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ORIGINAL ARTICLE

FROM LONELINESS TO COOPERATION: COPING STRATEGIES OF INTENSIVE CARE NURSING WORKERS

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ABSTRACT
Objective: to know the coping strategies developed by intensive care unit nurse practioners to maintain mental health. Method: qualitative descriptive study, with nursing workers from three Intensive Care Centers in a southern state of Brazil. Data collected between June 2019 and July 2021 through semi-structured interviews and submitted to thematic content analysis. Results: individual coping strategies based on situations that generate suffering were unveiled. The loneliness of work was evidenced because of the mismatches between the therapeutic spaces offered by the institution and the demands of the workers. Finally, the possibility of re-signifying loneliness in cooperation through collective strategies was identified as a path to face suffering at work and as a protective factor of greater effectiveness. Conclusion: collective coping actions and activities that strengthen the union and cooperation of intensive care nursing teams can be promoted.

DESCRIPTORS: Nursing; Occupational Health; Nurse Practitioners; Intensive Care Units; Adaptation, Psychological.

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INTRODUCTION

The Intensive Care Unit (ICU) is a closed unit within the hospital, which is characterized by care for patients in critical condition, who require permanent and specialized assistance. This requires that nursing professionals keep up with technical and technological changes, so that they are always aware of the clinical picture of critically ill patients[1]. The care of these patients demands from nursing professionals an uninterrupted assistance and demands attention, dexterity, and agility in the execution of the assistance[2].

The complexity of the ICU nursing work highlights the interface between work and subjectivity. It is known that work activity has repercussions on the health and, sometimes, on the sickness process of individuals, stirring feelings of pleasure and suffering[3]. According to Psychodynamics of Work, a French school of thought founded by the psychiatrist Christophe Dejours, the experiences of pleasure are established before the symbolic rewards provided by work. The experiences of suffering, on the other hand, are the result of the contrast between the real work and the worker's expectations[4].

In the face of this issue, workers develop coping strategies, defined as mechanisms through which individuals try to minimize the suffering experiences. Individual strategies are established at the psychic level based on the unconscious urge to adapt, but without the potential to change reality. Collective strategies, on the other hand, are undertaken by the work collective and offer more possibilities to transform the organization of work[4-5].

Nursing professionals use different mechanisms to mitigate the impacts that suffering causes in their psychological system. The importance of coping strategies in nursing is strengthened by the fact that the way these workers face the adversities of the job may interfere with the care provided to patients and their families[6], especially in the ICU, where the clinical pictures are severe or potentially severe.

However, beyond this, it is important to emphasize that effectively coping with suffering is important for the mental health of the nursing worker himself. It is expected that the work in nursing is a device for the construction of identity and meaning for those who work. That it promotes satisfaction and health, and not suffering. Therefore, it is relevant to understand how work, health, and subjectivity intersect in nursing, especially in critical environments, such as ICUs.

Finally, the literature reinforces the need for research to be conducted to investigate the coping strategies employed by health professionals in their daily work, including nursing professionals[6-7]. In this sense, this study aims to know the coping strategies developed by ICU nursing workers for the maintenance of their mental health.

METHOD

This is a descriptive qualitative study whose findings emerge from a multicenter matrix study. The research scenarios were ICUs of two philanthropic hospitals and a public university hospital, all large and reference hospitals for their macro regions in Rio Grande do Sul, Brazil.

The participants were nursing professionals (nurses and nursing technicians) of these institutions. The eligibility criteria for this research were: to be a nursing worker in the permanent staff of the ICUs and to have been working in the unit for at least six months, time considered for adaptation of the worker. Employees who were away from work or on vacation during the period in which data were collected in each institution were excluded.

The eligible population consisted of 332 nursing professionals. In all, 12 workers participated in the study. The participants were selected through a simple random drawing based on the lists of employees made available by the institutions. The population was not stratified at the time of the draw, because the objective was to know the object of study from the perspective of the individual who practiced nursing in ICUs. As five participants refused to participate in the study, a new draw was carried out, a procedure that was done in these cases.

When drawn, the professional was approached at his workplace by the research team or via application through message exchange, at which time the invitation was made. During data collection, after the interview with the twelfth worker, the theoretical saturation of data was verified, which marked the end of the field stage.

Data collection occurred through individual semi-structured interviews between the months of June 2019 and July 2021. During this period, there was the advent of the Covid-19 pandemic, caused by Sars-CoV-2. There was a suspension of student and researcher traffic on the hospital premises, which paralyzed the field stage for a few months.

Before the pandemic, 10 interviews had taken place in person, at the institutions, in comfortable, safe, and private places for the interviewees and researchers. During the pandemic, it was necessary to conduct the last two interviews online through the Google Meet platform, which allows dialogue between people with simultaneous image and video exchange.

The face-to-face interviews were conducted by three previously trained final year Nursing students. Online interviews were conducted by the project coordinator. After recording socio-occupational data (gender, age, education, unit of assignment, and time working in the sector), interviews were conducted based on a semi-structured script that investigated the workers' perceptions of their work, life, health, and the relationships among these aspects, seeking to understand their coping strategies.

The interviews lasted an average of 30 minutes. They were audio recorded, with the consent of the participants, and transcribed in full. The data were submitted to thematic content analysis, which is developed in three phases: pre-analysis; material exploration; and data treatment and interpretation[8].

First, an exhaustive reading was performed for content appropriation, enabling the selection of pertinent statements to answer the study's objective. Then, a color technique was used to decompose the material into units of meaning. These were organized and grouped according to semantic affinities, giving rise to two analytical categories. The interface of the data with the literature allowed conclusions that answered the study's objective.

The participants in this study were identified with the letter "W" (which begins the word "worker"), followed by a numeral corresponding to the order of the interviews and the unit from which the participant came. The project was approved by the Research Ethics Committee under Certificate of Submission for Ethical Appreciation with opinion number 3,346,134.

RESULTS

Regarding socio-occupational characteristics, of the 12 participants, one was male. Age ranged from 28 to 59 years, and the mean age was 38 years. Eight participants worked in the Adult ICU, three in the Neonatal ICU and one worked in more than one unit (Adult and Cardiology). Regarding education, eight were nursing technicians and four were nurses, and all had a post-graduation in Intensive Care. The time of work in the current sector

varied from nine months to 28 years, and the average was 6.37 years.

Next, the analytical categories that emerged from the content analysis will be presented: Loneliness at work: use of individual coping strategies by ICU nursing workers and From loneliness to cooperation: collective strategies as a way to cope with suffering at work.

Loneliness at work: use of individual coping strategies by ICU nursing workers

The data from the first analytical category suggest the use of individual coping strategies at work. The individual strategies were densely referred to by the participants and point to the individual coping with suffering. Among the strategies, the following stood out: subordination; self-charging; attempt to separate professional and personal life; acceptance; trivialization; detachment; self-control; resilience. Chart 1 presents statements that illustrate the use of these strategies:

Chart 1 - Individual coping strategies used by nursing workers in Intensive Care Units. Palmeira das Missões, RS, Brazil, 2021

Individual coping strategies	**Statements**
Subordination	[...] I know all the doctors and all the physicians, so you already know each one's way. [...] You know who you must please more. "Oh, let's do that today, doctor? Shall we go for a cup of coffee? Sometimes I didn't know how to treat people, and I was learning, unfortunately, by force. Or I was kicked. (W1, Adult ICU)
Self-charging	[...] hospital is that thing, you have a schedule to enter, and you can never leave exactly on time. If your patient is sick, you will not abandon everything and leave just because it is your time [to leave]. [I'll stay there until the time he is stabilized. (W2, Adult ICU)
Attempt to separate professional and personal life	When I take vacations, I leave the groups so as not to have contact with anything in the hospital. [...] We try to leave what is out there, out there, what is in here, in here, but we don't always succeed. (W10, Adult ICU)
Acceptance	We must be prepared for calm days and more stressful days. Two, three stops, because it is an ICU, it is not a spa, we are not in a hotel. (W5, Adult ICU) [With time you understand why he died. It is better than if he had stayed. (W8, Neo ICU)
Banalization	In the beginning I felt a lot, I cried... [...] Then you get used to it [...] almost every day you massage, the patient dies, you must do all those procedures and you get used to it. (W2, Adult ICU)
Detachment	[I try not to know too much about the patient's life history. [...] Sometimes we admit children, 11, 12 years old, it is very sad. (W1, Adult ICU) I think I became colder to deal with family [...] (W5, Adult ICU)

Self-control	[...] There are people who take medication to sleep, take medication to stay calm. No, I will not take it, because the moment you start taking it, you will take it all your life. [So, I prefer to try to control myself mentally [...] (W1, Adult ICU) I was very whiny. Today I learned to control feelings. (W4, Adult ICU)
Resilience	One can go through the challenges and make the best of them. Be much more resilient. To see a lot of things and not get upset [...]. (W10, Adult ICU)

The statements that illustrate Chart 1 show that there is work-related psychological suffering faced by a significant number of professionals through individual mechanisms. Added to this, there is a lack of spaces for talking, listening, and psycho-emotional care. ICU nursing workers experience genuine loneliness, which increases their suffering and weakens their mental health:

[...] we keep, we keep, and we get sick. Sometimes in our hurry we leave with many things here [...]. (W10, Adult ICU)

I am a person who likes to keep and not to talk, so I keep.... saving... and there comes a time when it explodes [...] I get home always at bath time, I cry [...]. (W11, Neo ICU)

Going along with these gaps found, one comes across reports of interviewees who feel psychologically helpless by their work institution:

[...] There is psychological accompaniment, but they don't listen to you. They do dynamics and don't listen to what you have to say. They don't give you space. (W4, Adult ICU)

Recently the psychologist came, and I even said: "Well, we could talk to the psychologist! But there is no way. [...] It is that thing... it is in a group, there is not that thing of being individual. (W11, Neo ICU)

Therefore, the data make it possible to infer that there are experiences of suffering at work, against which nurse practitioners often undertake individual coping strategies for the maintenance of their mental health. However, loneliness at work was expressed in the statements, aggravated by the absence of spaces for talking and listening.

From loneliness to cooperation: collective strategies to cope with suffering at work

The second analytical category reveals the use of collective coping strategies at work, that is, strategies developed by the group for the collective well-being. Although individual strategies are usual in the investigated scenarios, the statements showed that there are some initiatives, led by the participants, which seek in the collective more concrete mechanisms of transformation of suffering. One of these strategies is expressed by the management and organization of routines and the work process:

[...] we launch every day a different schedule so that the girls don't stay with the same patients the whole week. Because sometimes there are patients who demand more from them. [...] (W1, Adult ICU)

I've had employees with children with cancer, that I had to hold back, sit down and talk, then I had to manage beds. A patient with the same characteristics of the person's daughter came, I won't let her, then we had to manage. I've had employees' children here; I've had an employee's father who died here. [...] (W5, Adult ICU)

The handling of conflicts and interpersonal relationships was also identified in the study as being part of the collective coping strategies, being effective in coping with the stressful elements of daily work life:

I already know how to deal with the "Tantrum" doctor, with the team not to mention. I think that we grow in maturity, we realize that some things do not need to be taken to the front, then we also learn to deal with gossip among colleagues and nursing technicians. I think that we must remain very neutral in the conversations there, in the gossip, so as not to deviate our sense of justice. (W5, Adult ICU)

[when we have a problem with the team, we call the whole team, try to see their opinion too. We don't always succeed; it is not always possible to do this. [Sometimes there is resistance, but we try to solve the problem as a team, me, and my colleague (W10, Adult ICU)

Collective actions aimed at improving the team's work were also interpreted as being collective coping strategies, because based on these actions, bonds were strengthened and, consequently, the climate in the work environment was optimized:

If there is an interruption, we receive a lot of help, the team is very united, you will rarely be alone. [...] I sat at the computer and a colleague came and asked: "what do you need?", then I said: "I need to finish evolving and I need to close my [water] balances", and she: "give me a folder that I will help you! This is how it proceeds, one helps the other, so you will never be alone, there is always help. (W2, Adult ICU)

We try to work in the best way possible. On calm days, we always organize ourselves and have a snack, a cup of coffee. Each one brings something to make the day more pleasant. When someone has a birthday, we do something [...] (W3, Neo ICU)

At the end of this analytical category, it is possible to observe that, although loneliness and individual coping occur in many circumstances, there are initiatives on the part of nurse practitioners who seek to find in the collective means of coping with adversity. These initiatives can represent a counterpoint to loneliness and signal more effective ways of defense against suffering.

DISCUSSION

The first analytical category points to the individual coping strategies employed by ICUs nurse practitioners. Firstly, subordination was evidenced as a posture used to avoid confrontations with other members of the multidisciplinary team, especially after experiences in which professionals suffered retaliation. An Australian study showed that negative interpersonal behaviors, such as bullying in the workplace, are recurrent in the context of nurse practitioners. Tolerating and normalizing these behaviors reinforces their acceptance, as if they were inherent elements of power relations in the workplace[9].

Self-charging also stood out as a behavior used by professionals when facing work demands and requirements. Self-charging imposes on the worker the need to constantly adapt to the work environment[10], and it can be harmful to the quality of life when it is excessive[11] and, in these cases, it will not benefit the professional, the work, and the institution.

The workers also emphasized the attempt to keep the situations experienced at work away from the family routine. There is a certain caution on the part of hospital nursing workers in not sharing stressful work experiences with their families, which expresses an attempt to protect them and to keep their thoughts away from what is experienced inside the sector[3]. A similar result was found in a study with nurse practitioners from pediatric inpatient units[6].

In this sense, it is important to rescue the Psychodynamics of Work. It is considered that the subjectivity of the individual is the result of different stimuli present in his life, including work and life in society. Therefore, the split of the psyche based on work life and private life is a utopian rupture because there are no mechanisms that make this possible[5].

The acceptance and trivialization of stressful elements at work were also evidenced in this study. It is perceived that nurse practitioners tend to deny the feelings of unpleasure aroused by the particularities that involve the work environment and the performance of care[12].

This agrees with the findings of a research carried out with African nurse practitioners, in whom the experiences of suffering were accepted and understood as elements inherent to their work[13]. In another study, nurse practitioners understood that acceptance contributed to reduce emotional tension about situations that, from their perspective, were unchangeable[14].

The professionals also emphasized the emotional distancing in relation to patients and their families because they believed that the tightening of ties potentiates suffering in the face of death. However, the professionals themselves admitted that this strategy resulted in the provision of impersonal care. In this sense, it is known that emotional stress can compromise the self-control of emotions of the nursing professional, making his personality cold[15].

A study conducted with pediatric emergency nurse practitioners showed that they felt the need for emotional and affective distancing in relation to patients and family members to escape from situations of suffering[3]. Another study, conducted with Iranian nurses, revealed that escape from situations of suffering was a frequently used coping strategy. However, this strategy often impairs the quality-of-care provided[16].

The last individual coping strategy evidenced was resilience, considered an important strategy to mitigate emotional exhaustion[17]. Providing resilience in nursing is a necessity. Promoting a resilient nursing workforce can positively impact not only the mental health of workers, but also the quality-of-care provided[18].

Despite all the individual strategies undertaken by ICU nursing workers, there is suffering and loneliness at work. According to the Psychodynamics of Work, individual coping strategies, since they are the result of individuals' adaptive psychic movements, are restricted to "anesthetizing" the suffering experiences, however, without transforming them[4]. Research conducted with nurse practitioners showed that coping strategies more oriented toward the management of situations that caused suffering were associated with greater psychological well-being when compared to avoidance strategies (in other words, those based on escape and avoidance)[19].

The predominant undertaking of individual strategies due to the absence or inefficiency of speaking and listening spaces leads nursing professionals to feelings of loneliness. The absence of organizational support makes workers feel the negative impact of the emotional demands of their profession[13]. Spaces for listening to suffering are lacking, and the institution cannot adequately meet the workers' demands.

It is necessary to establish programs within the healthcare institution that welcome the worker and provide social support, aiming at the development of healthy coping strategies. Actions that value the bond and/or affection can be the foundation for resilience to be worked on in people[20].

This leads to the second analytical category in which these bonds and affections stood out precisely as subsidies for the professionals to finally elaborate their collective coping strategies, that is, those capable of modulating the organization of work and transforming the experiences of suffering, or even transcending loneliness and reaching cooperation. Collective strategies require group consensus and depend on conditions that are external

to the individua[l5]. These strategies are a form of group resistance to the experiences of suffering and contribute to the cohesion of the work collective[4].

The organization of routines and the work process is one of these examples, showing that care management considers, among many factors, group protection. The collective space is made by the cooperation and belonging of its members, manifestations of mutual trust and recognition[21].

The management and handling of conflicts also proved to be an important strategy. Strengthening collective strategies requires well-consolidated interpersonal relationships[22]. Managing relationships both with superiors and among peers is an integral part of the support system for health workers[13].

The bonds of friendship and collaboration are also considered an important coping strategy, which is in line with the results of other studies[3,6]. In spaces for discussion and reflection on work, it is possible to establish sharing and cooperation, which leads to a different way of coping and transforming the organization of work. That is, by sharing daily situations, the collective can build defense strategies against suffering at work[21].

We agree that coping strategies are important for the maintenance of mental health at work in the context of intensive care nursing. At the management level, they can be enhanced by improving the social and psychological support system for the workers[23]. Furthermore, at the management level, spaces for meeting, dialogue and exchange among nurse practitioners can be promoted. As an example, team meetings in which the sharing of perceptions and experiences also have room for socialization, and in which individuals have room to speak and listen. The strengthening of these devices can help maximize collective strategies and, consequently, transform loneliness into cooperation.

This study has limitations related primarily to the field stage intercepted by the Covid-19 pandemic. The discontinuity of data collection was a result of the relocation of many professionals to the units dedicated to Covid care. In addition, the impossibility of finalizing the interviews in person added to the difficulties of access to the critical units may have limited the interviews not only in number, but also in depth. However, the empirical material obtained in the 12 interviews allowed the theoretical saturation of data and, therefore, the achievement of the study's objective.

CONCLUSION

The nursing workers used coping strategies in their daily work. In greater intensity, the individual ones, capable of momentarily relieving stress and suffering, but without the potential to transform the factors that generate them. Collective strategies, however, may be more effective for organizing the work process and strengthening the group, actions that they needed to undertake among themselves due to the inefficiency of therapeutic spaces inside and outside the workplace.

At the institutional level, the results of this study can help the management, nursing managers, and workers of the service to idealize and promote collective actions of confrontation and activities that strengthen the union of the multi-professional team through continuing education. The socialization of these data can help the service to create spaces where there is health promotion in the work environment, and where the individual and collective expression of problems and thoughts is valued, consolidating the bond between management, supervisors, and workers, so that they feel supported in times of weakness and, from this, new forms of individual and collective coping can be built, making the worker the protagonist of the construction of their personal well-being.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - Silva Oliveira E da, Centenaro APFC, Flores CML, Franco GP; Drafting the work or revising it critically for important intellectual content - Silva Oliveira E da, Centenaro APFC, Glowacki J; Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - Silva Oliveira E da, Centenaro APFC. All authors approved the final version of the text.

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