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Meanings attributed to Hope by children with orofacial clefts through dramatic therapeutic play

Significados atribuídos à Esperança pelas crianças com fissuras orofaciais a partir do brinquedo terapêutico dramático

Significados atribuidos a la Esperanza por los niños con fisuras orofaciales a partir del juego terapéutico dramático

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ABSTRACT
Objective: To understand the meanings attributed by children with orofacial clefts to the factors that promote and threaten Hope, through Dramatic Therapeutic Play.
Method: A qualitative study, grounded in the theoretical–methodological framework of the Hope-Promoting Mutual Help Intervention Model and the theoretical framework of Symbolic Interactionism. It was conducted between March and April 2025 through Dramatic Therapeutic Play with children aged five to nine years old with orofacial clefts, who were receiving care at a support association in Paraná, Brazil. Data were analyzed using inductive thematic analysis. All ethical principles were respected.
Results: Sixteen children participated. Among the aspects that promote Hope, the following stand out: treatment experiences, multiprofessional care, family and social support, spirituality, acceptance of one's own condition, and playful strategies. Aspects that threaten Hope were related to dissatisfaction with appearance, negative treatment experiences, lack of emotional support, bullying, and social exclusion.
Conclusion: The experience of a child with an orofacial cleft is marked by meanings attributed to their own self-image, the treatment, and the social support received. Care actions and family and social interactions can strengthen or threaten Hope during treatment.
Descriptors: Play and playthings; Child; Hope; Cleft lip; Cleft palate.

RESUMO
Objetivo: Compreender os significados atribuídos pelas crianças com fissuras orofaciais aos aspectos promotores e ameaçadores da Esperança, por meio do Brinquedo Terapêutico Dramático.
Método: Estudo qualitativo, pautado no referencial teórico-metodológico do Modelo de Intervenção em Ajuda Mútua Promotor da Esperança e no referencial teórico Interacionismo Simbólico. Foi realizado entre março e abril de 2025, por meio do Brinquedo Terapêutico Dramático, com crianças entre cinco e dez anos incompletos com fissura orofacial, atendidas em uma associação de apoio no Paraná, Brasil. Os dados passaram por análise temática indutiva. Todos os princípios éticos foram respeitados.
Resultados: Participaram 16 crianças. Entre os aspectos que promovem a Esperança, destacam-se a vivência no tratamento, o cuidado multiprofissional, o apoio familiar e social, a espiritualidade, a aceitação da própria condição e as estratégias lúdicas. Observou-se ainda que os aspectos que ameaçam a Esperança estão relacionados à insatisfação com a aparência, experiências negativas no tratamento, ausência de suporte emocional, bullying e exclusão.
Conclusão: A experiência da criança com fissura orofacial é marcada por significados atribuídos à própria imagem, ao tratamento e ao apoio recebido socialmente. As ações de cuidado e a convivência familiar e social podem fortalecer ou ameaçar a Esperança durante o tratamento.
Descritores: Brincadeiras e brinquedos; Criança; Esperança; Fenda labial; Fissura palatina.

RESUMEN
Objetivo: Comprender los significados atribuidos por los niños con fisuras orofaciales a los aspectos que promueven y amenazan la Esperanza, por medio del Juego Terapéutico Dramático.
Método: Estudio cualitativo, fundamentado en el marco teórico-metodológico del Modelo de Intervención de Ayuda Mutua Promotor de la Esperanza y en el marco teórico del Interaccionismo Simbólico. Fue realizado entre marzo y abril de 2025, mediante el Juego Terapéutico Dramático, con niños de cinco a nueve años con fisura orofacial, atendidos en

una asociación de apoyo en Paraná, Brasil. Los datos fueron sometidos a análisis temático inductivo. Se respetaron todos los principios éticos.
Resultados: Participaron 16 niños. Entre los aspectos que promueven la Esperanza se destacan la vivencia en el tratamiento, el cuidado multiprofesional, el apoyo familiar y social, la espiritualidad, la aceptación de la propia condición y las estrategias lúdicas. Se observó también que los aspectos que amenazan la Esperanza están relacionados con la insatisfacción con la apariencia, experiencias negativas en el tratamiento, ausencia de apoyo emocional, bullying y exclusión.
Conclusión: La experiencia del niño con fisura orofacial está marcada por significados atribuidos a su propia imagen, al tratamiento y al apoyo recibido socialmente. Las acciones de cuidado y la convivencia familiar y social pueden fortalecer o amenazar la Esperanza durante el tratamiento.
Descriptores: Juego e implementos de juego. Niño. Esperanza. Labio leporino. Fisura del paladar.

INTRODUCTION

Orofacial clefts (OFCs) include both cleft lip and cleft palate and are among the most frequent congenital malformations of the head and neck region[1]. In Brazil, they have an incidence of one case for every 650 live births[2]. Children with this malformation may experience numerous difficulties in social interaction, especially those related to communication and school bullying, caused by appearance and also nasalized oral sounds[3], in addition to other repercussions such as anxiety and depression[4].

Living with an orofacial cleft, therefore, goes beyond biological and functional challenges and also includes social challenges, requiring subjective resources to cope with the condition and promote child well-being[5], with emphasis on Hope, as it is a psychosocial strategy that supports coping with adversities related to the condition[3].

According to the Model for Intervention in Mutual Help-Promoter of Hope (MIAMPE), Hope is understood as a phenomenon influenced by social relationships, being driven by aspects that awaken positive feelings and threatened by elements that generate suffering[6]. Thus, the support offered by family and friends throughout the treatment plays a fundamental role in overcoming the challenges faced[3].

Given this complexity, pediatric care requires professionals to be prepared so that each intervention aims not only at healing, but also at the overall well-being and healthy flourishing of the child within the possibilities of their environment[7-8].

Among the strategies used to support this process is Therapeutic Play (TP). Through its use, children can quickly demonstrate and realize their needs, in addition to assisting in the

care process, allowing professionals to recognize the child's needs and difficulties, and implement measures to solve or alleviate them[9-11].

TP, especially dramatic play, is a resource that allows the child to symbolically express and re-signify their reality[11]. In this process, play takes on a character of symbolic action, expressing meanings constructed from the social environment in which the child is inserted. This perspective dialogues with Symbolic Interactionism, highlighting that human beings act based on the meanings attributed to things, constructed in social interactions[12]. Additionally, play constitutes as a language through which the child communicates fears, desires and hopes, subjective elements deeply influenced by the social environment and lived experiences[13].

The available literature suggests that the use of therapeutic play with children with orofacial clefts is still underexplored, since studies focus on clinical[14], surgical[14] or speech therapy[15], aspects, with rare initiatives aimed at emotional care through play. Considering the challenges faced by children with orofacial clefts during rehabilitation, there is a need for integrated care strategies that value the child's subjective and emotional dimension. This study seeks to fill this gap by addressing the use of therapeutic play with children with orofacial clefts, considering Hope as a health- and well-being-promoting element.

Recognizing the scientific and social relevance of the theme of Hope in the mental health of children with orofacial clefts, especially in the context between diagnosis and rehabilitation, the following question arises: how does the child attribute meaning to aspects that promote or threaten Hope in their orofacial cleft treatment? In this sense, the study aimed to understand the meanings attributed by children with orofacial clefts to aspects that promote and threaten Hope, through Dramatic Therapeutic Play.

METHOD

This is a descriptive, exploratory study with a qualitative approach, grounded in the theoretical-methodological framework of the Model for Intervention in Mutual Help-Promoter of Hope (MIAMPE) and the theoretical framework of Symbolic Interactionism (SI). The study report followed the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ)[16].

MIAMPE was chosen as a framework because it considers Hope as a multidimensional phenomenon influenced by social relations and allows the identification of aspects that promote Hope, provoking positive feelings, and aspects that threaten Hope,

contributing to suffering[6]. SI, in turn, is a theory that considers that human beings act based on the meanings they assign to things and feelings, resulting from social interaction, and that these meanings may be modified throughout relationships. Thus, it contributes to understanding the meanings that children attribute to Hope[12].

The research took place at an association supporting individuals with cleft conditions, located in the northwestern region of Paraná, Brazil, which provides free multiprofessional care to children and adolescents with orofacial clefts from more than 80 municipalities in the region.

The sample size was determined by convenience, including children with orofacial clefts, between five and ten years of age, who were treated at the association. Children with isolated orofacial clefts (not associated with other syndromes), within the established age range and who regularly attended the service were included. Children with physician-certified cognitive impairment that prevented understanding of the questions were not included, since the research team did not have specialized professionals who could carry out methodological adaptations for children with cognitive impairment. Therefore, the non-inclusion of these children aimed at methodological adequacy and ethical protection. Sixteen children were included in the study, and there were no refusals to participate.

The age range was defined based on the understanding that, from the age of five, children demonstrate a greater capacity to represent reality based on their feelings and experiences. It is a period marked by symbolic play, which becomes less expressive as age advances[17].

The research was conducted between March and April 2025 by the main author, a nurse and master's student in nursing with experience in qualitative research. The researcher has prior involvement in the service, as she has been participating in a research project developed at the institution since 2021, however, she does not provide direct assistance and had no prior contact with the children. Data were collected individually, at the institution, in the interval between the children’s consultations, in a private room that ensured no interruption during data collection.

The materials offered to the children were diverse, allowing them to choose those that most closely reflected their experiences. These included dolls representing family members, healthcare professionals, domestic animals, household and hospital-use toys, superheroes and princesses, emotion stickers, inclusive dolls with orofacial clefts, toy cars, toys representing school and spirituality, and modeling clay. All toys used are shown in Figure 1.

Figure 1 – Toys used in the study. Maringá, PR, Brazil, 2025.

Source: The authors, 2025.

The data collection was conducted through a Dramatic Therapeutic Play (DTP) workshop, guided by the question: “Let’s play at being a child who has an orofacial cleft and is searching for Hope?”, and other auxiliary questions. From then on, the child could choose toys from a box to represent their story. DTP is a care tool that allows the child to express, dramatize and reveal their feelings, emotions and lived experiences. In addition, it is a technique that promotes bonding and facilitates communication with the child[11].

The workshop began with the establishment of a bond with the child, carried out by welcoming the child and presenting the session’s proposal. Then, there was free exploration of the available toys. Subsequently, the child was allowed to choose their preferred materials, dramatize the situations and stop playing[11]. The workshops were conducted only once with each child, with a maximum duration of 50 minutes. Time was managed using five toy clocks, and the child was informed that when only one clock remained, the session would be close to ending. If the child needed to end the session earlier, this was permitted. The children’s audio and image were recorded during the session, and at the end, the toys were collected.

At the time of data collection, none of the children had infectious diseases, and all the toys used belonged to the association’s own toy library and were shared among the children.

During the sessions, the researcher asked additional questions to continue data collection, as included in the instrument reviewed by a nurse with a doctoral degree in nursing who works as a faculty member in child and adolescent health. A pilot test was conducted with four children, and since no need to modify the question script, these interviews were included in the final sample. Data collection was completed when it was observed that the data were sufficient to answer the research objective, verifying the repetition of information and the quality of the statements[18]. This process occurred simultaneously with the data collection, through the analysis of the interviews and field notes made during the collection.

Alongside the data collection, the interviews were fully transcribed, but no feedback was provided to the children. The materials were imported into the Atlas.ti® software as an auxiliary tool for data organization and systematization. Verbalized statements and interactions with the toys observed during the session were considered data, and all information was transcribed.

The material was analyzed according to inductive thematic analysis, following six proposed stages: in the first stage, the interviews were fully transcribed by the main researcher and repeatedly read to promote familiarization with the data. During the second stage, inductive coding was performed, identifying relevant speech segments and interactions observed during Dramatic Therapeutic Play, with the support of the software[19].

Subsequently, in the third step, the codes were grouped by similarity, originating preliminary themes, which were reviewed and refined by returning to the original data, seeking to ensure internal coherence and representativeness. After this process, in the fourth stage the themes were defined and named, being interpreted in the light of Symbolic Interactionism and the Model for Intervention in Mutual Help-Promoter of Hope. The analytical process took place iteratively, with constant comparison between the data, codes and themes[19].

During the fifth stage, the analytical theme was refined and named. Finally, in the sixth stage, the constructed results presented the central analytical theme of the study, which was discussed and validated by two other researchers, specialists in this type of analysis[19].

To ensure methodological rigor, analytical records were maintained throughout the process, including field notes and analytical memos, which helped in organizing the interpretations and in the traceability of analytical decisions.

Symbolic Interactionism supported the understanding of the meanings attributed by children to their experiences, considering the social interactions represented in play[12]. While

MIAMPE guided the organization and interpretation of the findings related to the hope-promoting and hope-threatening aspects, allowing the data to be analyzed in the light of the relational and emotional dimension of care[6].

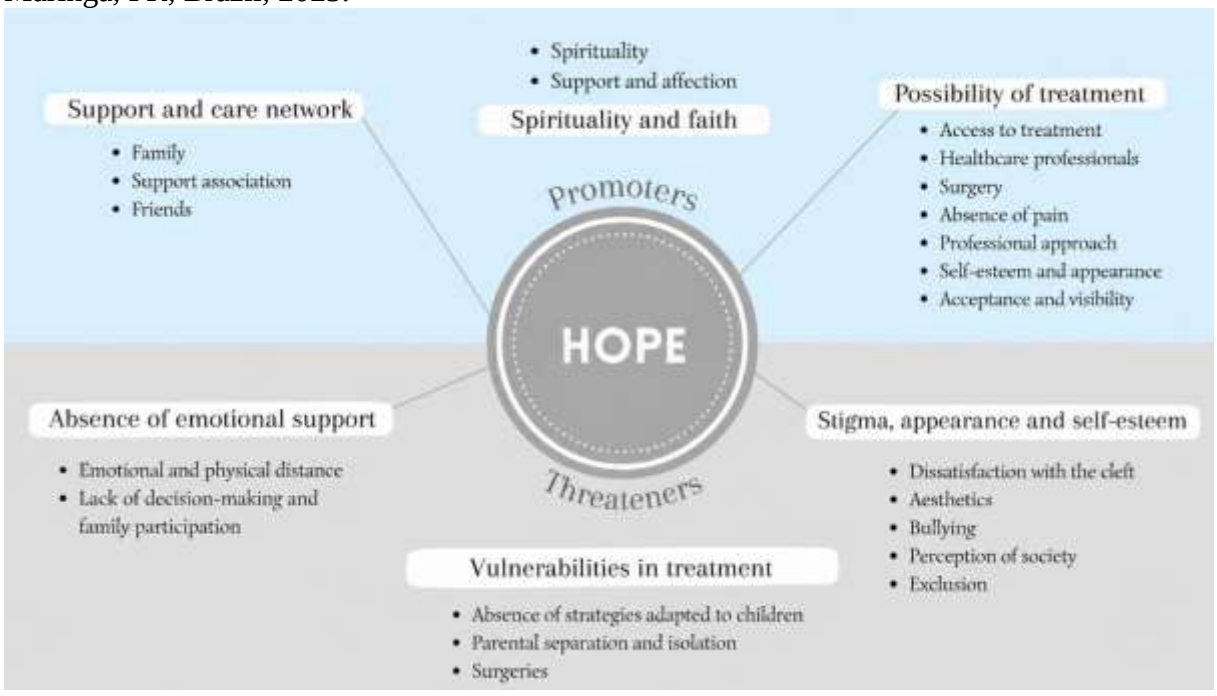
All ethical precepts were followed and explained to the children and their caregivers. The Informed Consent Form and the Informed Assent Form were both applied in duplicate. The study was approved by the Human Research Ethics Committee under opinion number 7.041.250/2024 (CAAE 81990024.0.0000.0104). To preserve the children's identities, they were identified according to the initial of the term "child," followed by the order of the interview and age (e.g., C1, 9 years old).

RESULTS

Sixteen children participated in the study, eight girls and eight boys, aged between five and nine years (mean 6.5 years). Regarding the type of cleft, eight had lip clefts and eight had lip and palate clefts. The number of surgical procedures the children had undergone ranged from one to three, with an average of two surgeries.

Based on the analysis of the interviews, two thematic categories emerged: "Interactions that build and promote Hope in children with orofacial clefts" and "Interactions that weaken and threaten Hope in children with orofacial clefts," as shown in Figure 2.

Figure 2 – Hope-promoting and hope-threatening aspects in children with orofacial clefts. Maringá, PR, Brazil, 2025.



Source: Research data, 2025.

Interactions that build and promote Hope in children with orofacial clefts

This category addresses the experiences and social interactions that strengthen the Hope of children with cleft lip and palate, highlighting the possibility of treatment, support and care network, and spirituality and faith.

Possibility of treatment for orofacial clefts

For the children, cleft lip and palate treatment was symbolically understood as an opportunity for transformation. During the therapeutic play session, the children expressed positive feelings related to the treatment, since it is through treatment that the changes affecting appearance, teeth, and speech are resolved. The children represented the professionals of the multiprofessional team as figures of care and support, important in building trust and hope during the rehabilitation process.

> *This one [picks up the doll representing the healthcare professional], she is a doctor and she is going to do my graft.* (C3, 07 years old)
>
> *I feel happy when it is almost the day to fix my cleft, I really like coming to the dentist to fix my teeth [playing dentist].* (C6, 05 years old)
>
> *I hope it gets even better, to do speech therapy. When I grow up, my speech will already be better.* (C13, 08 years old)
>
> *I go to hospitals or dentists, they know everything about us, they are very good at doing this.* (C16, 07 years old)

Aesthetics acquires meaning in the construction of self-image among children with orofacial clefts. The children associated physical changes with an intensification of Hope, influencing how the child perceives and feels about themselves.

> *I already got my nose fixed [shows nose and mouth]. The doctor fixed it, it was right there in the back, I didn't feel anything, I was happy.* (C9, 05 years old)
>
> *Fix my tooth because it's all broken.* (C10, 07 years old)

The way the child interprets and assigns meaning to their own condition is built from lived experiences. Some children reframe the orofacial cleft positively, in which the cleft becomes integrated into their identity, based on acceptance and Hope.

> *I'm not sad because of my cleft, I don't have to fight with it, it's not to blame for anything. I have to be happy, if I was born this way, I was born this way, I'm not to blame, and neither is the cleft.* (C11, 08 years old)

> *I am the only one in my classroom who has it. I feel normal. The first time they noticed it, they asked what it was, then I said that I had surgery to fix my little mouth when I was a baby.* (C16, 07 years old)

During the TP session, the children mimicked surgical procedures, recounting their experiences. At that moment, they expressed positive and hope-promoting perspectives and represented the stages of the procedure in a playful and meaningful way, without the presence of pain. Anesthesia, for example, was associated with a symbol of comfort and safety.

> *I felt happy because I was going to have surgery, some children have it and it is really cool.* (C4, 08 years old)

> *They give me medicine so I can sleep and not feel anything [plays while representing the surgical procedure]. Then I woke up and went to the mirror, I touched it like this and it was normal, I did not feel anything at any time. I feel normal because it does not hurt at all, nothing happens, I take a normal shower, if water falls on it, it does not sting, it is normal, nothing happens, it is calm.* (C5, 07 years old)

> *I am even feeling good, because I had my tooth removed and it did not hurt much, and I think it hurts less to put on this braces [shows on the doll how the braces are placed].* (C12, 09 years old).

> *I come here because I had surgery. When I was very little, my mother took me to the doctor to do the clefts [corrective surgery]. He put a little strip here [shows on the dentist doll] and told me to keep my mouth open, then he joined it and left it closed. I felt good, I had three surgeries, because he fixed and joined my little mouth.* (C14, 06 years old)

The approach used by professionals during care was dramatized and expressed by the children as meaningful. Effective communication enabled a positive professional – patient – family interaction, fostering Hope in treatment. The children played in the way they like to be cared for, demonstrating the importance of a playful approach.

> *The dentist is nice. The doctor, when I behave, she gives me a drawing.* (C1, 07 years old)

> *I feel good, because I like it. I play, I go to the dentist.* (C2, 06 years old)

> *I like it, and she [dentist] gives me a toy to take home, I choose a toy and take it.* (C8, 06 years old)

Support and care network

Social interactions within the family context are processes that build feelings of comfort and Hope in children. During the TP session, the children represented the relationships they build with their family members, dramatizing through play the gestures of care and affection they receive, which reinforces the children's Hope and confidence during treatment.

> *My father and my mother, they take good care of me and tell the truth. I did not know how to brush my teeth very well, then my mother helped me and now I know. [chooses the doll to be herself and her parents and reproduces the behavior] I used to brush only like this [in the front], then my mother brushed back and forth, and then I learned how to brush.* (C6, 05 years old)
>
> *My father puts ointment on me, so I do not scratch and remove the skin from my mouth.* (C7, 06 years old)
>
> *My aunt. My aunt takes care of me, when I was very little, when I do not know how to say what I was like, I always lived there, and my father left [under the aunt's guardianship, complex family context]*. (C8, 06 years old)
>
> *My father and my mother, they give me affection.* (C15, 05 years old)

Through play, the children represented the interaction they have with the support association and attributed to this place a meaning not only of treatment, but also of a social environment, where care is provided through play and coexistence with other children. Thus, the interactions they have with friends both at the association and with other children who understand and respect the orofacial cleft are aspects that promote the construction of Hope.

> *I have friends here. The [association] is precious to me, because it can do everything for my tooth, and it can remove all of my cleft.* (C1, 07 years old)
>
> *I feel normal. I have many friends, my friends support me. I feel normal, I feel happy*. (C11, 08 years old)
>
> *There was one time when I talked about my cleft to my friend and he listened to me*. (C12, 09 years old)

Spirituality and faith

During the therapeutic play session, the children identified or drew symbols that represented, for them, figures of God, Jesus, and angels. During play, they expressed their interaction with these symbols, explaining their meanings and how they related to their lives.

It was possible to perceive that faith and spirituality foster the Hope of children with orofacial clefts.

> *This one is me lying in bed, this one behind me is the doctor working on my mouth, and this one is God in the clouds taking care of me.* (C5, 07 years old)

> *[Chooses baby Jesus]. This represents hope, it is Jesus. So that I can have hope now and with the ones I like [begins to cry intensely]. I have a soft heart, I do not know how to explain it. I cannot speak.* (C12, 09 years old)

> *[picks up the angel toy] When I was in the belly, a little angel came and bit a piece, then he went away and I was born and stayed like this, and they saw me like this, and it is very rare for a baby to be born in the family with a cut little mouth, then in each family one is born with a cut little mouth. I was impressed.* (C16, 07 years old)

Among the aspects that promote the Hope of children with orofacial clefts, it is possible to highlight the experience of treatment, capable of improving appearance and well-being. Professional care, a welcoming environment, support from family and friends, spirituality, and acceptance of one's own condition strengthen Hope.

Interactions that weaken and threaten Hope in children with orofacial clefts

This category encompasses aspects that threaten children's hope, considering stigma and appearance, weaknesses in treatment, and the absence of emotional support.

Stigma, appearance, and self-esteem

Through everyday interactions, the child comes to assign negative meanings to the orofacial cleft, reflecting socially attributed stigmas. Aesthetic dissatisfaction and physical discomfort reduce self-esteem and social interaction.

It is observed that children attribute negative meanings to the orofacial cleft based on the experiences and social interactions they go through, permeated by aesthetic dissatisfaction and physical discomfort, weakening the construction of Hope.

> *The doctor forgot to fix this part here and a little hole, a little line, was left, then when I go to fix my nose, he will fix this part here. I am anxious because it will look prettier, and also when I fix the cleft in my mouth so this little bump goes away, it will be very pretty to put lipstick on and go to school. This here will be the lipstick [shows on the doll]. I already removed the little thing, the bump, then I come and put on the lipstick and it looks prettier, she is feeling happy.* (C6, 05 years old)

> *[...] my mouth has skin here [shows mouth], I do not like that there is skin on my mouth, and I keep pulling the skin from my mouth and it bleeds.* (C7, 06 years old)

> *I want to improve my nose so that others can understand me, understand what I say*. (C13, 08 years old)

> *Do something to make this disappear, so people stop asking what this is, what this is*. (C16, 07 years old)

Bullying situations frequently experienced by children with orofacial clefts are immersed in symbols that affect identity and emotional well-being. The use of play allowed the children to represent the meanings attributed to the aggression they suffered, influencing the construction of their Hope.

> *I don't care what people talk about me, sometimes they say my tooth is crooked, but I don't care. The first time someone called me that, I cried, but since everyone is talking about it, I already know.* (C1, 07 years old)

> *I felt like that for many days, but now I do not feel it anymore. Sometimes people make fun of me because I speak in a high voice. I used to feel bad.* (C12, 09 years old)

> *[playing dentist] Now I am putting in the teeth, actually his tooth has already grown, now we are checking the size to put braces on, because this little boy here called him toothless, and that was bad because that is either bullying or insulting others. He keeps bothering me, at my desk, he takes my things, and also in line when we go to recess he keeps saying "the girl is ugly," saying lots of things*. (C13, 08 years old)

Episodes of exclusion are experienced by children in the school environment and act as aspects that threaten hope. The statements below show how the children interpret their classmates' responses.

> *Did you know that I almost do not have any friends at school, I only have three friends. Most people do not like me at school, except my friends. I do not know why, I know that sometimes it is because of my cleft. Everything will be okay [says to Shrek]*. (C12, 09 years old)

> *Only when someone makes fun of me. One day I told I. that I had a cleft, then a girl said she did not want to be my friend anymore. I was sad, but later she became my friend again.* (C11, 08 years old)

The statements below show how experiences and symbols associated with the orofacial cleft shape their perceptions of society and influence their responses regarding the condition.

> *No, because nobody knows either. I am never going to tell. If I tell here, it will die here. I do not have the courage to tell others. Otherwise, people tell other people. I say do not tell, and then they go and tell.* (C11, 08 years old)

> *Humanity doesn't give me hope, humanity is completely bad. When I go outside I see that the world is very bad.* (C12, 09 years old)

Vulnerabilities in treatment

The children expressed dissatisfaction with the absence of care strategies adapted to children, such as the inclusion of play, which demonstrates how the absence of symbolic elements may compromise the construction of positive meanings regarding care, threatening Hope.

> *[...] I don't play much at the doctor's, but nobody plays, so I play with my parents.* (C4, 08 years old)

> *Being without playing with my friends and not seeing them anymore and having boring tests, doing lots of things.* (C13, 08 years old)

Some children attribute negative meanings to surgeries, associating them with hospital rules and restrictions, such as separation from parents during surgical procedures, or postoperative care. These situations, revealed through therapeutic play, threaten the construction of Hope.

> *I feel sad when my parents stay far away from me, but then they come back [at the hospital]*. (C4, 08 years old)

> *I was lying on a bed and she had to stay on the other side of the door because she could not come in [operating room], and I could not see her, but she was sitting there on the bench beside it [recreates with the toys]*. (C5, 07 years old)

> *I feel it when I am going to travel, because I get very nervous because I do not know what they are going to do with my tooth.* (C10, 07 years old)

> *I had to have surgery and I could not jump, I could not run. At school there was ground beef, and that day I could not eat ground beef.* (C13, 08 years old)

Absence of emotional support

When experiencing the absence of decision-making and participation by family caregivers, children construct negative meanings about treatment, which threatens Hope. Through play, these children expressed the desire for closeness and continuous care.

> *I hope I do not have to do the treatment again, because if my mother does not come, then I will miss her. Because I am doing treatment now and I cannot go see her*. (C5, 07 years old)

> *My mother, she could stay close to me and not let me feel afraid. I wanted her to hold my hand when I was in my treatment. I would feel safe with my mother*. (C11, 08 years old*)*

> *Sometimes I don't brush my teeth before sleeping, sometimes I brush when I wake up, sometimes my mother does not wake me up and I end up without brushing my teeth because I don't remember by myself, I have to learn that [playing dentist]*. (C12, 09 years old)

The Hope of children with orofacial clefts is threatened by negative situations they face during treatment, such as loneliness and the absence of playful strategies. In addition, dissatisfaction with appearance, bullying and exclusion, as well as lack of emotional support, also reduce Hope.

DISCUSSION

Hope is a subjective condition, constructed from individual perceptions of lived situations. The child's "self," that is, their self-perception, plays an important role in the formation of Hope, influenced by social interactions and the meanings attributed to habitual experiences[6,12]. The study showed, through dramatic therapeutic play, that the experiences of children with orofacial clefts in the face of treatment and their social relationships can be immersed in aspects that promote or threaten Hope.

The experience of treatment through the care provided by professionals who make up the multiprofessional team corroborates the notion that the child feels Hope in achieving a normal appearance without the alterations caused by the cleft. A meta-analysis conducted by Brazilian researchers identified that clinical care associated with the emotional support offered to children and adolescents with orofacial clefts contributes to a positive perception of their appearance[20]. Therefore, the Hope of children with orofacial clefts is sustained through care, both clinical care and the emotional support they receive from professionals on the rehabilitation team.

In addition, the absence of pain allows the child to reframe the surgical procedures necessary during treatment and understand their purpose, which promotes hope and makes them calmer during the rehabilitation phases. Furthermore, the professionals' approach and communication with the child, the presence of a welcoming hospital environment, together with the inclusion of play during hospitalization, contribute to the child assigning a positive

meaning to hospitalization and treatment[21]. This reframing is supported by elements of the conceptual framework of the MIAMPE, which values the therapeutic presence of the professional as a figure who listens, welcomes, and shares meanings with the child[6].

From the SI perspective, it is noted that the individual actions of each child take on a symbolic character in the face of the meaning they attribute and are shaped by previous experiences[12]. During data collection, the children chose dolls that represented their family members, team professionals, or even spiritual objects, as important elements for well-being in rehabilitation. According to MIAMPE, the positive re-signification in the face of the experience of suffering, mediated by the relationship of mutual help between the child-family-health professionals triad, culminates in Hope as a vital force[6].

Support and care networks are essential to strengthen the child's well-being. The family changes its routine to remain as a source of support, and this change becomes meaningful for the child with an orofacial cleft, given the alteration in social relationships due to the need for rehabilitation care[3,22]. Thus, MIAMPE allows us an understanding that values the relationship of reciprocity and emotional support between the family caregiver, as the one who provides cares, and the child who receives care[6].

The Support Association constitutes, for the child with an orofacial cleft, a symbol of welcome and a social environment that, in addition to assisting with clinical treatment, also promotes mental health and interaction with other children who have the same condition. Similarly, a qualitative study identified that family members of children with orofacial clefts also consider institutions specialized in caring for these children as a support network because of the social, instrumental, and emotional support they find there[23].

The children in the study demonstrated that having friends who respect their appearance and feelings promotes Hope. Social support is essential for the construction of children's health and well-being through respect and companionship[24]. This meaning, of how other people act toward them, makes a difference in the child's life within the social environment, with creations developed through human activities being determinants of their interactive process[12].

During the therapeutic play session, the children considered spirituality to be an important symbol in promoting hope for treatment. Spirituality, in the context of health, is capable of generating confidence, optimism and belief in the improvement of the clinical condition[6]. This finding was also identified in a study with adolescents with orofacial clefts, who highlighted the importance of religiosity and spirituality in coping with the condition

during adolescence[3]. A study developed by researchers in the United States pointed to the need to integrate spirituality into pediatric care, especially in children who have chronic conditions[25].

In Brazil, different investigations have shown that young people and adolescents with orofacial cleft have high levels of spirituality and/or religiosity, whose benefits include psychological, emotional, social, spiritual and financial support, with a positive influence on self-esteem, healthy lifestyle habits and, consequently, better perception of quality of life[26-28].

The desire to improve aesthetic appearance, through the attitude of undergoing treatment, acts as a symbol of self-care for children with clefts, thus aligning with the premise of Symbolic Interactionism of being open to transformations[6]. Researchers in Romania identified that, after surgical procedures to correct orofacial clefts, children and their families were able to integrate more positively into society due to the reduction of the emotional burden caused by the cleft[29]. Consequently, this refers to the desire for change or overcoming, being a concrete manifestation of Hope by seeking to demonstrate autonomy, engagement, and reconstruction of the meaning of living[6].

Although there are many promoters of Hope, the child with an orofacial cleft also deals with threatening aspects, which may often be ambivalent, such as dissatisfaction with their own appearance due to functional and aesthetic alterations. Health-related quality of life is lower in children and adolescents with orofacial clefts, which is related to psychosocial challenges, self-esteem, and social interaction[20]. This process experienced by children involves interpreting the actions of their environment, since symbolic meanings are elaborated in different ways and influenced by the context in which they live[12]. Therefore, the meanings attributed to their cleft are not intrinsic only to the children but arise from interaction and interpretation with others.

Negative experiences during treatment, such as separation from parents and loneliness during treatment, cause hopelessness. A study conducted with children hospitalized in a pediatric intensive care unit revealed that caregivers are crucial figures for the children's safety, care, and protection in an unfamiliar environment such as the hospital. In this sense, children have this right, and health professionals must guarantee it[30].

Some children attributed to the family a meaning of absence of decision-making and participation, wishing that their caregivers would participate more actively in the rehabilitation process, which was a reason for the reduction of Hope. Although there are care

models that aim to include the family actively in the treatment of children, such as the family-centered care model, participation is often limited due to the attitude of professionals or even the commitment of the caregivers themselves[31]. When bonds are absent or weakened, the child feels helpless, reflecting on their ability to maintain Hope[6].

Corrective surgeries for orofacial clefts require postoperative care, especially movement restriction and the use of upper-limb restraint[32]. These aspects were considered threatening to Hope in the children in the study, corroborating the suffering due to the alteration of the child's usual routine[6].

Another highly prominent point in the results was psychological violence marked by bullying, which greatly affects children with orofacial clefts and consequently their Hope. A study carried out in a Brazilian hospital revealed that adolescents with orofacial clefts experience difficult moments related to bullying and prejudice, especially in the school environment[3].

A vigilant look at the different fields of practice, such as health, social assistance and education, is necessary. Children who experience bullying in their lives need emotional and informational support to deal with the situation and do not feel excluded[3]. Care should be a restorative practice that values affection, empathy and listening as means of rebuilding hope weakened by these experiences of physical and emotional pain[6]. The context experienced by the child with orofacial cleft, both in the way they understand society and in the way they deal with the cleft, are the result of the meanings obtained through their own social interaction, capable of generating hope or hopelessness.

The negative experiences of children with orofacial clefts may influence their self-perception and future expectations. Thus, care for children with orofacial clefts goes beyond physical demands, making it necessary to include continuous psychosocial support, especially in the school environment[33]. Furthermore, social stigma is not restricted to only one phase of rehabilitation for this population and, if supportive interventions are not implemented, may persist during adolescence and adulthood[5].

A limitation of the present study is the performance of only one DTP session with each child, which may have influenced the depth of the meanings attributed to Hope. Conducting more sessions could broaden the child's familiarity with the theme of Hope and with the DTP proposal. However, as the session was planned and the children actively participated, it was possible to obtain in-depth data that enabled understanding of the

meanings attributed to Hope. The use of therapeutic play allowed the children to feel comfortable during the sessions, playing and talking, which also facilitated data collection.

The study results contribute to strengthening the implementation of therapeutic play in the rehabilitation of children with orofacial clefts by employing it as a strategy that allows understanding of the meanings attributed to Hope, considering their singularities and the subjective aspects of care. In addition, identifying the aspects that promote and threaten Hope provides support for targeted interventions, integrating Hope into the rehabilitation process. For pediatric nursing and the other specialties within the team, the study broadens the understanding of Hope, which may facilitate the development of practices that contribute to the promotion of children's mental health.

FINAL CONSIDERATIONS

The study identified the meanings attributed to aspects that promote and threaten Hope in children with orofacial clefts, which were expressed through DTP. The promoters of Hope are influenced by the experience of treatment, the care provided by professionals, the playful strategies applied, the support of family and friends, and expressions of spirituality, which generate happiness, trust, acceptance, comfort, strength, and affection. While the threatening factors include dissatisfaction with appearance, limitations in treatment, surgical procedures, bullying, and prejudice, generating sadness, anxiety, and insecurity.

It is noted that the children have an understanding of Hope and recognize its importance in coping with the rehabilitation process. Therefore, it is essential that professionals address it in order to promote it, using playful resources, qualified listening, and inclusion of the family in the rehabilitation process. Finally, further research is recommended, that addresses Hope in children with orofacial clefts, across different age groups and phases of rehabilitation.

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