

Institutionalized child care experiences: the hidden side of work

Experiências de cuidado da criança institucionalizada: o lado oculto do trabalho

Experiencias de cuidado del niño institucionalizado: el lado oculto del trabajo



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ABSTRACT

Objective: To know the caregiver's perception about the work/care with the institutionalized child.

Methods: Qualitative research that used the Theory of Attachment and Symbolic Interactionism as theoretical references and the Grounded Theory as a methodological reference. Data was collected through semi-structured interviews with 15 caregivers of a child sheltering institution, in the year 2015. The analysis was performed from the open coding and categorization.

Results: Care work aims to meet the needs of institutionalized children, focusing on food, hygiene and education. In addition, it is little recognized, which generates a feeling of devaluation in caregivers.

Conclusions: Continued qualification and support to the caregivers is indispensable for elaborating more effective and integral work/care strategies.

Keywords: Child, institutionalized. Caregivers. Women, working. Qualitative research. Nursing.

RESUMO

Objetivo: Conhecer a percepção do cuidador acerca do trabalho/cuidado com a criança institucionalizada.

Métodos: Pesquisa qualitativa que utilizou a Teoria do Apego e o Interacionismo Simbólico como referenciais teóricos e a Teoria Fundamentada nos Dados como referencial metodológico. Os dados foram coletados por meio de entrevistas semiestruturadas com 15 cuidadoras de uma instituição de acolhimento infantil, no ano de 2015. A análise foi realizada a partir da codificação e categorização.

Resultados: O trabalho do cuidado visa atender às necessidades das crianças institucionalizadas, focando na alimentação, higiene e educação. Além disso, é pouco reconhecido o que gera um sentimento de desvalorização nas cuidadoras.

Conclusões: a qualificação continuada e o suporte às cuidadoras são indispensáveis para a elaboração de estratégias de trabalho/cuidado mais efetivas e integrais.

Palavras-chave: Criança institucionalizada. Cuidadores. Mulheres trabalhadoras. Pesquisa qualitativa. Enfermagem.

RESUMEN

Objetivo: Conocer la percepción del cuidador acerca del trabajo/cuidado con el niño institucionalizado.

Métodos: Investigación cualitativa que utilizó la Teoría del Apego y el Interaccionismo Simbólico como referenciales teóricos y la Teoría Fundamentada en los Datos como referencial metodológico. Se recolectaron los datos a través de entrevistas semiestructuradas con 15 cuidadoras de una institución de acogida infantil en el año 2015. Se realizó el análisis a partir de la codificación y la categorización.

Resultados: El trabajo del cuidado busca atender las necesidades de los niños institucionalizados, enfocándose en la alimentación, la higiene y la educación. Además, es poco reconocido, lo que genera un sentimiento de desvalorización en las cuidadoras.

Conclusiones: La calificación continuada y el apoyo a las cuidadoras son indispensables para elaborar estrategias de trabajo/cuidado más efectivas e integrales.

Palabras clave: Niño institucionalizado. Cuidadores. Mujeres trabajadoras. Investigación cualitativa. Enfermería.

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■ INTRODUCTION

Sheltering institutions possess, historically, the function of taking care of and of keeping children and adolescents who cannot stay with their families⁽¹⁾. This sheltering is marked by the removal of the relations among children and their families⁽²⁾. Thus, when institutionalization occurs, the child needs to adapt to a new reality, where caregivers have a fundamental role in understanding the particularities and potentialities of each child. In addition, the institution has the function of providing care and education, providing resources to cope with the difficulties and favoring the affective, cognitive and social development of the institutionalized children⁽²⁾.

However, at the same time that it shelters the child, institutionalization may provoke anxiety due to the alteration of the environment, the routine and the people with whom they happen to live. Therefore, professionals working in the institutions need to be prepared to meet the physical and emotional needs of the children and adolescents⁽³⁾.

All professionals who work in a sheltering service must play a role as educators, being selected, trained and accompanied in the direct care of children and adolescents. To this end, a team with specific technical knowledge is needed to support the professionals who provide direct care⁽⁴⁾. Among the desirable traits, caregivers/educators should have motivation for the role, ability for group work and for the care of children and adolescents, empathy, ability to manage conflicts, affective availability and listening skill⁽⁴⁾. In addition, these professionals need to have knowledge about the following: child and adolescent development, the Statute of the Child and the Adolescent, the Single System of Social Assistance and the National Plan for Promoting, Protecting and Defending the Right of Children and Adolescents to Family and Community Living⁽⁴⁾.

It should be noted that in this study, professionals who provide care for children are admitted to the institution in two ways: contest (not specific for child care, general for all the sheltered institutions of the municipality), where they take a test, being necessary that they only have high-school education, without any specialization or qualification area; and selection, when they are hired on an emergency basis to meet the needs, having high-school education as only requirement. Therefore, the developed care is a lay one, that is, there is no specific training requirement for the caregiver, they act in an educator role and will be referred to as caregivers in this study.

Caregivers suffer from the institutionalization of children and adolescents, and may show high stress levels that affect their lives and interfere in the quality of their

relationship with the children⁽⁵⁾. Therefore, in order to take into account the specificities of this care work, professionals must be adequately selected and receive constant qualification, follow-up, and supervision⁽⁴⁾. In addition to basic daily care, preparation for work should include development of the reinforcing relationships that propitiate safety to the sheltered children⁽¹⁾. Thus, receiving and caring for children withdrawn from their families is not an easy task: it demands a lot of empathy, tolerance and respect from the responsible professional so that the sheltered may feel protected⁽⁶⁾.

In the care work, interaction networks are created that embrace emotions and relationships and affect all involved⁽⁷⁾. In this context, the caregiver must develop patience, calm, love and confidence in the search for balance⁽⁷⁾. However, this is not an easy task, since caregivers often suffer in the relationship developed with the child, especially, at the end of the sheltering, which makes them sad⁽⁸⁾. Therefore, training for the work is essential for caregivers to be able to perform their function in an integral way, and this is still quite flawed in most of the institutions^(7,9). From the above, the following guiding question was elaborated: What is the caregiver's perception on work/care with the institutionalized child? Then, the goal was to know the caregiver's perception on work/care with the institutionalized child.

■ METHODS

It is a qualitative research that used the Symbolic Interactionism⁽¹⁰⁾, as a theoretical reference and the Grounded Theory⁽¹¹⁾ as a methodological reference. This article displays an in-depth analysis for the category "Working with care", which is part of the theoretical model "Perceiving work/care with institutionalized children", built on the doctoral thesis referred to as "Linking and interaction among caregivers and children in a shelter"⁽¹²⁾.

In Symbolic Interactionism, human beings learn about and begin to understand their environment through interaction with others⁽¹⁰⁾. In the institutionalization, the child abandons the context known to them, needing to adapt to a new reality. In this reality, the caregiver plays a fundamental role, drawing new ways for providing care from the relationship with the child. In the Grounded Theory, conceptual schemas of theories are created, drawing the inductive analysis⁽¹¹⁾ from the data. Thus, data forms the basis, and its analysis will form the concepts.

The study was conducted in a sheltering institution, which receives children of the male and female genders, from zero to eight years old, located in the South of Brazil.

This is characterized as an institutional shelter⁽⁴⁾, attending at that time 12 children (a number that constantly changes by entering and leaving children) and counted on professionals from diverse areas: technical staff (a psychologist, a social worker, a pedagogue, an administrator), two general service workers (cleaning and laundry), one cook per shift (morning, afternoon, night), two nursing technicians, three caregivers (morning, afternoon, night 1 and night 2) and two caregivers per shift for girls and boys over three years old (morning, afternoon, night 1 and night 2). Fifteen professionals involved in the direct care activities (food, hygiene, among others) of children from zero to three years old took part. Such intentional sample was selected because it is in the phase of zero to three years old that the attachment and bond behavior with the main figure of care is developed⁽¹³⁾, considering that the Thesis⁽¹²⁾ instigated the formation of bonds and interaction in addition to care.

The 15 participants represented the totality of caregivers who met the inclusion criteria: working at the institution for at least three months (so that the caregivers could already have passed the experience period and become adapted to the service as well as developed links with the children) and providing direct care actions to children from zero to three years old. The technical staff (for not providing continuous direct care actions for the children) and a caregiver who had been in the institution for less than a month were excluded.

Data was collected from April to August 2015, scheduling meetings in advance, according to the availability of the participants (morning, afternoon and/or night). A semi-structured interview was used for collecting data, containing broad and open guiding questions about the experience of institutionalized child care work (routines, organization to meet the needs, potentialities and experienced weaknesses). The interviews had an average duration of 30 minutes, were recorded in an audio-recorder, and fully transcribed manually. It should be noted that they occurred in a private setting, within the institution.

Data was analyzed by means of an initial coding line by line, of each interview, with the initial codes emerging. Afterwards, a focused coding was performed, where the initial codes were compared to each other, creating the pre-categories; then, the pre-categories were reorganized into central categories and subcategories. Data was transcribed and analyzed along with the collect, and in each new interview a comparison was made among them, writing the memos to reproduce the theoretical logic of the analysis⁽¹¹⁾.

All the ethical precepts for human research under Resolution 466/12 were obeyed⁽¹⁴⁾, and the study was

approved by the Research Ethics Committee under CAAE 42696915.9.0000.5316 and written opinion number 1.035.995. The anonymity of the participants was maintained, nominated by the letter C (caregiver), followed by a sequential numeral (C1, C2, ...); in addition, everybody signed the Free and Informed Consent Term, declaring the will to be a volunteer.

■ RESULTS AND DISCUSSION

The study included 15 female caregivers aged from 22 to 58 years old, with complete elementary school education and up to complete higher education level, and eight to 12 years of work in the institution. Nine were single, four married, one divorced, and one lived in concubinage. In addition, nine had children. The categories "Working with care", "Facing daily work" and "Experiencing the impact of reality" are part of the construction for the theoretical model "Perceiving work/care with institutionalized children". In this article, the category "Working with care" is displayed, consisting of three subcategories: Caring and educating; Working with the unknown; Getting hidden. It is emphasized that in the DBT, theory arises from the researcher's reflective interpretation on the investigated context⁽¹⁵⁾.

Caring and educating

It was identified that the care of institutionalized children, in this study carried out exclusively by women, is configured mainly by hygiene and food, according to established schedules and also to the needs of the children.

[...] I come here and I'm already looking who is awake [...] go watch the milk, [...] they are peeing, we're going to change, look, they've got a fever, they are kind of hot, their nose is dirty, let's do hygiene. (C1)

[...] we give the milk, then change diapers, we have the routines of the baths, which is by turns, after that we bring them here to the street to get a little sun. There are snack times, at three, three thirty they have the snack. We stay with them until about four o'clock, then we go back with them inside, they stay in the baby nursery, they play, then we change diapers in the meantime, see how they are [...] then they dine, we do the hygiene, brush the little teeth of the bigger ones, we stay with them until 7:00 p.m. (C7)

Care is organized according to the experiences and knowledge of the caregivers, being adjusted to the specific needs of each child. Thus, the adult interacts with the environment on the basis of their cultural baggage, changing it according to their needs and also to those of the child^(10,16).

The knowledge acquired in the different life spheres is used by the caregivers to perform their tasks with these children, assimilating characteristics of that context and incorporating them into their practices⁽¹⁶⁾. Therefore, it is in the work development and in the interaction with the child that the caregivers create their care-related perspectives, influencing and being influenced by the coexistence with peers and with the children in daily socialization⁽¹⁰⁾.

The health care actions are reported several times, linked to the individual needs of each child who, often, already arrives sick to the institution.

[...] baby nursery is to change a diaper and take care of health that is complicated, [...] there are children who come very sick, [...] there are times when we do not even know what to do about the disease. (C15)

Thus, administration of medications is included, which is part of the routine:

[...] we have a medication folder, there we guide ourselves [...] we give medication, almost everyone takes some medication, almost everyone has a problem [...]. (C4)

From this report, the importance regarding the presence of health professionals in the sheltering context is being observed, offering support in drug administration and care. The nurse plays a fundamental role in promoting and maintaining patients' physical and mental health, and can articulate the network of attention in their care.⁽⁶⁾ In addition, preventing diseases is indispensable in order to avoid hospitalization, a point considered important not only for the child, but also for the caregiver.

[...] the more we preserve their health, it's good not only for them but for us, because we avoid that hospital function, such a situation. (C11)

Thus, preventive care seeks to avoid illnesses in children and also to reduce complications, because the demands increase and care becomes more complex with hospitalizations.

Doing recreational activities is also part of daily life; however, it is not always possible to develop them due to lack of time:

[...] you are involved in that function of changing, bathing, giving food and you can't play, do any activity. You just forget they are children, who need to play, run, get distracted, fiddle with the sand, fiddle with the earth, these things that sometimes they are missing. (C7)

Lack of leisure activities can interfere with child development, which is one of the main constraints of institutionalization, so it is important to spare time for play and

recreational activities. Playfulness is very important in the care for institutionalized children, since it favors the preservation of childhood and the problematization of difficulties and experienced conflicts, making new forms of care possible⁽⁶⁾. However, in sheltering institutions, cleanliness and order are often prioritized instead of social relations, affection and play⁽⁹⁾.

Among the leisure activities offered to children the most frequent ones are going out to the patio and watching television as entertainment. Joint play is also practiced, involving music, dance, talk wheels and interaction among children.

[...] people play a lot too, socialization [...], make wheels, people sit down, people play, watch television, talk, try to interact [...]. (C3)

Playing is one of the most developed activities in children's world, representing an important tool for socializing. During the stage of play, children assume the perspective of certain adults who are important to them and who they want to impress; they are their 'other signifiers'⁽¹⁰⁾. In the context of play, children interact and develop the ability to regulate their own behavior, arising from the perception of the 'other signifier', as a model to be followed, important for children physical and emotional development⁽¹⁰⁾.

Institutionalization aims to meet children's needs but, very often, care is focused on food, shelter and hygiene, making it difficult to meet the emotional and relational shortage.⁽²⁾ This greater preoccupation with issues related to physical survival, to the detriment of intellectual and social development, shows the urgency of a hygienist view among professionals, with established schedules and rigid routines, with no room for discussion, restricting the freedom and decision-making power of the sheltered ones⁽⁹⁾.

The maternal role or main figure of attachment, in the sheltering situation, is performed by the caregivers, since after the break with the family, children happen to live in a different environment than usual and with people who are strange to them. Caregivers perceive themselves as mothers, expressing this through feelings and attitudes:

[...] I see their attachment to us too [...] there are some that are already attaching to me, there are some who even call me mum [...]. Calling me mum, [...] you accept it, that I even somehow feel as if I really was [...]. (C2)

[...] you become a little of a mother to them, [...] as you develop a stronger bond with some, their response is also the same. [...] as if they were yours, regardless of whether you are a mother or not, they are a little yours here, and you are a little of a mother to them. (C7)

The bond between caregivers and children is often triggered by the stimulus launched by the child, who calls the caregiver mother and the caregiver responds by identifying herself as the child's mother⁽¹⁰⁾. The verbalization of a maternal feeling by the social mothers in front of the children is recurrent, and it is difficult to establish the limits between the work of the caregiver and the exercise of motherhood, that is, where the maternal desire ends and where the professional exercise begins⁽⁸⁾, a fact also perceived in this study among the sheltered children who often call the caregivers "mother".

Maternity is understood by C1 as a prerequisite for exercising the care of the child, and should be part of the profile for the work:

[...] there should be a profile in order to work with children [...] there should be at least some bond, [...] to have undergone some thing [...]. I think that at the very least you have to be a mother, to understand that child's stages. (C1)

Understanding the child's developmental stages is perceived by C1 as a caregiver function, possible only with previous motherhood experience. Prior childcare experience favors the acquisition of responsibilities and practice, assisting in preparation for dealing with issues related to child development⁽¹⁷⁾. In this context, motherhood can be a positive factor in the constitution process, when the caregiver does not have prior experiences working with children. On the other hand, C3 states that because she is not a mother, motherhood feeling is awakened by the care of the institutionalized child:

[...] here because I do not have a child I think this maternity thing wakes up more. (C3)

The statements of C1 and C3 have different conceptions, which are related to the previous experience of each one. However, it is believed that not being a mother does not prevent caring for the sheltered child, as well as being a mother does not accredit her for it. So these perceptions, in addition to being related to experience, are also linked to a cultural conception. There is also a third perception that is the complement of motherhood, reported by C10:

[...] so my motherly complement is here, but also my complement at home, because even with my son I have more patience. [...], you see a child in the cradle, then you see them crawling, [...] you see them laughing at you and then a little while later walking, then you are watching the evolution, as you see your child at home [...]. (C10)

It is observed that child's care is learned in the daily experiences, and that previous experiences favor the caregivers. Therefore, care is not natural, but it happens

through experience, and in child institutionalization the understanding of the life history and the suffering of the sheltered child is fundamental for performing the work⁽⁷⁾.

Child's care is similar to what they do with their children at home, with the development of affective bonding, love and also the imposition of limits, the difference is in breaking of the bond upon deinstitutionalization.

[...] I make this bond, [...] affection is important, [...] the lap is important, I think that limit is also important, all this in a certain dosage [...], as if they were my children. (C4)

[...] I have a great affection and bond for them [...] there is always one more, sure, look at a child and 'that is my daughter or my son' and such. We create a bond, even knowing the consequence, this is the difference of dealing with our own children and dealing with them here [...]. (C15)

The role performed by caregivers with institutionalized children is compared to their role with their own children, with the same concerns and dedication. However, affective attachment to the fostered child has the consequence of having to break the bond upon deinstitutionalization. The severance of the sheltered children causes psychological damage to the caregiver and, in many institutions, there is no support for these professionals, strengthening feelings of abandonment, lack of motivation and lack of capacity for care⁽¹⁾.

In the speeches, the understanding that the child depends on the caregivers to develop is also evident. It should be noted that the children in this research are between 0 and 3 years old, and that they do not yet have the conditions to provide for their own care, requiring assistance.

[...] the basic thing is the bond, because the child also needs to be secure, with the work that we are offering, in the needs that they demand. [...] this comes with the absence of a mother, and we have to [...] do everything to be able to supply. You will not meet the need for a father and a mother, but as long as you are there as an educator you will play your role. (C3)

The educator [...] it is a security, [...] a protection they feel, that they are not there alone, that when they need it, when they cry, when they are hungry, when they have everything, what they may be needing the educator and the other child will be there. (C9)

Caregivers understand their responsibility for the children, representing their safety, they stress out that they should be available for when the children need it. Sheltering exists there so that professionals may do the best they

can for the child, what they did not have, offering protection, physical and psychological well-being⁽¹⁸⁾.

Human beings are unique and therefore have specific needs that are different from one individual to another. Because they are more vulnerable, children need more attention to their individual needs in order to fully develop.

[...] you have to be more careful with the babies, one baby is different from the other, there is a bigger one, there is a little one, and there is one that is old, but is very small. So, you will not demand from this one what you may come to demand from the other one that is of time, such things like that. (C8)

It is observed that the individual needs serve to guide and organize the care-related work, being that the conditions considered as priority are taken care of first, like the smaller or more vulnerable children, according to the evaluation of the caregivers. In addition, caregivers report that to carry out effective care it is necessary to understand children's desires and individualities, seeking the most appropriate way to provide them.

[...] first you have to understand that each child is a child [...], the first step is to observe what that child is like and how the child likes to be treated [...]. (C4)

Interacting with the child falls on you, in certain moments, you become a child also with that child, you speak their same language. [...] respect them, listen to them, understand them. (C6)

Caregivers realize that they need to put themselves in the children's shoes to understand them, respecting their individualities. Thus, "institutionalization does not have to be synonymous with standardization, but it can be viewed as a learning moment, contributing to the child's development process [...]"^(8:206). Care-related individualization must consider the understanding of the particularities and potentialities of each sheltered child, since mass care represents a violation of rights⁽²⁾.

Caregivers realize that they are responsible for forming the children, that it is necessary to teach them, to impose limits and to show them the correct form to act.

...] teach them to respect each other, to play together, to exchange toys, because there are some who are selfish like that, and there are some who are aggressive, they take from the other, they pull their hair. So, we teach them to live together [...]. When they do wrong things [...] we make them think, they cannot hurt the other [...] we teach them to respect each other. (C5)

Fights arising from disputes over attention and toys are common among children, so caregivers seek a more harmonious coexistence, determining limits. Thus, sheltering institutions need to have clear rules, providing safety parameters for children and caregivers⁽²⁾.

Care is also understood as an exchange, where there is socialization and interaction, in which caregivers and children coexist and attribute meanings to their daily life and world. In addition, caregivers identify themselves as references for the children:

[...] I think interaction does this, it makes the child discover other things with the day to day, seeing the other [...] they go with the interaction discovering other things that they did not know before. (C9)

[...] the child mirrors themselves in the adult and who is the reference for her? It's us, they'll mirror us. (C11)

[...] you see the bigger one taking care of the smaller, so they have affection between them. [...] that's what excites me the most, caring for each other [...], that's what I think is one of the things we see so our work is worth it, because they have learned how to give affection [...]. (C14)

In interacting with the adult, the child begins to adopt their perspectives, the caregiver being a reference for the children, who reproduce it with each other from the care they receive⁽¹⁰⁾. Thus, it is evident that the meaning of things is formed, learned and transmitted through social interaction, because in interacting with the caregiver and with their peers children build up their relationship models⁽¹⁰⁾.

Working with the unknown

It was observed that the caregiver's lack of knowledge regarding the work of institutionalized child care is related to several areas, especially the situation of vulnerability and fragility of the sheltered children. The reason that brought the child to the institution is often unknown and may interfere with the care provided:

At first it was one thing [...] quite different, [...] when I got here I did not even know [...] what I had to do [...]. What was it that made them be here [...] it was over time that I learned [...] it was very exciting [...] I did not know anything [...]. (C2)

[...] we should know a little more about the child's life before coming here, because suddenly we have some situation, there is a certain child who does not like us to put them on the changer, we do not know if suddenly some time ago they did not suffer from something they recall. So,

this would be an important part for us to know what not to do with a certain child. (C9)

Knowledge about the child's history, according to the caregivers, would favor the care provided, thus avoiding problematic situations for the child. Lack of knowledge regarding the performance of the child's hygiene care was also reported:

[...] this here is all very new to me [...] when I came in here I had to bathe a newborn baby [...]. I said, 'I do not give a bath to a baby with a navel because I'm afraid' [...], but there came a moment when I said 'no, I have to lose this fear and give the bath'. (C6)

They just sent me here and we already started the following day, and I had never changed a diaper to a child, had no contact with a baby, thrown in the middle. (C12)

It is observed that lack of qualification for the performance of basic care interferes in accomplishing the activities and weakens the caregiver, who feels 'thrown in the middle'. This may reflect a sense of helplessness, where the caregiver does not have the experience or knowledge for performing the care, and it is necessary to invest in qualification, since that professional training is essential to guarantee the future citizenship of the sheltered children⁽⁹⁾. Thus, it is necessary to continuously update the professionals so that they can work in these institutions, since the situations experienced are dynamic and they are different every day, and learning is structured from practical experiences⁽¹⁸⁾.

Lack of knowledge about the child's eating habits prior to institutionalization may also interfere with care, as stated by C13:

[...] when I got here it was very complicated [...] there are schedules for everything, but you do not know if the child drinks milk with sugar, if that child does not drink milk with sugar, and then it is very complicated, you have to go kind of playing until you get their way or until they adapt to yours. (C13)

It is evident from this statement that institutionalization imposes the need to adapt to a new reality on the child. In this context, caregiver and child need, through interaction, to find care forms, adapting them to the needs.

Getting hidden

In this subcategory we find the words of caregivers about their sense of invisibility towards caring for the institutionalized child, which is not recognized nor valued by the society or by the legislative and judicial bodies. Low pay is one of the contributing factors to this perception.

[...] if you want to work here you forget about the financial part, then you have to donate yourself [...] it is pure charity so. (C7)

[...] regardless of the wage being small [...] because salary, of course we need that salary, peanuts [...]. (C11)

Although remuneration is not considered adequate, caregivers need it, this work is a means to obtain financial resources for survival, which does not give them financial satisfaction, generating the perception of work as a charity. The low wages received by the caregivers are a source for dissatisfaction and reflect on the quality of the bond established with institutionalized children⁽¹⁹⁾. In the caregiver's reports, lack of recognition also represents a negative factor in the performance of institutionalized child care.

[...] we are little recognized for what we did and this is the negative side. [...] it is you not wanting to know the other side, [...] each one of us is responsible for this side, for the frailties of society, so for the people it is better not to get involved, not knowing is better, if each one did a little bit it would be very different. (C6)

[...] our job is kind of anonymous, ah! what are you? I'm a social educator, like, what, where? [...] people are surprised because they do not know about our existence [...]. (C14)

It is observed in the speeches that the work of the caregivers in these institutions is unknown, negatively influencing care performance. In this context, there is a question about visibility and on issues that are excluded from social and political discussions, such as child care. It is believed that various factors are involved in this invisibility, while at the same time it is easier to deal with 'the frailties of society', if these are unknown or ignored. Ignorance exempts people from having to take actions that can minimize such social ills. In addition, care work has characteristics that make it barely visible as it is not amenable to direct apprehension or measuring. Thus, the production of care imposes a great psychic effort on the workers "to sustain the necessary sensitivity and lightness, in the interaction with the subjects and their demands"^(20:304).

For C14, lack of recognition is also related to the fact that they are female workers:

[...] I think it gives people as hardworking [...] we are just women in the house and I think about this thing of being hidden, we are little ants, we are women in the middle of a crowd, having such an important job. [...] I do not know if it is lack of interest or if we fall into oblivion [...]. Lack of recognition, this is the truth, our work is so important and at the same time it is leveled so low and in fact it had to

be very well prepared [...] you receive children in extreme situations. (C14)

Lack of recognition is understood by C14 as a social phenomenon that is related to female work, which is little valued, thus interfering in professional qualification. Care is historically linked to the identity and skills that are considered feminine, “regulating and reproducing a labor division model”, articulated to the female gender^(7,84). Collective silence and indignation is added to this lack of recognition:

[...] that you can scream and kick around, but that hardly anyone will hear us, [...] it is collective silence and collective indignation [...]. Because you're going to scream at what, you're going to make noise for what, for whom, what's going to change? Nobody does anything and really, we see that the forum people come here, look at the house, come in and out, what eyes do they have, and it is impossible that they can not see the same thing as us?...] we are transparent, they do not address us. We are nothing, [...]. (C14)

In this speech, lack of recognition is linked to the invisibility condition of the caregivers who, despite being with the children daily, are not heard as for their perspectives nor considered by the legal organs. In the care work for institutionalized children, the caregiver does not have a secure listening room, with constructive experience exchanges⁽⁷⁾. Thus, lack of preparation and guidance as well as deficiencies in communication weaken teamwork and the provided care⁽⁷⁾.

Lack of attention to the institutions and legal support for the performance of care outside the sheltering institution also have a negative impact on the work.

[...] you being more attentive to what happens here, for example: the employer who takes part more in the reality of the shelters, the internal life of the shelters, making periodic visits to know what they need, seeking training courses, or even self-help for the employee, because the employee is also a human being. (C6)

[...] it is very difficult to work like this, especially when we are outside the shelter, we do not have the support [...] you get coerced to work. (C14)

These reports reveal a feeling of helplessness inside and outside the institution, reflecting lack of support. In care actions that need to be moved to another environment, C14 says that she feels exposed, having no one to turn to. In addition, the caregiver reports that she feels biased in the performance of her institutionalized child care work.

[...] when we know that you have a hospital, we already stay [...], it is not [...] for the care of the child, but for knowing

that we will be exposed. [...] and there you have no endorsement, nothing, the maximum you can do is to call for the coordinator.[...] it seems that if one of our children gets sick it is because they have not been well cared for [...] it has this weight. [...] people come to you for knowing that that child [...] is sheltered, this generates a commotion, and if that child cries more with you than he/she cried with the other, it is because you are the bad aunt [...]. There is a very strong watchout over us [...] On the side of the mothers, the nursing team as well, it seems that it was our negligence, [...]Our incompetence [...]. (C14)

In hospitalization, all eyes turn to the child, throwing ‘a weight’ on the caregiver, who feels she is seen as ‘the bad aunt’ responsible for the child’s illness, being monitored. In this context, the meaning of caring for an institutionalized child is one of exposure and vulnerability. It is believed that the nursing team has an important role to play in minimizing this feeling of the caregivers, since it can talk to them and to the other people found in that context, in order to clarify that the conditions of child care are confidential and that these children have several vulnerabilities that interfere with their health condition.

■ CONCLUSIONS

The study’s findings point out that work/care with the institutionalized child brings a series of demands, where caregivers need to deal with the ills that institutionalization imposes on the children and on themselves. In this context, the feeling of motherhood arises, with the physical, psychological, emotional and educational needs of the child being met, creating bonds and attachment. Caregivers perceive themselves as being responsible for the children, yet they explain their invisibility to society and to public agencies, generated by a lack of recognition and support, impacting on the quality of the care provided and on the lives of the caregivers.

The study’s main limitation is the exclusive inclusion of caregivers for children from zero to three years old, since older children may have different needs that require different care. However, the study brings out important contributions to the research, pointing out to the need to further explore the reality experienced in the institutionalization context, with older children and adolescents, in order to broaden care and support strategies for caregivers and for care because, from the suffering experienced by the caregivers, there is a need to expand emotional and structural support, as well as active listening. In addition, the need for inserting the nurse in this context is visualized, which may help to organize care and strengthen the bond, minimizing

the harms resulting from the children's physical and emotional vulnerability, as well as supporting the caregiver.

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