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Challenges and confrontations in care by nurses: a study of social representations

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ABSTRACT

Aim: to analyze the challenges faced by nurses in caring for individuals with HIV/AIDS, and their means of confrontation seen in the social representation of nurses regarding their own vulnerability and empowerment. **Method:** thirty nurses from a public hospital were approached through a semi-structured interview. Later, there was an instrumentalized content analysis using NVivo 9.0 software based on a theoretical-methodological approach according to the Social Representations Theory. **Results:** the challenges are seen in the affective, imagery and cognitive dimensions of representation, while the means of confrontation are especially connected to the practical dimension. **Discussion:** vulnerability is confronted by the intersection between political-institutional and humane-affective factors, while empowerment is placed as a fluid process of reframing the performed role. **Conclusion:** there is an urgency to develop programmed tasks aimed at the health of nursing professionals who work with patients with HIV/AIDS.

Descriptors: Health Vulnerability; Nurses; Nursing Care; Acquired Immunodeficiency Syndrome; HIV.

INTRODUCTION

In this study, we assume that "vulnerability of the nursing professional" is a dynamic and mutable state of fragility, or typically a human inability generated by many factors and situations intrinsic and extrinsic to the professional. This state creates demands of confrontation strategies, leading to the empowerment needed to face the experience of the procedural intercourse between illness and carehealth. The threats found put at stake the continuity of the existence, the present or possible quality of life, as well as the social thread in which the professional is located, and take into consideration his personal characteristics, the witnessed stage of the illness, the configuration in which care is performed, both reconstructed psychosocially and by the sociocultural context, which surrounds the professional[1-2].

As a type of vulnerability seen in the routine of nursing there is one phenomenon that is relevant to nursing science[3]: the psychosocial understanding of behavior, values, attitudes, practices and images that compose the apprehension from nurses about the concept and of state of vulnerability and empowerment in the day-by-day care of patients with the Acquired Immunodeficiency Syndrome (AIDS)[1,2].

Changes in the nurses' workplace include many forces that move towards or against the plenitude to care, and the caregiver's health. Despite the efforts of nurses to succeed in the tasks performed, there are countless barriers between one and the other that can weaken professionals in their multiple domains[4].

The object of this study was limited to the challenges of care, and the means of confrontation seen in the social representations of vulnerability and empowerment of nurses who care for HIV seropositive patients. This research aims to analyze the challenges in the practices of the nursing care of patients with HIV/AIDS, and the means of confrontation present in social representations produced by nurses regarding their own vulnerability and empowerment. This study is justified by the proximal characteristic of nursing care, which permits the sharing of positive and negative aspects originated from the hospitalization process as seen by the authors of this study.

In addition to the lack of scientific evidence on the topic, as seen in a previous study[1], the analysis of the psychosocial reconstruction of vulnerability produced by nurses, under the auspices of AIDS, has scientific relevance, especially as it puts in evidence the code that guides the adoption – or the non-adoption – of protective measures.

METHOD

The theoretical and methodological approach used was the Social Representations Theory, under its procedural line, developed under the perspective of Social Psychology. The studied population was composed of 30 nurses working in a municipal hospital in the city of Rio de Janeiro – an institution specializing in the treatment of patients with HIV and tuberculosis. The decision for this number rests with the existing consensus within the Social Representations Theory that this is the minimum quantity needed to acquire social representation in a group[1,2]. The population comprised both male and female professionals, with no age limit, with six months or more professional activity in the chosen scenario. This last item was included due to the fact that time is a determining configuration in the elaboration of social representations. Subjects who refused to participate in the study were excluded. No other attribute was used as a justified criterion for exclusion.

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The chosen techniques to collect data were the social-demographic questionnaire (to characterize the subjects) and the deep semi-structured interview. The technique selected to treat the collected data was Thematic Content Analysis, after systematization and operationalization, using QSR NVivo software, version 9. It works with a free computerized code, followed by the distribution and storage of textual clippings in a nuclei of categorical sense[2]. The data was collected between October and December 2010.

Ethical principles, for research with individuals, were adopted and followed according to rules established by Resolution 466/2012 of the Brazilian Ministry of Health. The approval protocol, issued by the Committee of Ethics in Research of the Rio de Janeiro Municipal Health Department (CEP SMS-RJ, in Portuguese), was registered under number #200/08.

RESULTS

The subjects are mainly female (87%), between 41 and 45 years old (27%), Roman Catholic (40%), living with a partner (70%), specialists (*lato sensu* graduate) (90%), with 16 years or more working as a nurse (37%), with 16 years or more working with HIV bearers (30%), working in healthcare roles at the time of data collection (63%) and with access to scientific information (77%).

The instrumental analysis done by NVivo 9 resulted in 107 registry units (RU), distributed in 10 meaning units, and represented 6.3% of the analyzed corpus.

The organization of categories was based on the reconstruction of the subjects' social thinking regarding their own vulnerability and empowerment. With a didactical purpose, two axes of discussion were generated; one, about the challenges; the other, about the means of confrontation created by the subjects, despite the fact that between them they have strong relationships[1]. Therefore, based on the capacity that empowerment has in clarifying certain aspects of vulnerability, and vice-versa, both are described in the results of this study as psychosocial phenomena[1,2] that mutually design each other.

Axis 1 – *The social representations of vulnerability: The pending challenges in nursing care to people with HIV/AIDS.*

In this discussion axis, the contents are discussed by the group who nurse patients with AIDS regarding their vulnerability, especially regarding challenges faced by professionals during *their day-to-day work*.

Some of the subjects explain the reasons why they work with HIV/AIDS, and explain that it was not an option:

> I work here because I passed in the public contest, not as an option. If it was given me an option, I wouldn't have chosen this hospital, but I didn't know where to go or what to do. (E11)

It was observed that the practice of caring for HIV seropositive patients is not necessarily a deliberate choice. It can stem from a series of factors, including a random placement after the public contest, as well as the undetermined specialty of the job description *a priori* the contest was designed, and the necessity for personnel in the area.

The subjects described their first contact with a seropositive patient as a turbulent moment, during which they found it difficult to deal with the suffering, and the loss experienced by patients and their relatives.

> When I started to work here I used to see patients leaving… Because, the question of death was always a hard issue for me to deal with. And it is still complicated, until today! So, when I knew a patient was dying, leaving, I couldn't stand that situation. I used to suffer so much! For me, it is really difficult to deal with death, with the loss. (E10)

> I used to take care of the ill, and when they died, I used to suffer a lot. Death isn't beautiful at any time. They died over quite scary characteristics. (E12)

> I was very sorry. Once I arrived at the IPD [infectious and parasitic diseases] ward, which was a section with only two beds. There was a critically ill patient and the family was there. When I saw it was a critical situation, and that there was no hope, I left to the restroom in the ward and started to cry. I couldn't stop crying. (E13)

> In my opinion, it is scary. I know the end of the story. I see the death, the dead body and the end of a story. That's why I am afraid of it, you know? (E15)

The discursive excerpts mentioned above show the presence of a strong affective dimension on the social representations of the nurses. The imminent death of a patient generates a frightening scenario that places nurses in a higher sensation of vulnerability. The fear that comes from the possibility of having meaningful losses, or from witnessing the end of a life story of a certain individual, seems to psychologically awaken the nurses.

From the descriptions of the nurses, death is not an abrupt and isolated situation. It is a procedural challenge nurses actively experience, despite the suffering it generates in them. "Feeling sorry, crying", "being afraid", "being unable to stand the situation" are terminologies used by the nurses to express their vulnerability, which emerges from the certainty that loss and anticipated mourning is concrete.

In addition, there is the recognition of the physical signs that demonstrate the imminence of death. When verbalizing that "they see patients leaving", or that "the patients die with specific characteristics", the subjects unfold the existence of an imaginary dimension of representation strongly attached to the patients' physical modifications, due to the development of AIDS.

Consistent to the excerpts described above, there is another challenge present in the affective dimension of the representation of vulnerability: the feeling of powerlessness due to the inevitable death of the patients. It is believed that the challenges faced by nurses in their way of dealing with death is linked especially to their inability to solve it.

The difficulty in handling the death does not seem to be an individual phenomenon, but something that is present in daily interactions, and this study group reframes it.

The vulnerability created by nurses who care for those with HIV/AIDS also seems to be linked to the demands presented by the seropositive patient, the high level of responsibility in the function, the constant workload, excessive working hours, physical and mental exhaustion, and professional inflexibility prescribed by established routines.

> Patients with AIDS are very, very complex. (E1)

> It is hard to be a nurse in a reference hospital. One of these days, a colleague

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> of mine said: "The hospital is a worldwide reference in the treatment of AIDS and tuberculosis". This is heavy! It is a lot of responsibility! (E3)

> [...] get stuck in a routine is demotivating. I see some colleagues saturated with work. [...] it is a lot of work for us. I cannot say if it is because of the pathology, or if it is because of the excessive number of caring procedures required. It can be both of them. [...] I see that the group is somewhat saturated, a little hopeless, demotivated. (E6)

> We work too hard. We arrive at seven in the morning, and we continue until seven in the evening. It's a lot of work! (E7)

> There are moments I'm exhausted and pissed off. (E29)

Some challenges were linked to the cognitive dimensions of the social representation of vulnerability, for example, the high demands of caring for a seropositive patient. From the nurses' perspective, caring for people with HIV/AIDS demands permanent intensive care and continuous vigilance of their complex biological and psychosocial needs. To better support this section of the population, Specialized Healthcare Services (SHS) (one of which is the subject of this study), were introduced by government initiatives. This is placed as a participating element into the representative content of the subjects, who, on their part, self-determine a heavy load of technical responsibility by working in an institution with such characteristics.

Despite the nurses in this study working in a highly specialized hospital, the professionals affirm they feel demotivated by institutional routines to the point where management of their own tasks is reduced. In summary, it is seen that there is a work overload, excessive working hours and moments of exhaustion that place the nurses in a higher condition of fragility. Terminologies, such as "being bored", "being saturated", and that "work is hard" support this conclusion.

The affective and cognitive aspects mentioned previously are seen in the challenges present in the social representations of vulnerability of the nurses in this research.

Axis 2 – *Social representations of empowerment: Strategies of nurses to confront the daily challenges in care of people with HIV/AIDS.*

This axis describes strategies that the nurses use to deal with the physical and psychological difficulties of their roles. In their explanations about the representations of empowerment, nurses reported they established alternative ways to minimize or deconstruct their weaknesses.

> [...] in the beginning, I wanted to do [the proceedings] as fast as possible, to get over with them, so I could get away from that situation, which I saw as risky for me [...]. (E15)

> I hope that some of my colleagues forgive me for saying this, but many hide themselves during visiting hours because it is an annoying moment. (E3)

> [...] I prefer working in other wards, away from these patients. (E8)

> [...] in a certain way we end up not getting into the humanitarian aspects. We take care of the person, treating the patient well and all that. But we need keep a distance from the patient. At least, that's how I think [...]. (E16)

> We try to keep a little away, because of fear, because of prejudice. (E1)

> There are things I don't want to understand or to know where they come from. This is because I don't want to have any prejudice against them. Some questions related to the origins of the illness are closely connected to prejudice. (E4)

The nurses demonstrate the dimensions that are mainly practices of the representation of empowerment. As previously emphasized, vulnerability and empowerment – both objects of representation – have a close and highly complicated relationship. It was detected as a risk factor, an element present in the representation of vulnerability. However, in association, it emerges as a practical dimension of empowerment, illustrated by quickly performing the necessary actions.

The symbolical constructs of nurses who work with HIV/AIDS, in minimizing vulnerability, can be seen when they hide during visiting hours, become less involved, or distance themselves from the seropositive patient. This data relates to behavior adopted by the subjects of this study, who aim to protect themselves, but that end up threating the performance of caring practices, once this affective distancing from the patient and the intentional mismatch with relatives are actions that harm the empathy among the subjects involved and collective construction of care.

One of the subjects clearly declared his preference to work in other areas. The terminology "away from these patients" connotes a certain level of prejudice and rejection, which possibly comes from a negative attitude towards working with patients with AIDS.

It is recognized that the subjects justify the action of moving away from patients due to fear – a challenge strongly linked to the representational set of vulnerability – and by feelings of prejudice. In addition, confronting fragility can be translated as not wishing to understand certain aspects of the patient's infection history, in order not to have a hostile position. Based on empirical data, it is important to remember that prejudice has two distinct sides; one works as a justification for isolation, and the other is connected to the discomfort generated by the sensation of being biased.

Despite worries about the presence of prejudice in their actions, some testimonies highlight the infrequent presence of aggression in the nurses' relationship with patients.

> [...] my colleagues are sometimes very stressed and react with rudeness. I've seen that sometimes happening [...]. (E6)

> [...] I've seen that some colleagues… Not all of them, you know? Some are really aggressive. No tolerance. (E13)

> Many [colleagues] used to say: "I can't stand that patient. What a boring person!" And demonstrated that by saying to the person: "I've changed your diapers so many times and you don't stop evacuating, ringing the bell. I know that I have to change you. You have to wait!" There were cases I received complaints from patients when I was supervisor. (E29)

Therefore, there are moments of interaction with a seropositive patient when a nurse's expressions of vulnerability can *display* a more aggressive posture. This vulnerability can originate from certain incidents of violence, stress,

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frustration or anguish experienced by the nurses[1], especially when dealing with AIDS, as it can demand an incisive response from professionals, thus increasing the chance of the reactions described above.

It is important to mention that aggressiveness is, at the same time, placed by subjects as something generated in the mental suffering of the nurses, and it comes from the practice of the other, which means it is external to the professionals. This situation signals a possible zone of symbols in which a strong negative attitude of representation is present, because the subjects can deny aggression during interaction with the seropositive patient, despite the fact they recognize its existence, the possibility of such a situation, when observing the care provided by certain colleagues.

In the two of the excerpts mentioned above intolerance clearly appears and takes turns with other elements, such as aggressiveness. It is evident such episodes can occur during incidents of diarrhea or patients' noisy solicitation of professionals. In this case, according to the subjects, there is evidence that the repetition of certain expressions, linked to patients' fragility, can increase the nurses' feelings of vulnerability and who are searching for means to clearly verbalize their dissatisfaction. The affirmation below demonstrates this statement.

> There are times I feel like screaming, because we are also humans! Behind the professional there is a person, in bone and flesh. Much more flesh than bones. We have to be really, really patient! (E29)

Based on the objectification of human vulnerability present in the terminology "person in bone and flesh", nurses may try to find a higher level of empowerment through an impulse to demonstrate what they feel or think, despite the fact this impulse is located in the area of the desire, thus not being able to become concrete. There is also the observation of a possible strengthening practice, once this suffering reaches limiting levels in the nurses' psychosocial constructions.

In addition, nurses demonstrate escape mechanisms that they (or other colleagues) develop to confront the hostile reality of working with HIV/AIDS. To overcome unpleasant situations, for example, some subjects declared they delegate certain tasks they do not want to perform to other professionals – due to a high degree of involvement, empathic competence, and professional safety – or in other words, tasks that would cost them the comfort established by the perception of empowerment.

> It is easier to send a technician, because the guy [patient] is really annoying. He is picking on you! So you send the technician there, in your place. (E10)

> We ask them to come another time, on the next day, to talk directly with the physician. We can spot some doubts at the testimonies from the client. If we say something, the client may get it distorted. Then, it's better for a physician to say something. This way, we don't have any risk. (E24)

The exclusion of certain tasks seem to present, from the perspective of the nurse, an effective way to expose another professional, rather than the nurse himself, such as in situations of interaction during difficult moments, or in tasks related to education in health, all that in order to self-preserve from certain feelings. Delegating tasks means removing the responsibility for informing the diagnosis or removing doubts**,**

which are proceedings some professionals do not feel prepared to perform.

Giving the patient a different configuration, using humor or informality, is also seen in the discourse of one of the subjects.

> There is no time to play, to relax. We even joke a lot, but we always do it working. (E7)

To play represents an attempt to reduce the hostile nature of the working environment, giving it more positivity, joy and irreverence, alongside the countless tasks and seriousness of work. This practical dimension of the representation, despite demanding a high level of rapport among the members of the nursing team, needs to coexist with the high workloads and the non-stop characteristic of healthcare.

Yet, about the configuration of empowerment that is linked to the representation of the subjects**,** the role is shown as a challenge to be confronted, with goodwill, determination and acceptance of the risk.

> We have to deal with the risks of the profession. I take them all. All health professionals that deal with infectious illnesses take that risk. (E2)

> [...] So, I think we need to welcome the patient, receive him, and make him feel important, so he knows we are there to help him because we decided to. Not because we are obliged to. No! It is not our obligation to take care of a patient! We do it by choice. Then, we have to do it, and do it right. We have to do our best! (E17)

> [...] I think that the life experience can make each one of us surpass our fears and to take our work as a challenge. (E25)

"Accept the risks", **"**give your best" and "surpass the fear" are terminologies that mean, inside the representational background of the nurses, ways to simultaneously grade the assistance provided, deal with the hostility of the task performed, and enhance their knowledge/making capabilities. Acceptance refers to the recognition of the inevitable risks involved in healthcare. Confrontation in the representation of empowerment includes getting the best out of the professional, dedication, acquiring positive experiences from the challenges faced by working as a nurse in a infectious disease ward, and remain working with AIDS. This fact is especially important because this work is a choice, contradicting the previous subject who affirmed he was not working there out of choice. This last piece of information shows a possible internal divergence to nurses' representation.

DISCUSSION

As a terminology, vulnerability is a word largely used in the scientific and empirical analysis of situations experienced in our society, and it has an unobserved frequent polysemy at first glance. Hence, it is a phenomenon seen within human life. A concrete example is the inherent vulnerability of the process of hospitalization experienced by patients, so frequent in hospital routines, which influences the vulnerability of nurses who work with these patients, and vice-versa[1,2].

Nursing care in hospitals can generate situations of vulnerability, such as the deterioration of the physical and mental health of professionals, negative labor consequences about quality of service, a tendency to quit the institution and/

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or a large number of absences, and dissatisfaction with the care service provided[4].

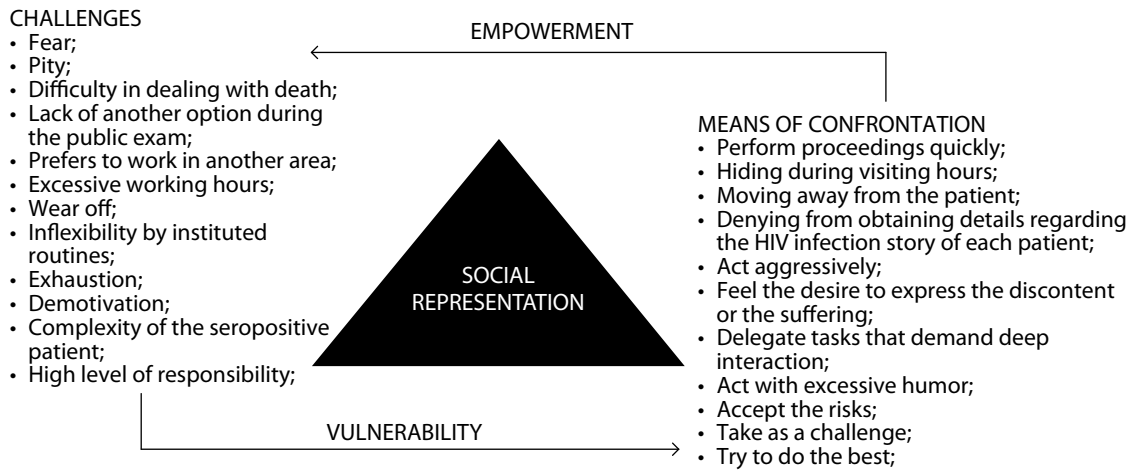
Stress, weariness, anguish and anxiety are expressive, influencing the service provided by nursing professionals. To minimize or overcome such situations of vulnerability, and to migrate to a context that permits the representation of empowerment, the nurses mobilize internal and external forces.

The subjects of this study demonstrated they tried to work in different areas, while they could have actually abandoned their positions at the beginning. However, the lack of options highlighted by some nurses can be grounded in a fear of unemployment and/or a lack of labor stability, despite the unfavorable conditions they face.

It is possible to infer that routine of nurses who work with HIV/AIDS matches their profession's high level of responsibility. Demands presented by patients during intense suffering, physical and mental exhaustion, excessive working hours, routines that can impede their professional freedom, the imminence of death on a daily basis, and many other elements may also influence the nurses' roles. As a whole, these elements are the current challenges seen in the representational sets of the nurses in this study regarding their vulnerability. On the other hand, the means of confrontation included in the social representations of their empowerment are: the quick execution of proceedings, hiding during visiting hours, keeping a distance from the patient, not wishing to understand the history of the HIV infection, acting aggressively, delegating bed-based patient tasks that demand a deep intersubjectivity**,** expressing discontent with caring, acting irreverently with the team, accepting the risks in nursing, getting the best out of the professional, and accepting the challenges in nursing patients with HIV/AIDS.

If in the first six means of confrontation it seems to have a mischaracterization of care – due to its ethic, aesthetic and philosophical postulates, on others nurses they seem to find managerial and creative resources to overcome obstacles and continue with life and work. This can occur through the development of capacities to live, trying to keep and preserve

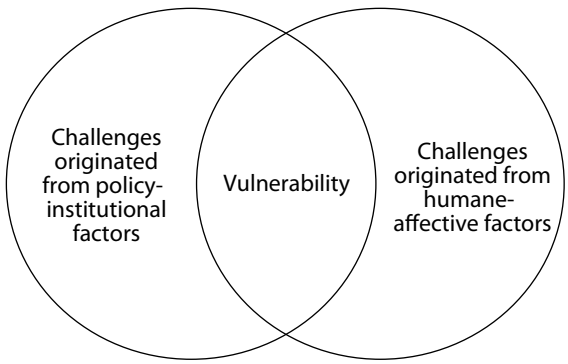
Image 1 – Diagrammatic sketch of the challenges and the means of confrontation of nurses. Rio de Janeiro, Brazil, 2014



the means against weariness, weakening or depletion. Under this perception of the empirical data, there is an analytic matrix based on the duality of vulnerability-empowerment from a previous study[1].

If on one side, the challenges experienced by nurses are, in their social representations, constituted by affective, cognitive and imagery dimensions, the means of confrontation are mostly built upon practical dimensions. Therefore, vulnerability represented by the nurses is configured by the intersection between policy--institutional and human-affective challenges (Image 2).

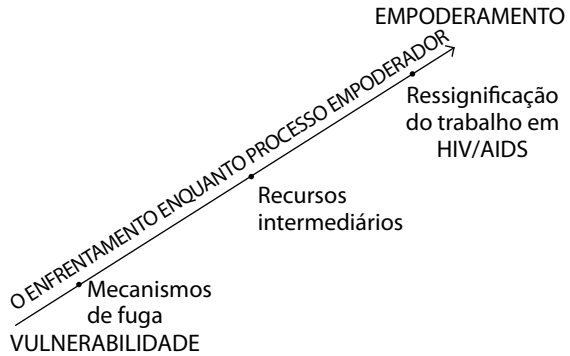
Image 2 – Diagrammatic sketch of the organization of the social thinking of nurses about the challenges present in the practice of care to patients with HIV/AIDS. Rio de Janeiro, Brazil, 2014



The means of confrontation are in a process of empowerment, which starts in the reckless practices mentioned above, moving through intermediate resources, and ends in reframing their work under a more positive aspect (Image 3).

The data found by this research is also found in other studies,[3,4,5-11] which demonstrate different areas of vulnerability and empowerment of nurses. More specifically, other research emphasized the problem of being exposed to the occupational risks of nursing[6-10], the high workloads for women working in nursing[9], long working hours and exposure to incidents of violence[1,10], the intensity of tasks, and the presence of pleasure and stress in nursing[10].

Image 3 – Diagrammatic sketch of the organization of the social thinking of nurses regarding the confrontation of the challenges present in the practice of care to patients with HIV/AIDS. Rio de Janeiro, Brazil, 2014



Other elements within the vulnerability of nurses include: conflicts in the social relationships between nurses, patients and relatives regarding AIDS[10,11]; the insecurity of professionals treating the syndrome, such as symbolic constructions about the presence of bonding and friendship, but also stigmas attached to nurses involved with seropositive patients[11]; the characteristics of patients with AIDS; limited human resources; difficult institutional issues; discrimination while working with HIV/AIDS; the effects of professional life on personal life; and, the ways found by nurses to transform their daily experiences [1,2,11].

Other research focuses on exploring the closer ties between nurses and individuals who live with HIV/AIDS, especially through nursing consultations[12], which preconizes welcoming and a sensible understanding of patients' needs. In this sense, it is important to mention the possibility of shared vulnerabilities between patients and nurses[13,14].

The context in working with HIV/AIDS, and/or other infectious illnesses with a strong

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stigmatizing culture, generates direct contact with the threat, or reality, of death and dying. This creates an environment hostile to the well--being of nursing professionals[11,14].

CONCLUSION

We conclude that a ward of patients with HIV/AIDS is an area where there is an oscillation between antagonist forces. The conjunctions occurring in this space, and with nurses or patients, have a new meaning. This reconstruction includes, among other situations, the vulnerability and the empowerment of both subjects. Therefore, the contribution of this study is to explore the psychosociological conformation of the phenomena of vulnerability and empowerment, described here under an analytic matrix of the duality of vulnerability-empowerment, detailed in a previous study.

Despite being performed in a single scenario, and with a reduced number of subjects, this study contributed in explaining the resources nurses need to manage this situation, and how it is possible to work in such an environment. Due to the fluidity of their vulnerability, the means of confrontation created by the nurses also demand a high level of energy. This can lead to shortages in the process of compensation, leading to serious harm to the health of the caregiver and of those being cared for. Therefore, the creation and development of caring policies specifically for those working with infectious diseases are extremely compelling. In particular, policies that not only focus on the biological risks these professionals face, but that also include the phenomena of vulnerability in a wide and multiple format, according to the demands included in the concept itself.

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Contribution of the authors:

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