Journal of Health Science & Education
An open access journal
eSciRes
JHSE-1-112
Research Article

Interpersonal Relationships as a Tool in the AIDS Nursing Care

Oliveira DC[1*], Formozo GA[2] and Costa TL[2]

[1]*Nursing Graduate Program and the Social Psychology Graduate Program, Nursing College, State University of Rio de Janeiro, Brazil*

[2]*Federal University of Rio de Janeiro (UFRJ), Macaé, Brazil*

Abstract

Objectives: To identify and analyze contents related to the interpersonal relationships in nursing professionals' social representations regarding nursing care provided to people living with Acquired of Human Immunodeficiency Syndrome (AIDS). **Method:** It is an exploratory-descriptive and qualitative study, guided by the Social Representations Theory (RST). The participants were 20 nurses and 20 nursing assistants in a university hospital. Data collection was carried out through in-depth interviews. Data analysis was developed by the lexical analysis with ALCESTE 4.10 software. **Results:** Social representations of nursing care were based, mainly, on the relationships established between nursing professionals and AIDS patients. However, it is affected and influenced by various institutional, behavioral and psychosocial elements Also, there was the involvement of family members and friends in the nursing care, with the feelings experienced by people living with AIDS while hospital stay. **Conclusion:** Interpersonal relationship is fundamental for the nursing care practices with people living with AIDS. Therefore, institutional investments are needed to achieve its appropriate development.

Keywords: Interpersonal relationship; Nursing care; AIDS; Social psychology

Introduction

Throughout almost three decades of Acquired of Human Immunodeficiency Syndrome (AIDS) pandemic, many representations of the disease and its carriers emerged. These representations went through changes as the years went by, influenced by, many times, pandemic changes, social organization and the scientific development of the field.

Following all AIDS pandemic phases, nursing care practices stand as fundamental for professionals, featured into two dimensions: Technical-instrumental and affection-expressive [1]. This latter, of higher interest for the researchers of this present study, comprises the interpersonal relationships universe. Care practices cannot be reduced to the simple act of executing technical procedures; however, they should also comprise the sense of being, since they regard relationships between human beings. In addition, they should be set as guidelines for nursing professional practices [1]. Therefore, nursing care needs, for its actual effectuation, commitment from the patient and the care taker to join into this intensive interaction.

Subjects and social groups' psychosocial positioning guiding behaviors and practices and justifying attitudes and behaviors can be defined by social representations (SR) on a certain object [2-4]. Representations built by nursing professionals are considered to influence care practices and can be expressed in relationships with people living with AIDS, under many ways including moral judgments that contribute for physical and relationship distancing while providing the care [5]. Social representations, in the psychosocial perspectives, are defined as a compound of concepts, propositions and explanations resulting from the routine in interpersonal communications. They are equivalent, in our society, to myths and beliefs from traditional societies; and, can also be the contemporary version of common sense [2,4].

Considering the nursing work process implies in physical care actions and relationship care, nursing practices can be reduced to the technical procedures dimension, damaging bonding between professionals and patients. Consequently, larger obstacles are placed for the activity's efficiency in promoting health and quality of life [6], grievance or re-infection prevention, adherence to medication therapies, considering investments in understanding the social abilities involved in the care process as a fundamental aspect. Social ability is understood as the suitable social development that allows for effective and satisfactory interpersonal relationships [7]. This abilities compound includes distinct classes and sub-classes that comprise empathy, assertiveness, emotions expression and communication [8].

The nursing professional may use empathy, which implies in understanding the other's feelings and perspectives for the care provided to AIDS patients. Professionals can equally understand the situation of the people living with AIDS; however, facing a great difficulty on dealing with the situation, results on distancing in the interpersonal relationship due to personal oddness feelings [9].

This study has the aim to identify and analyse the interpersonal relationships in nursing professionals' SR regarding the nursing care provided to AIDS patients. These relationships are understood as fundamental mediators in qualifying professionals' practices.

Materials and Methods

This is an exploratory-descriptive study, based on a quanti-qualitative approach and guided by the SRT. The scenario was a public university hospital located in the city of Rio de Janeiro–Brazil, in the four sectors: Infection-Parasites Diseases, Internal Medicine, Pulmonology and General Intensive Therapy Unity; where nursing professionals were closer to AIDS patients.

Twenty nursing assistants and twenty nurses who have already taken care of AIDS patients were studied, comprising 40 in-depth interviews. For data collection, two research instruments were applied: A socio-economic-professional data questionnaire and a semi-structured interview script. Guidelines and regulations for researches involving human beings established from the Brazilian National Council of Health.

The lexical analysis technique was used for data analysis, using the ALCESTE (Lexical Analysis by Context of a Set of Text Segments) software, version 4.10. This software automatically performs content lexical analysis by textual data treatment quantitative techniques. The analysis was executed by the formation of Elemental Context Units (ECU)–texts segments of equivalent sizes and classes. These latter comprise ECU compounds defined in a way that inter-class variations are minimized, comparing to intra-class variance, regarding the lexical units brought by the ECU [10]. The following socio-economic-professional variables were used for exploratory and discursive profile sub-groups identification purposes: Professional category, gender, age, monthly personal income, time working in nursing and time working with AIDS patients.

Results

The content analysis discourse of interviews resulted in six thematic categories (classes) where different representational contents were extracted. Therefore, discursive contents demonstrated to be organized around AIDS patients who determine all care features, as the nuclear element. Institutional dynamics and structure, medication treatment, interpersonal relationships, professional self-protection, institutional and social support, and treatment and diagnosis of AIDS emerge associated to this nuclear element, as shown in Figure 1.

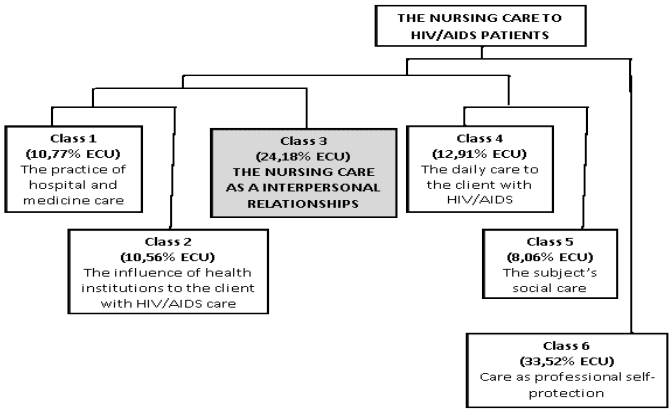

Figure 1: Dendrogram of the distribution of all Alceste classes. Rio de Janeiro, Brazil.

Figure 1 demonstrates that class 3 regards interpersonal relationships, expressed in care practices provided to people living with AIDS. Such class comprises 339 ECU, corresponding to 24.18% of the corpus analysed, constituting the second largest class, highlighting its importance for the analysis compound. Therefore, we explored these revealing contents of nursing care relationship aspects in this text.

Discursive contents observed in class 3 present statistical associations, (chi-square values=x^2), with some revealing variables from sub-groups: Strong association with the female gender (x^2=23.79) revealing a typically female discursive profile; important association with personal monthly income lower than US $1,500.00 ($x^2$=20.02), revealing a discursive profile associated to professionals with lower income in the compound studied; working time in the nursing area equal to or lower than 10 years (x^2=16.12), pointing a professional profile of some work experience, but still fully exercising it; nursing assistant position (x^2=6.68), with a weak statistical association, however, demonstrating importance when analysed along the income, since they are the professionals with the lower income; age equal to or above 45 years (x^2=7.14), also presenting weak statistical association (Table 1).

Analysis Variables	Categories Associated to Class	χ^2	Frequency in *corpus*	Frequency in class
Gender	Female	23,79	1075	293
Personal Monthly Income	< US$ 1,500.00	20,02	683	201
Working time in the nursing area	≤ 10 years	16,12	264	89
Age	≥ 45 years	7,14	656	180
Professional Category	Nursing Assistant	6,68	775	208

Table 1: Chi-square values regarding analysis variables with statistical association to class 3. Rio de Janeiro, Brazil.

Discursive contents can be explored through reduced ways that compose class 3, and their respective semantic contexts through chi-square values (x^2). In other words, those that presented higher statistical association to the class (Table 2). These reduced forms are the following: Talking (x^2=78.94); improving (x^2=44.34); care (x^2=40.27); taste (x^2=34.37); speech (x^2=29.29); pity (x^2=28.57); feeling (x^2=24.53); understanding (x^2=23.80); cure (x^2=23.10); and family (x^2=21.48).

Reduced Forms	Semantic Contexts	Chi-square	Frequency in *corpus*	Frequency in class
Talking+	talking, talk	78,94	51	39
Improving+	improving, improve	44,34	14	14
Care	care	40,27	24	19
Taste	taste	34,37	22	17
Speech	speech	29,29	35	22
Pity	pity	28,57	18	14
Feeling+	feeling, feelings	24,53	26	17
Understanding+	understand, understanding, understood	23,80	10	9
Cure	cure	23,10	12	10
Family+	family, families	21,48	23	15

Table 2: Distribution of the reduced forms and their semantic contexts in class 3. Rio de Janeiro, Brazil.

Based on the reduced forms composing class 3, revealing contents could be noticed from interpersonal relationships established not only between AIDS patients and nursing team members, but also with family members and friends, demonstrated while nursing care. Furthermore, emerging affection contents stand out throughout the establishment of these relationships through feelings.

These two thematic discursive were comprised into categories and sub-categories, ordering representational elements related to interpersonal relationships and feelings emerging from them, as shown in Figure 2.

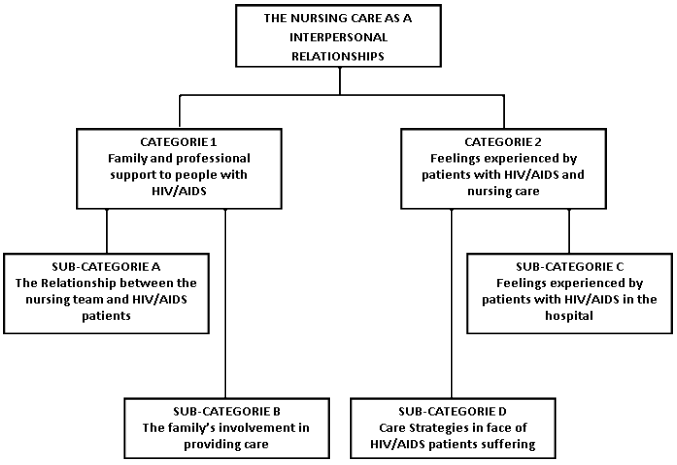

Figure 2: Category's and sub-category's diagram of contents discourses related to interpersonal relationships in care practice. Rio de Janeiro, Brazil.

Family and Professional Supports to Aids Patients

The nursing team and the relationship with AIDS patients

Most interviewees affirm that executing technical procedures is not enough. It should be aligned with establishing good interaction between professionals and patients. Each procedure should provide proximity between these two subjects involved in the care process, allowing for bonding and establishing mutual trust.

In addition, perceiving nursing care as an easy task is the result of ability to communicating and being available for such interaction. This way, the main instrument used in this interaction is the dialogue.

"It is not enough to bath them and give medication; the nursing professional must interact with the patient. When nursing professionals go to the patients' beds, they must communicate and talk about what they are doing despite, many times, knowing the patient in not reacting." (Interviewed 20, female, nurse).

Equally, they mention, many times, that AIDS patients are usually depressed while hospital stays. These cases require from the nursing professional to be closer, talk and search for strategies to improve self-esteem and change that person's perspective reg. These strategies are varied and should emerge according to the situation. They can correspond to the stimulation to perform some types of activities, motivating closeness to the loved ones, or even talking about their feelings.

Data show that the interaction between the nursing team and patients happens even when it cannot be expressed verbally or by gestures. These professionals keep this process to motivate more perceptive interactions-explaining medical improvement-or to maintain human dignity while providing a type of care for the other that is not reduced to a non-responsive structure.

Also, some requirements are mentioned to establish bonding between nursing professionals and patients, for instance, perseverance and not expecting fast results. In addition, the professional cannot show weakness or loss of hope, but always demonstrate that the patient has a future that must be built.

"We try to improve things. We try to motivate, talk to them and ask psychologists for help. We turn the TV on and call them to watch, talk, ask them if they want to call someone and

give them a message." (Interviewed 22, female, nursing assistant).

Reaffirming the affection-expressive face of care importance, another parcel of interviewees admits that they provide nursing care through getting closer to people living with AIDS, understanding that welcoming them is primary. They acknowledged that the nursing team, while hospital stays, represented the person's family, since they have continuous and long contact with them and, many times, family members are absent.

Overlapping the nursing team on patients' family members result from a historical moment when they were frequently abandoned by their family and friends, and only the relationships that involved other patients and the health team, mostly the nursing team, was left to them. Abandonment happened due to the function of the syndrome itself or the discovery of not recommended social behaviors as sexuality considered as deviant and drug abuse.

Higher trust given to the nursing team by patients comparing to what is given to the family stand out due to the nursing team exercise a lower pressure over patients, listening to them without the constant explanations of values and recommendations of what is considered right or wrong. At the same time, these social actors stand by their side at their most fragile clinical and psychologically vulnerable moments, whether for the family that feels blocked by hospital routines or show distance (intentionally or not) from the scenario experienced by the AIDS patient.

Therefore, some members of the team point out that they do not execute relational care due to the lack of time in care practice. They admit that, due to the great amount of technical activities they perform, interaction with patients is set as second choice. Also, they affirm that some members of the nursing team, even with the intense rhythm of activities, find time to talk and keep a certain relational interaction with patients.

"(...) I don't have the type of interaction I wished for with AIDS patients because there is not time since he is in the critical phase of AIDS." (Interviewed 15, female, nurse).

On the other hand, there are some team members that affirm seeking distancing from AIDS positive patients as a way of self-protection, because interaction causes suffering and an intense psychological and professional distress resulting from many difficulties faced by patients and the suffering caused by their eminent death. In addition to these factors, they mention that they have been thought, while professional education, that they should not bond to patients, and they should show only sympathy and treat them well.

Therefore, the reasons given for this need for distancing are originated from different scopes: Avoid suffering; not involve personal and professional life; preserve family and friends; incompetence feelings regarding a humane professional relationship; and even acknowledging that establishing bonds is not part of the nursing job, opposing the discourse regarding the role of this profession in other moments of these discourses, suggesting a subjacent tension regarding the professional scientific statute.

*"I feel very sorry, I cry in front of patients, I break down and, afterwards, I am the one needing a psychologist. Therefore, I try to keep a distance, but, sometimes the patients want us." (Interviewed 03, female, nursing assistant)***.**

The family's involvement to providing care

All interviewees acknowledge the importance of the presence of family and friends while hospital stay to people living with AIDS, since they understand that their proximity enhances patients' security and self-esteem, encouraging them to proceed with the treatment. This way, they point out that the ideal nursing care can be provided if proximity with the family can be experienced by patients.

"The ideal nursing care would be one where the family participates in the process." (Interviewed 08, female, nurse.)

However, there are limitations to family members or friends proximity in which the nursing team cannot act directly. Among these limitations, the lack of economic, social and psychological support to deal with AIDS patients stands out.

"(...) Bedridden and dependent, many times, the family has no support and AIDS patients stay in the hospital." (Interviewed 34, female, nurse).

If, initially, patients' abandonment is characterized by the psychological and emotional lack of capacity from family members in dealing with the AIDS in its whole and even due to certain moral judgments, currently this fact is structured around the socio-economic situation that generates many impeding factors. This difference followed epidemiologic transformations presented by AIDS, generating implications for care practice.

In this scenario, professionals work considering an ideal care as the one that the family is necessarily the co-participant. Also, it is important to point out that this ideal care is not supported by the practical collaboration that the team could receive if the family was established into the hospital context. It is related to providing the basic needs for patients, especially in its aggregating, psychologically and spiritual dimension.

Aids Patients Feelings and Care Strategies

Feelings experienced by AIDS patients in the hospital

While experiencing hospital stays, some of patient's feelings are observed by the nursing team, due to their interaction, regarding living with this grievance. These feelings oscillate between states of depression, sadness, rebellion, and loneliness. Also, they, many times, result from the perception of experiencing "social death", fear of the physical death and the bodily alterations they go through.

These feelings directly influence the care provided and can be demonstrated, for instance, when patients refuse to take medication or are rude to the nursing team:

"Sometimes, if the nursing professional asks something to the patient, they do not answer, or do not take the medication, wanting to be alone or being rude to the team." (Interviewed 28, female, nursing assistant).

Care Strategies in face of AIDS patients suffering

While AIDS patients' hospital stay, the nursing team member's face many doubts, uncertainty situations and other factors that cause this population's suffering. In face of that, these professionals judged executing care strategies guided to eliminate or minimize this suffering necessary. Nursing team members noticed that AIDS clients have many uncertainties and wrongful information regarding AIDS development, its treatment and ways of prevention. These aspects could result in the non-adherence to treatment or in the difficulty to prevent co-infections.

Therefore, interviewees acknowledge the fundamental role of the nursing team in guiding and explaining, always reminding that these individuals should be allowed to expose their doubts and needs. They also believed that, this way, patients' psychological improvement could be reached and, consequently, elevate self-esteem. This is a fundamental factor for a good prognostic in the nursing team perspective.

"AIDS patients need self-esteem improvement and to believe that (...) treatment is real and there are some AIDS patients who have been alive and kicking for fifteen years." (Interviewed 16, female, nurse).

Members of the nursing team also affirm that AIDS patients, sometimes, have negative feelings and develop suicidal thoughts as the solution for all the difficulties they face. Therefore, these eminent feelings generate early actions to prepare the environment with a view to prevent these events:

"The sector is prepared when a AIDS patient wants to commit suicide. Closed windows, talk and psychologists are called (...)" (Interviewed 19, male, nursing assistant).

This way, there is a need for nursing team members to acknowledge the situations in which they can act and those where they need to require the help of other health professionals. Beyond suicide prevention, the help of a psychologist is mentioned as necessary, mainly when the client receives the AIDS diagnosis, so they can talk and evaluate acceptance and understand the disease.

Discussion

According to the contents expressed in this study, the females from the nursing team with personal monthly income lower than US $1,500.00 and in exercise of profession for 10 years or less, demonstrate that they socially represent the care provided to AIDS patients from elements referring to interpersonal relationships. Heading towards the positions assumed by the nursing team members approached in this research, many authors affirm that to fully provide nursing care, scientific knowledge and technical abilities must be allied to affective interactions and sensibility expressions [11]. A consensus among this field's theoretic thinkers on the supposition that to execute nursing care, affective welcoming is necessary along with sensible listening of the human being that is under care. Also, the proximity between the care provider and the care receiver is primordial, requiring solicitude, dedication and mutual commitment [12].

Communication while hospital stay is of vital importance because it is the tool for the patient to express his requirements and needs in the process, to the nursing team. Therefore, they can finally by understanding the importance of participating in the nursing care that is provided to them. Within this scope, the dialogue is understood as an expressive nursing care. The dialogues have vital importance in the people living with AIDS nursing care process [12].

The availability of the nursing team is perceived by means of demonstrating attention while providing care or by talking about subjects that are not related to the care itself. Therefore, the care taker needs to have empathy, respect and authenticity, with a view to a better adjustment of the patient to the treatment. This way, the empathy mentioned here is mentioned as being different from the affective bonding with patients, because it only presumes understanding feelings and behaviors of another person, including the act of caring for the other persons' well-being [13].

The presence of a regulation establishment positioning in professionals' conception in this study regarding dialogues, highlighted by lexical reduced presence of speech as a reduced format, and by frequently highlighting guidance and explanations stand out. A gap regarding the listening process interaction can be observed, since it is a fundamental element for a relationship based in empathy, for acknowledging the other's needs and terms. Difficulties in social abilities to negotiate and deal with the distress experienced by professionals in face of patients' rejection regarding nursing interventions as medication administration are found. A fact that can lead to a mistaken perception of the professional role, therefore, its social identity [14,15].

While the acquaintance established between the nursing professional and AIDS patients, many feelings are manifested, for instance, compassion, distress, impotence, attachment, satisfaction, pain by stigmatization, fear, rebellion, anxiety, and even prejudice. These feelings are multi-determined by social, beliefs, values representations and the information degree of team members. Dealings with issues as death, sexuality and drug abuse require from the nursing team members to be prepared for the quest, a fact that is not always observed. An important reflection on the need and effectuation of relationship care refers to the professionals' capability to improve. Considering that the limits between helping professional relationship and affective relationship are a very fine line, interviewees showed lack of distinction among these two modalities, revealing the lack of professional ability to develop the first modality. Considering that the care holds as essential attribute the bonding with patients, it is

necessary to reflect on this bonding attribute and the necessary professional training for its effectuation [16].

The difficulties spoken by the members in this study on establishing relationship care point to three psychological processes: One is the professional establishes a personal-affective relationship with the patient; a second the professional seeks to keep distant due to self-preservation, however, not distant from the patient; and a last one expressing distancing and denial of interaction processes that are executed while the care. This last modality can be tactically assumed, or simply retracted due to a lack of time and excessive tasks. The last aspect, despite the relationship care is broadly defended by theory thinkers in nursing, and more recently by other areas; it is not yet understood and assumed by hospital institutions (and even by nursing team members) as an attribution for the nursing team, needing planning, training and time available for its execution.

As for empathy, understood as the act of placing yourself in the other's place in order to understand his needs and feelings, it is seen as an essential part of nursing care. It is seen as fundamental for the professional to understand the patient's world and therefore, offer individual care [17].

However, professional unpreparedness of the nursing team to relate to patients is observed. Especially when regarding patients with stigmatized pathologies that bring eminent death as AIDS. Thus, the lack of time due to the intense working rhythm can be used as justification for these nursing team members, because they know the importance of such interaction and they do not perform it because of many other reasons, even because they do not feel psychologically prepared to do so. So, some authors [14,15] mention emotional contact or personal lack of well-being, when subjects acknowledge the feelings lived by others, however, they tend to keep a distance due to the suffering load generated by the process. It corresponds to a difficulty in developing the cognitive component of empathy. In other words, in the distinction between oneself and the other in the interaction; in the diverse way of empathy involvement, it tends to discourage subjects into helping others. In the case of nursing care professionals with AIDS patients, some researchers analysed this aspect under the expression burnout [18].

The family is still understood as a fundamental piece in the good development of the treatment for AIDS patients, since they need to feel acceptance by their closest members to maintain elevated self-esteem and to find meaning in proceeding with the treatment and on taking care of them. Thus, it is acknowledged as the source of help for the patient, contributing for their physical and mental balance [19,20]. However, meanings given to carrier of AIDS by society are also shared by the family, and they determine their behavior. Therefore, it results, many times, in prejudice, consequently excluding them from the family. For family members to feel capable to support AIDS carriers, they must feel able for this task and aware of their feelings regarding the disease. The nursing team must be available to help them with their difficulties by interacting with a view to finding the best way to care for the subjects with AIDS. As from the statements analysed here, this proposition seems far away from the nursing professional routine, whether for relationship reasons with the nursing team or for the social and cultural context that makes dealing with it difficult [20].

Moreover, pointing out the presence of family members while hospital stay can also consist in a strategy for professionals to deal with the suffering experienced in the hospital stay process with AIDS patients. Therefore, it is possible to share affective demands resulting from these last aspects, for which, as mentioned before, the nursing team refers as not appropriately prepared and supported by the work institution.

Another aspect that stands out is the adverse effects of anti-retroviral therapy and opportunist infections, as bodily disfiguration appears, keeping the AIDS diagnosis secret becomes more difficult. The person living with AIDS is, closer and closer to society's acknowledgement and, therefore stigmatized. In face of the possibility of being acknowledged, AIDS carriers feel more and more vulnerable to prejudice actions from society. Negative feelings emerge from that, as hopelessness, guilt, rage, and depression, gradually decreasing self-esteem, and possibly leading to suicide, if not appropriately taken care. Feelings experienced in face of a disease as AIDS are complex and very peculiar. At the same time, dealing with eminent death can lead the patient to experience an emotional process that can lead from depression to extreme euphoria, leading to a more conscientious acceptance of their actual state [20].

The team caring for these patients must be aware of the moment in which each patient is to understand the feelings experienced by them and better deal with them. However, this awareness is not always possible, since psychological treatment is not developed for all patients. The nursing team, 24 hours present, searches for ways to deal with these altered psychological states as from their intuition on the occurrence of them, referring these professionals to a lack of training needed for this task.

In face of the results, the nursing team is observed to exercise an important function concerning the identification of patients suffering and the strategies to ease them. It all happens because there is a single health team that stays full-time in contact with patients while hospital stay. Thus, if they are not able to plan and execute strategies, they can acknowledge the need to require the action of other health professionals as, for example, the psychologist.

It is primordial that the nursing professional must be sensible to listen to doubts, uncertainties and experiences, and to be aware of attitudes and expressions of the patients while caring for them.

Conclusion

The relationship established between the nursing team and the AIDS patients it is possible to mitigate affective states as sadness, rebellion, depression in face of the diagnosis, as well as reduce denial attempts. Treatment adherence also can be associates to the dialogue and to the search for strategies to mitigate adverse effects and psychosocial barriers to the

treatment, as social exclusion, lack of family support and the absence of a psychosocial network support. This is influenced by various elements, whether institutional, behavioural or psychosocial. Among behavioural reasons, physical and moral violence noticed and/or practiced by people living with AIDS against nursing professionals are featured. Facilitating factors for interpersonal relationships are observed, as empathy, the identification of common features between the professional and the patient, as age, sex and religion or soccer team. In professional representations, ambiguous attitudes in face of AIDS patients are observed. Thus, many feelings are experienced by nursing professionals regarding AIDS patients, going from compassion and pity to rage and fear. These representations are understood as guiding for practices of care. This care can be possible if the professionals face their values, feelings and prejudices, so they can feel capable to explain and help AIDS patients and their families to overcome barriers involve the AIDS diagnosis.

Support

Capes Foundation–Coordination of Improvement of Higher Level Personnel.

References

1- Waldow VR (2004) O cuidado em saúde: As relações entre o eu, o outro e o cosmos. Vozes, Petrópolis, Brazil.
2- Moscovici S (1981) On social representations. Social cognition: Perspectives on everyday understanding. Academic Press, London, pp: 181-209.
3- Abric JC (2001) O estudo experimental das representações sociais: EdUERJ, Rio de Janeiro, pp: 155-169.
4- Sá CP (2002) Núcleo Central das Representações Sociais. 2ª. ed. Vozes, Petrópolis, Brazil.
5- Ezedinachi EN, Ross MW, Meremiku M, et al. (2002) The impact of an intervention to change health workers HIV/AIDS attitudes and knowledge in Nigeria: A controlled trial. Public Health 116: 106-112.
6- Oyeyemi A, Oyeyemi B, Bello I (2006) Caring for patients living with AIDS: Knowledge, attitude and global level of comfort. J Adv Nurs 53: 196-204.
7- Hidalgo C, Abarca M (2000) Comunicacion interpersonal: Programa de entrenamiento em habilidades sociales. (5th edn), Ediciones Universidad Católica de Chile, Santiago.
8- Del Prette ZAP, Del Prette A (2001) Inventário de habilidades sociais: Manual de aplicação, apuração e interpretação (IHS-Del-Prette). Casa do Psicólogo, São Paulo, Brazil.
9- Eisenberg N, Strayer J (1992) Cuestiones fundamentales em el estudio de la empatía. Desclée de Brower, Bilbao.
10- Oliveira DC, Gomes AMT, Marques SC (2005) Análise estatística de dados textuais na pesquisa das representações sociais: Alguns princípios e uma aplicação ao campo da saúde. (1st edn), Casa do Psicólogo, São Paulo, Brazil, pp: 157-200.
11- Alves IC, Padilha MICS, Mancia JR (2004) A equipe de enfermagem e o exercício do cuidado a clientes portadores de HIV/AIDS. R Enferm UERJ 12(2): 133-139.
12- Santos MLSC, Padilha MICS (2002) Os caminhos da afetividade no cuidar de enfermagem. Esc Anna Nery R Enferm 6(3): 397-409.
13- Galvão MTG, et al. (2006) Analysis of proxemic communication with HIV/AIDS patients. Rev Latino-am Enfermagem 14(4): 491-496.
14- Preston SD, De Waal FBM (2002) Empathy: Its ultimate and proximate. Behav Brain Sci 25(1): 1-72.
15- Decety J, Jackson PL (2004) The functional architecture of human empathy. Behav Cogn Neurosci Rev 3(2): 71-100.
16- Ribeiro CG, Coutinho MPL, Saldanha AAW, et al. (2004) Estudo das representações sociais sobre a AIDS por profissionais de saúde que atuam no contexto da soropositividade para o HIV. DST – J bras Doenças Sex Trans 16(4): 14-18.
17- Beschle JC, Beggs CM, Russell GE (1995) Interviews with home health aides caring for people with AIDS. Home Healthc Nurse 13(6): 20-24.
18- Bennett L, Michie P, Kippax S (1991) Quantitative analysis of burnout and its associated factors in AIDS nursing. AIDS care 3(2): 181-192.
19- Gomes AMT (2005) Silêncio, silenciamento e ocultamento na terapia anti-retroviral: Desvelando o discurso de familiares-cuidadores [tese de doutorado]. Escola de Enfermagem Anna Nery, Rio de Janeiro.
20- Kovacs PJ, Bellin MH, Fauri DP (2006) Family-centered care: A resource for social work in end-of-life and palliative care. Soc Work End Life Palliat Care 2(1):13-27.

***Corresponding author:** Denize Cristina de Oliveira, Ph.D, Doctor in Public Health by the University of São Paulo. Full Professor by the Nursing College, in the Nursing Graduate Program and the Social Psychology Graduate Program of the State University of Rio de Janeiro (UERJ), R. Gal. Ribeiro da Costa, 178-apto.1201, Rio de Janeiro, 22010-050, Brazil, Tel: 55-21-99307-1771; Email: dcouerj@gmail.com

Received date: June 27, 2017; **Accepted date:** July 22, 2017; **Published date:** July 27, 2017

Citation: Oliveira DC, Formozo GA, Costa TL (2017) Interpersonal Relationships as a Tool in the Aids Nursing Care. *J Health Sci Educ* 1(2): 112.