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COPING STRATEGIES IN ONCOLOGY NURSING: AN ANALYSIS OF CARE PRACTICES AND WELL-BEING

ESTRATÉGIAS DE COPING EM ENFERMAGEM ONCOLÓGICA: ANÁLISE DAS PRÁTICAS DE CUIDADO E BEM-ESTAR

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RESUMO

Objetivo: Identificar estratégias de *coping* adotadas por enfermeiros frente aos desafios da assistência a pacientes oncológicos. **Método:** Este estudo qualitativo foi conduzido com 14 enfermeiros atuantes na assistência direta em um centro de alta complexidade em oncologia de um hospital universitário na cidade de Maceió, estado de Alagoas, Brasil. A coleta de dados ocorreu por entrevistas semiestruturadas e a interpretação seguiu a análise de conteúdo de Bardin. **Resultados:** Predominaram estratégias de autoproteção emocional, incluindo distanciamento de lembranças e responsabilidades do trabalho, atividades de lazer, espiritualidade, convívio familiar, prática de esportes e contato com a natureza. Citaram-se, ainda, ações de autocuidado, realização de terapia e busca por aperfeiçoamento profissional. Houve demanda por melhorias estruturais, apoio psicológico institucional e valorização do trabalho. Observou-se que muitas estratégias são iniciativas individuais, pouco incorporadas às políticas organizacionais. **Conclusões:** As estratégias de *coping* adotadas expressam o esforço dos enfermeiros para manejar as exigências emocionais do cuidado oncológico e evidenciam a necessidade de intervenções institucionais que fortaleçam essas práticas e promovam o bem-estar dos profissionais.

Descritores: Saúde do trabalhador; Saúde mental; Habilidades de enfrentamento.

ABSTRACT

Objective: To identify coping strategies adopted by nurses in response to the challenges of caring for oncology patients. **Method:** This qualitative study included 14 nurses providing direct care at a high-complexity oncology center within a university hospital in the city of Maceió, state of Alagoas, Brazil. Data were collected through semi-structured interviews and interpreted using Bardin's content analysis. **Results:** Emotional self-protection strategies predominated, including distancing from work-related memories and responsibilities, engaging in leisure activities, spirituality, time with family, sports, and contact with nature. Participants also reported self-care practices, psychotherapy, and seeking professional development. There was a reported need for structural improvements, institutional psychological support, and recognition of work. Many strategies were individual initiatives with limited incorporation into organizational policies. **Conclusions:** The coping strategies described reflect nurses' efforts to manage the emotional demands of oncology care and highlight the need for institutional interventions that strengthen these practices and promote staff well-being.

Descriptors: Occupational health; Mental health; Coping skills.

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What is already known:	What this study adds:
• Oncology nurses face high levels of stress and risk of burnout syndrome. • Individual strategies such as leisure and spirituality are commonplace. • Institutional support is crucial to prevent illness and improve the quality of care.	• Shows the predominance of emotion-focused strategies among oncology nurses. • Identifies demand for institutional support, infrastructure, and specialized training. • Reinforces the urgency of policies targeting the mental health of nursing staff.

INTRODUCTION

Oncology nursing — particularly in high-complexity institutions — requires technical, emotional, and human competencies to address intense suffering, end-of-life issues, and complex clinical needs. This study examines the coping strategies used by nurses working at a high-complexity oncology center in a university hospital in the city of Maceió, state of Alagoas, Brazil. In this specialized setting, professionals encounter daily demands that require not only technical preparation but also emotional balance and institutional support to ensure care quality and protect mental health.

Work in oncology units presents distinct challenges: pain management, care for patients in advanced stages of disease, and support for families facing bereavement and end-of-life. Work overload, resource constraints, pressure for resolutive care, and constant exposure to suffering make the environment stressful and emotionally draining[1]. The absence of institutional policies focused on worker health exacerbates this scenario, leaving many professionals to face these pressures in isolation, with direct impacts on care quality and team well-being[2]. Consequently, risks of chronic stress, anxiety, depression, burnout syndrome, and moral distress increase[1].

Evidence from Brazil and other countries indicates that prolonged exposure to high emotional demands without adequate support contributes to physical and psychological illness among health workers[2-4]. Such conditions undermine patient safety and weaken the retention and motivation of nurses in specialized services, reinforcing the urgency of discussing institutional strategies for caring for the caregivers.

In this context, coping strategies — cognitive and behavioral mechanisms to address stressors — may be oriented toward the problem, the emotion, or social support[5-6]. Identifying how such strategies are mobilized by nurses in high-complexity settings can inform workplace-health policies, guide actions to promote well-being and prevent illness, and enhance the quality of oncology care[2]. Mapping these practices and the professionals' expressed needs in relation to work processes helps reveal vulnerabilities and points to ways of promoting worker health, with positive repercussions for care quality.

Accordingly, this study was guided by the questions: "Which coping strategies are used by nurses in caring for oncology patients?" and "What solutions and/or needs do these professionals express regarding their work processes?" The aim was to identify strategies adopted by nurses to cope with the challenges they face in their daily care of oncology patients at a high-complexity oncology center in a university hospital in Alagoas, Brazil.

METHODS

Study design

This qualitative study focuses on the universe of human production, understood as the field of relationships, intentionality, and the subject's representativeness. This approach enables an in-depth investigation of participants' meanings, motives, values, inspirations, and attitudes within their social reality, facilitating the understanding of the meanings they ascribe to their own actions and relationships[7].

Setting

The study was conducted at the high-complexity oncology center of a university hospital in the state of Alagoas, Brazil.

Participants and sampling

Eligible participants were nurses aged ≥ 18 years with at least 3 months of experience in oncology at the high-complexity oncology center and who met the inclusion and exclusion criteria. Professionals on vacation or on any type of leave were excluded. Recruitment used non-probability convenience sampling, based on expressed interest in participating.

Data collection

Data were collected individually in September 2022 using a semi-structured questionnaire. The instrument comprised two parts: i) participant characteristics and ii) open-ended questions (Chart 1). After each question, participants could choose the option "I do not wish to answer." Interviews were conducted in a private room available at the high-complexity oncology center.

Chart 1 – Guiding questions for data collection. Maceió, AL, Brazil, 2022.

1. What strategies do you use to face difficult situations when caring for oncology patients?
2. What solutions and/or aspirations are related to your professional practice in caring for oncology patients?

Source: adapted from Louise de Oliveira do Carmo, Guerra Siman, Almeida de Matos, and Toledo de Mendonça, 2019[8].

Data analysis, methodological rigor, and ethical considerations

Interviews were audio-recorded, fully transcribed, and subjected to content analysis, understood as a set of systematic procedures for identifying, grouping, and interpreting themes that reveal values, concepts, and models present in the narratives[9].

First, all transcripts underwent successive readings to grasp their overall meaning. Next, recording units — passages expressing central ideas — were highlighted and assigned representative codes. Codes were grouped by seman-

tic similarity to form provisional thematic nuclei which, after refinement, yielded subcategories such as: physical activity and leisure; spirituality; use of humor; affective-distancing strategies; communication among colleagues; psychotherapy; and reframing of work. From comparative analysis of these nuclei and discussion among the researchers, two core categories emerged: strategies used to face difficult situations in oncology and wishes related to oncology work processes. The procedure included peer validation, verification of saturation, and comparison with the literature, ensuring methodological rigor and supporting the study's external validity.

Data collection ceased upon reaching theoretical sufficiency — when additional interviews no longer contributed relevant information to the study objectives — considering available resources and the incorporation of findings into the analytic design.

Data were stored on a personal Google Drive® with restricted access for the research team, ensuring secrecy, privacy, and confidentiality, and will be retained for five years after study completion. To ensure originality, trustworthiness, transparency, and rigor, reporting followed the COnsolidated criteria for REporting Qualitative research, indexed on the EQUATOR Network[10].

All participants provided written informed consent and a separate authorization for audio recording; each received a copy of both documents. Anonymity was preserved at all stages by identifying participants as NUR followed by the sequential interview number (e.g., NUR1, NUR2).

The study complied with national and international ethical guidelines and was approved by the Research Ethics Committee for Human Subjects at the Professor Alberto Antunes University Hospital, Universidade Federal de Alagoas, under approval no. 5.628.707 (CAAE: 61122422.0.0000.0155).

RESULTS

The sample (Table 1) comprised 14 nurses — 12 women and 2 men (85.7% and 14.3%, respectively) — aged 29–55 years. Regarding time in oncology, 12 participants had worked in oncology services for more than 3 years (85.7%), while two had less than 7 months of experience (14.3%).

In terms of training, 11 participants reported no specialization in oncology (78.6%). Eight indicated they had not received technical and/or practical oncology content during undergraduate education (57.1%).

Table 1 – Participant characteristics by gender, age, time working in oncology services, specialization in oncology, and exposure to technical and/or practical oncology content during undergraduate training. Maceió, AL, Brazil, 2022

Participant	Gender	Age (years)	Time working in oncology services	Specialization in oncology	Exposure to oncology content/practice during undergraduate training
NUR1	Female	38	15 years	Yes	No
NUR2	Female	35	3 years	No	Yes
NUR3	Female	46	19 years	No	No
NUR4	Female	30	6 months	No	No
NUR5	Female	46	18 years	Yes	Yes
NUR6	Female	38	3 years	No	Yes
NUR7	Female	33	7 months	No	Yes
NUR8	Female	29	4 years	No	No
NUR9	Female	48	4 years	No	No
NUR10	Male	36	6 years	No	No
NUR11	Female	32	7 years	No	Yes
NUR12	Female	45	7 years	Yes	No
NUR13	Male	44	6 years	No	Yes
NUR14	Female	55	6 years	No	No

Source: prepared by the authors, 2025.

Following content analysis, two categories were identified and are presented below, illustrated with interview excerpts.

Strategies used to face difficult situations in oncology

Multiple coping strategies aimed at mental and emotional self-protection were reported. Frequently cited practices included distancing from work-related memories and responsibilities during nonworking hours; physical activity; reading; films and leisure; contact with nature; and time with family — recognized by participants as highly relevant strategies.

> *I see physical activity as an ally; I usually work out before coming to work, early in the morning.* (NUR1)

> *On weekends I disconnect completely* […] *I also take a break, I've been going out, taking walks on the beach, at least to look at something, to clear my head, and having a little wine, right? To really relax.* (NUR5)

> *Every weekend, especially with my family, I go to the beach. I need to get back to doing sports, because it's very important. When I was exercising, I even felt better, and on weekends and in my free time I try to do as many things as I like as possible — study other subjects, I really like to read, and I read a lot when I have time. My son is also my escape valve; I try to take care of him and do things with him* […] *I go to the beach a lot, I love going to the beach; even if you're very stressed, just looking at the sea, at nature, helps you relax. People try to develop defense mechanisms, you know? To push the feelings a bit further away.* (NUR6)

> *I seek balance — not always getting involved with the patient — in the sense of not letting emotions actually harm my care.* (NUR8)

> […] *I learned to crochet some time ago, and it's a relief for me.* (NUR9)

> *I read a lot about the patient's own context, about the difficulties, so I don't take things too personally. There were times when I did, and it harmed me a lot.* (NUR11)

> *I try to rest a lot on my days off. I try to unwind, watch movies, and disconnect by doing activities that have nothing to do with work — for example, I really like tinkering with computers, I like watching films and working with IT.* (NUR13)

Good humor was mentioned as a facilitator in daily work and in solving problems in oncology care.

> *I use good humor and do my job as best I can; I try to find solutions.* (NUR7)

Spirituality was also cited as important support for coping with adversity.

> *I have a lot of faith; I'm Christian, and many times I hold on to my religion to understand what is happening. It's not easy, but we need it.* (NUR2)

Workplace communication and harmony among peers emerged as tactics to manage difficult situations, including seeking support from other professionals and the need to liaise with management.

> *To deal with these situations* […] *we seek help from other professionals.* (NUR3)

> *I strongly believe in dialogue — talking with the stakeholders to try to be more resolutive, generate new ideas, and shift the work process toward something more efficient. So you need this liaison with management to try to solve things, because the nurse at the bedside can't coordinate with multiple hospital areas and implement a routine alone.* (NUR10)

Access to psychotherapy was reported as a mental-health care strategy.

> *You have to work on your mind, right? You have to work on it. When I see things are getting bad, I go back to sessions with my psychologist. Therapy also helps us take care of ourselves, because otherwise we're just seeing losses, losses, losses all the time.* (NUR5)

> *I did therapy some time ago* […] *I think we should all do it — especially oncology nurses — so we can better deal with pain and death.* (NUR6)

Accounts also emphasized the pursuit of personal and professional development and the reframing of one's work as forms of coping.

> *As I seek knowledge — not only technical knowledge but also the patient's context, the context of finitude, my limits, how far I can go to help* […] *I think this really helps you deal with difficulties. We start to see that colleagues will get tired and we will go through hard times, but we shouldn't personalize these conflicts or take them upon ourselves; we should treat them as elements of the professional environment that need to be addressed, remembering that this professional also needs support and is a human being.* (NUR11)

Wishes related to oncology work processes

In this category, participants voiced solutions and wishes regarding care in the high-complexity oncology center, emphasizing structural, organizational, and training improvements. They mentioned the need to increase bed capacity, redefine care pathways, and improve the physical environment to enhance and integrate care.

> *I wish the number of beds would increase.* (NUR3)

> *I hope the unit expands, because we're feeling very overwhelmed here — the demand is huge and the space can't accommodate it* […] *even to ensure quality care.* (NUR12)

> *I think if the roles and functions of each person within their sector were well defined, everything would flow better* […] *but I believe this is a broader issue the hospital leadership needs to address — review the pathways, organize the charts and flows — so work can flow better.* (NUR9)

> *My wish is for the service to provide more comprehensive patient care, to have more physical structure, and for things to truly work 100% in an integrated way.* (NUR13)

Professional qualification was cited as a way to improve care and enable more active participation in structuring the service.

> *My wish is to specialize in oncology, because I liked the field. Even though it's very tough, I identified with it. I think you either love it or hate it here, but I liked it; I really want to do a specialization, take more courses, and study.* (NUR6)

> *I want to provide care that offers dignity to patients* […] *I hope to reach a point where I can consolidate my oncology studies and truly have a more active role, contributing to structuring the service as a whole so it adds more quality and more resources for patient care.* (NUR11)

Participants also emphasized ensuring holistic, empathetic care, highlighting the need for protected time to implement the nursing care plan.

> *Oncology patients need a great deal of attention* […] *sometimes care becomes more mechanical. I wish we*

had more dedicated time for the nursing consultation; I think that would be important. (NUR1)

Treating the patient as a whole when they arrive to you is the least we can do. (NUR9)

My wish is to remain a humanized, empathetic professional — resilient in facing situations calmly and in the best way possible. (NUR8)

Finally, statements acknowledged that oncology care is complex and exhausting across multiple dimensions (e.g., physical, mental, spiritual, economic, and social), with impacts on workers' mental health, reinforcing the desire for ongoing institutional psychological support.

I think we would need psychological follow-up for the nurses working here. We need therapy — support we don't have. They say we do, but I'd like it to be something focused on us here [...] *that these interventions would be natural, like an afternoon once a month, a talking circle. I think that would be very important for those of us working in this area because it's very heavy.* (NUR12)

DISCUSSION

This study showed that nurses in an oncology unit mobilize diverse strategies to manage psychological distress and the emotional demands of care. The most frequent forms of coping were mental distancing from the workplace through leisure activities, spirituality, family support, use of humor, access to psychotherapy, and ongoing pursuit of technical and humanistic training. Participants also expressed desires for better structural conditions, reorganization of care pathways, humanization of care, and institutionalized psychological support. These findings align with recent literature on worker health in high-complexity settings.

Coping refers to cognitive and behavioral efforts used to deal with stressors, especially when they exceed usual problem-solving resources[4-6,11]. In the present study, emotion-focused strategies predominated — psychological distancing, leisure practices, spirituality, and social support — to mitigate the emotional impact of oncology care. Research indicates that in intensive caring professions these strategies tend to be more common than problem-focused approaches, given the often uncontrollable nature of situations such as finitude and prolonged suffering[2-4]. Even so, more active strategies — such as psychotherapy and professional development — were observed, signaling adaptive mobilization in the face of adversity. It is incumbent upon institutions to recognize, strengthen, and encourage these resources.

The use of extracurricular and leisure activities as an outlet is widely described. Physical exercise, contact with nature, reading, and family time foster temporary disconnection from the hospital environment and contribute to maintaining mental health[12-13]. Participants' accounts reinforce the importance of promoting healthy habits among professionals.

Spirituality emerged as a relevant subjective resource, understood as emotional support in the face of suffering associated with finitude. In contexts of intense human suffering, such as oncology, it can lend meaning to professional practice and promote resilience and well-being[14-15]. The participants' faith-based narratives are consistent with literature recognizing spirituality as a promoter of these outcomes.

Understood as the personal search for meaning, the transience of life, and a relationship with the transcendent — with or without a religious component — spirituality influences life purpose, offers comfort and well-being, and assists coping with difficult situations; thus, it stands out as a powerful health-promotion strategy[16].

Good humor and lightness in relationships were mentioned as ways to make daily work less burdensome. Humor can strengthen team bonds, facilitate communication with patients, and act as a protective factor against occupational stress, provided it is used consciously and empathetically, avoiding denial of suffering or invalidation of legitimate emotions[17-18]. In care contexts, happiness is understood as a sense of life satisfaction; when present, it expands the capacity to handle daily events and the difficulties associated with illness[16].

Emotional distancing as psychic self-protection was also identified. Although it may temporarily reduce overload, indiscriminate use tends to weaken the therapeutic bond. The challenge is to balance empathy and self-care, preserving a healthy therapeutic relationship without fully absorbing the other's suffering[16].

The importance of communication and intra-institutional cooperation was reiterated. Interpersonal support and open dialogue foster cohesion and belonging and mitigate the effects of moral and emotional distress — especially in high-demand services with structural constraints, as is common in oncology[19-21]. Seeking external psychological support through psychotherapy emerged as an effective strategy to process recurrent losses and emotional strain, contributing to the prevention of anxiety, depression, and burnout syndrome[22-23]; nevertheless, institutional resistance to offering such support systematically was noted.

A training gap was observed: many professionals lack specialization in oncology and did not encounter oncology content/practice during undergraduate studies, which affects care safety and emotional preparedness. Targeted qualification is essential for care quality and for handling the field's complexities, indicating the urgency of curricular review and expansion of specialization and continuing-education programs[24].

Desires for structural improvements, reorganization of care flows, and increased bed capacity converge with studies describing shortcomings in oncology services in Brazil, including insufficient infrastructure and human resources amid rising demand, which generates overload and compromises comprehensive care[2]. These findings reinforce the need for investment and organizational planning.

Finally, participants emphasized the need for professional recognition, humanization, and valuing empathy in daily work. Creating institutional conditions that sustain ethical and safe practice is essential. In this regard, several individual strategies may promote health and well-being: watching preferred or humorous programs/films; reading; contact with animals and nature; foods with affective meaning; encouraging pleasure and laughter; engaging in enjoyable activities (music, singing, sewing, knitting, dance, painting); expanding social interactions; conversations using positive language; acts of kindness; integrative and complementary practices (auriculotherapy, aromatherapy, meditation); and sleep hygiene, among others[16,25].

Limitations of the study

Because this investigation was conducted in a single institution, the findings are not generalizable to other settings and contexts. Because of the qualitative, interview-based design, the information reflects subjective perceptions that are susceptible to individual and momentary influences, which limits identification of broader trends. The absence of a longitudinal component also prevents assessment of changes in coping strategies over time.

Implications for practice

This study contributes to nursing by highlighting the psychosocial strategies mobilized by professionals in oncology care and their wishes for transforming the work environment. By giving visibility to coping practices and the need for emotional support, it strengthens the debate on mental health at work and underscores the urgency of institutional policies to support the nursing staff. It also prompts reflection on professional training, indicating the need for greater inclusion of oncology content in undergraduate curricula and in nursing specializations.

CONCLUSIONS

Nurses working in oncology units develop a range of individual strategies to manage the emotional and physical demands of care. Mechanisms such as mental distancing, leisure activities, spirituality, psychotherapy, and the use of humor were reported as essential to mitigate suffering and preserve mental health. Interpersonal support and reframing of work experiences also stand out as pillars that help sustain professionals' engagement in the face of daily challenges.

Participants expressed a desire to transform working conditions, emphasizing improvements in physical infrastructure, organization of care pathways, and valuing holistic care. The pursuit of further training and the humanization of care reflects a commitment to excellence despite difficulties.

Beyond individual strategies, there is a clear need to build institutional spaces for listening, support, and emotional care — especially in high-complexity contexts such as oncology. Future studies should expand the sample and include multiple oncology centers with regional and structural diversity as well as adopt longitudinal approaches to follow professionals' emotional trajectories. Research on the effectiveness of institutional interventions — such as support groups, therapeutic workshops, and continuing education programs in oncology — may provide robust inputs for occupational health policies in nursing.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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