

ANALYSIS OF PROXEMIC COMMUNICATION WITH HIV/AIDS PATIENTS

Marli Teresinha Gimeniz Galvão¹
Simone de Sousa Paiva²
Namie Okino Sawada³
Lorita Marlena Freitag Pagliuca⁴

Galvão MTG, Paiva SS, Sawada NO, Pagliuca LMF. Analysis of proxemic communication with HIV/AIDS patients. Rev Latino-am Enfermagem 2006 julho-agosto; 14(4):491-6.

This descriptive and exploratory study analyzed the proxemic factors of the nursing team and HIV/AIDS patients in a hospital environment in Fortaleza - CE, between October and November 2004. Data were collected through non-participant observation. Forty-one interactions were analyzed, in which no gender influence was observed. The professional's position towards the patient was mainly standing; intimate distance occurred in 21.95% of interactions, which were mostly related to technical procedures; personal distance predominated in 63.41% of cases, which were related to technical care; social distance occurred in 14.64% of interactions, which were aimed at conservation; obstacles were present in 15 interactions; local touch was the most frequent contact behavior; visual contact was present in 11 interactions, with a view to regulating the conversation flow; the tone of voice was found always adequate. Through proxemics, we can identify important factors in communication with HIV/AIDS patients.

DESCRIPTORS: communication; acquired immunodeficiency syndrome; HIV-1; nurse-patient relations

ANÁLISIS DE COMUNICACIÓN PROXÉMICA CON PACIENTES CON VIH/SIDA

Estudio descriptivo y exploratorio en que fueron analizados factores proxémicos del equipo de enfermería y portadores del VIH/SIDA en un ambiente hospitalario en Fortaleza - CE, entre octubre y noviembre de 2004. Los datos fueron recopilados mediante observación no participante. El análisis de 41 interacciones no reveló ninguna influencia del sexo. La posición del profesional ante el paciente fue en pie; la distancia íntima ocurrió en el 21,95% de las interacciones y, en la mayoría de los casos, estaba relacionada a procedimientos técnicos; la distancia personal predominó en el 63,41% de los casos, relacionados a la atención técnica; la distancia social ocurrió en el 14,64%, con objeto de conversar; en 15 interacciones hubo presencia de obstáculos; el toque localizado fue el comportamiento de contacto más frecuente; el contacto visual estuvo presente en once interacciones para regular el flujo de la conversación; el tono de la voz fue siempre adecuado. Consideramos que la proxemia permite identificar factores importantes en la comunicación con el paciente portador del VIH/AIDS.

DESCRIPTORES: comunicación; VIH-1; síndrome de inmunodeficiencia adquirida; relaciones enfermero-paciente

ANÁLISE DA COMUNICAÇÃO PROXÊMICA COM PORTADORES DE HIV/AIDS

Este estudo descritivo e exploratório analisou os fatores proxêmicos da equipe de enfermagem e portadores de HIV/AIDS em ambiente hospitalar em Fortaleza - CE, entre outubro e novembro de 2004. A coleta de dados foi pela observação não participante. Analisou-se 41 interações e não foi observado influência do sexo. A posição do profissional em relação ao paciente foi de pé, a distância íntima ocorreu em 21,95% das interações e estavam relacionadas a procedimentos técnicos na maioria delas, a distância pessoal predominou em 63,41% relacionadas à assistência técnica, a distância social ocorreu em 14,64% e foram para conversação; em 15 interações houve presença de obstáculos, o toque localizado foi o comportamento de contato mais frequente; o contato visual esteve presente em onze interações com a função de regular o fluxo da conversação; o tom de voz foi sempre adequado. Consideramos que a proxemia permite identificar fatores importantes na comunicação com o paciente portador de HIV/AIDS.

DESCRIPTORES: comunicação; síndrome de imunodeficiência adquirida; HIV-1; relações enfermeiro-paciente

¹ Professor, e-mail: marligalvao@gmail.com; ² Nurse, Master's student. Federal University of Ceará; ³ Associate Professor, University of São Paulo at Ribeirão Preto College of Nursing, WHO Collaborating Centre for Nursing Research Development, e-mail: sawada@eerp.usp.br; ⁴ Full Professor, Federal University of Ceará

INTRODUCTION

Mankind has been living with aids for three decades and, as observed, the disease has experienced an unlimited growth, increasingly affecting individuals at the height of their reproductive life.

Nowadays, the use of antiretrovirals grants patients a similar quality of life and survival in comparison with other chronic diseases⁽¹⁾. Thus, hospitalization appears as a different resource than what was used in the first decade of the epidemic, when neither efficient tests nor more specific (antiretroviral) drugs were available. Today, the main reasons for hospitalization result from late diagnosis, medication intolerance and opportunistic diseases.

During hospitalization, individuals leave their environment to adapt to a world and routines they are hardly familiar with. HIV patients require longer periods of hospitalization and experience a hospital environment marked by constant solitude. In view of constant preoccupations with the evolution of the disease, patients often get isolated in their hospital bed.

Due to biosafety measures and physical isolation of aids patients, nursing care attributes very peculiar characteristics to this care⁽²⁾. Out of fear for contagion, care delivery is extremely technical and impersonal, predominated by the relation with things and objects. This gives rise to concerns and care with different forms of communication.

Communication is similar to breathing: human beings do not stop communicating⁽³⁾. In view of its importance, communication is indicated as a basic nursing care instrument, as it allows for the nurse-patient relation⁽⁴⁾. Thus, more thorough analysis is needed with a view to the proper knowledge and use of communication in daily nursing practice.

Communication can be verbal and non-verbal. Studies have shown that 35% of the meaning of messages is transmitted verbally and 65% non-verbally⁽⁶⁾. Hence, one of the aspects to be taken into consideration in communication with patients is their personal and territorial space, called proxemic communication⁽⁵⁻⁶⁾. The term proxemics is a neologism created by Edward Hall to designate the set of observations and theories related to how man uses his space⁽⁷⁾. Proxemic communication studies the social meaning of space, that is, how man unconsciously structures his own space⁽⁶⁻⁷⁾.

According to this author, proxemic analysis involves eight factors, covering the following dimensions: 1. Posture-sex code: analyzes the sex of the participants and the basic position they may be in, for example: standing, sitting and lying; 2. Sociofugal-sociopetal axis: The sociofugal axis demonstrates discouragement of interaction, while sociopetal implies the opposite. This dimension analyzes the interlocutors' angle: face to face, back turned, among others; 3. Kinesthetic factors: These are responsible for provoking closeness between interlocutors. This dimension analyzes short-distance physical contact, such as touching or brushing the skin and the positioning of body parts; 4. Touching behavior: This factor refers to forms of tactile relations such as caressing, grabbing, feeling, prolonged holding, pressing against, spot touching, accidental brushing or no physical contact; 5. Visual code: verifies the manner of eye contact during interactions, ranging from eye to eye to no contact; 6. Thermal code: refers to the heat perceived by the interlocutors; 7. Olfactory code: analyzes the characteristics and degree of odor perceived by the interlocutors; and finally 8. Voice loudness: assesses the interlocutors' perception in relation to the interpersonal space.

As a result of our care experience and research with HIV/aids patients, we believe this study is needed, with a view to analyzing proxemic factors during interactions between the nursing team and HIV/aids patients in a hospital environment.

METHODOLOGY

We carried out an exploratory and descriptive study at a hospitalization unit in a specialized institution, which is a reference hospital for infectious-contagious diseases in Fortaleza, Ceará, Brazil, in October and November 2004. Participants were members of the nursing team and patients who were hospitalized at the unit and accepted to participate.

Data were collected through non-participant and systemic direct observation of the interactions that occurred during the nursing shift between professionals and patients. We recorded all interactions realized during the observation and identified proxemic factors, according to an observation script divided in three parts. In the first

part, we wrote down patients' identification data; in the second the professional's data and, in the third, we described the observations of the interaction, including: situation or procedure carried out, duration, professional's position and distance, voice tone, interlocutors' axis, contact behavior, visual contact and obstacles.

In order to analyze communication, the patient was observed for twelve hours by a previously trained researcher. Observations occurred for two consecutive hours at most in the morning or afternoon, between 7:00 and 19:00h, during two or more days. Data collection was closed off when all proxemic factors between professional and patient had been identified, i.e., we adopted the criterion of saturation.

The collected data were analyzed in the light of proxemic factors⁽⁷⁾. After being studied and interpreted by a first researcher, categorizations were confirmed by two other researchers, to allow for the description and discussion of results.

The study complied with the determinations of Resolution No 196 on research involving human beings, issued on October 19th 1996 by the National Health Council. All participants were properly informed and signed a free and informed consent term.

DATA ANALYSIS AND DISCUSSION

Subject description

We observed 15 nursing team members and five patients. Three nursing team members were nurses and women; six were nursing auxiliaries, with one man; and six were trainees from the technical nursing course, as the research institution is a teaching hospital that receives students from all levels. Ages were distributed as follows: 30-39 years (5), 20-29 years (4), 40-49 years (3), under 20 (2) and 50 or older (1). Eight professionals were white and seven were mulattoes.

Two patients were women and three men; two were mulattoes, two were brown and one white. Ages were distributed as follows: 30-39 years (3), 20-29 years (1) and over 39 (1). All patients came from Fortaleza. As to education, two had not finished primary education, one had not finished secondary education, one possessed a higher education degree and one patient could only write his name. In total, we observed 41 situations.

Analysis of proxemic factors

Posture – sex code

First, we analyzed participants' sex and interlocutors' basic position: standing, sitting or lying. We did not identify any influence of sex on the interlocutors' position, as the number of male participants was little representative. A study with laryngectomized patients did not find any interference of sex in the adopted position and attributed this fact to the type of professional technical interaction⁽⁶⁾.

Moreover, discussing gender issues in this patient group is quite delicate and complex, as it boils down to discussing merely the sexual meaning of being a man or woman. The standards, values, perceptions and representations in society accompany these subjects who, in general, do not perform the roles society expects from them in terms of sexual identity.

In a study on gender issues and male sexuality in the age of aids, man has been considered the pivotal piece in transmission and responsible for performing sexual practice, reproducing a stereotype that puts them in a risk situation⁽⁸⁾. Although this study did not intend to investigate how they caught the disease, we inferred that sexuality-related issues and sexual preferences interfere in interlocutors' non-verbal communication. Patients can feel ashamed, inferiorized and discriminated against.

In all observed situations, the professional was standing. A patient was standing in only one interaction, and sitting or lying in the others. When one interlocutor stands while the other sits, this social distance evokes an impression of dominance⁽⁷⁾. Hence, by sitting, somewhat inferior to the care professional, particularly when hospitalized and being submitted to hospital orders and routines that are not always pleasant, interlocutors can block the communication process and avoid expressing their true feelings, doubts or fears. Health professionals need to pay attention to these aspects in order to optimize the communication process with these patients.

Sociofugal-sociopetal axis

This factor refers to the interlocutors' willingness (sociopetal) or unwillingness (sociofugal) to interact with one another, and analyzes the angle of the shoulder relative to the other person, and the

subjects' position: face to face, side by side or back turned. We found face to face and lateralized communication in 16 situations each, while professionals talked with their back turned towards the patient in six interactions, even in cases of verbal communication. In one situation, the patient had his back turned towards the professional.

Positions changed during interactions, partially due to nursing professionals' hurry and situations of "fleeing" from moments with the patient, mainly when (s)he questioned something at the moment of interaction.

Earlier studies identified patients' complaints about the health team, related to indelicacy, invasion of privacy, demonstration of indifference, discouraged facial expression and rushing⁽⁹⁻¹⁰⁾.

In spite of the small number of interactions in which one interlocutor had his/her back turned towards the other, we detected nineteen situations in which the professional seemed discouraged to interact with the patient, although the latter sometimes demonstrated the opposite. These situations were observed when the professional turned his back towards the patient while realizing a procedure or even while passing information to the patient. The professional looked at the television that was turned on, to the serum equipment or to blood traces on the Jelco[®] extension. The team member gave rapid and evasive answers to the patients' inquiries. Patients, in turn, carefully looked at the care professional, attracted his/her attention to a perceived change or verbally expressed their dissatisfaction. They addressed the professional or researcher and complained that nobody paid attention, no matter whether their opinion about the subject was being asked.

Professionals' difficulties to interact with patients and patients' manifested need for attention partially derive from one patient's terminal situation. Literature reports that many health professionals still do not know how to handle the possibility of losing a patient with an incurable disease and unconsciously take distance. Terminal patients remind them of human fragility and oblige them to think and act on the finiteness of the body and the existence of death⁽¹¹⁾. Patients, on the other hand, look for emotional part, which they generally do not receive from society, or from relatives. Thus, patients expect emotional and psychological support from persons with whom they maintain their last or perhaps only contacts: the professionals who accompany them.

In 14 interactions, we observed sociopetal behavior by a nursing team member, who demonstrated attention during care delivery or talked about subjects unrelated to care. These behaviors are important in health professionals' relation with patients, as communication is how relations are established. Care professionals should develop communication skills through empathy, opening, authenticity and respect, aimed at establishing a help relation with a view to increasing patients' adaptation and improving treatment results⁽¹²⁾.

Kinesthetic factors

These identify the closeness between interlocutors and determining factors. Kinesthetic factors analyze short-distance physical contact, such as touching or brushing the skin, as well as the positioning of interlocutors' body parts.

Table 1 displays the distance maintained between interlocutors and the type of intervention carried out during the interactions.

Table 1 - Distances maintained between interlocutors and type of intervention carried out during 41 interactions

	Distance						N	%
	Intimate		Personal		Social			
	9 (21,95 %)		26 (63,41%)		6 (14,64%)		41	100
Intervention Type	N	%	N	%	N	%	N	%
Technical procedure	7	77.78	19	73.08	2	33.33	28	68.30
Conversation	2	22.22	7	22.92	4	66.67	13	31.70
Total	9	100	26	100	6	100	41	100

Intimate distance occurs in little less than 21.95% of interactions and is more frequently related to technical procedures (77.78%). This distance is used for comforting and protecting; odor and irradiated heat perceptions are intensified in this situation, with possible muscle and skin contact. When strange contact occurs, the basic tactic is to stay immobile or dodge⁽⁷⁾. When maintaining this distance during technical nursing care, professionals may invade patients' personal space, causing negative reactions and blocking communication and the establishment of a therapeutic relation between patient and professional. The space of hospitalized HIV patients, almost always dominated by different feelings, depressed, revolted or frustrated about the possibility of imminent death, needs to be preserved as much as possible.

Personal distance was found in more than half of the situations we observed (63.41%). Approximately 73.08% of these involved technical care. When maintaining personal distance, body heat is imperceptible, the interlocutors' traits are not visually distorted and their upper extremities can touch. This distance is adequate for discussing personal questions⁽⁷⁾, recommendable in patient teaching processes⁽⁶⁾.

We observed social distance in a minority of interactions. At this distance, most interactions involved conversation with the patient (66.67%), when professionals passed information or when evolution occurs. Non-verbal signs are hard to perceive. Thus, social distance is improper for verbal communication with the patient, which we more frequently observed in social distance interactions.

We studied the obstacles that existed during interactions due to their influence on the adopted distance and the difficulties they impose on physical contact. We found 15 situations in which communication obstacles predominated. The most common impediments included the use of a mask, although the patient did not present any airborne disease; serum support in between the interlocutors and television turned on, distracting the subjects. In two situations, professionals observed blood traces on the Jelco[®] extension, which deviated their attention during communication with the patient. Other obstacles were the height difference between interlocutors and the professional being occupied with another activity.

These obstacles, particularly the use of a mask and the professional's attention directed at the blood on the Jelco[®] extension while talking with the patient, may indicate these professionals' fear of infection and related diseases. At a hospital specialized in infectious-contagious diseases, unhealthy conditions are frequent among health team members and represent a risk to these professionals. There is a need to identify actual risks and how to proceed so that patients do not feel ignored as a result of the disease.

Contact behavior

This factor ranks the tactile relations that occurred as follows: caressing, grabbing, feeling, prolonged holding, pressing against, spot touching, accidental brushing or no physical contact. We did not find any skin brushing among interlocutors.

Touching was found in half of the interactions at intimate distance and the remainder at close personal distance.

Spot touching occurred in 18 situations, 14 of which were associated with technical procedures. Three aimed to attract the patient's attention or wake him up and one to tranquilize a patient who was mentioning pain. Research describes the predominance of instrumental touch in interactions between nursing team members and patients, whether during hospitalization or in outpatient appointments⁽¹³⁻¹⁴⁾. In most interactions, no contact behavior was found, in view of professionals and HIV/AIDS patients' mutual interaction difficulties.

Visual code

This factor verifies how visual contact occurred during interactions, such as eye to eye contact or no contact. Visual contact was present in 11 interactions, all related to verbal communication and probably aimed at identifying non-verbal language signs, as vision is mankind's most specialized sense and provides the nervous system with a much larger quantity of information than touch and hearing. The eyes are able to identify an individual's emotions, such as signs of surprise (greater eye opening), happiness (shine) or sadness (smaller eye opening)⁽⁷⁾. Another function of the look is to regulate the conversation flow. Therefore, this factor is essential for patient interaction.

We did not analyze the thermal and olfactory code dimensions, described as proxemic factors 6 and 7, due to the fact that the data analysis method did not allow us to detect this information.

Voice loudness

This factor analyzes interlocutors' perception of interpersonal space by ranking voice loudness and intensity during interactions: whispering, screaming or normal tone. Loud voices were not present in any situation. In most interactions, voice tones were normal (hearable). Low voices were found in only five interactions. In these cases, communication distance was intimate or personal, so that patients could hear, although the researcher did not know what was being said. No verbal communication occurred in five interactions.

In all interactions, the ventilator was loud. In 22 cases, the television was turned on and in seven, the volume was high. In four interactions, noise from construction works was present. Environmental noise is considered an invasion of hospitalized patients' personal and territorial space, entailing a series of human responses that took the form of feelings, attitudes, values, expectations and desires⁽¹⁰⁾. Professionals should pay attention to these noises, which can interfere in communication with patients. One patient presented productive and frequent tossing, which turned communication more difficult.

CONSIDERATIONS

We observed that professionals' posture transmits the idea of their domination and supremacy towards patients, strengthened by the institutional organization of the proxemic environment. Not all procedures allow professionals to choose one or another position. However, we recommend that, at least during conversations with patients, team members sit down, at the same height as the patient and with their face turned towards him/her, mainly

when communicating with HIV/aids patients, who are frequently marked by the stigma of disease and death.

Distances were not appropriate to the situations we observed. Technical procedures at intimate distance should be avoided. Although professionals cannot always obey this rule, due to technical requirements to invade patients' personal space, we could perceive patients' indisposition by their non-verbal language and, thus, deal with the situation. Teaching processes should be carried out at personal distance, as the interlocutors' traits are not distorted and body heat does not interfere in the interaction. Social distance should not occur during conversations with patients, as non-verbal signs are hard to perceive.

Proxemics can be used when observing the communication process between nursing professionals and patients to assess the delivered care by identifying the different proxemic factors. Then, it is possible to interfere in these factors, reconsidering behaviors during professional-patient communication and, if possible, changing the space of the interaction, with a view to improving interpersonal relations in the hospital environment and establishing more efficient communication.

REFERENCES

1. Galvão MTG, Cerqueira ATAR, Marcondes-Machado J. Avaliação da qualidade de vida de mulheres com HIV/aids através do HAT-QoL. *Cad Saúde Pública* 2004 janeiro-fevereiro; 20(2):430-7.
2. Sadala MLA. Cuidar de pacientes com aids: o olhar fenomenológico. São Paulo (SP): Unesp; 2000.
3. Santos RE. As teorias da comunicação: Da fala a internet. São Paulo (SP): Paulinas; 2003.
4. Cianciarullo TI. Instrumentos básicos para o cuidar: Um desafio para a qualidade da assistência. São Paulo (SP): Atheneu; 2003.
5. Stefanelli MC. Comunicação com paciente: Teoria e ensino. São Paulo(SP): USP; 1992.
6. Sawada NO, Zago MM, Galvão CM, Ferreira E, Barichello E. Análise dos fatores proxêmicos com o paciente laringectomizado. *Rev Latino-am Enfermagem* 2000 agosto; 8(4): 72-80.
7. Hall ET. A dimensão oculta. Lisboa: Relógio D'água; 1986.
8. Mota MP. Gênero e sexualidade: fragmentos de identidade masculina nos tempos da Aids. *Cad Saúde Pública* 1998 janeiro-março; 14(1):145-55.
9. Spitzer RB. Meeting consumer expectations. *Nurs Admin Q* 1988; 12(3):31-9.
10. Sawada NO. O sentimento do paciente hospitalizado frente a invasão de seu espaço territorial e pessoal. [dissertação]. Ribeirão Preto (SP): Escola de Enfermagem de Ribeirão Preto/ USP; 1995.
11. Maia CIB, Guimarães LER, Ribeiro LHO. Diante do fenômeno da morte: um estudo sobre mecanismos de defesa de auxiliares de enfermagem In: Neme CMB, Rodrigues OMPR. *Psicologia da saúde: perspectivas interdisciplinares*. São Carlos (SP): Rima; 2003. p.3-22.
12. Kasch, CR Interpersonal competence and communication in the delivery of nursing care. *Adv Nurs Sci* 1984 janeiro; 6(2): 71-88.
13. Silva MJP da, Domingues J. O toque: percepção de idosos hospitalizados. *Texto e Contexto Enfermagem* 1997 maio-agosto; 6(2):291-9.
14. Pinheiro EM, Rocha IF da, Silva MCM da. Identificação dos tipos de toque ocorridos no atendimento de enfermagem de um serviço ambulatorial. *Rev Esc Enfermagem USP* 1998 outubro; 32(3):192-8.