ISSN: 1676-4285

Association between resilience, quality of life and substance use in psychiatric emergencies: a cross-sectional study

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ABSTRACT

Objectives: to identify possible associations between quality of life, substance use and resilience of health professionals in psychiatric emergencies. **Method:** cross-sectional exploratory study, quantitative approach. Non-probabilistic sampling of convenience, with 18 participants. Inclusion criteria: health professionals with higher and secondary education, of both sexes, working in the emergency room of the hospital. Exclusion criteria: less than three months of hiring, leave or vacation. Data collection in December 2016, through three questionnaires on quality of life, resilience and substance use, totaling 59 questions. Responses analyzed by statistics, using the SPSS program. Study approved by an ethics committee. **Results**: the physical and environmental domains of the quality of life test for individuals who consume tobacco derivatives were associated, with no relationship with resilience. There were no other associations.

Descriptors: Substance-Related Disorders; Psychological Resilience; Quality of life.

Beretta LL, Santos ML, Fuly PC, Berardinelli LM, Santos WA. Association between resilience, quality of life and substance use in psychiatric emergencies: a cross-sectional study. Online Braz J Nurs [Internet]. 2020 [cited year month day];19(1):e20206345. Available from: https://doi.org/10.17665/1676-4285.20206345

INTRODUCTION

Resilience consists of a multifactorial ability that allows to re-signify potentially risky situations, resulting in more positive outcomes[1]. With regard to responding to the crisis, it is a tool that brings new approaches to care. Such assistance imposes significant difficulties for professionals, such as fear, anxiety and unpreparedness for its management; factors that predispose maladjusted behaviors and can be modified from a resilient perspective[1,2].

In addition, working in a psychiatric hospital in the post-Psychiatric Reform context involves complex issues as the existence of this tool shows that the reform's objectives have not yet been widely achieved. This dichotomy contributes to the professional maladjustment.

From the perspective of Psychiatric Reform, the objective is to guarantee a profound transformation in the mental health system, based on social inclusion, human rights and the guarantee of significant improvements in accessibility and quality of care[3].

However, the psychiatric hospital continues to exist and play an important role in the mental health network of cities like Niterói, for example. It is a facility for when the crisis goes beyond the resources available in extra-hospital services.

This occurs for various reasons: physical structure, scarce extra-hospital services, lack of medicines and professionals, for example. In this way, referrals are made to the psychiatric emergency and, in a significant number of cases, this serves as a gateway to mental health services, replacing an important function of psychosocial care centers.

When reflecting on this context in which they are inserted, the health professional has to deal with the practical issues that involve care individually, and collectively, with the questions about working in a facility that structurally goes against what is recommended by the psychiatric reform. In this way, there is an impact on subjectivity itself.

In this context, the worker can experience various forms of psychological distress, in addition to varying adaptations in response. Substance use is an adaptation strategy[4,5]. This suffering, despite being initiated in the work environment, has the potential to present itself and affect other aspects of life. In this scenario, resilience acts as a facilitator in the process of balancing risk and protection factors, and can contribute to a more positive perception about the life that one leads.

The individual perception of quality of life is given to its position in life, in the context of the culture and value system in which it lives and in relation to its objectives, expectations, standards and concerns[5].

A more resilient stance indicates skills to resist adversity, adaptation to the context, which promotes well-being and is protective against psychological pathologies[6].

Therefore, the object of this study was the association between resilience, quality of life and use of psychoactive substances in health professionals working in psychiatric emergency services. The main hypothesis assumes that there is an association between resilience, quality of life and use of psychoactive substances in these professionals. The null hypothesis assumes that there is no association.

The objectives were to identify possible associations between the quality of life of these professionals and the use of substances and resilience.

METHOD

It was a cross-sectional exploratory study with a quantitative approach carried out in the Reception and Intercurrences (emergency) department of the Psychiatric Hospital of Jurujuba, located in the neighborhood of Charitas, in Niterói, Rio de Janeiro. The hospital is one of the mental health network facilities in Niterói which covers the entire territory of the city, and has 125 beds - twelve of them intended for emergency care.

It was a non-probabilistic convenience sample composed of 18 health professionals who work in the emergency room at the Psychiatric Hospital of Jurujuba.

The inclusion criteria were: health professionals with secondary and third-level education, of both sexes, working in the emergency department of the hospital.

The exclusion criteria were: professionals with less than three months of employment (period stipulated as adaptation to the service) in the department, and those on leave or vacation.

All professionals working at the time of data collection were approached personally. However, due to low salaries and poor employment relationships, most employees had only worked in the service for a short time due to the professional turnover levels, and for this reason, they were discarded from the study according to the exclusion criteria. Thus, the sample was composed of all professionals who met the aforementioned criteria.

A short period of experience in a new work environment can be seen as a confusing factor, since the change can positively or negatively alter the balance between risk and protection factors for resilience, quality of life and even the pattern of substance use.

Data collection took place in December 2016, using three instruments: the Wagnild and Young resilience scale, the WHOQOL-brief and ASSIST. The questionnaires were applied during the work period at times when employees had completed their usual tasks, and there were no patients waiting for care.

The statistical software SAS version 9.1.3 was used for data analysis. At first, a descriptive analysis of the quantitative and qualitative variables was carried out, both of the demographic data and of the tests of resilience, quality of life and substance use.

After that, the scores were marked according to the recommended syntax for each of them. For the substance use test, the analysis was performed considering the first question of the questionnaire (who indicated the use of any of the substances mentioned).

At the beginning of the analysis, the Shapiro-Wilk normality test was applied, since the sample had less than fifty volunteers. First, a Spearman correlation was performed, with 0.05 significance and 95% confidence only with the quality of life test to verify which domains are most significant amongst them.

By performing a multiple regression test, it was possible to understand which facet was most significant for each domain and the domain is explained by these facets. This test is performed with 0.05 significance and 95% confidence.

Through the Kruskal Wallis statistical test, we were able to find out if there is a significant difference in the tests in relation to sex and profession.

Resilience consists of the dependent variable; substance use and quality of life are considered independent variables.

This research was submitted and approved by the Research Ethics Committee of the Faculty of Medicine of Universidade Federal Fluminense (UFF), Hospital Universitário Antônio Pedro under opinion number 1.826.055, commening only after its approval, according to Resolution CSN 466 / 12.

RESULTS

Table 1 - Table of frequency of demographic variables

Variable		Frequency	Percentage (%)
Sex	M	5	29.4%
	F	12	70.6%
Profession	Doctor	3	17.6%
	Nurse	4	23.5%
	Psychologist	3	17.6%
	Nurse Technician	6	35.3%
	Social worker	1	5.9%
Salary	1-2 wages	10	58.8%
	3-4 wages	3	17.6%
	5 wages or more	4	23.5%
Employment type	RPA	12	70.6%
	contract	3	17.6%
	Public servant	2	11.8%
Schooling	Post-graduate in mental health	3	17.6%
	Post-graduate	4	23.5%
	High school	6	35.3%
	Third-level	4	23.5%
Civil status	Single	11	64.7%
	Married	5	29.4%
	Divorced	1	5.9%

Source: Elaborated by the authors.

Table 2 - Descriptive analysis table of demographic variables

Variables	Average	Median	Standard deviation	Minimum	Maximum
Age	40.82	40	13.15	24	64
Emergency experience	4.16	3	3.62	0.33	12

Source: Elaborated by the authors.

Table 3 - Frequency table of results of quality of life and substance use resilience tests

Variable		Frequency	Percentage (%)
Resilience	High	3	17.6%
	Medium	8	47.1%
	Low	6	35.3%
Overall 1	Very good	2	11.8%
	Good	13	76.5%
	Normal	1	5.9%
	Needs to improve	1	5.9%
Overall 2	Very good	2	11.8%
	Good	7	41.2%
	Normal	7	41.2%
	Needs to improve	1	5.9%
Physical domain	Good	8	47.1%
	Normal	9	52.9%
Psychological domain	Good	5	29.4%
	Normal	11	64.7%
	Needs to improve	1	5.9%
Social Domain	Good	7	41.2%
	Normal	6	35.3%
	Needs to improve	4	23.5%
Environmental Domain	Normal	9	52.9%
	Needs to improve	8	47.1%
Tobacco derivatives classication	Intensive treatment	1	11.1%
	Brief intervention	4	44.4%
	No intervention	4	44.4%
Alcoholic Beverages Classification	Brief intervention	10	71.4%
	No intervention	4	28.6%
Marijuana Classification	Intensive treatment	1	25.0%
	No intervention	3	75.0%
Hypnotic/Sedative Classification	Brief intervention	1	50.0%
	No intervention	1	50.0%

Source: Elaborated by the authors.

Table 4 - Correlation table of the domains of the quality of life test, such that the first line is the correlation coefficient and the second is the p value

Variables	Overall 1	Overall 2	Physical	Psychological	Social	Environmental
Overall 1	1	0.37295	0.28516	0.47323	-0.05159	0.55723
		0.1404	0.2672	0.055	0.8441	**0.0201**
Overall 2	0.37295	1	0.29166	0.46485	0.32312	0.38539
	0.1404		0.256	0.0601	0.2059	0.1266
Physical	0.28516	0.29166	1	0.37828	0.53083	0.38562
	0.2672	0.256		0.1343	**0.0284**	0.1263
Psychological	0.47323	0.46485	0.37828	1	0.42536	0.25728
	0.055	0.0601	0.1343		0.0887	0.3188
Social	-0.05159	0.32312	0.53083	0.42536	1	0.35949
	0.8441	0.2059	**0.0284**	0.0887		0.1564
Environmental	0.55723	0.38539	0.38562	0.25728	0.35949	1
	0.0201	0.1266	0.1263	0.3188	0.1564	

Source: Elaborated by the authors.

Table 5 - Table of correlation of the tests of resilience, quality of life and substance (tobacco), such that the first line is the correlation coefficient and the second the p value

Variables	Resilience	Overall 1	Overall 2	Physical	Social	Environmental	Psychological	Tobacco derivatives
Resilience	1	-0.35795	-0.11927	-0.40560	0.33065	-0.12657	-0.35813	-0.34360
		0.4305	0.7989	0.3666	0.4688	0.7868	0.4302	0.4505
Overall 1	-0.35795	1	0.33634	0.02653	-0.45187	0.40014	0.25715	-0.70776
	0.4305		0.4608	0.9550	0.3087	0.3738	0.5777	0.0752
Overall 2	-0.11927	0.33634	1	-0.23262	0.50313	0.44031	0.35287	-0.20550
	0.7989	0.4608		0.6157	0.2497	0.3228	0.4375	0.6585
Physical	-0.40560	0.02653	-0.23262	1	0.10727	-0.79006	0.28765	0.07399
	0.3666	0.9550	0.6157		0.8189	**0.0345**	0.5316	0.8747
Social	0.33065	-0.45187	0.50313	0.10727	1	-0.28387	0.37011	0.18220
	0.4688	0.3087	0.2497	0.8189		0.5373	0.4138	0.6958
Environmental	-0.12657	0.40014	0.44031	-0.79006	-0.28387	1	-0.07921	-0.16251
	0.7868	0.3738	0.3228	**0.0345**	0.5373		0.8660	0.7277
Psychological	-0.35813	0.25715	0.35287	0.28765	0.37011	-0.07921	1	0.12376
	0.4302	0.5777	0.4375	0.5316	0.4138	0.8660		0.7915
Tobacco derivatives	-0.34360	-0.70776	-0.20550	0.07399	0.18220	-0.16251	0.12376	1
	0.4505	0.0752	0.6585	0.8747	0.6958	0.7277	0.7915	

Source: Elaborated by the authors.

Table 6 - Table of correlation for the tests of resilience, quality of life and substance (alcohol), such that the first line is the correlation coefficient and the second the p value

Variable	Resilience	Overall 1	Overall 2	Physical	Social	Environmental	Psychological	Alcoholic drinks
Resilience	1	-0.18070 0.5547	0.15179 0.6206	-0.18323 0.5490	-0.01969 0.9491	-0.14641 0.6332	0.05108 0.8684	-0.12293 0.6891
Overall 1	-0.18070 0.5547	1	0.39951 0.1762	0.15469 0.6138	-0.18593 0.5431	0.49181 0.0878	0.46505 0.1093	0.12109 0.6935
Overall 2	0.15179 0.6206	0.39951 0.1762	1	0.19251 0.5286	0.19211 0.5295	0.33895 0.2573	0.55108 0.0509	0.35663 0.2316
Physical	-0.18323 0.5490	0.15469 0.6138	0.19251 0.5286	1	0.37607 0.2054	0.06014 0.8453	0.40809 0.1663	-0.11609 0.7057
Social	-0.01969 0.9491	-0.18593 0.5431	0.19211 0.5295	0.37607 0.2054	1	0.22367 0.4626	0.43499 0.1374	0.02532 0.9346
Environmental	-0.14641 0.6332	0.49181 0.0878	0.33895 0.2573	0.06014 0.8453	0.22367 0.4626	1	0.46684 0.1078	0.03591 0.9073
Psychological	0.05108 0.8684	0.46505 0.1093	0.55108 0.0509	0.40809 0.1663	0.43499 0.1374	0.46684 0.1078	1	0.08798 0.7750
Alcoholic drinks	-0.12293	0.12109	0.35663	-0.11609	0.02532	0.03591	0.08798	1

Source: Elaborated by the authors.

DISCUSSION

Substance use is a public health problem worldwide. In a Brazilian study carried out in 2016 with about 17 thousand people, it was found that 3.2% of Brazilians used illegal substances in the 12 months prior to the survey. In addition, about 46 million (30.1%) reported having consumed at least one dose in the previous 30 days, showing alarming consumption[7]. The beginning of use is multifactorial, triggered by experimentation and the individual's need to maintain altered consciousness.

Among the professional categories, health workers have been identified as a risk group for mental illness, since working in this area increases exposure to physical and mental exhaustion, which makes resilience a constant challenge in this work environment[2]. It is noteworthy that psychiatric hospitals are one of the services responsible for caring for people in psychological crisis, requiring professionals to be sensitive, alert, attentive and prepared to deal with the unpredictability of a variety of clinical conditions[8].

Dealing with the complexity of this type of work exposes the health team to situations that can generate distress and contribute to the emergence of functional diseases[8]. High levels of burnout produce an incidence of musculoskeletal disorders, occupational injuries, absenteeism, job dissatisfaction, as well as alcohol and other types of drug abuse[9].

In addition, the mismatch between training and what is required in daily practice generates insecurity, conflicts in the work environment, suffering and illness[10]. There are also difficulties in relation to organizational issues, such as insufficient human and material resources[11]. Concerning difficulties in the hospital environment, there are physical and psychological upheavals, poor environmental structure, lack of materials, dissatisfaction with remuneration, double working hours, activity overload, the exhausting work process,

night work and the absence of professional recognition[11].

These represent the worker´s vulnerability and, as an escape valve, the consumption of psychoactive substances can be used. Such a scenario can lead to the deregulation of social and work life, in addition to other negative cognitive and organic effects, also affecting the individual's perception of their own life[12].

It is necessary to clarify that the work itself is not the biggest motivator for substance use, but when the working conditions are exhausting, stressful and demotivating for the worker, the chances of his refuge in the use of any drugs increase, whether legal or illicit[12].

In this scenario, poor professional training can hamper the development of strategies to control emotional distress. In addition, the possibility of suffering physical violence while attending to the crisis with psychomotor agitation at work is also a factor related to drug use that deserves further investigation in future research[12].

On the other hand, people with more resistance experiment in a more positive way. The resilient individual makes use of coping strategies to change stressful experiences or modify the emotional response[1].

In this context, self-esteem and the feeling of being able to deal with challenges are inserted. In the face of adversity, having these characteristics allows the development of another conception about situations and, consequently, other ways of acting when faced with them.

Although what the person feels is individual and varies, there are factors that stand out in relation to more positive elaborations regarding life and building resilience. These are called protective factors, which have a protective value for resilience.

These are positive processes that reduce poorly adaptive outcomes in risk conditions[1]. Among them, individual factors (temperament, cognitive, skill), the quality of social relations and the broader environmental factors (safety, quality education and regulatory activities) stand out[1].

There are also factors that hinder the development of resilience, increasing the vulnerabilities of the subjects: the risk factors. As well as protection factors, what influences fragility is also related to cultural and social aspects, among others. The risk is determined by the evaluation of the experience, its consequences and the coping strategies used to reframe the emotional response[1].

It is worth noting that resilience levels can change, despite being relatively stable and long-lasting characteristics. Resilience should not be considered a static phenomenon, but rather a dynamic process, open to change and modification[13]. Thus, it can be identified and stimulated even in the work environment.

Some people are more resistant and able to deal with difficult situations; however, it should be noted that this ability can be powerful in one context, and vulnerable in another[13]. The fact is that resilience is related to better outcomes, allowing the development of adaptive mechanisms[7].

However, there are situations in which there is an imbalance between risk and protection factors associated with limited subjective resources. In this scenario, the alcohol use can be considered as an inappropriate adaptation strategy for stress.

Substance use is presented as the antithesis of resilience, being seen as a "poorly adapted adaptation strategy", claiming the lack of resilience. Drug use is also presented as a risk factor compromising the ability to be resilient[14]. In this perspective, stimulating the development of protective factors can contribute to the work environment prospering, as well as the quality of the service provided to patients. Therefore, the collaboration of those involved ensures the basis of this process.

Teamwork favors self-resilience insofar as the relationship with another professional reflects their own weaknesses and strengths, contributing to a resilient praxis. It is also noteworthy that resilience can be enhanced when professionals guide their practices from the clinical supervision of the cases attended and the theoretical study of the chosen clinical approach[2]. Although the health workforce suffers from high rates of mental health problems, generating effects for both workers and patients, there is limited evidence on how to promote mental health and well-being in the health workforce given the complexity of factors at the organizational level that influence health and the work environment[15].

Given the above, attention should be paid to the way in which the work process takes place and its repercussions. The complexity of the subjectivity of individuals and the potential of working with it in favor of adaptive elaborations favorable to a more positive life are emphasized.

CONCLUSION

For individuals who consume tobacco derivatives, there was an association between the physical and environmental domains of the quality of life test, with no relationship with resilience being evidenced. For alcohol users, it was observed that there is no correlation between any variables. It was not possible to perform the correlation test regarding the use of marijuana or hypnotics/sedatives due to the number of responses.

The most significant domains for quality of life were physical, environmental, psychological and social. The consumption pattern of the participants evidenced the abuse of alcohol and tobacco, and the level of resilience of the professionals was mostly average.

Psychoactive substance abuse among health professionals exists in those who work in the psychiatric emergency in question, a fact corroborated by the scientific literature. However, the findings of this study do not corroborate the data available in the literature. Therefore, further studies are needed, using different methodologies in order to better understand the phenomenon in question.

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Received: 12/23/2019

Revised: 04/18/2020

Approved: 05/19/2020