Promoting affective attachment at the neonatal intensive care unit: a challenge for nurses*

PROMOÇÃO DE VÍNCULO AFETIVO NA UNIDADE DE TERAPIA INTENSIVA NEONATAL: UM DESAFIO PARA AS ENFERMEIRAS

PROMOCIÓN DE VÍNCULO AFECTIVO EN LA UNIDAD DE TERAPIA INTENSIVA NEONATAL: UN DESAFÍO PARA LAS ENFERMERAS

Claudete Aparecida Conz[1], Miriam Aparecida Barbosa Merighi[2], Maria Cristina Pinto de Jesus[3]

ABSTRACT

The study was motivated by observations of the routine at neonatal intensive care units (NICU), thoughts about the dichotomy between theory, discourse, and the practice of many nurses towards the newborns' parents. The objectives were to learn about nurses' experiences regarding neonatal care to newborns and their parents, and to understand how nurses experience the process of affective attachment between newborns hospitalized at NICUs and their parents. This study was developed according to the social phenomenology approach of Alfred Schütz. Study subjects were eight practical nurses who had worked at NICU of public and private hospitals. Categories of experience emerged from the discourses, including Human Contact. The analysis revealed that nurses see themselves as the connection between parents and children, and believe they play an important role in creating the affective attachment between parent and child.

KEY WORDS

Infant, newborn.
Nursing care.
Neonatal Intensive Care Unit.
Professional-family relations.

RESUMO

As observações do cotidiano na Unidade de Terapia Intensiva Neonatal (UTIn), as reflexões sobre a dicotomia entre a teoria, o discurso e o modo de atuação de muitos enfermeiros junto aos pais dos recém-nascidos, suscitaram-nos inquietações que nos levaram a desenvolver este estudo, com os objetivos de conhecer a vivência da enfermeira no cuidado ao recém-nascido e aos seus pais na UTIn e compreender como as enfermeiras vivenciam o processo de vínculo afetivo entre recém-nascidos internados em UTIn e seus pais. Realizamos a pesquisa de acordo com a abordagem da fenomenologia social de Alfred Schütz. Os sujeitos do estudo foram oito enfermeiras assistenciais, com experiências em UTIn de hospitais públicos e privados. Dentre as categorias concretas do vivido, que emergiram dos discursos, destacamos o Contato Humano. Os resultados da análise mostraram que as enfermeiras percebem-se como elo de aproximação entre filhos e pais e acreditam que exercem papel importante na formação de vínculo afetivo entre eles.

DESCRITORES

Recém-nascido.
Cuidados de enfermagem.
Unidade de Terapia Intensiva Neonatal.
Relações profissional-família.

RESUMEN

Las observaciones de lo cotidiano en la Unidad de Terapia Intensiva Neonatal (UTIn), las reflexiones sobre la dicotomía entre la teoría, el discurso y el modo de actuación de muchos enfermeros junto a los padres de los recién nacidos, nos suscitaron inquietudes que nos llevaron a desarrollar este estudio, con los objetivos de conocer la vivencia de la enfermera en el cuidado al recién nascido y a sus padres en la UTIn y comprender como las enfermeras experimentan el proceso de vínculo afectivo entre recién nascidos internados en UTIn y sus padres. Realizamos la investigación de acuerdo con el abordaje de la fenomenología social de Alfred Schütz. Los sujetos del estudio fueron ocho enfermeras asistenciales, con experiencias en UTIn de hospitales públicos y privados. Entre las categorías concretas de lo vivido, que emergieron de los discursos, destacamos el Contacto Humano. Los resultados del análisis mostraron que las enfermeras se perciben como un elemento de aproximación entre hijos y padres y creen que ejercen un papel importante en la formación de un vínculo afectivo entre ellos.

DESCRIPTORES

Recién nacido.
Atención de enfermería.
Unidad de Cuidado Intensivo Neonatal.
Relaciones profesional-familia.

*Extrated from the thesis "A Vivência da Enfermeira no Cuidado ao Recém-Nascido e aos Seus Pais na Unidade de Terapia Intensiva Neonatal: uma abordagem da fenomenologia social", School of Nursing, University of São Paulo, 2008.

[1] Nurse. M.Sc.in Nursing, School of Nursing, University of São Paulo. São Paulo, SP, Brazil. thais.clau@uol.com.br [2] Nurse. Full Professor at Maternal and Child Health Department, School of Nursing, University of São Paulo. São Paulo, SP, Brazil. merighi@usp.br [3] Ph.D. in Nursing, Nursing Department, Federal University of Juiz de Fora. Juiz de Fora, MG, Brazil. cristina.pinto@acessa.com

Received: 04/30/2008
Approved: 11/18/2008

INTRODUCTION

At the present time, the theme of humanization is becoming increasingly prominent in the nursing field.

Although humanization is emphasized in health policies, the implementation of practices promoting humanization is still compromised, especially regarding the Neonatal Intensive Care Unit (NICU). Professionals' work overload is an important contributing factor, since humanization requires specific and complex commitment, and the permanent tension level owing to accelerated technologic development and intense work load makes establishing changes difficult.

The development of NICU requires improvement of nurses' knowledge on neonatal physiology, competent and skillful response to children's specific needs, an appropriate environment, providing individualized family-centered care, and further efforts to place newborn infants' fathers as part of the health care team[1].

A study performed with the fathers of newborn infants admitted to the NICU demonstrated that care does not regard technical procedures only. The attention received by parents, the interpersonal relationship between parents and nurses, the fact that parents are allowed to have contact with their children and that they can be informed of their clinical condition are conditions that generate feelings of safeness and trust[2].

Affective bonding between the child and the family, and in particular the mother, is crucial so that the psychological foundations of the future adult can be fully established[3].

Nursing professionals must establish communication and interaction with the families of babies admitted to Neonatal Intensive Care. Parents must be encouraged to participate in care.

Nursing professionals must establish communication and interaction with the families of babies admitted to Neonatal Intensive Care. Parents must be encouraged to participate in care. This builds a care process that succeeds in nursing actions that depend on effective communication, preserving the singularity and individualism of the child and parents, starting with the lived experience of the family cared for by the nurse. The process favors interaction that provides information, help, and understanding, and eases anxiety by offering tranquility[4-6].

Research that aims to understand the meaning assigned by nurses to the experience of caring for newborn infants and their family in the NICU points out that these professionals feel rewarded by supporting the family when they are available for answering parents' demands. Nurses provide this support by clearing parents' doubts about their baby's situation and letting them talk about their feelings, showing sympathy for them[7].

Nurses' actions to promote affective bonding between children and parents are based on care, empathy, social integration, and sharing distress with parents of babies admitted to the intensive care unit.

In view of the foregoing observations, it is evident that nurses are important in the process of bringing admitted newborn infants to NICU closer to their parents and in care more generally. In the process of creating the parent-child bond, they are able to be not only visitors but active participants in the care of the child. These professionals are the closest people to the newborn infants and their parents, which enables them to meet each other and interact. This fact builds a link between children and parents so that affective bonds can be consistently built.

We believe that nursing care to newborn infants' parents can be reduced neither to its relationship aspects nor to its technical aspects. The application of technical-scientific knowledge and the presence of a well-prepared professional are extremely important. However, a balance between expressive care and technology must be observed.

Reflection on the relationship in the NICU routine between theory and discourse and the actions of many nurses when dealing with the parents of high-risk newborns leads to important questions: *Do nurses acknowledge parents' needs to perform their motherly/fatherly role and the importance of affective bonding to their children? How do they see themselves in the process of building the affective bond? What are the nurses' actions to bring newborn infants closer to their parents?*

In the present study we investigate nurses' experiences while caring for newborn infants admitted to the NICU and their parents. Also, we investigate the significance of their actions in the affective bonding process in order to create resources for education and practice related to this expert care delivery.

OBJECTIVES

The present investigation aimed to learn about nurses' experience while caring for newborn infants and their parents in the NICU and to understand how nurses experience the affective bonding process between newborn infants admitted to the NICU and their parents.

Since we sought to understand the reality experienced by nurses, we chose the following comprehensive approach.

METHOD

The need for learning and understanding more about the care nurses provide for newborn infants and their parents in the Neonatal Intensive Care Unit (NICU) and their actions with respect to affective bonding led us to investigate and examine the theme through a qualitative approach using a social phenomenology framework.

The social phenomenology framework was chosen because it enables the understanding of meaning for the person in the world. The being-with-the-other is contextualized

in inter-subjectivity, configuring a social group. Phenomenologist Alfred Schütz's thoughts were the guide for data analysis and interpretation of meanings in this research.

As it explains human actions and thoughts, social science should start by describing pre-scientific fundamental structures: the world of daily life within the fundamental reality of humans. *This routine life reality is no private world; it is shared with others from the beginning, an inter-subjective world*[8]. Schütz's social phenomenology points to a methodology for understanding the phenomenon that we propose to investigate: *the nurse in the care for newborn infants and their parents in the NICU*, and her actions with respect to affective bonding contextualized in this social group's inter-subjectivity.

The purpose of this research was to learn about the group of nurses that work in the NICU and care for admitted newborn infants and their parents and their natural attitude in their personal worlds, in order to understand many interpretative practices through which reality is built into social and personal perspectives.

Nursing professionals who worked with newborn infants in the NICU of public and private hospitals were sought to participate in this research. The institutions had to allow parents to be present full-time, and had to have some type of attachment method between children and parents: Kangaroo Method, Participant or any other previously mentioned. As we selected them, we did not consider age, marital status, gender, graduation time, or working activity.

Therefore, data collection did not require a definite location. The investigation area was the situation where the phenomenon occurred, the actual world where nurses experience daily care for children admitted to the NICU and their parents. For the phenomenological method, the investigation area is the perplexity area - the known location for the researcher's concerns; therefore, it is not a physical space, but a conceptual context where people act[9] .

Approaching nursing professionals depended on the knowledge of the researchers and on third party information on these care deliverers. This type of sample is defined as *snowball, where the first informers are required to indicate other participants for the study*[10] .

Considering the nature of the study, the number of participants was not previously established. It was determined from discourse contentsas the interviews happened. In other words, whenever we felt that answers became repetitive, we ceased to collect them. In all, eight nurses participated in this research.

In phenomenology, the essence of the phenomenon is the main object of inquiry. It is demonstrated by the subjects' descriptions. Interviews were guided by two questions: *How do you, as a nurse, experience the care for newborn infants in the NICU and their parents? What do you expect with your care delivery?*

Data collection was initiated after the approval of the Research Ethics Committee of the Nursing School of the University of São Paulo (USP). Process # 616/2007/REC – EEUSP. Interviews were performed in a private location so to preserve the interviewees' privacy. All interviews were recorded with nurses' consent, and after the end of recording, they were transcribed by the researchers.

Nurses' preferences regarding date, time and location for data collection were respected, ensuring the right to decline participation in case they felt it necessary. According to the stated in Resolution 196/96, on Regulating Guidelines and Norms regarding research on human beings[11], nurses were informed about the objectives of this research, the measures for maintaining secrecy, and the right to participate or decline to participate in the research. After these explanations, they were asked to sign a Free and Informed Consent Form. Interviews were identified by the letter D, followed by a number sequence 1…8.

In order to proceed with discourse analysis, we followed the steps proposed by Parga Nina and modified by researchers of social phenomenology[12-14].

A comprehensive analysis of the phenomenon was gradually carried out as follows: each interview was read fully and in detail, first with a view to identifying the global sense of nurses' lived experiences; then, the meaningful discourse aspects that represented content convergences were grouped, creating identified categories. The transcripts were then read again in an attempt to identify the actual categories: effective speech that expressed meanings for the understandings and motives that nurses caring for newborn infants admitted to the NICU and their parents had, and what they expect from this care delivery. The next step was to identify the actual categories that would comprise the participants' actions and to establish the meanings of nurses' social actions when caring for newborn infants to the NICU and their parents, and also to the type of participants' discourse to establish lived experience. Grouping and meaning analysis according to the thought of Alfred Schütz was the framework for the discussion and data analysis.

Emerging categories in discourses were: *Improve; Inform and Prepare Parents; Acquire Parent's Acknowledgement and Trust; Human Contact.*

For the purposes of this article, the category understood as *Human Contact* stands out. The category proposes a proximity bonding between child and parents and suggests actions to help them accept and live with the child admitted to the NICU with the help of the institution.

RESULTS AND DISCUSSION

Nurses' discourse shows acknowledgment of the importance of promoting affective bonding between children and parents. They perceive themselves as a link in this relationship. However, in order to act effectively, they must want to be available, change ideas and establish communication between the family and the newborn infant.

> The communicative act aims at, not only being acknowledged by someone, but also that the message will motivate the person acknowledging it to assume a particular attitude or develop some kind of conduct[15].

Nurses see the family of the newborn infant admitted to the NICU, and they feel the need to place the family into the context of care. They are aware that parents help the child's recovery when they are present. The actions that bring them closer to their child frequently involve technical care, and do not stimulate the mother to be a mother by touching, caressing, and talking to the child.

> [...] Also what I can see is that some mothers at a certain moment seem to stand back a little, as a way of self-defense, but there are others that follow the whole development closely. She strengthens herself and supports the child with hope. In both cases, I try to tell them that they can touch the child, so they can bond to them, because if the child's condition is severe, their contact is more distant. Sometimes, depending on what I have to do – for instance, change diapers – I ask if they'd like doing it [...] D1.

In the NICU, nurses hold a position that enables them to care, support and establish a more human contact with parents of an admitted newborn infant. This is an important moment for the family, which is going through an event involving insecurity, fear, and distress. The communication with these parents will help define the relationship between them and the infant.

Experiencing a similar situation, such as by having their own children admitted to the NICU, changes nurses' way of acting. They start sharing their feelings, becoming more human when care is regarded, and start to understand other parents that are in the same situation. They start to value them, not only through care, but also through touching, caring, and exercising being mothers and fathers.

> The real world is from the beginning inter-subjective, cultural. We live among similar people who we can influence and share common experiences, understanding and being understood by them[16].

> A certain Biographic Situation is only one situation, an episode in the path of life. Your position is the one of a person who has in your life path a series of experiences, solely yours[17].

> [...] I think that everything changed after I had my son, it was one thing before, and now it is something else, mainly after I went through a similar situation. My son needed intensive care, not neonatal, but ICU; so, I began to notice other things. Before that, I saw them just like another patient, another client, they are tiny, I treat them with more care, speak differently, but after I had my son, I say: Oh Gee, it's someone else's son, he could be mine, my vision about it changed a lot […] D5.

Nurses feel like the link bringing together the newborn infant and the parents. They believe that if they insert the family in the care context, they will provide an improvement to the affective bonding between them, making them recognize each other and helping the child to get better more rapidly. These actions comprise a face-to-face relationship where one recognizes the other as being similar.

> [...]. I think that I am a link between the family, the infant and the neonatal unit. I have to unite parents with children, a well prepared nurse can do that […] D7.

> The reality of *common sense* is given through universal historical and cultural formats. However, the way these formats are expressed in individual life depends on the total experience a person builds throughout existence[16].

> The *common-sense world, the world of daily life, the routine world* are the various expressions that indicate an *inter-subjective world* experienced by men. The world of common sense is the essence of social action; men enter into a mutual relationship, understanding each other and themselves[16].

Nurses realize their importance for the link of bringing the child closer not only to the mother, but also to the father.

> [...] I see myself as a bridge between parents and children; when a mother or father has more difficulty accepting the situation, seeing the potential, I can bring them closer. The father, since he has not conceived, is able to see the child differently in the first moment. Some mothers, I frequently see that they are afraid because the child is too small, they are afraid of getting involved, suffering, thinking that the child might die and they will lose him. My role with these parents is very important for supporting and showing other experiences that children do get well, and it really works D8.

The whole knowledge both from parents and nurses forms a basis for their motivation to achieve common goals: the recovery of the child, affection bonding between the child and parents, and the trust in the professional delivering the care.

Parents' presence in the NICU allows them to know their child better in their habits and reactions, and at the same time they are strengthening their affection bonds and forming a family. Experiences are not the same for every human being. The contact with others enables them to grow. When they experience a common routine world, they become actors in the same stage and scenery, sharing the same feelings, establishing an inter-subjective relationship tie, and understanding each other in the so-called social action world.

> [...] I, as a nurse, have some mechanisms that I've already used to help them build a stronger bond between them, and it helps a lot. For example, I encourage them to touch the child, even when they are tiny, I allow them to help me by holding the catheter for the milk, changing the diaper – the smallest things, I try to make them take part in them. I make the mother's digital print or the baby's footprint and write notes for the mother, expecting that parents will first notice that their child is there, fighting to survive because they are too little, and that they are aware of their presence and they trust them. Children need that their parents to really believe that things will work out fine, that they are fighting and they will make it D8.

The main point of this research lies in this world of inter-subjectivity, full of meaning for nurses and newborn infants' parents, where the interviewed nurses demonstrate

how they are aware of themselves and how they feel regarding the admitted father-mother-child to the NICU.

> Sharing the same space and time with someone demonstrates how this person really is, nothing more than that, indicating a genuine simultaneity of our thoughts, a relationship involving *us*[18].

Nurses take responsibility for a more humanized care by acting to bring parents closer to the admitted child. They mention the need for getting continually more prepared for this. They notice a certain distancing when the newborn infant has to stay in the NICU and can't go home. They believe that this interferes with affective bonding, that the famiies won't acknowledge their own children and their habits, likes and behaviors if they are not close to them. They feel important not only for the improvement of the child's condition, but also as a fundamental piece in this care delivery for the parents, helping them to acknowledge their child as their own.

> [...] For nine months, the mother has waited for this baby, sometimes a little less. They've been imagining the child, making plans, and all of a sudden, the child is here in the ICU, and not everyone knows what's inside an ICU. They arrive here and see it full of devices, this extraordinary thing, much noise, beeps, tubes, extremely severe, the child arrives and the mother can't even touch the baby. So, I believe bringing them closer is necessary both for the baby who has been inside the mother for a long time, and for the family that was caressing the belly, playing songs, talking to the baby. As they get here, they see a bunch of people, noise, beeps, and there is nothing they can acknowledge as their own (baby) D4.

In this case, there is an opportunity for new perspectives where everyone can grow. As the nurses provide care, they become more humanized, building a face-to-face relationship not only with the admitted newborn infant to the NICU, but also with the parents; care is now seen as professional, intentional, aware action guided to their multidimensional needs.

> The face-to-face situation assumes an actual simultaneity from each distinct consciousness. To make them aware of the situation, participants need to become intentionally aware of the other person[16].

> [...] At the first moment, mothers are scared, when they say it's their first contact with the child, then I keep a distance and almost don't interfere. I just interfere after a little while because I feel this is the moment she has to acknowledge her child as her own. I can't go there and say: look he has a line here, a catheter there, is intubated. She won't understand a thing, so I say: Get in, wash your hands and put your hand on the baby. I encourage putting the hand on the bay a lot. Most mothers don't touch them. I don't know if it's for the pain or fear; some say they will hurt the baby, get in the way of my work, and I say: you are not in the way. Then I leave. I get the sensation that if I stay, she will be afraid of doing something and I will call her attention, so I leave and come back later. If she is crying, I let them cry; when she is okay, then I return and ask: are you okay? Would you like to know anything? Are there any doubts? [...] D6.

We noticed another concern in nurses' discourse about admitted newborn infants' parents. They believed that institutions could act to motivate parents to keep close to their child. It is not enough to motivate humanization in care delivery if actions are not promoted for the same purpose. Institutions must care for these clients, being aware of issues that facilitate a more humanized care delivery such as easy communication between professionals, humanization among the health team, interconnection among various sectors of the hospital, appropriate physical environment, resting places, recreational activities, and many others.

Actions are

> Never separated, disconnected from others and from the world. Whether manifest or latent, every action has horizons regarding reality[16].

> [...] I think the institution could offer them meals so they did not have to leave all the time, and some of them have no resources to eat […] because if the mother is not here, she will become distant and won't create an affective bond. Another thing that we could have here is a place for mothers to rest while their child is in the ICU, she would be a kangaroo mother and stay here, not as an admitted patient, but as the companion with an appropriate location for her to rest when she feels really tired, not only sitting on these chairs we have here, but because they underwent a C-section, they are swollen […] this action would certainly facilitate staying with the baby, it would bring them closer to the child D7.

It is clear that nurses are aware of themselves as the primary source of connection between parents and the child. They understand the importance of this action both for child's recovery and for their acceptance. They show interest in bringing them closer, know they need help to become a family, and hold the acuity and sensibility that they are the closest and more capable professionals to interact with parents who feel unprepared for the situation.

FINAL CONSIDERATIONS

As we initiated this study, we had a few concerns regarding the interaction between nursing professionals and newborn infants' parents admitted to the NICU. In our daily experience in this reality, we believed that newborn infants' care and the care for their family were valued for expert competencies and high-profile technological resources, frequently disregarding parents' presence and their affective needs.

Now, our data have demonstrated that nurses are aware of themselves as an important bonding link between parents and children, acting to promote affective bonding; they take responsibility for more humanized care delivery, although they feel unprepared for this relationship.

Therefore, listening to the nurses speak about their own experience in promoting affective bonding in the NICU allowed us to identify new directions for the care of newborn infants and their parents.

Since humanized care is a challenge for nurses, it is necessary that biotechnology researchers aim to achieve practical, quantitative objectives on care delivery processes, and parallel

developments seeking to understand the experience and identify new directions for this care delivery are also necessary.

The inclusion of human relations topics is urgent for Nursing Graduation courses, because it is not only the anatomy, pathology, and physiology of the human being that must be approached, but also the psychological and emotional aspects of a disease in any part or function of the body.

The integration of human beings, along with the family in body system functionalities will allow for nursing professionals to be prepared, from the beginning of their education, to deal not only with patients but also with their family, acknowledging it as part of the care delivery context.

This connection would bring theory closer to practice, and to nurses' daily routine acting in the NICU with newborn infants and their parents. It will be understood by the various perspectives involving this care delivery, bringing reality closer in various experiences and promoting humanized and technically competent care delivery.

We consider this issue as primary for nursing education and practice, since the need to ensure care delivery with technical biological sophistication is evident, but to contemplate it through its subjectivity and inter-subjectivity is also fundamental. This leads to a broader care delivery supported by the personal relationship framework, in which attention, commitment, respect and empathy for others are applied to caring actions.

As this study is over, it is time to share our findings with nurses, students from the Nursing Graduation course, and the scientific community, seeking to rethink personal relations with the working staff and commitment to care delivery. Let it neither be superficial nor indifferent, but authentic.

Also, we point out that although we understood one aspect of the phenomenon, one perspective is not sufficient; each new look offers a different understanding. We believe that new perspectives are possible within the phenomenology framework, in order to develop broader proposals for care delivery for newborn infants at the NICU and their parents for affective bonding.

REFERENCES

1. Pressler JL, Turnage-Carrier CS, Kenner C. Developmental care: an overview. In: Kenner C, McGrath J, editors. Developmental care of newborns & infants: a guide for health care professionals. St. Louis: Mosby; 2004. p. 1-27.
2. Cescutti-Butler L, Galvin K. Parent's perceptions of staff competency in a Neonatal Intensive Care Unit. J Clin Nurs. 2003; 12(5):752-61.
3. Oliveira BRG, Collet N. Criança hospitalizada: percepção das mães sobre o vínculo afetivo criança-família. Rev Lat Am Enferm. 1999;7(5):95-102.
4. Reis JD, Vetorelli SP, Vieira MRR. Família do recém-nascido em UTI: há comunicação com o enfermeiro? In: 8º Simpósio Brasileiro de Comunicação em Enfermagem – SIBRACEN; 2002 out. 15-19; Ribeirão Preto, BR [evento na Internet]. Ribeirão Preto: EERP-USP; 2002. [citado 2006 maio 10]. Disponível em: http:/ www.proceedings.scielo.br/pdf/sibracen/n8v1/v1a012.pdf
5. Rolim KMC, Cardoso MVLML. O discurso e a prática do cuidado ao recém-nascido de risco: refletindo sobre a atenção humanizada. Rev Lat Am Enferm. 2006;14(1):85-92.
6. Oliveira MMC, Almeida CB, Araújo TL, Galvão MTG. Aplicação do processo de relação interpessoal de Travelbee com a mãe de recém-nascido internado em uma unidade neonatal: relato de experiência. Rev Esc Enferm USP. 2005;39(4):430-6.
7. Gamboa NSG. Cuidar para enfermeiros de UTI neonatal: descrição das categorias significantes [dissertação]. São Paulo: Escola de Enfermagem, Universidade de São Paulo; 1997.
8. Schütz A, Luckman T. Las estructuras del mundo de la vida. Buenos Aires: Amorrortu; 1977.
9. Merighi MAM. Fenomenologia. In: Merighi MAM, Praça NS. Abordagens teórico-metodológicas qualitativas: a vivência da mulher no período reprodutivo. Rio de Janeiro: Guanabara Koogan; 2003. p. 31-8.
10. Polit D, Beck CT, Hungler F. Fundamentos da pesquisa em enfermagem**.** 5ª ed. Porto Alegre: Artes Médicas; 2004.
11. Conselho Nacional de Saúde. Resolução n. 196, de 10 de outubro de 1996. Dispõe sobre diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Bioética. 1996;4(2 Supl):15-25.
12. Parga Nina L. Estudos das informações não estruturadas do Endenf e sua integração com os dados quantificados. Rio de Janeiro: PUC; 1978.
13. Merighi MAB. Enfermeiras obstétricas egressas da Escola de Enfermagem da Universidade de São Paulo: caracterização e trajetória profissional [tese]. São Paulo: Escola de Enfermagem, Universidade de São Paulo; 2000.
14. Carvalho GM. Recorrência da parentalidade na adolescência na perspectiva dos sujeitos envolvidos [tese]. São Paulo: Escola de Enfermagem, Universidade de São Paulo; 2006.
15. Schütz A. Fenomenologia del mundo social: introduccion a la sociologia comprensiva. Buenos Aires: Paidos; 1972.
16. Schütz A. El problema de la realidad social: escritos I. Buenos Aires: Amorrortu; 1974.
17. Wagner HR, organizador. Fenomenologia e relações sociais: textos escolhidos de Alfred Schütz. Rio de Janeiro: Zahar; 1979.
18. Schütz A. El problema de la realidad social: escritos I. Buenos Aires: Amorrortu; 1974.

Correspondence addressed to: Claudete Aparecida Conz
Rua Diana, 675, apto. 72 - Perdizes
CEP 05019-000 - São Paulo, SP, Brazil