding by the family member and low level of schooling, the study by Gold et al. (2013), showed that the mothers had little knowledge about the reasons for hospitalization, resulting from the difficulty of understanding the information that was transmitted by the health team. In the same vein, the study by Soderback and Christensson (2008) found that low level of education and socioeconomic conditions that indicated social vulnerability, resulted in difficulties in understanding the treatment and other aspects related to hospitalization, a result that is consistent with those of the present research.

However, there is a need to build communication strategies to address the particularities of these relatives, as the team has shown that the caregivers present feelings of guilt, and this has been highlighted in researches conducted in pediatric burn units (Bakker et al., 2010; McGarry et al., 2014; Oliveira et al., 2015). The fact that guilty feelings make communication difficult allows emphasizing that the different psychological, socioeconomic and cultural aspects to which they relate the population served require the use of different strategies for the transmission and welcome of messages to flow adequately.

In other studies, difficulties in establishing communication were attributed to the limited time of contact with the child and family caregiver, to overwork, and to the reduced number of professionals in the sector (Dorociaki & Dyniewicz, 2000). The facilitating and hindering elements relate exclusively to the behaviors of children and their caregivers (Souza & Oliveira, 2010). Thus, it is possible to verify that in the burn unit there are specific demands that are divergent with the results of studies carried out in general pediatric units, which shows the need to develop contextualized actions.

Final considerations

The professionals of the health team in the Burn Unit use different forms of communication, and the sharing of information is carried out through the welcome respecting the moment of the child and family, which allows to provide engagement making them active in the communication process . It was identified that through the empathetic contact the information is transmitted gradually, in a welcoming way, with adequate words to facilitate the understanding of the child and the relative.

The facilitators of the communication refer to the participation of the family member, and the possibility of health professionals to use educational materials. On the other hand, low level of education of the family member represented the hindering element. The objective of understanding the communication process between the health team, child and family in the burn sector was reached due to the reports evidenced by health professionals. It is recommended that future studies investigate the reports of children and their families to contribute to the development of research, and thus reflect on the possibilities of psychological intervention focused on the communicative strategies of all those involved.

In view of hindering elements, it is recommended that interventions in communication skills be performed so that professionals develop strategies to be used with family members that present low-level of education and in specific cases of drug users. Another point is the possibility of building informational instruments, for example, booklets, so that they can help the communication between health team and family, and in this way, new studies contribute to this task. In summary, the health team of the Burn Unit demonstrated an interest in the different forms of communication through the construction of links, which is congruent with the work process in the health area through the welcome and the expanded view about the process of health and disease.

In short, the welcoming and the smooth and empathetic communication represent aspects that help in the treatment and recovery of the child in the hospital context, in a way that affects the relationships established between the family and the health team. Numerous implications occur when the welcome is performed by the health professional empathetically, for example, improvements in communication between all involved (health tem-family-hospitalized child) and the building of bonds that help in the development of support networks, which are health promoters.

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Received: Mar. 09, 2017
Approved: Nov. 13, 2017

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