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Original Article

INTERPERSONAL COMMUNICATION WITH ONCOLOGICAL PATIENTS IN PALLIATIVE CARE

COMUNICAÇÃO INTERPESSOAL COM PACIENTES ONCOLÓGICOS EM CUIDADOS PALIATIVOS

COMUNICACIÓN INTERPERSONAL CON PACIENTES ONCOLÓGICOS EN CUIDADOS PALIATIVOS

Maria Ireni Zapalowski Galvão[1]
Moema da Silva Borges[2]
Diana Lúcia Moura Pinho[2]

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Objective: to understand the interpersonal communication process in the trajectory of patients under palliative care in the perspective of Peplau's theory. Method: exploratory, descriptive study with a qualitative approach. Patients under palliative care from a hospital in Brasília, Distrito Federal, Brazil, participated in the study. Data were collected in September and October 2015 through semi-structured interviews and were submitted to content analysis with the use of the software Alceste. Results: content analysis generated two axes. The first one refers to communication of bad news, the treatment, and coping strategies; the second one relates to resilient factors that helped them to overcome adversities. Conclusion: the needs experienced by patients were met by means of an effective communication, and the team mobilized the best skills and potentialities of the human being to cope with these stressful situations and maintain the autonomy and dignity of individuals under their care.

Descriptors: Communication. Palliative care. Nursing theory. Interpersonal relations. Oncology.

Objetivo: compreender o processo da comunicação interpessoal na trajetória dos pacientes em cuidados paliativos à luz de Peplau. Método: estudo exploratório e descritivo de abordagem qualitativa. Participaram pacientes em cuidados paliativos de um hospital de Brasília, Distrito Federal. Os dados foram coletados em setembro e outubro de 2015, por meio de entrevista semiestruturada e foram submetidos a análise de conteúdo com auxílio do software Alceste. Resultados: da análise de conteúdo emergiram dois eixos. O primeiro refere-se à comunicação das más notícias, o tratamento e as estratégias de enfrentamento; o segundo relaciona-se a fatores resilientes que ajudaram a superar as adversidades. Conclusão: as necessidades sentidas pelos pacientes foram atendidas por meio de uma comunicação eficaz, e a equipe mobilizou as melhores capacidades e potencialidades do ser humano para enfrentar as situações estressoras e preservar a autonomia e a dignidade de pessoas sob seus cuidados.

Descritores: Comunicação. Cuidados paliativos. Teoria de enfermagem. Relações interpessoais. Oncologia.

Objetivo: Comprender el proceso de comunicación interpersonal en la experiencia de pacientes bajo cuidados paliativos a la luz de Peplau. Método: Estudio exploratorio, descriptivo, de abordaje cualitativo. Participaron pacientes en cuidados paliativos de un hospital de Brasília, Distrito Federal. Datos recolectados en setiembre y octubre de 2015, mediante entrevistas semiestructuradas, sometidos a análisis de contenido con ayuda del software

[1] Nurse, Master of Nursing. University of Brasília. Brasília, Distrito Federal, Brazil. irenigalvao@yahoo.com.br
[2] Nurse. PhD, Professor at the Nursing Department of the School of Health Sciences and the Graduate Program in Nursing, University of Brasília. Brasília, Federal District, Brazil.

Alceste. Resultados: Del análisis de contenido surgieron dos ejes. El primero hace referencia a la comunicación de las malas noticias, el tratamiento y las estrategias de enfrentamiento; el segundo se relaciona a factores resilientes que ayudaron a superar las adversidades. Conclusión: Las necesidades sentidas por los pacientes fueron atendidas mediante una comunicación eficaz, y el equipo empleó las mejores capacidades y potencialidades del ser humano para enfrentar las situaciones generadoras de estrés y para preservar la autonomía y dignidad de las personas bajo sus cuidados.

Descriptores: Comunicación. Cuidados paliativos. Teoría de enfermería. Relaciones interpersonales. Oncología.

Introduction

The communication process and interpersonal skills represent basic components in a high-quality service as well as for professional competence[1]. Therefore, they support human relationships and represent a therapeutic assistance tool that supports the provision of the individualized care required by patients under palliative care[1-2].

In this context, the theory of interpersonal relationships by Hildegard Elizabeth Peplau, which presents theoretical influences of psychology and psychiatry, established a new focus and meaning for the care in nursing based on the psychological and subjective dimensions of individuals, that is, the patient[3]. This theory seeks to remove the disease condition from the main focus of the nursing care, and valued the expression of feelings by patients, as much as the mechanisms to help them to cope with this experience[3-5].

Peplau's theoretical model emerges from the psychodynamic nursing, and defines it as "[...] being able to understand the behavior of some individuals in order to help others to identify the experienced difficulties and apply principles of human relationships to the problems that occur in all levels of experiences"[4:426]. This definition enables the elaboration of structural concepts of the interpersonal process, the stages of the nurse-patient relation, and the nursing roles that occur during the therapeutic relationship between nursing and patient[3-6].

Peplau describes four stages of the nurse-patient relationship: orientation, identification, exploitation, and resolution[3-6]. The orientation stage is related to clarifications provided by the nurse when a patient seeks professional support and describes a "felt need". In the identification stage the patient establishes affinity with the nurse and responds in a selective manner to people that may fulfill their needs. In the exploitation stage, the patient uses the resources provided by the relationship to obtain benefits and the best possible services; the level varies according to their interests and needs. The final stage consists of the resolution, representing the moment in which the patient adopts new goals as their needs were contemplated by the therapeutic relationship established with the nurse. The four described stages are interrelated and overlapped. The duration of each one varies according to the evolution of the process until the problem is solved or the therapeutic goals are achieved[3-5].

The other essential component of Peplau's theory consists of the six roles of the relationship between nurse and patient that occur during the therapeutic process, namely: stranger, resource, leadership, teaching, surrogate, and counseling[3-7]. The stranger role is performed in the first meeting, when nurse and patient are strangers to each other. As a resource person, the nurse promotes specific, clear answers to broad questions raised by the patient, especially regarding health. In the leadership role, the nurse is responsible for referring and following up the goals of the patient in order to help them to achieve their expected results. The teaching role is the combination of all roles and its action results from what the patient knows and the ability to use information. The substitute role is designated by the patient when they understand the nurse as if he or she were replacing someone. The nurse's role consists of helping the patient

to recognize similarities and differences between the nurse and such person. Lastly, the counseling role occurs through the way the nurse responds and listens to the requests made by the patient through communication skills and supportive attitudes[3-5].

For this interaction the theorist emphasizes that the nurse should ensure the development of an interpersonal relationship through the use of communication tools, such as listening, clarification, acceptance, and teaching[5]. It is important to mention that in the disease process the patient experiences two-way feelings of knowing and understanding the disease, the treatment, and the prognostic process, as well as feeling known and understood in their individualities and needs[8].

On the other hand, despite perceiving the importance of interpersonal communication, health professionals mention difficulties to use it as a therapeutic resource in care, especially in relation to the approaches to communicate bad news and end of life[1-2,8].

Considering that the theoretical model of Peplau conceived a new paradigm for nursing directed to the interpersonal relationships that occur between nurse and patient and contributed to a new approach to the patient based on the valorization of interpersonal relationships, privileging this aspect in nursing care[3-5], the objective of this study was to understand the interpersonal communication process in the trajectory of patients in palliative care in the perspective of Peplau. The interrelation between theory, research, and clinical practice is considered indispensable for the continuous development of nursing as a profession and science[9].

Methodology

This is an exploratory, descriptive study based on a qualitative approach. It was developed in the oncology program of a rehabilitation hospital in Brasília, Distrito Federal, Brazil. In addition to treatment complementation with the physical-functional rehabilitation of patients, this service offers surgeries and chemotherapy.

Inpatients in palliative care presenting primary malignant bone and soft tissue tumors participated in the study. Inclusion criteria were patients aged over 18 years, both genders; presenting, in the period of data collection, information related to the progress of the disease registered in their electronic medical record, with the terms: tumor progression, nodule enlargement, unresectable tumor, metastatic, progressing, palliative radiotherapy, or multiple nodules. Although the established treatment modality was palliative, this terminology was used as not all medical records informed whether the patient was under palliative care. Exclusion criteria were patients with cognitive alterations and difficulties in verbalization. The establishment of the number of interviews followed the data saturation criterion, that is, when homogeneity in the studied group is achieved.

Data were collected in the period between September 16 and October 15, 2015, through access to the documentation registered in the electronic medical records in order to search for terms for inclusion of patients in palliative care in the study. In addition, a questionnaire was used in the profile design of the individuals, as well as a semi-structured interview script, sequenced and elaborated according to the four stages of Peplau's nurse-patient relationship. Although Peplau's theory has been related to the nursing practice, in this study the nurse-patient stages were expanded for the communication of the palliative care team. All the interviews were conducted in the oncology program, in a private place, with duration of approximately 60 minutes.

Data obtained in the interviews were transcribed in full, and the corpus of the text was submitted to content analysis with the use of the software ALCESTE – *Analyse Lexicale par Contexte d'un Ensemble de Segments de Texte*. This software is considered a methodology as it uses sophisticated statistical methods to allow grounding content analysis[10]. The corpus of the text is in accordance with criteria required

by the program. Systematic counting of words in the text was carried out during the lexical analysis in order to recognize the total number and types of words. At this level of analysis the group of words presenting the higher *Chi*^{2} (chi-square), that is, greater relevance, allowed the conformation of the qualitative analysis into classes in which the identification of significant aspects of experiences of the group was focused. This process enabled the grouping of semantic roots, defining them by classes according to the function of the word in the speech.

The program identified the variables named Initial Context Units (ICU) used to individualize the speech of each interview, characterized by its relevant aspects (age, profession, gender, educational level, among others). The participants in the study were identified by the letter P (patient) and the number corresponding to the order of the sequence of interviewees. The corpus of the research in ALCESTE produced a set of statements that are meant to translate different points of view of patients, allowing several sources of interpretation and epistemological discussion on the investigated theme.

The results generated by the program were graphically represented in correspondence space, and a dendrogram of the Descending Hierarchical Classification Analysis (AHD) evidenced the relations between the classes/categories that were theoretically interpreted by the authors, being subsequently empirically justified.

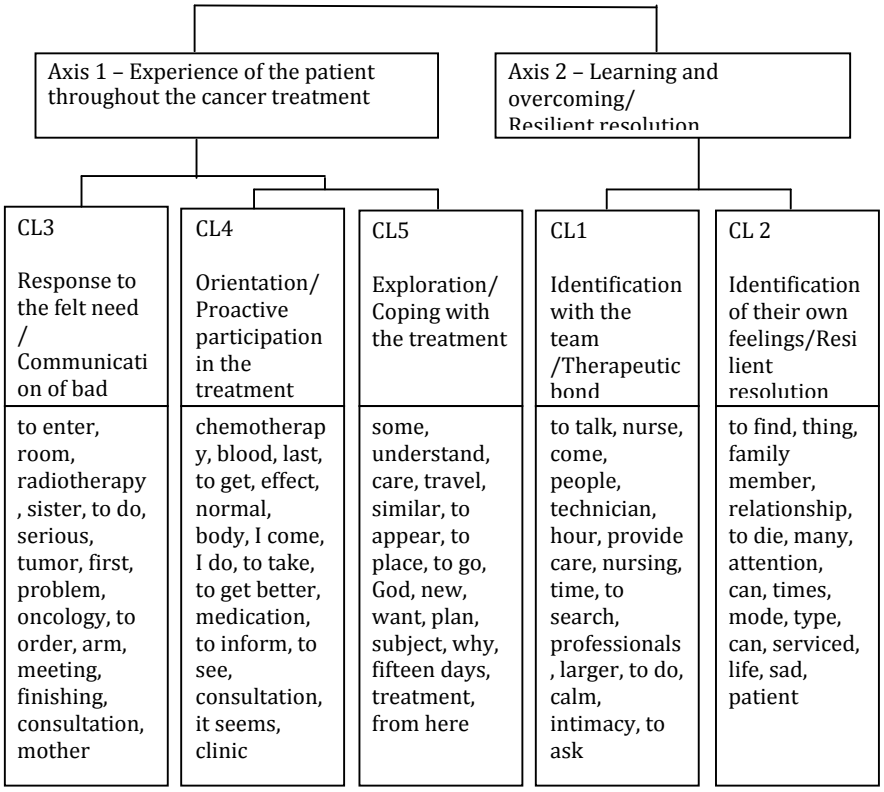
The study was developed in compliance with Resolution 466 of December 12th 2012 of the National Health Council. It was submitted to the Research Ethics Committees of the School of Health Sciences at the University of Brasília (UnB) and the Association of Social Pioneers of the Distrito Federal, and was approved under the Certificate of Presentation for Ethical Consideration (CAAE) number 42277015.7.3001.0030. All patients signed a free and informed consent form.

Results

Ten patients participated in the study; six with a diagnosis of primary malignant soft tissue tumors and four with primary malignant bone tumors. The profile of these patients was as follows: six were male and four were female. Regarding their age group, 4 were aged between 20 and 29 years old, 3 were between 30 and 39 years, and 2 were between 40 and 49 years, 1 was between 60 and 69 years. Thus, seven interviewees were aged between 20 and 39 years, characterizing a group made up of young adults. Regarding religion, six were Catholic and 4 were Protestants. In relation to the follow-up period, 5 were in the program between 0 and 1 year, 2 between 2 and 3 years; 2 between 4 and 5 years; and 1 between 6 and 16 years. The five patients that were being followed up in the institution for up to 1 year had been admitted to the program at an advanced stage of the aggressive tumor.

The exploration of content of the interviews by the software generated five classes, namely: response to the felt need; proactive orientation/participation in the treatment; and treatment exploration/coping. These three classes refer to the communication of bad news, treatment, and individual effort of patients in managing the disease-related stress and the suffering caused by the therapy. The two classes named "identification with the team/therapeutic bond" and "identification of their own feelings/resilient resolution" mention the result of the work of the care team translated into the personal effort undertaken by patients to cope with the disease, as shown in the dendrogram of Figure 1 below.

Figure 1 – Dendrogram with the axes and classes that emerged from the interviews with patients. Brasília, Distrito Federal, Brazil – 2015. (N=10)



Source: Created by the authors.

Discussion

Axis 1 – Experience of the patient during the cancer treatment

The profile of the participants confirmed that cancer is considered a public health problem, a serious, highly lethal disease, and that the number of cases has been increasing in developed and developing countries[11-13]. In Brazil, about 600,000 new cases of cancer are estimated for 2016 and 2017[12].

The diagnosis of cancer inflicts a long and aggressive treatment to the patient. This path is permeated by communication of bad news and different therapies and coping strategies[11-13].

Response to the felt need

In this class, the presence of the verbs to enter, to order, and to do associated to the words room, radiology, sister, serious, tumor, first, problem, oncology, meeting, visit, and mother, in the speeches of patients, specifies when, where, and who was/were present at the moment of the diagnosis of the disease. The speech of the patients indicated that the communication of the bad news occurred at different moments of the therapeutic process.

Reading the communication of the diagnosis in the perspective of Peplau's theory evidenced that, in response to a felt need (severe tumor), patients sought to investigate and understand the disease process, corresponding to the guidance

stage described by Peplau. At that moment, the palliative care team played the role of a stranger, and their attitude was based on solicitude. This relationship favored the expression by patients so that they could jointly identify the need for help[1-3].

> *When I joined to the oncology, there was a lecture on the first day. They explained that the problem was serious and that my arm could be amputated because they had to remove the disease* [...] (P9).

> *When I was hospitalized, even before starting the chemotherapy. This meeting occurred in the very beginning.* (P1).

Communication of bad news is one of the most complex activities faced by physicians and other members of the healthcare team. Informing a diagnosis of cancer represents bad news as it changes radically or negatively the perception of patients about their future[14]. The announcement of bad news causes a strong emotional impact on the patient, often followed by fears, distress, and uncertainties, representing a timely moment for the professional to establish the role of a counselor. Moreover, the more careful the way of communicating, the greater the understanding by the patient in relation to their disease and the treatment process[8,11,13].

It was observed that the healthcare team intervened at different moments to enable the interaction and for exchange of information between patient and professionals in order to favor a satisfactory response to the felt needs, as pointed out by Peplau[3-5].

> *There were several meetings* [...] *The most difficult one was when I started and finished the chemotherapy; it was not working* [...] *Now I have to undergo some exams. Then, after the results of these exams, they will give me some explanations.* (P8).

> *In a meeting, they told me that it was not possible to carry out a surgery because the tumor was too deep, between the pelvis and the spine.* (P10).

The diagnosis was informed to the patient by the palliative care team in the presence of their family members. This behavior corroborates the theory of Peplau when it determines that the team, patient, and family members need to join forces to unveil and clarify the problem situation[3,15].

> *When I joined to the oncology there was a lecture on the first day, a long consultation with the doctor* [...] *and the team. They called my family, my father, my mother, my brothers.* (P9).

> *The meeting at the hospital occurred in the presence of my husband, my two brothers and a couple of friends, the nurse, the psychologist, and the doctor. These people were present to discuss about the disease.* (P6).

The communication of bad news should occur in a welcoming physical environment, which provides privacy, individuality, and allows the continuous expression of thoughts; an environment devoid of noise[16-17]. According to this guidance, it was observed that the announcement of bad news occurred in a private place in the presence of the team-family-patient triad.

> *In a separate, isolated room. I think it was a meeting room* [crying] [...]. (P1).

> *It was in an office, a private room [deep breathing]. It was in a room here at the Oncology sector, where this meeting occurs.* (P6).

A private space is essential to preserving the privacy of patients. As a rule, reviewing and talking about this moment mobilizes feelings of sadness, expressed in crying and deep breathing. On this occasion, the interviewer presented the behavior of an advisor by interrupting the conversation to provide the listening and therapeutic support required by the patient. This behavior is supported by Peplau's theory, which emphasizes the psychological meaning of the events and that the feelings should be included in the nursing interventions[3-6].

Orientation/Proactive participation in the treatment

This class comprises the verbs to come, to get, to take, to do, to improve, and to inform, associated with the words chemotherapy, blood, last, effect, normal, body, medication, consultation, and outpatient, denoting the active participation of the patient. This attitude is recommended by Peplau, who suggests the action of the patient as a collaborator in the treatment[3]. The adherence by the patient to the therapeutic process is directly related to the importance given by them

to the guidance provided by the healthcare team, the understanding of the disease, the perception of healing or control of signs and symptoms, the way they deal and cope with the disease, and the place of the team in their thoughts. Therefore the adherence to the therapy involves a multifactorial process established in the partnership between those receiving and those providing care[18].

The patient needs to be well oriented and receive information related to their therapeutic process, as well as establish bonds of trust and authenticity[18-19] so that they may assume the position of protagonists of their own treatment and present a participative behavior. Self-management and shared decision-making are important tools to empower patients[18]. Sharing decisions is in line with the recommendations by Peplau, which emphasizes the offer of conditions; thus, the health care may be transferred from hospital to home as a role of the team[3-5,7,15].

> *I come for an appointment and the doctor tells me everything that I will undergo. In the beginning of the treatment he informed me about everything, and we agreed; now we are just doing what was agreed.* (P2).

> *After my chemotherapy sessions, I can go back home safely. The doctors prescribe drugs to help us get better.* (P2).

The speeches evidenced that the patients understood the objective of the treatment, the procedures undertaken, and the behavior to be adopted in the event of intercurrences at home. It was also observed that the team adopted the role of a teacher by encouraging the active participation of the patient in the treatment, clarifying doubts, the potential side effects of the medication, and favoring the shared decision making.

> *I underwent chemotherapy sessions and faced the side effects attacking my body; and I try to go through it normally, like if it is just a stone in the middle of the road.* (P2).

> *You can introduce me to any available treatment. I am not afraid. Unless I can't resist to the treatment, but I'll do it. If it is for my health, then I have to do it.* (P9).

The active participation presented by the patients in the treatment is in consonance with Peplau's theory. It states that the self-management of the treatment results from an effective communication and an interpersonal relationship of trust with the healthcare team[18]. Thus, patients become self-sufficient, present initiatives, and adopt appropriate attitudes to achieve the goals aiming at a better health condition[3,5,15].

In the speeches of the patients, it was possible to infer that the responses of acceptance and attitudes to a diagnosis, prognosis, and treatment were directly affected by the interpersonal relation and the way professionals conducted the communication process in the transmission of information.

Exploitation/Coping with the treatment

In this class the verbs to understand, to travel, to go, and to place refer to the restrictions imposed on patients by the cancer treatment. The words service, God, plan, subject, and treatment refer to the different strategies used in coping with these constraints. It was possible to understand that despite the difficulties and barriers determined by the disease patients recommended the treatment, assumed the conditions imposed by the disease, and explored the offered resources, overcoming adversities. While coping with the disease, particularly in case of a threat to life, human beings seek to find a meaning for their existence and resize some abilities[19].

The speeches of patients suggested that these abilities were used to unveil the available solutions. This behavior set the exploration stage, characterized by the active use of the benefits available in the services, according to their interests and needs[3-5].

> *I underwent a treatment and used some medication, it did not work. I am undergoing another one, then some doubts arise* [...] *has the disease evolved, will it recede? But I know that there are other attempts. There is a way, there are other possibilities.* (P6).

> *Being in a nice place. There are resources here, the service and the hospital are very nice, the food, the bed. It is different from other hospitals* [...] (P9).

In the exploitation stage, the patient uses the coping strategies in the face of a serious disease and its aggressive treatment. This involves a dynamic, multidimensional process that raises a

number of responses. These responses involve the interaction of the individual with their environment and the use of mechanisms to manage an imminent threat as well as difficult situations in life[20].

The speeches of patients allowed the clarification of the several strategies used to respond to the needs of the treatment course. Aiming to mitigate the stressful impacts on the emotional, physical, and well-being conditions, the study highlighted:

a) the search for information, aimed at acquiring essential resources to solve the problem or balance emotions[20];

> *Because I ask the doctor about what is going on, and he explains it very clearly. Then, if I don't understand something, I ask him again, until I understand it.* (P10).

b) the direct action, with the aim of solving the problem that is being presented[20];

> *When the nurse talks to you, you have to tell her what you feel: for example, if I am nauseous. She says: now I am going to give you a medicine.* (P9).

c) inhibition of action, in order to control the actions deemed dangerous to the patient[20];

> *We no longer attend to weddings, family meetings, trips; some activities are not practicable when we have some type of serious disease.* (P7).

d) intrapsychic efforts, which ensure the refutation or avoidance of the problem in order to regulate the emotions in the face of a threatening situation[20];

> *I wanted to know how much time I have, you know?* [...] *And I still have this doubt, but I have never asked; I did not want to know.* (P6).

e) the search for the other, a strategy aimed at using the support to solve a problem[20].

> *At the time of bathing, dressings, other procedures, placing a catheter, they are always there with us, providing care.* (P1).

During the treatment, it was evidenced that patients also used a coping strategy focused on the emotion and the problem[19-20]. In the coping strategies the individual seeks to control emotions, the emotional response to the stressor, through behavioral and cognitive strategies[20].

Patients used coping strategies in the separation emotion as they sought to remain focused on life, avoiding thinking about the treatment. They could also make a positive reassessment in relation to the disease, for example: "there are worse things than this".

> *Because I can live, sometimes I even forget about the treatment, avoiding getting worried about the disease, but thinking about life. I also avoid asking myself: Why me? I have to be thankful, because I know that it could be worse.* (P5).

However, the problem-focused coping strategy works directly on the stressing factor. The proactive seeks to foresee and anticipate the potential stressors and act early to prevent their impact on life. In the combative, the individual reacts or tries to escape the stressor that cannot be prevented[19-20].

The following fragments illustrate the problem-focused proactive and combative coping strategies, respectively:

> *I think it is interesting to understand what is going on in our body, right?* (P10).

> *If something happens, here is the best place to be. If I go home, how can I get better? You have to take the right medicines rather than go home in a hurry. I think the right thing to do is tell the doctors what is going on* [...] (P3).

Finally, patients used spirituality as a support and source of energy to fight the disease and adversities[21] It was observed that patients feeling fragile and sick sought resources in their religious rites and beliefs to find a meaning and a purpose for their lives. This resource favored a psychological maturation, helping to cope with the adverse experiences of life[20-21].

> *I live what I believe. If I did not believe that there would be a way I think I would not have this strength. And I am faithful, I cling to God.* (P6).

Axis 2 – Learning and overcoming /resilient resolution

According to Peplau, learning is the result of the the health care behavior team towards the patient and the relationship developed during the disease process in order to motivate positive

changes in their health and resilience in the face of the disease process[1-3].

Resilience is the ability to elaborate coping strategies throughout life despite the adverse circumstances, as well as reestablishing and thriving after stressing situations. Resilience supports may be developed for therapeutic purposes in the face of a serious disease with limited prognosis[19]. It is a mechanism that occurs in the course of life through adjustments between risk and protection factors[20].

It was possible to observe two protection factors, which may be interpreted by the therapeutic connection of trust with the team, particularly nurses, as they spend most of the time interacting with the patient, influencing them, and promoting changes in their behavior and attitude. Another factor is related to the resilient personality of the patient in the face of stressing situations.

Identification with the team/Therapeutic bond

In this class, the verbs to talk, to provide care, and to search, denote the shared care. The words nurse, technician, professionals, calm, and intimacy unveil the efforts of the healthcare team to meet the needs of patients. This attitude favored the recognition of the availability of the team to accept the pain to find the solutions that may provide tranquility and intimacy.

Peplau points out that an effective interpersonal communication gives the patient space and voice, leading them to an identification with the team providing follow-up[15] as their needs are not restricted to those concrete ones, such as drinking, eating, sleeping, breathing; it also includes the subjective ones, such as their own experiences, feelings, beliefs, and attitudes. In this process the patient determines the professionals that can meet their needs, establishing a solid and trustful interpersonal relationship[3-5].

Considering that the nursing work is based on a meaningful and therapeutic interpersonal process[1-2,19], it was observed that in the perspective of patients the nurse is the professional available for a higher level of bond. This fact confirmed Peplau's theory as it pointed out that nursing was emphatically attentive to the importance of giving space and voice to patients, fully understanding them.

According to patients, proximity with the nurse allows the establishment of affinity and the development of bonds of trust. The nurse works in different stages of the oncologic disease, namely: after the diagnosis and beginning of the treatment, providing guidance, clarifying medical information, listening and discussing with the patient and family members about the therapeutic proposals offered by the doctor[11,19,22]. During the active treatment, listening to the concerns, assessing the symptoms, and guiding the patient and family members to share their doubts and about how to act in different situations. In the advanced stage of the disease they show sensitivity and attention to the concerns of patients and family members[22].

> *I particularly like to talk with the nurses, I think their language is simpler. The doctor is there to give the verdict. But the nurse has a broad knowledge of the area where they work, so I opt for this process.* (P7).

> *I request the support from nurses. Nurses are always there by our side when we need them. They just come and ask what you feel* [...] *There is more affinity with them.* (P2).

The speeches of the patients also referred the valorization of other members of the palliative team that provided direct and supportive care. It was confirmed that teamwork may be understood as a working strategy, a role of individuals and resources aimed at improving the effectiveness and problem-solving capacity of the health services resulting from the complexity of the health/disease process[1,19].

> *It is one of the best teams I know. They are always there to help* [...] *everything I ask, regardless of the time, they come and help.* (P2).

> *They are professionals duly qualified to provide care. Humanized, prepared to deal with these situations* [...] *From the cleaning staff to the doctor, they are all excellent.* (P6).

The recognition of the team by the patient during the course of the treatment enabled a

therapeutic, interpersonal relationship and the elaboration of protective factors for resilience.

Identification of their own feelings/Resilient resolution

In this class, the verbs to find, can, to respond, to do, and to ask were highlighted. These verbs denoted that the patient sought, in the course of the treatment, to understand the experienced situation in order to be able to overcome it.

Peplau explains that the team should encourage the patient to recognize their feelings and elaborate strategies using their potentialities to adapt to the problem situation, give the disease a new meaning, and achieve, within their limitations, their autonomy. Therefore these patients elaborate realistic goals in relation to their health condition, aiming at a better quality of life[3,15].

In this perspective, the resilient personality seeks to modify an uncomfortable personal experience into a personal skill as they interpret and handle stressing situations in a positive manner as overcoming factors[23]. Resilient patients usually consider the experienced events as a learning, being the protagonists of their environment[20]. Thus, they easily identify the available resources and use them as protective factors.

According to Peplau, nurses and other professionals should provide an atmosphere of acceptance and support so that the patient is self-conscious, using strengths to minimize weaknesses[3].

Therefore, the so-called protective factors contribute to the identification of helpful strategies to overcome adverse situations. They are structured into three groups[20]:

a) external supports, characterized as "I have", are those that patients have and use in their own benefit, helping them to become resilient[20]. In the speech of the patient the support "I have" referred to the help provided by the team and family members;

> *The whole team provides a good care and has a good relationship with us.* (P4).

> *My family takes good care of me* [...] (P4).

b) internal supports of the individual, defined as "I am", are the internal supports of the patient, those behaviors that reinforce the confidence and commitment in the face of an adversity[20]. For the patient, believing in life and having strength denoted hope in the future and indicated an aspect of the resilient personality;

> *I, I live what I believe, in life. If I did not believe that there would be a way, I think I would not have this strength.* (P6).

c) interpersonal supports conceptualized as "I can" are the means used by the patient to fight the adversities resulting from their situation[20]. Despite the inability to determine the meaning of the events related to the disease and the feeling of being unable to accurately predict the outcomes, patients remained willing to fight;

> *Because there is this treatment, and I don't know how it is going to be, but you know, regarding my way of thinking, I go after things, even without my limb I do not intend to quit.* (P6).

Therefore, it is possible to infer that the disease represented an opportunity for learning and growth. "The suffering caused by the disease is the raw material for the renewal of life; the disease generates health when it raises awareness of the internal power of overcoming"[19:87]. In this perspective, the disease process was used as a "path for light emersion". And the resilient personality was able to give a new meaning to the disease and use the protective factors in their favor. According to Peplau, professionals and patients become stronger and more mature as a result of this process[3].

This study suggests the expansion of studies using the Theory of Interpersonal Relations in different contexts experienced by oncological patients in order to offer subsidies so that professionals may improve the interpersonal relationship with the patient and establish a humanized, integral, science-based care.

As limitations of this study, it is necessary to take into account that it was conducted in a single place in a historically dated period and scenario, with patients hospitalized under palliative care in satisfactory clinical conditions and presenting preserved language abilities. It is suggested to

expand the study to different scenarios and with focus on patients presenting reduced or lack of speech and writing language skills.

Conclusion

The reading of experiences of oncology patients under palliative care in the perspective of Peplau's theory pointed out that the interpersonal communication process between the patient and the team was initiated in the guidance stage through the response to a felt need – diagnosis and clarification of the disease and its appropriate treatment.

Considering that the stages of the nurse-patient relationship according to Peplau are intertwined and overlapped, it was observed that the self-management of the treatment, the bond of trust – identification –, the use of the available resources – exploration – and the mobilization of internal resources – resilient resolution – resulted from interpersonal and communication skills of the healthcare care team.

Hereupon, the results of the study allow to conclude that the felt needs presented by patients were met by means of an effective communication; as much as a healthcare team who have mobilized the best skills and potentialities of the human being to cope with stressful situations and who maintained the autonomy and dignity of individuals under their own care.

The priority of the communication skills related to the use of appropriate communication protocols and techniques, in consonance with the need to be attentive to the feelings of the patient, the emphatic attitudes during the treatment, the strategies that facilitate the active participation of the patient in the therapeutic process and coping with cancer in order to the patient become resilient in the face of the disease and the treatment is reaffirmed.

Finally, the study affirms that the opportunity to correlate the interpersonal relations theory of Peplau to the current context of communication of patients under palliative care evidenced its contemporaneity. Although the theory has been created in the decade of 1950 under a different historical point of view, it remains up to date as it is based on premises that transcend the focus on the disease and advance into the subjective world of the patient, which has always been and will always be the essence of the nursing care.

Collaborations:

1. conception, design, analysis, and interpretation of data: Maria Ireni Zapalowski Galvão and Moema da Silva Borges;

2. writing of the article and relevant critical review of the intellectual content: Maria Ireni Zapalowski Galvão, Moema da Silva Borges and Diana Lúcia Moura Pinho;

3. final approval of the version to be published: Maria Ireni Zapalowski Galvão, Moema da Silva Borges and Diana Lúcia Moura Pinho.

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