75 - PERCEPTION OF THE PATIENT WITH HIV/AIDS ON ATTITUDES OF PROFESSIONALS IN BUILDING INTERACTIVE RELATIONS

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INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS) poses a serious problem to Public Health, a fact that has led to the continual development of prevention and treatment strategies. Being unhealthy in this context implies experiencing threatening physical and emotional situations involving a multiplicity of aspects when faced with the disease. While undergoing drug treatment individuals with AIDS experience grave side effects, changes in behavior and a need for discipline and emotion equilibrium, which represent the minimum conditions for quality of life. In this process, both professionals and patients are subject to conflicting experiences that may cause obstacles in perception or in the expression of needs (BRASIL, 2000).

Studies have shown that fear of solitude, abandonment, discrimination, prejudice and exclusion, in addition to low self-esteem, has caused infected individuals to feel marginalized, a fact that has led them to band together, generating a certain distancing in the search for adequate treatment and even to concealing their serology from professionals, family and friends. Denial, guilt, disgust and depression are emotional states that afflict patients with HIV/AIDS, interfering and impeding them to seek help (HANAN, 1994; SEFFENER, 1995; OLIVEIRA, MACHADO, 2002).

The professional in this process is a mediator of interpersonal relations, which means searching for the essence of patient behavior, facilitating their inner expression, their feelings, knowing their manner of dealing with things, creating opportunities for exchange through interrelations, thus contributing to their growth. Therefore, the therapeutic alliance formed by the relation established between professional and patient is fundamental, a transpersonal relation that will implicate in interactive attitudes and will have therapeutic or anti-therapeutic significance, depending on the experience aroused in the patient. This process must be a practice of individualized listening, centered on the patient, which assumes the capacity of establishing a relation of trust, aiming at assisting the individual as a whole (BRASIL, 2000; PERESTRELLO, 1982; BUENO, TERUYA, 2004; KANAAN, 2002; SILVA ET AL., 2002).

Certain facilitating attitudes are the differential for patient acceptance of care as an “unconditional positive consideration”, facilitating their free expression of feelings; an “empathetic understanding” of their subjective world, professionals putting themselves in their patients'place, something experienced in the building of the dialogic relation, experiencing with them the “authenticity and congruence” of their opening to self through their free expression. This attitude leads professionals to an understanding of patient needs and difficulties, as well as to the responsibility of adapting experience, awareness and communication. In the care perspective, the sensitivity to deal with this unhealthy Being must be a reflexive practice of not only technical competence, but mainly interactive in the act of knowing the empathic dialogic relation , with stimulation and meaning of anxieties and expectations (ROGERS, 2001; AMATUZZI, 1989; FREIRE, 1980; OLIVEIRI, 1985; SILVA, 2003).

Thus, in light of the complexity faced by the patient with AIDS, the purpose of the present study, seeking to create strategies for improving the quality of life and treatment received in the universe of human relations and interactions with health professionals, was to identify positive relational attitudes that characterize themselves as facilitating conditions for treating individuals with HIV/AIDS and striving to understand how these attitudes are perceived by users of a major public ambulatory service.

METHODOLOGY

The study was developed at a major state ambulatory service for HIV/AIDS patients in Natal-Brazil, where activities are elaborated related to prevention, treatment and assistance. As is the practice in studies with human beings and according to Resolution 196/96 of the National Health Council, this study was approved by the UFRN Research Ethics Committee.

It is an exploratory, descriptive, qualitative study that investigated the phenomenon of relational attitudes. This approach answers questions that cannot be quantified and aims at learning the subjects' points of view. The collection instrument, a semi-structured interview based on a previously elaborated script, was recorded and subsequently transcribed. The interview was selected as a form communicative interaction to obtain revealing patient data (MARCONI, LAKATOS, 1996; MINAYO, 2000).

The subjects, selected by intentional sampling, corresponded to 34 patients who were present at the study location. The criteria of inclusion were: age of majority, agree to participate in the study, be registered in the service and previously attended there by a professional. Sampling was considered satisfactory when, according to the theory of saturation or redundancy observed in the interviews, the numbers were sufficient to respond to the questions (MINAYO, 2000).

The personal demographic data obtained in the interviews were analyzed by descriptive statistics using frequency and percentages. Bardin's (2004) technique was used for content analysis of the interview discourses. It analyzes communication and describes the content manifested by recording the frequency of textual elements such as: words, expressions, sentences that allow us to go beyond immediate understanding, through a closer observation of the meanings in the text. As a basic procedure we used the description of symbolic data from records of key words in context. Armed with all this information, we codified and grouped the data, establishing categories and subcategories, based on the frequency of each response. The categories and subcategories identified expressed the perceptions, opinions, beliefs, values and expectations of the subjects interviewed.

RESULTS AND DISCUSSION

The results are presented initially by the sample profile of the subjects, starting with sociodemographic characterizations and the analysis of textual content grouped into analytical categories and subcategories resulting from the textual material (Chart 1) described and illustrated with the reports of the study subjects.

Of the 34 patients interviewed, 25 (73.53%) were single, widowed and separated. The sample was relatively homogeneous as to sex; 16 (47.05%) male and 18 (52.94%) female, but heterogeneous as to age group; 17 (50%) between 31 and 45 years, 13 (38.23%) between 19 and 30 years, 3 (8.82%) between 46 and 55 years and 1 (2.94%) between 56 and 65 years. A predominance of low education levels was verified: only 1 (2.94%) was a university graduate, 10 (29.41%) were secondary school graduates and the remainder did not complete their primary education. With respect to profession/occupation: 9 (26.47%) practiced unremunerated domestic activities, 7 (20.59%) were undocumented workers, 5 (14.70%) were unemployed, 8 (23.52%) received retirement or disability pensions and only 5 (14.28%) had steady employment.

Categories	Codification	Subcategories	Codification
Facing the infirmity	FI	Contact with the infirmity Treating the disease	Ci Td
Professionals perceived as technicians	PPT	Technical competence Clear language Interaction difficulty	Tc Cl Id
Empathetic attitudes	EA	Observing the professional Valorizing the professional	Op VP
Level of satisfaction	QSA	Positive aspects Negative aspects	Pa Na

Facing the infirmity

This category was divided into two subcategories: contact with the infirmity and treating the disease. Some of the patients reported that to visit the service is to remember that they had AIDS, one of the most difficult moments, as described below:

"…being here is to get treated, remember this damn disease…it's seeing this place…I can't stop thinking about when I found out I had HIV… I got desperate, I wanted to die…" (A)

"… I came to have a blood test, part of the treatment, looking at the blood makes me think of the disease that makes me different from everybody…this place reminds me of that…" (M)

The reports reveal feelings of anguish, anger, discrimination, likely stimulated by the place that revives threatening memories, non-elaborated situations, necessities not understood. These data are reinforced by the literature (HANAN, 1994; BRASIL, 2000; OLIVEIRA, MACHADO, 2002), which describes that this threat interferes in physical and emotional integrity, requiring actions that valorize the patient by elaborating content meaning, because of the stigma of the disease. One meaning that must be constructed through a relation of help, "being able to hear the patients" , giving importance to their existence.

Professional perceived as technicians

This category reveals the perception of the technical-cognitive characteristics of the professional. The subcategories were technical competence, clear language and interaction difficulties.

"… I have confidence in my doctor… he's a specialist, he knows everything about disease, he explains the treatment, the medication, he talks clearly to me, I follow his instructions, there isn't much time to talk about other things…" (T)

Here (T) shows confidence in the competence of the professional, undergoes treatment and receives information, discusses reactions, reviews medication, is committed to the treatment, in exchange for the care provided; there is an understanding of the information. Clinical care resulting from technical knowledge is observed, but what also emerges is a void of perception, interaction and communication with the patient; there is no listening or opening up to patient needs, to their story (FREIRE, 1980; HEIDEGGER, 1999).

In the report below patient (An), reveals a total omission in explaining the HIV-positive condition, questions the technical knowledge surrounding the treatment, since the professional does not perceive her doubts. The same seems to have occurred with patient (Z), which according to Silva (2003), constitutes ignored anguish and unperceived needs, facts and experiences that lead to an utter lack of faith in facing the disease.

"…he's very smart, very good…but I have so many doubts… they don't stop to see if I understand…they are technicians trained to treat the disease, the virus.., it's as if I was a… life isn't only this…there are so many doubts they don't have time to listen to.. (An)" .

"…they ask if I use a condom, if I take care of myself…they talk of nothing else… they should worry about our feelings too, not just our body…they don't get involved…it seems that they do, but the reality is different…" (Z).

The expressiveness of this patient seems not to be reciprocated by the professional; an incongruent attitude in the relation is perceived. There are indications in the reports of technical and systematic routine, mainly on the part of the medical professional. Time may be thought of as a distancing factor, since rapid treatment does not allow a perception of the patient's inner world. There is communication and clearly understood language in the orientation and information provided, but what the interviewed patients reveal is the need for a professional who listens to the anguish of their unhealthy condition, a process in which sharing occurs with the medical professional who then becomes an accomplice in the treatment. Capara & Franco (1999) refer to the intellectualization of knowledge and the valorization of science, with the patient as an object of scientific investigation in which medical actions are repetitions of the knowledge acquired. Thus, there is no dialogic relation, perception and understanding of reality is rendered difficult, transforming the encounter into an antagonic relation. Rogers (1983) sees in the communicational moment a possibility of really listening to the other.

Bueno & Teruya (2004) writes that facilitating attitudes, such as asking a patient a question in a clear and open manner, leads to a continuity in non-inquisitional communication, demonstrating understanding with a nod of the head, an attentive eye and encouraging the patient to speak. Empathic skills facilitate interaction, and it falls to professionals to modify their routine and technical attitude. Olivieri (1985) considers that treating the disease can be impersonal, but when treating an unhealthy human being, the listening must be personal, interactive and empathetic in order to understand and interpret it. It requires attention and care, patience in the clinic, a view of the whole, linked to feelings.

Empathetic attitude

In this category two subcategory aspects were analyzed: First, what patients observe about the professional when they are being attended, revealing that being received with interest, attention, respect and even the look in the professional's eyes were most perceived. Second, what they value about professional treatment, verifying that understanding, attention, manner of speaking, concern with privacy, listening and affectivity were most important.

"… security is in the expression, the welcome,… if he looks me in the eye, if he doesn't I never go back…he has to look to see who he is talking to, to establish bonds, he has to feel, listen…I need to see if he is interested, attentive… if he worries about my privacy…" (Jp)

It can be verified that the subject reports a number of fundamental attitudes adopted by the professional. Observing, according to Amatuzzi (1989), consists of building, contemplating, knowing. Here, there is no concern about gathering information, but rather in having a perception of the Being the professional is. Thus, there is a non-verbal comprehension, through subtle signs, of facial expressions, in which the professional does not seek to interpret, but rather to understand. The report demonstrates the relevance of the professional-patient contact, since the latter are closely observing their manner of being. At the same time as they are observing, they perceive a number of treatment aspects that they value.

"… good things that I value and make life flow, even if there is suffering, the tenderness…, the love of what he does,…the attentive look, the sureness…the understanding of our communication. Knowing how to listen,…having an expression compatible with what he sees, what he says and what he thinks. These are values that cannot be measured,…but we perceive,…feel… (L)

To value is to place a certain worth on something and according to the reports, one can perceive just how much the subject value the welcome, listening and understanding in the relation with the professional. Kanaan (2002) writes that listening is a mutual construction, a complicity in which one is affected by the other, and where there is a recognition of the availability of each one. According to Bueno, Teruya, (2004) and Rogers (2001), empathy, the ability to see others, to put oneself in their place, is an important skill for treating and advising, the key for identifying and understanding one another; in this case listening implies demonstrating the understanding of feelings. The attention and look in the eye are seen by these patients as facilitating attitudes that they observe and value in professional care.

Level of patient satisfaction with the care received

In this category, various actions and interventions related to care were considered. The subcategories were positive and negative aspects of care.

" attention is a positive point,…confidence in the treatment…but I see lack of privacy as negative, the students invade the offices without us being informed, taking away all the doctor's attention… this is a devaluation…" (Q)

Heidegger (1999) writes that discourse is a form of reflecting on existence, the presence of the other, the understanding and comprehension of being in the world, which must be shared in this discourse. Not listening to patients is not giving significance to their needs. Significant attentive care is a form of concern, human being with human being , both understanding.

"…the service is busier, but the number of personnel seems to be the same,.. there's abandon, disinterest, indifference..life is not a routine…"

"…it's good being a major center…but there's a lack of organization and coherence among the professionals and the team. There should be group work with the patients, lectures, videos available…information is lacking. Here everything has been abandoned … only the basic minimum is done, humanization is needed, both in the care and in the service" (D)

Patient satisfaction with the health service can be observed in relation to attention and treatment reliability, but on the other hand, their dissatisfaction is registered, pointing to failures in respecting privacy, as reported by subject (Q), lack of professionals (G), the crushing boredom generated by the routine, reflected in the report of (D), describing care as " something that has been forgotten". Olivieiri (1985) writes that life is an open system of communication with the world, and it is this system that leads to the organization of Being. With disease being a conflictive manner of being in the world, patients experience this conflict and hopes to be able to use and enjoy the resources of understanding in order to be like others. When in contact with a welcoming environment, they modify, evolve with care and understanding, which enables their autonomy and responsibility.

FINAL CONSIDERATIONS AND CONCLUSION

The results found were only possible through qualitative research, using a structured interview, which enabled the recording of the significance of a welcoming environment, listening of the professional, but mainly of the "looking into your eyes", ways of being and receiving, fundamental in health practice in the perception of the subjects interviewed. Thus, it seems significant to identify empathetic understanding and congruence as facilitating attitudes for understanding HIV/AIDS patients, in order to comprehend their non-perceived anguish and anger, introducing the dialogic interactive relation of the professional and mainly that of the physician in detriment to the technical competence of knowledge in order to be congruent to the necessities of the patient. An approach to be constructed in the clinical-professional- patient relation.

This study also shows us the significant association that can be made in relation to the disorganization of the services and disintegration of the teams, when analyzing boredom with the routine and abandonment . The humanization of actions and quality of care are directly related to the organization of services, which allows us to infer that failures in attending and caring for the patient are due to the inadequate organization of these services.

It can be concluded in this study that fragments of this encounter need to be reformulated, in the sense of broadening facilitating attitudes that strengthen the professional-patient relation, enabling the construction of the existential vaccum of the unhealthy Being. Reflecting on the place of this Being in the world, a humanized know-how in the daily actions of professionals, with patients as active subjects that indicate, demand and share their needs, fundamental aspects for care and essential attitudes for interaction. This study suggests the need for a deeper representation on the part of the medical professional with the patient, in the context of AIDS treatment.

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PERCEPTION OF THE PATIENT WITH HIV/AIDS ON ATTITUDES OF PROFESSIONALS IN BUILDING INTERACTIVE RELATIONS

ABSTRACT

Patients with HIV/Aids undergo conflictive physical and emotional situations in addition to aggressive drug therapy

involving significant behavioral changes. The professional becomes the mediator of facilitating attitudes with respect to prevention and treatment.

The purpose of this study was identify positive relational attitudes in professional care, from the perception of patients with HIV/AIDS at a major state medical service in Natal, Brazil. It is a qualitative study using semi-structured interviews with 34 patients, and content analysis technique for textual data interpretation. There was a predominance of the 31 to 45 year age group (50%), homogeneity as to sex, without conjugal union (73.53%), low education level (67.65%), unemployed (61.76%).From the analysis of the textual content of the interviews, four categories emerged: 1) Facing the infirmity, 2) Professionals perceived as technicians, 3) Empathetic attitudes, 4) Level of satisfaction. The appearance of AIDS rouses feelings of anger, discrimination and threatening memories. Patients perceive the technical competence of professionals, associated to interaction difficulties and incongruent attitudes. There is a lack of "looking patients in the eye" and of "listening" as a set of expressions necessary to empathetic coherence. In relation to care, a welcoming environment, respect for privacy and humanization of services are the principles of interactive relations. The study reveals significant associations in relation to inadequate organization in the services and professional teams, thus interfering in the quality of care. There is evidence of care with the disease and in its treatment, but with limitations in listening and understanding, preventing an integrated view of patients as active subjects who indicate, demand and share their needs. Fragments of this encounter need to be reformulated to enable facilitating attitudes of a humanized know-how between professional-patient. **KEYWORDS:** HIV/aids. Interaction. Professional-patient.

PERCEPTION DU PATIENT HIV/SIDA À PROPOS DES ACTIVITÉES DES PROFESSIONNELS DANS LA CONSTRUCTION DES RELATIONS INTERACTIVES.

RÉSUMÉ

Être malade dans le contexte HIV/SIDA produit des situations conflictuelles phisiques et émotionnelles, thérapeutique médicamenteuse agressive, menant à des changements significatifs du comportement. Le professionnel devient médiateur des actions qui facilitent les soins de prévention e traitement. L´Objectif est identifier des actions positives du professionnel dans le rapport avec les patients, em partant de la perception du patient hiv/sida, dans un hôpital publique de référence, à Natal RN. Êtude qualitative utilisant des entrevues semi-structurées avec 34 patientes, et la technique d´analyse du contenupour l´interprétation des donnés. Prédominance entre 31-45 ans (50%), homogéneité à propos du sexe, sans liaison conjugale (73,53%), baisse scolarité (67,65%), au chomage (61,76%). De l´analyse des contenues des entrevues, on a trouvé quatre catégories: 1) confrontation avec la maladie; 2) les professionnels aperçus comme techniciens; 3) actions d´entente; 4) dimention de la satisfaction. La SIDA éveille des sentiments de haine, de discrimination et des pensées de menace. Les patients aperçoivent la compétence technique du professionnel, associé aux difficultés d´interaction, comme des actions incongrues. Il manque "les yeux dans les yeux" et "l´ecoute coherence" comme un ensemble d´expressions necessaires à la comérence du rapport. Dans la perspective des soins, l´accueil, le respect à l´intimité et l´humanisation de l´attention sont aperçus comme des principesfondamentales pour les relations interactives. L´étude montre les associations significatives entre l´organisation inadéquate des services et de l´équipe professionelle, intervenant dans la qualité de lá attention. Il y a des évidences de la pratique des soins avec la maladie et le traitement mais il y a aussi des limitations á l´écoute et aux actions de compréhension pour regarder le patient comme un sujet complet qui indique, réclame (= protest) et partage ses nécessités. Les fragments de ce recontre doivent s´ajouter, pour faciliter le savoir-faire humanisé entre professionnel patient. **MOTS CLÉS:** HIV/SIDA. Interaction. Professionnel - patient

PERCEPCIÓN DEL USUARIO CON VIH/SIDA SOBRE LAS ACTITUDES DE LOS PROFESIONALES EN LA CONSTRUCCIÓN DE RELACIONES INTERACTIVAS

RESUMEN

Al adolecer en el contexto del VIH/SIDA genera situaciones de conflicto, terapéutico medicamentoso agresivo, envolviendo cambios de comportamiento significativos. El profesional se torna mediador de actitudes facilitadoras para acciones de cuidado en la prevención y tratamiento. Este estudio cualitativo, objetiva identificar actitudes relacionales positivas en el atendimiento profesional, partiendo de la percepción del usuario con VIH/SIDA en un servicio de referencia de la ciudad de Natal, RN. Aplicó una entrevista semiestructurada a 34 usuarios, y empleó la técnica de análisis de contenido para interpretación de los datos textuales. Predominio de la faja etaria de 31 y 45 años (50%), homogeneidad con relación al sexo, sin vínculo conyugal (73,53%), baja escolaridad (67,65%), sin trabajo (61,76%). Del análisis de los contenidos de las entrevistas emergieron cuatro categorías: 1) confrontación con la enfermedad, 2) profesionales percibidos como técnicos, 3) actitudes empáticas, 4) dimensión de la satisfacción. El SIDA aparece suscitando sentimientos de rabia, discriminación y recuerdos amenazadores. Los usuarios perciben la competencia técnica del profesional, asociada a dificultades en la interacción y con actitudes incongruentes. Falta "el mirarse a los ojos" y la "escucha" como un conjunto de expresiones necesarias para la coherencia empática. Dentro de la perspectiva del cuidado, traen la acogida, el respeto a la privacidad y la humanización como principios de las relaciones interactivas. Revela asociaciones significativas en relación con la inadecuación en la organización de los servicios y del equipo profesional, interfiriendo en la calidad de la atención. Se concluye que hay evidencias de la práctica del cuidado de la enfermedad y del tratamiento, pero con limitaciones de la escucha y de las actitudes de entendimiento en el sentido de ver la integralidad del usuario como sujeto activo que indica, reivindica y comparte sus necesidades. Fragmentos de ese encuentro precisan ser reconstruidos, posibilitando actitudes facilitadoras. **PALABRAS CLAVE**: VIH/SIDA. Interacción. Profesional-usuario.

PERCEPÇÃO DO USUÁRIO COM HIV/AIDS SOBRE ATITUDES DOS PROFISSIONAIS NA CONSTRUÇÃO DE RELAÇÕES INTERATIVAS

RESUMO

O adoecer no contexto do HIV/Aids gera situações conflituosas físicas e emocionais, terapêutica medicamentosa agressiva, envolvendo mudanças comportamentais significativas. O profissional torna-se mediador de atitudes facilitadoras para as ações do cuidado com a prevenção e tratamento. Este estudo objetiva Identificar atitudes relacionais positivas no atendimento do profissional, partindo da percepção do usuário com HIV/Aids em um serviço de referencia estadual em Natal, RN. Estudo qualitativo utilizando-se entrevista semi-estruturada com 34 usuários, e a técnica de análise de conteúdo para interpretação dos dados textuais. Predomínio faixa 31 e 45 anos (50%), homogeneidade quanto ao sexo, sem vínculo conjugal (73,53%), baixa escolaridade (67,65%), sem trabalho (61,76%). Da análise dos conteúdos textuais das entrevistas emergiram quatro categorias: 1) Confronto com enfermidade, 2) Profissionais percebidos como técnicos, 3) Atitudes empáticas, 4) Dimensão da satisfação. A Aids aparece suscitando sentimentos de raiva, discriminação e lembrança ameaçadora. Os usuários percebem a competência técnica do profissional, associada a dificuldades na interação, com atitudes incongruentes. Falta "o olhar nos olhos" e a "escuta" como um conjunto de expressões necessárias à coerência empática. Na perspectiva do cuidado, trazem a acolhida, o respeito à privacidade e humanização no atendimento como princípios para relações interativas. O estudo revela associações significativas em relação à inadequação na organização dos serviços e da equipe profissional interferindo na qualidade da atenção.

Conclui-se que há evidencias da prática do cuidado com a doença e o tratamento, mas com limitações à escuta e atitudes de entendimento para olhar à integralidade do usuário como sujeito ativo que indica, reivindica e partilha suas necessidades. Fragmentos desse encontro precisam ser reconstruídos, possibilitando atitudes facilitadoras de um saber fazer humanizado entre profissional-usuário.

PALAVRAS-CHAVE: HIV/Aids. Interação. Profissional-usuário.