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Nursing team's perceptions on care for children and adolescents hospitalized with mental disorders[a]

Percepções da equipe de enfermagem sobre cuidados de crianças e adolescentes internados com transtornos mentais

Percepciones del equipo de enfermería sobre la atención a niños y adolescentes hospitalizados con trastornos mentales

Gabriela Morilhas Barbosa[1]
Aldair Weber[1]
Ana Paula Rigon Francischetti Garcia[1]
Vanessa Pellegrino Toledo[1]

1. Universidade Estadual de Campinas, Faculdade de Enfermagem. Campinas, SP, Brasil.

Abstract

Objective: to know the perceptions of the nursing team about the care of hospitalized children and adolescents with mental disorders. **Method:** social phenomenological qualitative study whose data collection was carried out with 12 members of the nursing teams by means of phenomenological interviews. **Results:** "Reasons why" described in two categories: the perception of the nursing team in view of the care provided and actions and care of the nursing team of the child with mental disorders. "Reasons for" expressed in the category: the recovery of the child with mental disorder and his return home. **Conclusions and Implications for practice:** The possibility of establishing a face-to-face relationship between the team, the family, and the child to apprehend the biographical situation and the body of knowledge of the subjects involved, and then understand their real needs and demands promotes comprehensive care. Through Alfred Schutz's social phenomenology, it brings as implications for practice the possibility of understanding the perception of the nursing staff about the relevance of the face-to-face relationship in caring for children and adolescents with mental disorders.

Keywords: Comprehensive Health Care; Nursing Care; Nursing, Team; Hospitalization; Mental Disorders.

Resumo

Objetivo: conhecer as percepções da equipe de enfermagem ante o cuidado de crianças e adolescentes com transtornos mentais internados. **Método:** estudo qualitativo fenomenológico social cuja coleta de dados foi realizada com 12 membros das equipes de enfermagem por meio de entrevista fenomenológica. **Resultados:** "Motivos porque" descritos em duas categorias: a percepção da equipe de enfermagem em face dos cuidados prestados e ações e cuidados da equipe de enfermagem da criança com transtornos mentais. "Motivos para" expressos na categoria: a recuperação da criança com transtorno mental e o seu retorno para casa. **Conclusões e Implicações para a prática:** a possibilidade do estabelecimento da relação face a face entre equipe, família e criança como forma de apreender a situação biográfica e o acervo de conhecimento dos sujeitos envolvidos e, então, entender as suas reais necessidades e demandas promovem um cuidado integral. Através da fenomenologia social de Alfred Schutz, traz-se como implicação para a prática a possibilidade de compreender a percepção da equipe de enfermagem sobre a relevância da relação face a face no cuidado de crianças e adolescentes com transtornos mentais.

Palavras-chave: Assistência Integral à Saúde; Cuidados de Enfermagem; Equipe de Enfermagem; Hospitalização; Transtornos Mentais.

Resumen

Objetivo: conocer las percepciones del equipo de enfermería sobre los cuidados prestados a los niños y adolescentes hospitalizados con trastornos mentales. **Método:** estudio cualitativo fenomenológico social cuya recogida de datos se realizó con 12 miembros de los equipos de enfermería mediante entrevista fenomenológica. **Resultados:** "Motivos-por qué" se describen en dos categorías: la percepción del equipo de enfermería ante los cuidados prestados y las acciones y cuidados del equipo de enfermería del niño con trastornos mentales. "Motivos-para" expresadas en la categoría: la recuperación del niño con trastorno mental y su regreso a casa. **Conclusiones e Implicaciones para la práctica:** La posibilidad de establecer una relación cara a cara entre el equipo, la familia y el niño como una forma de aprehender la situación biográfica y el cuerpo de conocimiento de los sujetos involucrados y luego comprender sus necesidades y demandas reales, promueve la atención integral. A través de la fenomenología social de Alfred Schutz, aporta como implicaciones para la práctica la posibilidad de entender la percepción del equipo de enfermería sobre la relevancia de la relación cara a cara en el cuidado de niños y adolescentes con trastornos mentales.

Palabras clave: Atención de Enfermería; Atención Integral de Salud; Grupo de Enfermería; Hospitalización; Trastornos Mentales.

Corresponding author:
Aldair Weber.
E-mail: aldairweberr@gmail.com

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INTRODUCTION

The situations experienced by individuals throughout life, especially during childhood and adolescence, may lead to outcomes that affect their mental health.[1] From this perspective, a global epidemiological study on the prevalence of mental disorders in children and adolescents indicates that among the most frequent mental disorders in childhood are evidenced anxiety and attention disorders. In early adolescence, there are conduct disorders, and at the end, mood disorders are more likely to present.[2]

Such a worldwide epidemiological scenario shows the need for attention focused on this public. A study conducted in Brazil shows a higher frequency of mental disorders in adolescents who are children of mothers with chronic depression and in less favorable socioeconomic conditions,[3] in addition to another study of the Brazilian reality that demonstrates a high prevalence of children and adolescents treated by the services of the Brazilian Unified Health System (SUS), mainly in Primary Health Care (PHC), but who require specialized care, pointing to the need for referral for care and follow-up, improving their prognosis.[4]

In the context of SUS, the Psychosocial Care Network (RAPS- in Portuguese) is structured beyond primary health care with the Psychosocial Care Centers (CAPS- in Portuguese) and psychiatric beds in general hospitals, being resources available for acute and chronic care of mental disorders.[5] The hospital care of children and adolescents with mental disorders can occur in pediatric or psychiatric inpatient units through beds organized to receive this public.[5] On this aspect, studies point out that the physical structure to care for children and adolescents together with adults with mental disorders in the same unit is a challenging problem experienced by health teams.[6]

Besides the physical structure, other challenges are experienced when caring for children and adolescents with mental disorders. It is observed that the work process of the nursing team in the Child and Youth Psychosocial Care Centers (CAPSij- in Portuguese) is marked by the mismatch between theoretical knowledge and the practice they perform, referring that the care is provided based on the biological perspective, focusing on technical procedures, and marked by the knowledge of another professional, who points out the action to be performed.[7]

Another challenge of nursing in the action of care is the persistence of the asylum view with traditional knowledge and practices that go back strictly to basic care, the vigilant and punitive attitude, abandonment, and violence, based on a hospital-centered central structure with prejudice and resistance to provide comprehensive health care to children and adolescents with mental disorders, presenting an insufficient intrinsic stock of knowledge in mental health, as well as difficulty in identifying and differentiating the types of mental disorders.[6,8,9] According to Schutz, a stock of knowledge is defined as all the memories and experiences of a subject, elements that are sought when facing the unknown.[10]

In this sense, studies with nursing teams show that it is necessary to develop an empathic, respectful, and understanding relationship with those who will be cared for, involving the family in the treatment, and identifying strategies that allow for more adequate care within a therapeutic relationship with the other, such as occupational activities, therapeutic groups and the use of play as a care strategy.[8,9,11]

The experiences of nursing teams show that it is necessary to explore the field of care for children and adolescents with mental disorders, because knowledge of the reality of the other makes it possible to think of new ways and actions of how to care.[10] For this, it is necessary to revisit the nuances of the psychiatric vision present in care and promote a greater search for stock of knowledge with children and adolescents, approaching their life world and their experiences.[6,10] As well, in view of the epidemiological reality experienced[3,4] and the existing gaps in scientific production for care, it is necessary to develop more scientific research that expands and unveils the phenomena.

Therefore, nursing is present in the care of children and adolescents with mental disorders and has an important role that can be played in the follow-up and psychosocial rehabilitation, being necessary to understand how to care and to understand how the care is being provided.[7] With the intention of expanding the perspectives on care, this research aims to know the perceptions of the nursing staff regarding the care of children and adolescents with mental disorders hospitalized in the inpatient units of the pediatrics and psychiatry units of a university hospital in the interior of São Paulo.

METHODOLOGY

This is a qualitative research supported by Alfred Schütz's social phenomenology.[10] The qualitative method considers that the research subject is human, lives permeated by his culture, and is in constant transformation, allowing the researcher to understand his thoughts and reactions when experiencing an experience.[12] In Alfred Schütz, social phenomenology is based on understanding the social action of the subject contained in his life world, which is guided by his actions and intersubjective relations face to face, from his stock of knowledge, as commented above, and by his life biography, which, according to the author, is about everything that has been lived and, thus, becomes a fundamental part of the cultural and social composition of each subject.[10]

Schütz's social action refers to intentional human conduct, charged and accompanied by conscious experiences, directed at others. The author names the everyday life of people as lifeworld, which is translated by the place in which the subject lives together with his or her fellows, being intersubjective and cultural, relating through reasons for and reasons why. Intersubjective relations or social relations correspond to the interactions between subjects, in which for every action there is a reaction, the bearer of another action.[10]

The choice of this method is justified because this study aims to know the perceptions of the nursing staff (subjects) in face of the care (social action) of hospitalized children and adolescents with mental disorders (intersubjective relationship) (life world) according to the theory.[10] The study was developed in the pediatric and psychiatric wards of a university hospital located in a city in the interior of the state of São Paulo, Brazil, and approved by the Research Ethics Committee under opinion no. 4429514 on November 30, 2020.

Twelve professionals from the nursing team participated in this study, including five from the psychiatric inpatient unit (two nurses and three nursing technicians) and seven from the pediatric unit (two nurses and five nursing technicians). The number of participants does not correspond to the total number of professionals in the teams from the different periods of each admission unit. No invited professional refused to participate in the research, and there were no exclusions based on the established criteria. Inclusion criteria were being a member of the nursing team; being present in the wards at the time of data collection; and having already performed some type of care and/or procedure with children and adolescents with mental disorders. The exclusion criteria were being on vacation and/or away during the period in which data collection was performed; and not having cared for children and adolescents with mental disorders.

To gain access to the participants, the snowball method was used, in which one interviewee indicates the next, and so on, successively, and the key informant was the nurse who was responsible for the team at the time of data collection. To ensure their anonymity, we named S for "seeds", the first individuals in each ward, and C for "children", the remaining participants.[13] Data collection occurred from February 4 to 17, 2021, in a reserved room in each unit, in person, using the phenomenological interview, which is an approach whose goal is to capture the way people live, experience, and attribute meanings to the phenomena of the world,[14] through two guiding questions: "Have you ever cared for a child with mental disorder in the ward? How was this care? What do you expect with your action?". The first two questions aroused in the interviewee past experiences, which substantiate how he performs and understands his care (reasons why).[10] The last question referred the interviewee to his future, making him idealize possibilities after his care (reasons for).[10] The interviews were digitally audio recorded and later transcribed, with an average duration of ten minutes. The letter I was used to code the word interview, followed by the number of the interview conducted. Data collection was closed when the researcher's concerns were answered, once no new themes emerged in the interviews and the theoretical saturation of meanings attributed to the phenomenon was reached.[15]

In the organization and analysis of the data, the interviews were first carefully read to understand the global meaning of the phenomenon.[16,17] Then, they were reread to identify the most relevant and significant aspects concerning the team's perceptions of their care, which were subsequently grouped into units of meaning, which encompass the essence of the experience common to all individuals and can be expressed by a word, phrase, or behavior. Finally, from the synthesis of the meaning units, the categories were built.[17]

RESULTS

From the "we-relationship", constructed in the face-to-face relationship of the researcher with her interviewees, three concrete categories were formed, the first two expressing the stock of knowledge of the interviewed subjects and their past experiences, and the third category, constructed from the objectives, expectations, and motivations, expressing the "reasons for", by which health professionals carry out their care.

The "reasons why " were described in two categories: the perception of the nursing team in view of the care provided and actions and care of the nursing team to the child with mental disorders. The "reasons for " were expressed in the category: the recovery of the child with mental disorder and his or her return home.

The perception of the nursing team in face of the care provided

During the interviews, the participants reported that the types of disorders presented by children are distinct from adults, as they are confused about what is mental illness, what is lack of boundaries, and what is the way of life of the child and/or adolescent.

> *Then we already have a difference in the type of disorder that we are internal, basically from adolescent to adult. (*S1*)*
>
> *Because there is that question, what is the disease, what is the lack of limits, for them... This confuses us a lot. (*I2*)*
>
> *We end up sometimes confusing if it is a mental disorder or if it is a way of life of the children. (*I9*)*

In addition, they mentioned that caring for this public requires patience, affection, and care, identifying that a vocational attitude such as having a gift is necessary to deal with mental disorders.

> *We must be patient, especially with children.* (I7)
>
> *The child depends on a certain affection. He needs to know you to be able to trust you, to be able to get things to take care of you better.* (I1)
>
> *I think we have that extra affection when it is a child.* (I2*)*
>
> *It is not even experienced, it is more the gift, that thing of dealing with patients with mental disorders.* (I8)

The nursing staff also associated this care with positive aspects, as it was gratifying to observe the improvement of the patients, as well as the learning obtained.

> *It is rewarding to take care of and then you see the person. Anyone who is getting better, especially a child.* (I1)
>
> *We learn to deal with them. Each one we need to know how to deal with in a particular way, each one is unique there*. (I7)

However, they reported negative perceptions about caregiving, such as: difficulty in caring for a mental disorder; frustration for not caring for the situations that lead to the acute condition; and mixing up the roles assumed by the team.

> *Because it is a mental picture, so it has these difficulties. Here, it is not a specific pediatric psychiatry.* (S2)
>
> *It is a little frustrating because we are involved in the control of his acute condition, but the issues that brought about this situation, that led to an acute condition, are not handled by us.* (S1)
>
> *We put ourselves in the place of our own child and everything, it is more complicated because then everything gets mixed up, you feel sorry, you end up taking care as a mother, but you must have a limit*. (I2)

Another aspect mentioned by the participants was the influence and involvement of the family in nursing care, since the child is never admitted alone, and this can be a challenge for care, questioning how therapeutic the presence of the family in the hospitalization process can be, and how it can prolong or reduce the patient's hospital stay.

> *Because they don't hospitalize alone, it is usually a family hospitalization. Then the family ends up reinforcing some symptoms that are more reactive, more provocative. Sometimes we think how therapeutic the presence of the family is, but at the same time we forget that it is to this home, to this environment that the child will return.* (S1)
>
> *We also have an approach with the family, we also involve the parents in the care* (I7)
>
> *Mothers interfere a lot in medical and nursing procedures... they end up interfering even in the treatment of the child, they end up delaying [...] The mother's acceptance... The treatment would be reduced in the time of treatment.* (I9)

Actions and care of the nursing team to children with mental disorders

For the interviewees, the care provided was configured as basic nursing care. In addition, they evaluated that the context of the service makes the autonomous work of nursing unfeasible, in such a way that the care is based on medical prescriptions and those of other professionals. The lack of autonomy is accentuated by the absence of pre- and post-hospitalization follow-up.

> *All the care. Oral medication, IV medication, changing a diaper, bathing, all the basic nursing care...installation of an O2 [oxygen] catheter, everything, right?* (I5)
>
> *Our interventions here are very medical. Because I can advocate and think of a more autonomous nursing care, at the same time within an interprofessional context, but this is unfeasible for the reality of the service we have. [And then some interventions end up being prescribed by the other professional* (S1)
>
> *There is no follow-up afterwards and no follow-up before. So, at that moment it's to fulfill what the doctor is expecting.* (I9)
>
> *When the therapist is working with us, she establishes a project and tells us what needs to be done* (I4)

To execute the interventions, the professionals observe more the patients' behavior and speak less, to elaborate a form of approach. Listening and conversation based on communication techniques were pointed out as care strategies.

> *So, I try to observe to identify what is the best approach. Because depending on whether it is a more aggressive issue, I try to observe more, talk less. It is a strategy like this, you must create a strategy for the approach [...] the best way to approach.* (I5)
>
> *To be able to listen to what the person has to say, sit by the side, keep talking... I think that listening is the minimum that can be done.* (I4)
>
> *We already enter the room saying good morning, introducing ourselves, saying that we will take care of him, I will check his signs, 'can I put the thermometer? Everything you must keep talking to them. I look them in the eye. Really facing them and showing them what you are going to do with them. [...] But everything like this, with preparation beforehand.* (I7)

In their daily lives, the nursing professionals interviewed offer games, music, dancing, and drawings for the children to pass the time.

> *We try to arrange activities for the children to do. Play. Put music from the cell phone. I put it on, I play, sometimes I dance with them, to try to pass a little time. [I put drawings from my cell phone for them to watch.* (I4)
>
> *When there is time, we play, we play... there are some games here in the infirmary, we play, they paint.* (I1)

The recovery of the child with mental disorder and his return home

The professionals interviewed expect an appropriate infrastructure to receive children and adolescents, separate from

the space for adults, assessing the risk of a mixed ward. And, in addition, they consider that the child needs to frequent adequate spaces for the development of their care, such as a playroom.

> *I think this was essential for them, to have a space separate from the adult that I think this is very harmful for them. I don't think it is nice for the child to be in the same space as the adult* (I4)

> *I think the ideal would be to have a separate place, right? To hospitalize, especially children, because when children come here it's complicated, because with all these adults here, right? [...] Like, many want to go to the pediatric ward, to the playroom, but it's a struggle, right? Because they don't want to leave* (I2)

The participating subjects identify the need for psychological support and a more prepared team to improve care. In addition, they aspire to the presence of a professional who provides security for the team, about what they can do, how to approach and act, in such a way that this would reduce the patient's treatment time.

> *I think we should have a psychological support here for us to give a better assistance to the patient. I think that if we had a more prepared team, in the sense of helping these patients in a professional way, I think it would help in this treatment [...] So I think, if we had someone that could give us this security, of what we can do, how to do it, to give an idea, 'oh, she acts this way, if you approach her this way, she will understand', I think it would be very rewarding for us and for the patients themselves, because the treatment would last less time, right?* (I9)

And finally, the respondents expect acceptance of nursing care by their patients and that the therapeutic expectations will be met: the patient's reintegration into society and family.

> *There must be an explanation, because they are not always going to accept it when it's a child.* (I2)

> *Reinsertion in the social environment. [...] A positive response about his care, about the treatment of the child. We expect this, that he is reinserted in society, the family as well.* (I7)

DISCUSSION

In this study, participants point out that the types of mental disorders presented by children and adolescents are different from those presented by adults. However, depression and anxiety disorders appear as the most prevalent mental disorders in both populations.[18] Particularly in childhood and youth, the more specific disorders of that age, such as attention deficit hyperactivity disorder (ADHD), conduct or behavioral and personality disorders, are evident.[18-20]

In addition, the participants of this study reported difficulty in discerning what is mental illness as much as what is the lack of boundaries of children and adolescents. In accordance with this finding, a study with primary care health professionals pointed to the lack of a "differentiated look" as a difficulty in distinguishing between what is proper of child and adolescent development and what needs care and intervention.[21]

In their normal developmental cycle, children and adolescents present a series of behaviors that are challenging and disruptive, and when they occur sporadically and in isolation, they are considered expected for their age; however, if they appear in a constant and standardized manner, they may be suggestive of mental disorders.[22,23]

In the context of work, the nursing team and the patient project their actions from their respective biographical situations in conjunction with their body of knowledge, that is, individuals act in different and specific ways according to their subjective experiences.[10] Together, these experiences and the knowledge made available through parents and educators articulate with the body of knowledge that is available to the subject, guiding and motivating their actions in the life world.[17] In this way, the professional will understand what the child's and adolescent's way of life is, understanding how those involved in the relationship position themselves in the life world.[16]

The interviewees of the study also pointed out that the action of caring for hospitalized children and adolescents with mental disorders requires patience, affection, and affection, as well as gift as a vocational attitude. The development of these feelings with pediatric and hebiatric patients is recurrent among the professionals who deal with this public, because, in this way, they believe they are contributing to the improvement of their patients.[24] It is noteworthy that children and adolescents long to be cared for with respect, consideration, affection, welcoming and recognition of their specificities, which will enable them to develop affective bonds, cooperating with care.[25,26]

As for the vocational attitude, studies present reports of nursing workers in which the lack of a vocation, natural disposition, ability, and "gift" were attributed to the difficulties in establishing a relationship and providing care to children and adolescents with mental disorders.[27,28] The components mentioned above are close to what a face-to-face relationship, elaborated by Schutz, needs to happen, since it is characterized by the simultaneous presence of the subjects involved in the same space and time, in such a way that one is aware of the other.[10] It is also important to reflect on the need for preparation, training, and development of practices based on scientific evidence of nursing teams, which promotes the acquisition of knowledge and the improvement of care performed by nursing professionals, considering the complexity of mental health care and teamwork, both structured by the humanized and multi-professional practices of the mental health care clinic.[29]

The subjects of this study associated the care provided with both positive aspects, such as rewarding, tranquil, and interesting, and negative perceptions, such as: difficult; and frustrating for dealing only with the acute condition. For this scenario, a study evidenced that the multi-professional team that provides integral health care to children and adolescents has difficult and challenging experiences, because the diagnosis of mental disorder is a complicating factor, requiring from professionals' greater vigilance and attention to the lack of knowledge of the history and reasons that led the patient to be hospitalized, in addition to being limiting points for care.[23,30]

It is possible to understand the findings described above based on the understanding that nursing care is an action, that is, a human attitude planned and performed by the individual intentionally and that carries reasons for and why, placed in the world of life, added to the technical-scientific specificity, in which the caregiver bases his actions on his body of knowledge and his biographical situation. Professional caring also demands a specific social relationship between the individuals involved in it, being permeated by a social context that expresses disparate conceptions of health and the like. All these factors can lead subjects to have positive and negative experiences when they experience the action of caring.[10,17,31]

As for the issue of care being complicated because it calls on the team to mix assumed roles, the literature points out that due to a historical-social construction, nursing is still strongly associated with the feminine condition and the characteristics considered intrinsic to the traditional role of women in society, such as the performance of their maternal function of promoting care.[32] These gender issues influence and are transferred to the professional, so that care is transposed by sensitivity and involvement in the suffering of others, awakening sensations and feelings.[32]

Another important finding of the research refers to the influence of the family in the care provided, since the child's hospitalization is always performed in the company of family members, who are also involved in the care. The family is a complex system that influences the formation of the social, emotional, and biological being of its members, thus, it plays an extremely important role in the hospitalization situation due to its ability to guarantee the maintenance and protection of the healthy development of the child and adolescent, even in an adverse context.[33]

In addition, children and adolescents find in their parents or family figures the strength and security to go through this time full of uncertainties and challenges, besides having their suffering eased with their presence.[33] Thus, it is recognized, and it is essential that the nursing team encourage the presence and participation of parents or family members in the hospital environment, promoting a care centered on the child/family dyad. One possibility to mark the advance of knowledge is to recognize families as direct participants in the care and health-disease process from the services to the health policies, adopting holistic approaches to the family that improve the patient's responses, reduce stress, and optimize the experience lived by the family members. It also highlights the need for nursing to migrate from a patient-illness centered model to a collaborative model perspective of care between patient and family with the support built by the relationship of nursing with the respective families.[33,34]

The care provided by the nursing team to hospitalized children and adolescents with mental disorders requires hygiene care and comfort, medication, and even restraint, when necessary, for the promotion of excellent care.[1] However, nursing work should not be limited to such activities, although the biomedical model still predominates within hospital institutions, promoting care based on a hierarchy consisting of manuals, standards, routines, and the subordination of nurses to physicians. These factors limit the full exercise of autonomy by nursing, leading to fragmented, plastered and verticalized care.[35,36]

The professionals in this study have different elements to systematize care, using strategies such as child observation, listening and dialogue, elements that constitute the face-to-face relationship, since the nursing professional explains the actions to prepare the child for nursing care. Through Schutz's face-to-face relationship, the professional can enter the children's universe, allowing the children and adolescents to express themselves based on their biographical situation.[10,37,38]

Playing a game, playing with a ball, painting, and watching videos appear to the study participants as ways to pass the time of children and adolescents within the hospital routine. The literature points out that hospitalization can cause difficult and stressful moments for children, and that playing is a possibility of effective communication, establishing a bond between the child and the professional, and can be performed in various circumstances and hospital environments.[39,40] In view of the above, it is recommended that playing be considered a systematized action of care, seeking its stock of knowledge to facilitate the establishment of the face-to-face relationship and the development of care as a social action.[10]

In this context, studies point to the act of playing as an important tool to create a bond between the nursing team and children during hospitalization, relying on the participation of professionals seeking to implement playful activities to provide well-being. In view of this, the Therapeutic Play (TP) is a structured technology used to provide care through the planning and systematization of assistance and, currently, it has been disseminated as a strategy to be adopted by teams with the perspective of enhancing the humanized care of children. Therefore, we suggest the use of such a tool to enable the care of children and adolescents with mental disorders in hospitalization settings and performing mental health follow-up.[39,40]

As for the achievement of objectives and expectations in performing their care, the participants point out the issue that there should be a separate place for the hospitalization of children and adolescents, evaluating the risks that involve such care in an inpatient unit. It was identified that the lack of adequate physical infrastructure plus the risks of a mixed ward harm the care

provided to hospitalized children and adolescents with mental disorders, as the professional performance may be impaired due to the emotional overload and concern with the safety of their patients due to the greater need for surveillance of this public.[30]

The need for case supervision to explain behavior and management as an expectation brought by the study participants corroborates a study that points out the lack of skill, training, and knowledge about infant and juvenile mental disorders, causing professionals distinct negative feelings, understanding that care is not being provided adequately because they do not know how to act.[30]

And, finally, the nursing team aims for children and adolescents to accept their care, that is, a face-to-face therapeutic relationship must be established to provide care. The team's ambition is also the reinsertion of the patient into society and the family. It is perceived that this motivation for the team can reinforce the importance of these children and adolescents to circulate through different spaces, broadening the experiences of their life world, bonding, developing, and building relationships through which they understand and are understood.[10]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The theoretical and methodological approach of Alfred Schutz's social phenomenology provided insight into the perceptions of the nursing staff about caring for hospitalized children and adolescents with mental disorders, their motivations, and what they expect from this action.

When caring, the nursing team is faced with the mixture of personal and professional roles, as well as difficulties in managing children and adolescents with mental disorders. They also point out positive points experienced from the practice and care with this public. The family is part of the care provided to the child and the adolescent, with the nursing staff providing basic care, but wishing to have more space to develop their work autonomously. The team hopes that the care is well received by children and adolescents, enabling their improvement, recovery, and return to society.

As an implication for practice, it was possible to understand the perception of the nursing team about the relevance of the face-to-face relationship in caring for hospitalized children and adolescents with mental disorders based on the social phenomenology of Alfred Schutz. The expectations of professionals in relation to care were also identified, as well as the challenges experienced during the period of hospitalization of children and adolescents with mental disorders, creating strategies to ensure proper care. It is emphasized that in caring for this public, it is also necessary to care for the family.

Care as a social action, practiced from the biographical collections of nursing professionals, revealed the life world that exists in the work developed when caring for hospitalized children and adolescents with mental disorders. Further studies that explore the care of children and adolescents with mental disorders are suggested, given the existence of gaps in the scientific knowledge of nursing, also highlighting the importance and need for psychiatric and mental health care for this public. Among the limitations of the study, the pandemic had a direct impact on data collection, taking more time to access the professionals, and the units had teams with no availability due to internal transfers to the units caring for patients with the new coronavirus (COVID-19), in addition to the insecurities of the nursing team professionals that are present due to the high risk of exposure and contamination by the virus.

AUTHOR'S CONTRIBUTIONS

Study design. Gabriela Morilhas Barbosa. Aldair Weber. Ana Paula Rigon Francischetti Garcia. Vanessa Pellegrino Toledo.

Data Collection. Gabriela Morilhas Barbosa. Vanessa Pellegrino Toledo.

Data Analysis. Gabriela Morilhas Barbosa. Aldair Weber. Ana Paula Rigon Francischetti Garcia. Vanessa Pellegrino Toledo.

Interpretation of results. Gabriela Morilhas Barbosa. Aldair Weber. Ana Paula Rigon Francischetti Garcia. Vanessa Pellegrino Toledo.

Writing and critical revision of the manuscript. Gabriela Morilhas Barbosa. Aldair Weber. Ana Paula Rigon Francischetti Garcia. Vanessa Pellegrino Toledo.

Approval of the final version of the article. Gabriela Morilhas Barbosa. Aldair Weber. Ana Paula Rigon Francischetti Garcia. Vanessa Pellegrino Toledo.

Responsibility for all aspects of the content and integrity of the published article. Gabriela Morilhas Barbosa. Aldair Weber. Ana Paula Rigon Francischetti Garcia. Vanessa Pellegrino Toledo.

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