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Death and dying of newborns and children: relationships between nursing and family according to Travelbee

Morte e morrer de neonatos e crianças: relações entre enfermagem e família segundo Travelbee

Muerte y morir de neonatos y niños: relaciones entre enfermería y familia según Travelbee

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ABSTRACT

Objective: Identify the nursing staff's perception of their relationship with families of newborns and children who are in the process of death and dying. **Methods:** Qualitative research, carried out in the Neonatal and Pediatric Intensive Care Unit of a public maternity hospital in Rio Grande do Norte, with 17 nursing professionals, through a semi-structured interview. After being transcribed, the data were subjected to Bardin's content analysis and interpreted in the light of the theory of Interpersonal Relations proposed by Travelbee. **Results:** Four categories emerged from the analysis: "Caring and welcoming people, feelings and stories"; "Reactions in the midst of pain: moving between acceptance and suffering"; "Communication of bad news: challenges and strategies"; "The weight of caring and suffering". **Final considerations:** Family assistance can be established using Travelbee's principles, as they offer timely theoretical support for nursing actions in the context of the process of death and dying.
Descriptors: Death; Interpersonal Relation; Family; Nursing, Team; Pediatric Nursing.

RESUMO

Objetivo: Identificar a percepção da equipe de enfermagem sobre sua relação com familiares de neonatos e crianças que se encontram no processo de morte e morrer. **Métodos:** Pesquisa qualitativa, realizada em Unidade de Terapia Intensiva Neonatal e Pediatria de uma maternidade pública do Rio Grande do Norte, com 17 profissionais de enfermagem, mediante entrevista semiestruturada. Após transcritos, os dados foram submetidos à análise de conteúdo de Bardin e interpretados à luz da teoria das Relações Interpessoais proposta por Travelbee. **Resultados:** Quatro categorias emergiram da análise: "Cuidar e acolher pessoas, sentimentos e histórias"; "Reações em meio à dor: transitar entre a aceitação e o sofrimento"; "Comunicação de más notícias: desafios e estratégias"; "O peso do cuidar e do sofrer". **Considerações finais:** A assistência aos familiares pode ser estabelecida usando-se os princípios de Travelbee, pois oferecem aporte teórico oportuno para ações de enfermagem no contexto do processo de morte e morrer.
Descritores: Morte; Relações Interpessoais; Família; Equipe de Enfermagem; Enfermagem Pediátrica.

RESUMEN

Objetivo: Identificar la percepción del grupo de enfermería sobre su relación con familiares de neonatos y niños que se encuentran en el proceso de muerte y morir. **Métodos:** Investigación cualitativa, realizada en Unidades de Cuidado Intensivo Neonatal y Pediatría de una maternidad pública del Rio Grande do Norte, con 17 profesionales de enfermería, mediante entrevista semiestructurada. Tras transcritos, los datos fueron sometidos al análisis de contenido de Bardin e interpretados basados en la teoría de las Relaciones Interpersonales propuesta por Travelbee. **Resultados:** Del análisis, emergieron cuatro categorías: "Cuidar y acoger personas, sentimientos e historias"; "Reacciones en medio al dolor: transitar entre aceptación y sufrimiento"; "Comunicación de más noticias: desafíos y estrategias"; "El peso del cuidar y del sufrir". **Consideraciones finales:** La asistencia a los familiares puede ser establecida usándose los principios de Travelbee, pues ofrecen aporte teórico oportuno para acciones de enfermería en contexto del proceso de muerte y morir.
Descriptores: Muerte; Relaciones Interpersonales; Familia; Grupo de Enfermería; Enfermería Pediátrica.

INTRODUCTION

Nursing as a science of human care[1] represents the link between subject, family and other professions[2]. Therefore, during hospitalization in Neonatal Intensive Care Units, as well as in pediatric wards, bonds between the nursing staff and the families of newborns or children can be strengthened[3].

In cases where there is an imminent possibility of the death of children, that is, when the perspective of the natural order of life cycles is interrupted, several questions surround family members and professionals about the existence of the being[4-5]. At this point, it is essential that the nursing team understand all the implications and contributions of the care given to the child and his family. Feelings must be welcomed and opportunities for listening, support and overcoming pain can and should be performed[6] and will certainly occur through interaction between those involved.

Considering the importance of the relationships between family members and health professionals in the experiences of death and dying in neonatology and pediatrics and the relevance of incorporating nursing theories into our practices and training as a means of strengthening the disciplinary matrix of this profession, this study was chosen. by the mid-range theory of the Interpersonal Relationship, formulated by Joyce Travelbee[7], in 1966, as a possibility of a care strategy. This theory was developed around the relationships between two people, in which one provides assistance to the other, due to their own state of illness or the conditions imposed by the illness of another[8]. This theoretical model guides the nurse and subject/family interaction, aiming to teach the professional to explore the meaning of disease and suffering, with an emphasis on supporting the other to discover new meanings in the midst of pain[8-10].

Caring, in the theory of relationships, is an active, mutual interaction process, established through communication, in which relationships become therapeutic while there is a commitment and intention to see the other as unique in their singularities and needs[8,10].

Travelbee's theory can provide the conditions and circumstances necessary to unveil the interactional aspects of the nursing team with the families of newborns and children who experience the feelings arising from the repercussions of the illness process, terminality of life and grief. Therefore, it was chosen.

Care in the process of death and dying requires knowledge and skills that go beyond the technical dimension and the biomedical model and bring greater contextualization of the spiritual, social, and philosophical perspectives on life and death. This is because all these dimensions surround the different ways of coping that the nursing staff and families experience when accompanying children and newborns at the end of life[11]. A study carried out with the nursing team on death and dying in a pediatric ICU revealed the presence of feelings of guilt, failure, and denial of death. It was shown that the difficulty in accepting death results from variables such as lack of support in the work environment, length of hospital stay and consequent greater contact with the patient, monitoring of child development and opportunity to live with the family[11].

In this context, it is highlighted those studies promoting technical and scientific development on nursing care in the death and dying of patients and families are as important as those aimed at reflecting and living with the issues involved in this process. Therefore, it is believed that this research is relevant for nursing professionals as it reveals perceptions of an important professional practice; at the same time, it sheds light on these aspects through a theory capable of helping to improve the experiences of care in the face of the end of life for children, families, and professionals.

It is understood that the process of death and dying may present peculiarities according to each stage of the child's development and that, consequently, the repercussions for family members and professionals also have their specificities. However, this study does not intend to make comparisons according to the child's age group, but rather to give voice to the experiences of professionals who perform care in an environment in which technical mastery combined with sensitivity and humanization is required.

It is noteworthy that the use of nursing theories helps to create, expand, consolidate and incorporate new knowledge of the profession and walks in convergence with health systems based on universality and integrality, such as the Unified Health System (SUS)[12].

Thus, considering the above, the present study presents the following research question: What is the perception of the nursing staff about their relationship with the families of newborns and children who are in the process of death and dying?

OBJECTIVE

Identify the perception of the nursing staff about their relationship with the families of newborns and children who are in the process of death and dying.

METHODS

Ethical aspects

This study is one of the products of the primary research entitled "Perceptions of the nursing team on palliative care for children", which was approved by the Research Ethics Committee of the Faculty of Health Sciences of Trairi (CEP-FACISA), Federal University of Rio Grande do Norte (UFRN), in accordance with Resolution No. 466/2012 of the National Health Council. the data were collected only after agreement and signature of the Informed Consent Form (ICF) by the participants.

It is noteworthy that there was no relationship established between researchers and respondents before the study. Regarding the conduct of the interview, the first author was trained by the other authors before the start of data collection and was directly responsible for the collection. The instrument was tested through a pilot test carried out with other professionals who were not part of the sample.

Study type

This is a descriptive, exploratory study with a qualitative approach. To ensure better validity of the methodological aspects, the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ)[13] were followed, used as a checklist for qualitative studies as provided by the EQUATOR network.

Study scenario

The study was conducted in the Neonatal Intensive Care Unit (NICU) and Pediatrics sectors of a public maternity hospital located in the interior of the state of Rio Grande do Norte. It is a health unit that provides maternal and childcare services to more than 21 cities in the state, offering medium-complexity hospital care to its target audience.

Data source

In this study, the convenience sampling method was used. Participants met the following inclusion criteria: being a nursing professional (technician or nurse) working in the NICU or Pediatrics and being in professional activity in the sectors during the period of data collection. The sample size was determined by data saturation, so that 17 professionals participated in the survey, 10 nursing technicians and 7 nurses.

Data collection and organization

Data collection took place between August and October of 2019. It was carried out through individual semi-structured interviews in the presence of two researchers and the interviewee, in a waiting room outside the entrance to the NICU and in a reserved room within Pediatrics, depending on the sector of activity and the best convenience for each participant.

The professionals were approached while on duty, the research objectives were presented, and the researchers were waiting for a moment considered favorable by the interviewees. There was no refusal by the professionals contacted. To ensure methodological rigor, the consent form was presented, followed by the consent form for voice recording, and the interview began only after each participant signed both. Each interview was conducted in just one meeting; all were recorded on a digital device and later transcribed in full.

The interview script, prepared by the authors, was made up of open questions, namely: "Have you ever had to provide assistance to patients who are out of therapeutic possibilities for a cure? If so, talk about the experience"; "What is palliative care for you and how can it be performed?"; "How do you deal with these situations of neonatal and/or pediatric patients in the process of death and dying and in the relationship with family members?"

To guarantee the anonymity of the participants, the nurses were identified with the acronym "NUR", and the nursing technicians, "TEC", followed by the number corresponding to the order of the interviewees.

As feedback after the interviews, the participants revealed that thinking about the topic raised reflections on the need to prepare for terminal situations through training provided by the maternity in question and having its own team specialized in palliative care to support the service professionals.

Data analysis

For data analysis, content analysis was used, in three stages: pre-analysis; codification; and categorization of material[14].

After categorization, the results were interpreted in light of the theoretical framework of the theory of Interpersonal Relations, by Joyce Travelbee[7], seeking to correlate the dimensions of the relationships between the nursing staff and the families of newborns and children in the process of death and dying with the interactional and applicability aspects of the theory to the studied scenario.

The choice for this theory is based on its assumptions, according to which the interpersonal relationship is the way to reach the objectives of professional nursing care; and yet, through communication, the therapeutic relationship is established in order to help the patient and his family to deal with the disease and find meaning in the pain and suffering they experience[8].

Therefore, the results will be presented below according to the four categories that emerged from the analysis, namely: "Caring for and welcoming people, feelings and stories"; "Reactions in the midst of pain: moving between acceptance and suffering"; "Communication of bad news: challenges and strategies" and "The burden of caring and suffering".

RESULTS

Caring for and welcoming people, feelings, and stories

Participants described their perceptions, as members of the nursing team working in the Neonatal or Pediatric ICU, about the need to provide the family, through humanized care, with welcoming, support and strengthening the bond. These actions are essential during the experience of promoting care in the face of the process of death and dying, considering the repercussions of the process of illness and terminality of life in the whole family, as can be seen in the following statements:

> […] *as for the family, it is [important] to strengthen the bond and the relationship of care at these times, because, regardless of the temporality, it is important that this experience be experienced in a positive way.* […] *It's the way to welcome the feelings that come from the family and the team and try to build something positive within that.* (TEC05)

> […] *keeping care as humane as possible in the neonatal reality is the most important thing. Humanization as the most important thing to be maintained, because the family still needed to be assisted. The NICU has this difference, not only of a baby is taken care of, but the entire family is also taken care of. Often, relatives arrive that, for the staff, sometimes, it was not meant to be so close, but that baby had a lot of meaning for them, they dreamed of that baby. So, it is thought that, in the neonatal reality, it is to provide the most humanized care possible within our reality.* (NUR02)

For the professionals, the implemented care must transcend the idea that it is limited to the use of scientific technological resources offered in the services and include in their care the integrative strategies in the relationships based on the humanization of this care.

> *Implementing care in the process of palliative care in children, in pediatrics, is much more about having tact, having to deal with issues of humanity, rather than science, artifacts, inputs; it is much*

more a matter of tact, of management than the implementation of proper physical or material care. (NUR05)

Reactions in the midst of pain: moving between acceptance and suffering

This category concerns the way in which the reactions of suffering or acceptance by family members regarding the process of death and dying of their loved ones have an impact on the experiences of nursing professionals, as shown in the following excerpts:

> *Remembering this case, it was humanized as much as possible, the staff were sensitive to that mother's wishes, so it was calm* […] *it wasn't difficult for the team because it was well accepted by the mother. It seams there wasn't a feeling of revolt. The mother saw how much her little boy was struggling to survive,* […] *the mother had a feeling of acceptance and experienced that process very well,* […] *the mother put it on her lap, and was totally gentle about it. The mother helped us a lot more. It is thought that, if one will see what happened, the mother was the stronghold of the moment.* (NUR02)

> *It is thought, the most difficult thing is the relationship with family members, because pediatric patients, unlike adult patients, are not aware of the process. The adult patient, they may be aware or not, but the pediatric patient never is, and the family may sometimes be prepared and may not be, then, in case they are not, It is thought it is even more difficult for professionals to deal with this.* (NUR01)

> *Each loss is totally different, how many parents accept it well is* […] *it's not* […] *the word isn't even that... the phrase isn't even that "they accept well", when they manage to have a calmer feeling, because each one also reacts to one another. way, some explode, they really freak out, others don't, they manage to receive that news with more delicacy, with more tranquility. So the attitude of professionals* […] *their feeling is good in relation to this: parents who freak out, we end up suffering a lot more; parents who receive with peace of mind, we manage to take it with humanization. It is dealt with it, responded to according to what the family gives us as well.* (NUR02)

Communication of bad news: challenges and strategies

When reporting information about the critical clinical condition of the child or newborn to the parents, the participants perceive the difficulty between dealing with the news and the possible meanings and expectations that it can generate in the family.

> *It's difficult, it's not easy, in neonatology it's not easy to report death, to report that the baby is getting worse is super difficult, right? It's like it is said* […] *the child has little time to live, but the child was dreamed of a lot, there is a whole dream behind that baby. In the end they have to face it, it's not easy, it's painful, they end up suffering, getting emotional when the baby needs to be put in the mother's lap.* (NUR02)

> […] *the staff are in a kind of delicate situation, in this way, because, even if there is a previous conversation with the family, some still have some hope that that patient will come back... and for the staff it is difficult because they are aware that that baby may not evolve* [well], *right? There's a great chance of not evolving* [well], *but the family believes that it does, so it's a kind of delicate situation, the staff try to approach it in the best way, but it's sometimes kind of sad, even because you're seeing that family so willing to have the baby in that... to go back to family life, and the staff know that it won't happen there.* (NUR04)

The nursing team states that seeking meanings in spirituality and using words of comfort can be ways of coping together with the family member at the time, seen as difficult, as expressed in the following statement:

> *So it's a very difficult moment, it's very sad for the team because they think it's a life that still lies ahead, right, to be lived, but the staff try to comfort the family in the best way possible, like, saying that they did what he could, explaining that there is a lot that medicine cannot explain, and at these times the spiritual part, if the family has faith, something... this will help a lot and that's it, comfort for the family, the staff try give it like that with a hug, right? Try as much as possible to comfort the loss of that mother, father, grandmother, finally the companion you have.* (NUR06)

One of the participants emphasized that the team should try not to generate false expectations in family members, using sincerity to understand the finiteness of the child's life and being prepared to identify when it is time for the end of the therapeutic investment.

> *Staff always need to explain to the family member, to keep the patient in comfort, not to generate an expectation that the staff know will not exist, because sometimes it is difficult for the health professional to tell the family that there is no longer any way. Often, the professional, for not receiving this preparation in training, ends up creating this expectation* […]. *Not to generate an expectation for the family member, because sometimes, depending on the patient's general condition, he* [has] *some involuntary movements, and the mother or family thinks it's some answer and a chance, of possibility, and it is thought that staff have to be as honest as possible with the family. Understand that there is a moment when this patient will enter palliation, and the team needs to be prepared, that there is a moment when they have to stop the issue of investment in therapy.* (NUR07)

The weight of caring and suffering

The feeling of impotence, sadness and professional embarrassment can be experienced by the team when, despite their efforts, they are unable to help the family in their pain.

> *It's embarrassing, it's also sad because when someone sees a child die and the staff have to be supporting the family and you know that nothing anyone says or does will console because it's a loss, right? And it's kind of embarrassing and sad to have to go and talk to the child's parents knowing that what is going to be said won't comfort that family.* (TEC10)

> *It's an experience that brings a certain feeling of powerlessness to the team, sometimes, right? In general, it's fine* […] *it's not that simple, because generally the expectation is that there is a cure; and when it is out of therapeutic possibility, then, in a way, it brings this feeling of impotence.* (TEC05)

These statements make it clear that the family's suffering makes the care process performed by nurses more burdensome, causing their work to be often permeated by pain.

DISCUSSION

The professional practice of nursing in situations of therapeutic impossibility of cure and the end of life in children and newborns requires a look that goes beyond the care restricted to the sick person[15], as seen in the speeches presented.

Professionals must provide the family with the support of their needs throughout the process of comprehensive care for the child, which occurs until the moment of death in a dignified way, without pain and in peace, in addition to considering the mourning of those who remain[3]. These actions favor relationships of support to family members, considering that they also experience illness, the end of life, grief and the repercussions of the loss of their loved one[16].

Family members who experience diagnoses of diseases with a high possibility of aggravation and death of their loved one's face pain, suffering and anguish, requiring care that commits to creating strategies to share these feelings and the support needed to make difficult decisions. Internal conflicts and feelings aroused in the face of illness and the recurring fear of death make family members also need the assistance provided by the nursing team - the team, which often acts as a link between the multidisciplinary team and the subject/family, with a view to reach of comprehensive care, that is, covering the physical, social, psychological and spiritual aspects[17].

In this sense, humanized care is necessary to offer support in the process of death and dying, and its full inclusion in family care[18] is essential, without ignoring that professionals also need spaces for welcoming, training and emotional comfort.

In this light, the speeches given and grouped in the first category of this study reveal that nurses and nursing technicians perceive the need to provide emotional support to the family, are sensitized to the situation of a scenario permeated with frailties, anguish, and pain in neonatal care and pediatric and propose the interaction between the people involved.

According to Meleis[8], in the theory of Interpersonal Relationship, by Joyce Travelbee, the interaction discussed and proposed between nurses and people who are in a state of suffering, caused by some disease, can be considered as a premise for professionals to deal with the pain and suffering of family members. It is through the establishment of interactions that you get to know the person and get involved with them, becoming aware of their needs. Also, this fulfills the objective of nursing, defined by this theory as supporting the patient or family member, in a situation of illness, to face and learn from the experience, finding meaning in the pain and suffering they experience[8,10].

From the perspective of the theory of interpersonal interaction, recognizing the other in their singularities is as essential as carrying out technical procedures[8]. In line with this perspective, it was observed that one of the participants in this research pointed out the need for awareness in choosing the use of light technologies instead of hard technologies during assistance in the process of death and dying.

It is noteworthy that hard technologies configure primarily technical care, with the use of devices, standards and machines[19], which are increasingly present in the reality of the Neonatal and Pediatric ICU, due to a significant technological progress over the years[20]. Soft technologies, on the other hand, refer to the production of welcoming and bonding relationships, based on humanization capable of capturing the singularities, ethical, family, and contextual aspects of people, providing new perspectives for the clinical reasoning of health professionals[19,21].

Thus, by valuing human relationships and health in an integrated manner within an environment surrounded by equipment and techniques, professionals are able to access other mechanisms, such as communication, which help them to understand the dynamics of human relationships and interactions, given that the affective and family environment has a significant impact on the health-disease process[21-22].

Regarding the family members' reactions to the finitude of life, the speeches of the participants in the second category indicate that, depending on the involvement between the nursing professional and the family, the bond and trust relationship can allow both to find mutual support to face the pain and the sadness. The speeches also reveal that, when these reactions demonstrate tranquility and acceptance, the professional finds it easier to deal with and help the family; in contrast, when the reactions are of anger and despair, attitudes become more difficult to manage.

In the Interpersonal Relationship theory, pain and suffering are associated, and suffering is being immersed in an ocean of pain[8]. The experience of suffering is inherent to human beings, and each responds to it in a unique way. Guilt, non-acceptance and great anguish are common responses to suffering, but other reactions may be presented, such as acceptance without protest or with an affirmative reaction, possibly stemming from the individual's personal philosophy, convictions, religion and own perceptions of nature and humanity[8]. From this perspective, by realizing all the meanings surrounding the experience of people in the midst of disease and suffering, the nursing team can assess the potential for confrontation of these family members and provide nursing interventions to prevent suffering and despair[10].

In professional health practice, the communication of bad news involves the complexity of feelings established in the therapeutic relationship between the caregiver and the caregiver[1]. Thus, the professional's experience with family members needs to be based on clear and effective communication, because in some experiences, such as those of children who are out of therapeutic possibility of cure, family members continue to hope that the child will heal yourself. This situation requires, then, the approach through palliative care to help them in this acceptance process[16,23].

Thus, in the statements highlighted in the third category, it was shown that professionals consider the time to communicate information about the clinical picture or the death of newborns and children to the family member as something painful and challenging, because, in both situations, they need moving between the scientific knowledge they have and the skills to deal with family members' expectations and feelings[24].

With this reflection, it is seen that the professional has the possibility of using interaction as a strategy for establishing bonds of trust that facilitate effective communication and a

therapeutic relationship in order to achieve new meanings in the lived experience[8].

Regarding the clear transmission of messages to family members, other authors showed that families of children in a neonatology unit can positively perceive the content of news communicated by professionals when there is clarity in the information to the point of making them better understand the clinical status of the child[25]. The family may or may not reveal their insecurities, hopes, strengths and weaknesses based on how the bad news was conveyed by the professional. Participants in that study also noted that communication is influenced by the professional's involvement with the family and that the professional's length of experience influences their attitude when sharing information[25].

The theory in question proposes that communication methods to establish relationships are strategies that can be used, namely: indirect approaches, which include the sharing of analogous stories or personal experiences; as well as the use of indefinite pronouns; and direct approaches to building appropriate questions or explaining the situation with propriety[8,26]. Care will then become person-centered when the therapeutic use of the self is incorporated into clinical and scientific knowledge[10].

Therefore, the relationship between nurse and family member needs to go through some phases for its establishment, starting with the first meeting, in which the first impressions between the nurse and the person appear; throughout the interaction, the second phase takes place, that of emergent identities, that is, the recognition of the singularities of the other; then comes the phase of feeling empathy, which is the ability of both to understand the other's experience and establish the desire to help; then, the development of the feeling of sympathy, when the nurse demonstrates emotional involvement and wants to reduce the suffering of the other. Finally, the rapport phase, which can be defined together with all the previous ones, when both are able to assess the relationship and the therapeutic results. Rapport can also be considered as the catalyst that makes the interactions between the caregiver and the subject of care transform into meaningful relationships[8,10,26].

Still, Travelbee's theory signals that it is necessary to understand disease and suffering as not only physical encounters for human beings, but also emotional and spiritual encounters[8]. In this sense, nursing professionals must see the needs of the spiritual dimension of those who are experiencing a moment of suffering caused by the process of terminality of life, as mentioned by one of the participants, who reports helping the family member to find comfort and meaning in faith.

From the perspective of the work process in the face of death and dying, the hope that the professional must produce in the other, as a form of intervention, must be enlightening and realistic, ensuring the constant presence of the team alongside the patient and their family[9].

Regarding the last category of analysis, feelings of impotence and personal and professional frustration in the face of the early terminality process were evidenced, as professionals may feel the need and obligation to ensure all alternatives to achieve a good prognosis and prolong the life of the child or neonate. However, when they do not achieve this goal, they may also experience feelings of denial and grief[27].

Considering that the nursing theory adopted in this study characterizes sympathy as the act of giving a part of oneself to the other and, in doing so, becoming vulnerable, the nursing professional may experience a denial in an attempt to protect and hide feelings as a way to prepare for when the experience of death arises[9].

A study pointed out the coping strategies of professionals facing the imminent death of children with cancer, considering the emotional burden involved in the process. The identified strategies are based on psychological support from institutions and co-workers themselves, in addition to institutional training on the topic "death and the dying process" in order to provide a safer and more productive daily life for these professionals[28].

The daily contact with situations of imminent stress, such as the early termination of life and its individual repercussions, favors the feeling of helplessness in professionals[27], prompting discussion about emotional support for them. This is because these issues can be permeated by emotional fragility and unpreparedness to deal with such situations and, thus, trigger damage to their physical and biopsychosocial integrity[29].

The suffering linked to the process of death and dying is linked to physical, emotional, and spiritual issues; and helping people to find meaning and hope in these situations is one of the tasks of nurses, who also have their own sufferings and limitations. Through Travelbee's theory, it can be recognized that such characteristics permeate the need and commitment to perceive the self and the other as unique, valuing them and creating coping strategies, as well as providing nursing interventions that can prevent and accommodate the suffering and despair, in addition to generating hope and the ability to give new meaning to the lived experience[10].

Study limitations

A possible limitation of the study is the fact that, even though it is a theory recognized in studies on people with no therapeutic possibility of cure and on their families, Travelbee does not explicitly describe its understanding of family or about how nursing can act. to her.

It is also important to mention that, in the scenario where the research took place, there is still no specialized Palliative Care service, which possibly justifies the fact that the participants' responses pointed to the process of death and dying, rather than portray palliative care itself.

Contributions to the field of Nursing

It is possible to understand that - by aiming to alleviate suffering, the development of empathy and sympathy through the interaction between nursing professionals and people who are experiencing the pain and suffering caused by a disease within the scenario of death and dying — Travelbee's interpersonal theory has the potential to serve as a conceptual model for therapeutic relationships, supporting possible nurses' actions for comprehensive care, centered on the person and their family.

In order to be able to transfer the Interpersonal Relationship theory proposed by Travelbee to clinical practice, nurses must be aware of their own approach and expectations, committed

to the need to understand patients and their families, in order to alleviate their suffering, promoting hope even at the end of life[9].

It is noteworthy that, in the relationships between nurse and family, there may be a therapeutic use of the self, that is, what nurses do to help the other can be a bridge that helps them to go through a difficult time and find new meanings in the experience[10]. The phases of this interaction can be expressed as shown in Figure 1.

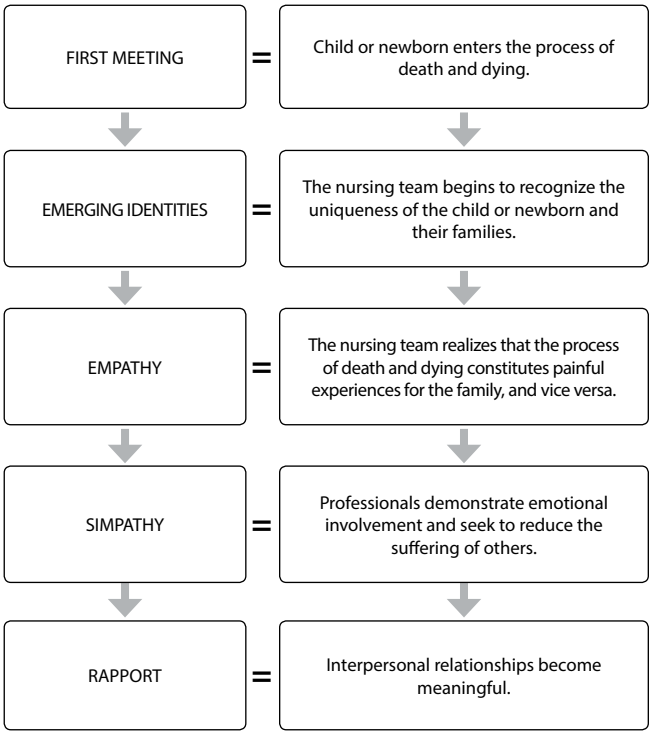

Figure 1 – Phases experienced in the person-person interaction, according to the Travelbee model, Santa Cruz, Rio Grande do Norte, Brazil, 2020

FINAL CONSIDERATIONS

The work process from the perspective of care in the face of death and dying of newborns and children is an experience permeated by different and complex feelings, representations and reflections for the sick person, professionals and family members involved in hospital care.

Accepting the terminality of early life is a challenge found not only in the experience of family members, but also in the experience of professionals themselves, who seek to use humanization, emotional support and respect to help families experience such a difficult moment. During the process of death and dying, some professionals feel frustrated because a cure is not possible, but they still understand that, at that moment, they need to offer emotional support to the person being cared for and their families.

The analysis of the results based on the theory of Interpersonal Relationship proposed by Joyce Travelbee supported the deepening of these reflections on the role of interaction and its dimensions in the relationship between nursing professionals and their families. Therefore, the study proposes that assistance to families of newborns and children can also be established in the principles of Travelbee's theory, as it offers timely theoretical support for nursing actions in the context of the neonatal and pediatric death and dying process.

It is noteworthy that the study in question did not propose a comparison of experiences in the sectors of neonatology and pediatrics, which may be the object of future research. Thus, even though the importance of specialties is recognized, it is highlighted that some participants in this study are professionals with experience in both areas of activity, therefore they have a broad view of the phenomenon studied and brought important contributions.

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