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OCCUPATIONAL THERAPY: HEALTH EDUCATION ACTIONS WITH THE CAREGIVER OF CHILDREN WITH TYPICAL DEVELOPMENT

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ABSTRACT

Characterize the actions of health education carried out by an occupational therapist to caregivers in a University context. Descriptive cross-sectional study, according to documentary survey. Information form of the children and adolescents were examined during practical lessons of discipline Occupational Profile of Children and Adolescents, the Occupational Therapy course at the Federal University of Pernambuco, from February 2012 to January 2014. Caregivers brought demands on comprehensive development of children and adolescents, and were active in the construction of knowledge on health. In this way, the occupational therapy intervention moved to accommodate these demands, guiding the caregivers within the perspective of health education, as the appropriate posture to stimulate the performance of occupational roles of child/adolescent.

Keywords: Health Promotion, Caregivers, Health Education, Occupational Therapy.

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INTRODUCTION

The development of a child is heavily connected to the practice of physical and cognitive stimulation and care offered by their family, since she is singled out as the main base of care network, allowing the child to overcome their own limitations and at the same time, increase their quality of life[1].

The child's interaction with others and with the adult is one of the main elements for an appropriate stimulation in the family space and helps her develop her perception, drive and control its behavior, in addition to acquiring knowledge and skills[2].

Primary caregiver is the person responsible for the care and the child's diary, and that may be the mother, father, grandmother, or any other person who performs this role[3]. In this context, the caregiver has a fundamental role in the development of the child as it is responsible for fostering a stimulating environment[4].

The care of life appears as if considers it important that care, and this is the Mission of the caregiver as it is indispensable for the dedication of time, covering waivers, responsibilities, involvement with the suffering and the confidence of success with life[5].

According to Oliveira et al (2008: p.276)[6]: O cuidador vivencia diversas situações na família, de caráter financeiro, de exercício de papéis familiares, sentimentos de desamparo, perda de controle, exclusão e sobrecarga, os quais podem trazer um estresse ao mesmo, sendo uma resposta às exigências. Nem sempre é possível o lado positivo da experiência de vida que transforma a tarefa do cuidar em prazerosa e com menores dificuldades físicas e emocionais.

Thus, the social support is an important factor in minimizing the effects of stressful situations in family functioning. These sources can be both formal social organizations (health services) as the professionals, aiming to provide assistance to those in need[7].

It is the responsibility of the health team has a key role to explain/guide families in relation to the care that will be needed for the child, through a clear and understandable language, avoiding the use of technical terms, she needs to perform the feedback, in order to prove that the guidance provided the family was understood[1].

This guidance is made in the context of health education, because this is a feature through which the knowledge produced in the field of health, brokered by health professionals, reaches the everyday life of the people, in order to prevent disease and promote health[8].

Health education is regarded as a dialogue between professionals and users, which enables you to build knowledge and increase the autonomy of the people about their care[8]. In this way, in whatever space, educational action symbolizes a moment is developed integral care to people's health[9].

In this way, the occupational therapist cares to empower people to perform their daily activities, can instruct the caregiver to provide welfare to the familiar, to the extent that this care is a daily activity for this caregiver[5]. In addition, it is essential that the occupational therapist, in this approach of health education, which prioritizes the shared construction of knowledge, make a wire expanded the demands of the client/family and

their expectations and enable critical reflection about their health condition, as well as the familiar[10,11,12].

In this sense, the aim of this study is to characterize the actions of health education carried out by an occupational therapist to caregivers in a University context.

METODH

This is a descriptive and retrospective study with cross section. The survey was conducted in the occupational therapy department at the Federal University of Pernambuco (UFPE/DTO) through the Occupational Profile Discipline of children and adolescents, which deals with children's normal youth development, and brings in his methodology reviews/comments of the occupational performance typical of children and adolescents, in order to trace the occupational profile of these, making a listening to the complaints and demands of parents/caregivers, clarifying your questions and guiding them about human development.

The dynamics of the discipline consisted of: initial contact with the families to explain the proposed discipline and questioning about the difficulties and potentialities of the child related to the performance of everyday activities; During the sessions, were collected information by means of an unstructured interview, conducted by an occupational therapist/teacher responsible for discipline, which contained data on the age, sex, degree of kinship caregiver, complaint/demand date of the evaluation, the main behavior of child/adolescent, observed aspects of the caregiver, vacant of an occupational therapist for the return of family caregivers on the guidelines and additional notes, and finally, these interviews were filed with the teacher responsible for discipline.

All caregivers were targets of this research. Spontaneously, children/adolescents, along with his caretaker, were invited to participate in the note, which was performed in meeting only; identifying complaint/demand of the caregiver and/or child/adolescent. The fed back of the caregivers were collected immediately after the guidelines given in day. In this study, we analyzed the actions developed in the period of February 2012 to January 2014.

The data were analyzed in simple frequency and discussed according to what was found in the literature on the topic in question. The study was approved by the CEP/UFPE (CAAE number 23122713.1.0000.5208).

RESULTS

The sample consisted of 25 caregivers, observed during the period established.

The frames 1, 2, 3, 4 and 5 present the complaints/demands that caregivers have brought to the assessment; the record of observations of caregivers during the evaluation process; Besides the posture and feedback that the caregivers have given the process of observation and the guidance provided by the occupational therapist.

The frame 1, data relating to the caregivers of babies from 0 to 1 incomplete year, indicates that the complaints relate to the Neuropsychomotor Development, demonstrating the interest of those in information and possible ways to stimulate the child in order to facilitate the development of these.

Frame 1: Characterization of the occupational

profile of carers of babies from 0 to 1 incomplete year. Recife/PE, 014.

Complaint/demand	Comments	Posture of the caregiver
Difficulty in shower sitting/wants to be on his arm, with the adult always standing	*Caregiver:* Quite shy and observer	Receptive from the guidelines, questioned the use of infant Walker
Doubts about the DNPM and the effects of overuse of the stroller.	*Caregiver:* Overprotective/low frustration threshold.	Receptive Mindful of the guidelines, asking and thinking of alternatives.
Doubts about the DNPM/Just want to stand up/Conduct distinct from parents	*Caregiver:* Father's posture and the cold ground, induces the permanence in the cradle.	Receptive Aware of the needs of the child, thinking of alternatives.
How to stimulate the DNPM/stays for a long time with the tongue out of the mouth.	*Caregiver:* Anxious/Overprotective/ wear socks and non-skid Kneepads/Offers through the Tablet/stimuli Interfered, diverting attention from the child	Receptive From the guidelines, took new questions, analyzed their conduct and proposed feasible changes.
Resistant to walk, even with support.	*Caregiver:* Overprotective/Restricting the environmental exploitation.	Receptive Mindful of the observations, but the grandfather resistant in assuming their own shortcomings (identifies them in others)

The complaints of the applicants in caregivers aged 1 to 2 years of age are related to the child's behavior, as can be seen in frame 2. Caregivers require information about the best way to interfere in behavioral issues, without prejudice to the development of the baby. Thus, the guidelines are directed to the holding environment permission and independence in daily activities, but enforcing.

Frame 2: Characterization of the occupational profile of carers of babies from 1 to 2 incomplete year. Recife/PE, 2014.

Complaint/demand	Comments	Posture of the caregiver
Don't hold the bottle/Language	*Caregiver:* Overprotective, preventing child protection reactions.	Receptive and the guidelines
Not accept orders.	*Caregiver:* Shy, but interfered positively in activity, reinforcing the orders given to the child	Receptive and the guidelines Aware of the changes needed
Doubts about the DNPM/emotional attachment with their mother.	*Caregiver:* Anxious, Overprotective	Receptive Aware of the guidelines, asking and thinking of alternatives.
Aggressive/questions about place of punishment	*Caregiver:* Overprotective/permissive Stance	Mindful of the observations, very responsive, aware of the changes that need to be done.
Difficulty sleeping/ tearing her hair out.	*Caregiver:* Anxious/excessive Transfers responsibility for the eldest daughter.	Receptive, showed understanding to what was said. Committed to changing the behavior in relation to the eldest daughter and the baby.

The age group between 2 to 11 years are marked by demands on the child's personality and his/her DNPM (frame 3 and 4). In this phase the guidelines relate to a healthy routine for your child, always

stimulating about access to toys and places suitable for their age group.

Frame 3: Characterization of the occupational profile of carers of children from 2 to 6 years. Recife/ PE, 2014.

Complaint/demand	Comments	Posture of the caregiver
How is the development of the child.	*Caregiver:* Interacts well with the child/limits/shared with another activity in parallel.	It wasn't too receptive, listened and agreed with the comments.
How to deal with the temper of the child.	*Caregiver:* Participatory	Open, aware of the problem.
Very polite, does activities for the little sister.	*Caregiver:* Participatory	Open, aware of the problem.
Very active, has no daily routine and sleep too late.	*Caregiver:* Not too permissive/Participatory/Expectation of "cure" it.	Enough receptive about the guidelines and stated that they would follow them.
Pasty in food textures rejects.	*Caregiver:* Participatory	Aware of the difficulty, brought information about the difficulty that the mother has to allow games of this nature.
How is the development of the child/ If the child is very "accelerated".	*Caregiver:* excited about the attitude and behavior of the child.	Receptive, aware of the need of the child and thinking about alternatives.
Authoritarianism	*Caregiver:* Stayed tuned, but did not interfere, only strengthened the orders given by the therapist.	Was receptive and agreed with the guidance of the Therapist.

Frame 4: Characterization of the occupational profile of carers of children from 7 to 11 years. Recife/PE, 2014.

Complaint/demand	Comments	Posture of the caregiver
Lack of attention/overuse of electronic games/paternal Boundaries	*Caregiver:* Participatory, but without interfering	Receptive Aware of the difficulties and seeking alternatives to expand the forms of play.
Has some "fears" related to the death.	*Caregiver:* Collaborative enough.	Receptive From the guidelines, took questions, and can define possible alternatives to work the fear of death.
Clutter	*Caregiver:* Difficulty of organizing your routine with the child/tend to clean up the mess.	Receptive Aware of the difficulties, seeking alternatives.

The 5 framework, referring to the teenagers ' data, indicates that the complaints of the caregivers relate to the DNPM, as well as the use of electronic resources and performance in school activities. Thus, the caregivers are instructed to stimulate sports practices, because in motor development, as well as encourage interaction with people of the same age group.

Frame 5: Characterization of the occupational profile of carers of adolescents. Recife/PE, 2014.

Complaint/demand	Comments	Posture of the caregiver
How is the development of the adolescent	*Caregiver:* Passive, interacted little in attendance	Receptive Aware of the difficulties
School/manual activities that require planning and reasoning	*Caregiver:* Participatory	Receptive Aware of the difficulties, seeking alternatives to help
How is the development of the adolescent	*Caregiver:* Impatient, anxious, but participatory	Receptive Aware of the difficulties
Escola, uso excessivo de jogos eletrônicos	*Caregiver:* Participatory	Receptive Aware of the difficulties, seeking alternatives to help
How is the development of the adolescent.	*Caregiver:* At the request of the teenager, the caretaker did not attend the service	Receptive Anxious and curious looking to know what had happened, wanting to know the space in which the note.

DISCUSSION

In this study we used the client-centered approach to assessing children/adolescents and provide guidance according to the demands brought by caretakers. It is noticed that a large part of the caregivers actively participated in the process of assessment/observation and reported complaints and specific demands, in order to stimulate the full potential of the child or adolescent.

Among caregivers survey, it was identified the prevalence of mothers/parents as caregivers, but there is a significant quantitative various family members, probably by the new family conformations. This new model arises due to the need of the family adapt to the cultural, political and economic changes of the contemporary world[13]. So many children are reared by grandparents, paternal and maternal grandparents; a practice considered natural, because these are the grandparents considered as equivalent to a “second mother”.

Authors describe that the restructuring of the family may be improved if the parents and the professionals take on joint strategies to counter the improving health and increasing assistance to look for his family and his affinity with the child[14].

Thus, the orientation is a means of family support of health professionals that increases levels of perception of the family in relation to the difficulties of the child. The family has a decisive role in the process of child development, and the child leads to overprotect prejudice the development of independence in functional skills[15].

Understanding that health education is a broad and complex process, it is essential that this construct of knowledge is shared, critical analysis and discussed by the reality of the subject, making room for dialogue, allowing the criticality of the subject about his health condition[10,11,12]. When that guidance is given according to this benchmark of health education, it is possible to notice that the caregiver’s posture after those guidelines, allowed the same reflect critically about your posture before the child/adolescent, to understand the problem and expressed the desire for change in this posture for this healthy development.

It is noticed that the guidelines given to carers,

refer, mainly the stimulation of activities of daily life more independently, on the appropriateness of the routine of the children, in the imposition of rules and limits, and the stimulation of sports practices for teens. That way, the one who takes care of the child needs to understand and practice activities that provide pleasure and at the same time encourage the development and learning of the child requiring that the caregiver is physically and psychologically well for better care[6].

Therefore, the child needs to be taken care of by the family, in order to achieve its maximum potential. However, the family also needs to be taken care of by the team of health, in a way that can resize your way of being-in-world to care for the child[1].

FINAL CONSIDERATIONS

Therefore, the appropriate family stimulation influence the development of children and youth, and so she effectively occurs, the caregiver needs to know the paths to this stimulation, and good about yourself.

Thus, the occupational therapist is a professional who works in the area, prompting the caretakers about the complications that may occur in the process of human development, and establish a relationship to support these caregivers.

It is important to note that the guidance provided, within the perspective of health education, promote a space of shared construction of knowledge between professional and caregiver and of empowerment of the same. Thus, these guidelines have favoured a critical consciousness about their reality and about the need for change of postures, and contributed to the stimulation of occupational performance.

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