

# Body, stress and nursing: Ethnography of an Intensive Care and Surgical Center

## *Corpo, estresse e enfermagem: etnografia em Centro de Tratamento Intensivo e Centro Cirúrgico*

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### Abstract

This text seeks to reflect on the concepts of stress among nurses that work in the Surgical and Intensive Care Centers of a teaching hospital in the State of *Paraíba*. Qualitative ethnographic research allowed us to perceive that when talking about stress, these professionals mentioned their bodies and bodily manifestations. The research undertaken allowed us to understand the intimate relationships between the body, stress and nursing.

**Uniterms:** Body; Intensive Care Units; Nurses; Stress; Surgical center.

### Resumo

*Este texto busca refletir sobre as concepções de stress dos(as) enfermeiros(as) que atuam no Centro Cirúrgico e no Centro de Terapia Intensiva de um hospital-escola localizado no estado da Paraíba. Uma pesquisa qualitativa, de cunho etnográfico, permitiu perceber que, ao falar sobre estresse, esses(as) profissionais evocavam seus corpos e manifestações corporais. A pesquisa empreendida possibilitou compreender as íntimas relações entre corpo, estresse e enfermagem.*

**Unitermos:** *Corpo; Centros de Terapia Intensiva; Enfermeiros; Estresse; Centro cirúrgico.*

This text seeks to reflect on the concepts of stress among female and male nurses who work in the Surgical and Intensive Care Centers of a teaching hospital in the State of *Paraíba*. Qualitative ethnographic research allowed us to perceive that when talking about stress, these professionals mentioned their bodies and bodily manifestations. The research undertaken allowed

us to understand the intimate relationships between body, stress and nursing.

The text is organized as follows: first we discuss stress and the body, presenting the main approaches to the theme; we then describe the research field, outlining the hospital and routine in the Surgical Center (SC) and in the Intensive Care Center (ICC), briefly



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present our interlocutors, and initiate a discussion concerning ethnography, in an attempt to highlight the methodological procedures. During the discussion and results, we analyze our interlocutors' narratives regarding stress and reflections on the body, stress and nursing. We end with an approach concerning the caregiver's body.

## Stress

Some studies have emphasized that stress is a reaction mechanism to diverse demands that can be physical, psychological, and sociocultural in nature, in which physical, mental and chemical components are involved. According to the authors, the origin of the stressors can be internal or external: internal stressors refer to personal characteristics - values, beliefs and ways of interpreting and dealing with situations; while external stressors are linked to situations that occur in our daily lives Lipp, Malagris and Novais (2007).

Several authors have addressed this theme, including works on the occupational context of stress (Handy, 1991) and the social construction of mental disorders (Helman, 1985), as well as studies that are tangent to the discussion, such as depression (Good & Kleinman, 1985). Hocking (1982) elaborated an overview of anthropological studies on stress.

In Brazil, studies on stress are diverse and cover various fields of knowledge. The relationships between stress, nurses and hospitals, for example, have been the subject of several studies. Menzies (1960) was one of the first authors to define the nursing profession as stressful, arguing that the demands of sick people can lead both male and female nurses to experience feelings that are incompatible with their professional performance. Lipp (1984; 2000; 2003; 2009); Lipp, Malagris and Novais (2007) analyzed stress and described its "biopsychosocial" and "neuropsychophysiological" manifestations. Bianchi (1990) argued that the lack of recognition of nursing as an essential activity, the lack of autonomy to make decisions, and the inadequacy of legislation specific to their professional practice are important factors that produce anxiogenic stress. While examining the relationship between stress and night work, Chaves (1994) suggested that the stress of the hospital nurse is closely related to the

organizational characteristics of the hospital and its power structure.

Research conducted by Rodrigues (2005) revealed that the source of nurses' stress is rooted in the fact that the hospital is a place where people lead a closed and formally administered life and are set apart from the wider society for a considerable period of time. Added to this structure are other elements inherent to and arising from contact with suffering, pain and death, which result in new stressors. A study by Maslach and Leiter (1999) indicates work overload, lack of control and/or autonomy, and the absence of reward for the nurse's work as three conditions that favor the development of physical and emotional fatigue. In their study regarding psychological distress among nursing staff working in the hospital, Gomes, Lunard and Erdman (2006) described certain factors that could lead to stress among the nursing staff, including characteristics fundamental to the Intensive Care Unit: a closed environment, with artificial lighting, air conditioning, vigilant supervision/coordination and constant orders, demanding routines, deficiency in human resources, death and suffering.

Regarding research more directly focused on the SC and ICC, while investigating intensive care nurses, Ferreira (1998) showed that nursing professionals present certain stress-related diseases. Both Lima (1997) and Massaroni (2001) studied the stress of nursing staff who worked in surgical centers, and Meirelles and Zeitone (2003) observed the occupational stress of nurses who worked in a surgical oncology center. Vieira (2001) and Carvalho, F.C.A. Lima, Costa & E.D.R.P. Lima (2004), studied the occupational stress of hospital nursing staff working in closed sectors (SC and ICC) and verified that female and male nurses showed symptoms of anxiety and stress, emphasizing that, within the dynamics of care, fatigue and tension arise when dealing with the suffering and death of patients. In a study on physical stress among nurses, Lautert (1997) evaluated the dimension of time on the tasks performed. According to his report, in the case of the SC and ICC, it is not so much the emergencies that cause fatigue, since nurses are trained and capacitated to work, but the time pressure on the execution of the tasks.

In the case of the subjects of this study, nursing professionals who work in the Surgical Center and Intensive Care Center of a teaching hospital, the situations experienced in these centers - particularly existing with pain, suffering and death, under constant pressure, in circumstances in which the very lives of patients are at stake - are related to bodily reactions inscribed in the bodies of these female and male nurses. In their narratives, stress is manifested through bodies in the act of caring for other bodies. Thus, in an attempt to reflect on our interlocutors' problems and questions, we were faced with persistent discussions concerning the body, which made us take the statements of these female and male nurses seriously. Thus, before entering into a discussion regarding the enunciations of the nurses and the relationships between body, stress and nursing, perhaps it is necessary to answer the following question posed by Almeida (1996): after all, what is body?

## Body

This issue has been discussed by numerous Social Sciences theorists, who never tire of pointing out the sociocultural dimensions of the body, which cannot only be considered organic. Turner (1995) expostulated that some ways of approaching the body usually ignore its social nature and its primary character as material activity. Through education and social life, activities are mediated by the body and take forms of culturally shared meanings. Thus, corporeality has a unique importance as a unifying category of human existence, as its social appropriation is nothing more than the prototype of all the social production of the person (Turner, 1995).

Mauss (1974) systematically studied the concept of body, highlighting the intrinsic relationship that exists between the physiological and social phenomena. This anthropologist expostulated regarding the crucial value of a study of body techniques for the human sciences, defined this as the ways in which each society imposes on the individual a rigorously determined use of their body; i.e., through education of the bodily needs and activities, a society imprints its mark on individuals.

The question of transmission through teaching is highlighted by Mauss as critical to the effectiveness

of the technique, which, in turn, is an effective traditional act that is transmitted and imitated. Thus, in all elements of the art of using the human body, whether biological, psychological or sociological, education stands out to the extent that everyone pass through a determined education and, whether skilled or unskilled, imitate this aware of both the prestigious and unprestigious techniques. It is precisely this notion of prestige that authorizes the imitator. Thus, social, biological and sociological elements are inextricably mixed in the same act.

Body techniques are, according to Mauss, acquired and unnatural ways of using the body. Nothing occurs "naturally" in the adult human. We continuously adapt the body to its uses through techniques defined as "physio-psycho-sociological assemblages". We are always in the presence of physio-psycho-sociological assemblages of different series of acts, such as: techniques of reproducing ourselves, of breastfeeding, of holding a child, of climbing, of imprinting movements of strength, among others. Movements related to the limits of pain and pleasure are also criteria that depend intimately on collective approval or disapproval, rather than the function of individual or physiological particularities. Instead of looking at humans as a product of their bodies, Mauss showed that humans make their bodies the product of their techniques and their bodily representations. The dimensions brought about by body techniques present not only information regarding the practical use of the body, but also its moral use, and how, through the body, it is possible to reveal cultural contacts, the transmission of gestures from generation to generation, exchanges between social groups, and the incorporation or exclusion of techniques by a group.

After Mauss, the concept of body went through different moments of reflection. A review of the theme can be found in Almeida (1996); Berger (2006); Bourdieu (1997); Le Breton (1999, 2003a, 2003b); Csordas (1990, 2008) in Ortiz (1993) and Rodrigues (1999). However, it is Foucault's elaborations concerning body, which we discuss in greater detail below, and that we most availed ourselves of in this work. Foucault stimulated us to examine bodies in their direct and indirect confrontations with other bodies within the hospital routine and as we approached the mechanisms that

act upon the female and male nurses. Our interlocutors revealed to us, through the language of stress, that the professional practice and techniques learned and arduously developed also act upon the bodies of those who should monitor, control and manage hospital work.

## Method

### Study location

The teaching hospital where the research was conducted is subject to the Ministry of Education and forms part of the *Sistema Único de Saúde* (SUS, Brazilian National Health System). Located in a neighborhood with easy access for the population, this hospital is a referral center for the State of *Paraíba*, receiving patients from every municipality, principally for specialized outpatient care. Although construction of the building was initiated in 1968, its inauguration only occurred in February 1980. It is a single block consisting of seven floors that house the hospitalization and administrative sectors. It also has multiple annexes, most of which are outpatient specialty clinics.

The hospital consists of a single unit divided into two areas: outpatient services, with 80 consultation rooms; and the hospital itself, classified by the Ministry of Health as midsize, which is equipped with 220 beds and can perform 250 surgical procedures and admit approximately 700 patients per month. In the outpatient clinics, where approximately 20 thousand people per month are attended, specialized consultations in various areas are provided. In addition to consultations, the hospital performs a range of medium and high complexity examinations (about 50,000 per month) in its ten laboratories, which encompass Clinical Pathology, Anatomopathology and Cytopathology, Radiology, Ultrasound, and Diagnosis.

To attend the diversified clientele, the hospital has a large number of personnel. The nursing staff, for example, is composed of 116 registered nurses, 262 auxiliary nurses and 76 nursing technicians, female and male, totaling 454 professionals, among the nearly 1,100 personnel throughout the hospital. The SC employs 32 nursing professionals, 6 registered nurses, 24 auxiliary nurses and 2 nursing technicians, while in the ICC, 57

nursing professionals, 13 registered nurses, 5 auxiliary nurses and 39 nursing technicians are employed. The SC team, consisting of surgeons, anesthetists and nursing staff (registered, auxiliary and technicians), coordinates the remaining teams and services (laboratories, radiology services, blood bank, etc.). The SC nursing staff perform activities ranging from the acquisition, handling and maintenance of specific equipment, following strict aseptic techniques, to patient care during the pre-, intra- and postoperative periods.

Both the SC and the ICC are located on the first floor. In the SC, low, medium and high complexity surgical procedures are all performed. This location, separated from the main circulation, is strategic, "to prevent nosocomial infections, misuse of materials, better control of personnel and equipment," as one nurse explained. The SC is composed of several interconnected areas, providing the right conditions to perform the surgical procedures. Regarding the ICC, this hospital unit differs from the other units in that, in addition to material and technological resources, it has a concentration of highly skilled professionals to provide the best postoperative clinical care for patients whose health status is critical or terminal. There is constant observation and the medical and nursing care is continuous, with the assistance of a multidisciplinary team and sophisticated technological equipment. The ICC is a model of medical practice directed toward the artificial prolongation of life. According to Menezes (2000), the main characteristic of this hospital sector is, ultimately, the process of the denial of death.

These areas where surgical procedures are performed are endowed with a physical functional structure compatible with the complexity of the actions performed by the nursing professionals and the demands of the sector. Although they are spaces that are restricted to those who develop their activities there, the work performed in this sector is not isolated from the remaining hospital contexts. The procedures performed require continuity, attunement and close coordination with other teams and sectors. For example, among the SC nursing staff, the nurse manager organizes, coordinates and supervises, teaches, and supplies and predicts the amount of materials and

equipment required. This professional elaborates the organizational instruments in nursing, such as the standards, routines and procedures to be followed. They also prepare shift schedules, and supervise the operating rooms and other elements of the sector. Having described the hospital where this research was conducted, we begin presenting our interlocutors and the instruments that we made use of.

## Participants

While conducting the year-long study, during which we diligently visited the hospital to observe the reality of the female and male nurses of the SC and ICC, we maintained close contact with twenty nursing professionals, of whom, only fourteen remained until the end of the study. We had the opportunity to deepen our inquiries and accompany seven of them, four female and three male nurses, in numerous procedures and activities within the hospital and at their homes<sup>2</sup>.

In ethnography, the representativeness of the study subjects is not treated in the same way as it is in other branches of the social sciences (Becker, 1994; Zaluar, 1975), in which the informants are carefully chosen according to criteria formulated in advance and must be representative of analytical categories used in the initial formulation of the problem. In ethnography, the researcher first chooses the field and then seeks to understand its representativeness. The researcher arrives in the field with certain questions or hypotheses, but it is known that these undergo modification throughout the process of contact established with the study subjects. The starting point of ethnographic research is the interaction between the researcher and their "flesh and bone natives", and what is most important is to understand what is being said by the participants, our interlocutors (Fonseca, 1999). It was through this methodological option that we sought to accompany the interlocutors, taking a chance on the proximity constructed, trying to establish a field of intersubjectivity that would allow us to deepen our inquiries.

The age of our seven key interlocutors ranged from 26 to 54 years, three were married, two were single, one was legally separated, and one was widowed. Regarding professional training, three were registered nurses with university degrees, three were nursing technicians, and one was an auxiliary nurse. Evidently, these data do not provide much concerning the complexity of our interlocutors, so we will try to present them, though briefly, during the course of our narrative.

## Instruments

Considering the questions of our interlocutors and the debate within Social Sciences concerning body, we sought to listen to the female and male nurses who practiced in the SC and the ICC of the *Paraíba* teaching hospital mentioned above. The aim was to register their discourses and observe their professional and social activities with the intention of learning their most immediate concepts of the phenomenon stress, as well as the relationship between stress and the body. Over the course of a year, we engaged in ethnographic research, conducting lengthy and semi-structured interviews (Martin, 2009; Minayo, 1993; Victora, Knaut & Hassen, 2000). We sought to develop an ethnographic study, i.e., an intense direct experience of observation over a relatively long period of time.

Our ethnographic findings were thus derived through everyday observations in the hospital, field diary entries and interviews that were recorded and later transcribed. However, ethnography exceeds these research techniques, including all lived experience, even failures and problems in the field; all of which can be grasped by the anthropological view. The choice of ethnographic research should be based on its relevance and actuality in healthcare research. Even when performed differently from quantitative methodology, in which the main characteristics are objectivity, neutrality, statistical treatment of the data, a priori hypotheses, etc., ethnography has proved important in diagnoses in healthcare regarding the possibilities and limits of the use of ethnography in health research Caprara and Landim (2008).

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<sup>2</sup> To maintain their anonymity, during the research, these interlocutors suggested aliases linked to precious stones (Aquamarine, Pearl, Diamond, Solitaire, Onyx, Ruby and Crystal). Seven other nurses - here named Sapphire, Turquoise, Granada, Emerald, Jade, Jasper and Topaz - expressed a desire to have their views recorded in this study; considering their participation at the beginning of the study, they are mentioned occasionally.

However we understand ethnography - whether in the traditional sense defined by Malinowski (1978), or in contemporary ethnographic experiments (Marcus & Fischer, 1999) -, the methodological procedure requires intense involvement between the researcher and their interlocutors, to enable an approximation of the meanings and senses that people attribute to their practices and ways of thinking. With this intention, we sought to achieve participant observation (Malinowski, 1978), attempting to observe the activities and tasks of the female and male nurses.

The study was approved by the Research Ethics Committee of the *Universidade Federal de São Paulo* under Protocol nº 1840/08 on December 12<sup>th</sup>, 2008, and all participants signed the terms of free prior informed consent before their inclusion in the sample.

## Results and Discussion

The biomedical definition of stress is a state resulting from a specific syndrome, characterized by alterations produced in the biological system, or due to the disruption of the equilibrium process, and which requires adaptation processes (Selye, 1976). According to Garfield (1983), references to stress are ambiguous because the term is sometimes used for organic states and, in other works, for environmental factors.

It should be noted, however, that the purpose of this article was to focus the research results on the statements of the female and male nurses, seeking to understand their problems and formulations. Thus, what matters most are not biomedical concepts of the phenomenon stress, but ultimately how our interlocutors defined and characterized it. After all, as Viveiros de Castro (2002) emphasizes, the anthropological endeavor leads us to try to understand the questions of our interlocutors, instead of looking for answers to our own questions.

During the research, it was nurse Diamond, a 53-year-old woman born in *Paraíba* and a registered nurse for 28 years, who most directly discoursed on stress. She reported that sometimes she lay on a bench in the locker-room, trying to recuperate from the day's work. She often constructed images of her own body as "*something broken, worn out and lifeless*". However,

this body resisted, even if nurse Diamond could not explain exactly why. In our meetings, she wondered insistently how it was possible to resist the suffering caused by her work. Other images emerged when we asked her what she considered stress was. On several occasions, she spoke of "*disorganization, professional disrespect, hypocrisy, and physical and mental exhaustion*". Using these expressions, Diamond constructed an image of stress. She later added that getting stressed is "*getting angry, uncontrolled, bad-tempered*". In her narratives, there were frequent references to professional relationships that acted directly on her broken body, stress-provoking relationships.

Diamond's insistence on images of the "fatigued body" as a product of stress extended to all the nurses we talked to. In their narratives we noted something in common: their foremost images were those that associated body and stress.

Crystal, a nursing technician for 29 years, considered the SC her "home from home" due to the amount of time she spent there. Despite emphasizing that her work in the SC was rewarding, she attributed stress to the problems at work and contentious interpersonal relationships. In the interview she stated, "*I consider the work we perform as a team interesting, but it is difficult because of the lack of adequate materials. This causes stress*". According to Crystal, the routine work in the SC and ICC causes a different mode of thinking and feeling. Numerous examples and situations were used to define what she called stress, "*...what causes our stress, at least for me, is the lack of more leisure, i.e., time is badly distributed for each thing in my life*". This stress "*compromises the job because concentration, dialogue, and relationship are missing*".

Like many nurses, Pearl, a young nurse (26 years of age), admits, "*with the stress of work, it is difficult to separate work and personal life, we end up taking it home and even having personal problems*". Stress arises from poorly distributed time and causes lack of concentration, difficulties in dialogue and in maintaining relationships, both at work and in personal relationships. When mentioning the situations that she considered most stressful in the SC - described as a highly complex and exhausting environment for both the patient and the team that performs the procedures -, Pearl highlighted stresses related to patient deaths, as they generate

anguish precisely because *"nothing can be done"* or because, on the contrary, death can be the result of a procedural error. Pearl pointed out that, the events in a SC, which cause lack of concentration, back pain, tiredness, and general discomfort, lead to *"impatience, tension and death"*. The nurse's body responds immediately to the situation of a patient's death, *"one body dies and ceases, another falls ill and languishes"*, concluded Pearl.

The time of a surgical act is critical, both because of the tension of the procedures, in which mistakes cannot be made, and the possibility of the patient's life being at risk. These crucial moments require peace and quiet because *"everything has to go right"*. Aquamarine, a 52-year-old woman and a SC nursing technician for 27 years, told us that everything here is very quick and *"requires skill and knowledge. The patient is always on the threshold between life and death"*. A small mistake can be fatal. Nurses are trained to provide care, to save lives, to intervene directly on bodies in order to produce possibilities of life. When something erupts, when the imponderable arises between desire and practice, the objectives seem to backfire. In this moment, the nurses are tested. Statements describing feeling fatigued are not uncommon when coming out of a moment such as this. Aquamarine told us, *"My body moves, back-and-forth in a way that even I don't understand. I just know that I need to handle everything. ...the things I do crush my body"*.

The body seems to absorb the entire moment. This temporal interval (of the surgical act) can be described by means of symptoms: headaches, fatigue, tiredness, sweating, trembling hands, and the inability to perform simple physical techniques, such as bending over or lying prone. Furthermore, according to Aquamarine, the tired body needs to take account of the activities of the shift: *"I can't get sick. Disease makes me think of my body, broken, helpless and fragile. I get sad, lifeless, when I feel anything different in my body. If I'm tired and stressed, I feel bad and my body screams. I can't tell you how, but it screams"*.

It is, therefore, in the detailed reporting of these symptoms that the nurses focus on discoursing on stress. Nurse Solitaire, a 53-year-old man with 29 years SC and ICC experience, considered other factors to be stress generators: the lack of integration among

colleagues, the orders given by the management, the lack of communication between team members and the intense attention required in the SC and ICC. Since relationships within the hospital itself are considered stressful, criticism then turns to the establishment of these relationships. Thus, stress is not only a biologically defined disease, but also a way of talking about labor relations, of criticizing them, of showing the "effects" these relationships and their own work activities have on the body (Garfield, 1983).

Both female and male nurses seemed to tell us that the established relationships are themselves signs of stress, expressed in the way labor relations and the events of everyday life in the hospital are talked about. Turquoise, a 35-year-old female nursing technician with 8 years experience working in the SC and ICC and who was studying for a specialization in the same field, was clear on the matter, stress arises *"when dealing with a stressed, authoritarian doctor, or when we have to live with a boss that doesn't value or listen to the [nursing] professionals"*. If something goes wrong, the body feels it, a body that, in the words of the nurses, is not only an individual thing, but a set of relationships. And when these relationships deteriorate, the body also deteriorates. This discussion refers to the approach of Duarte and Ropa (1985) and that of Duarte (1986a, 1986b), concerning person and individual.

The content expressed by the nurses reflects the result of what they feel in their bodies in the dynamic of activities in the SC and ICC, both objectively (*"I feel back pain, tiredness and tension"*) and subjectively (*"Sometimes I'm not sure what to say or how to act"*). For Turquoise, *"when I'm stressed, my mind's not right. I end up decompensating my body. There are times when I want to throw it all away or leave it all behind"*. When discoursing on stress, Topaz, a 38-year-old female nursing technician with 10 years SC experience, complains that: *"My body is broken, tired, screaming. I feel weak and impatient. I'm out of energy"*. She explains that she has reached her limit, *"My body and mind suffer. I try to make the stress go away, but I can't"*. Topaz refers to her own body as the focus of the stress experience. It is the apprehension felt in the body that shows its limitation.

Another occurrence linked to stress is death. On this subject, nurse Onyx, a 51-year-old male professional

with experience in intensive care and a graduate degree in the field, reported that those who work in the ICC must have *"emotional self-control, a lot of patience and calm, [because] the health status of the patient is most often critical"*. He says that when someone dies, *"the feeling is bad, you feel a mixture of anguish... I have to be strong, think that I did the best I could..."*, which is why he seeks to *"manage the situations, maybe even with a certain coldness"*.

Ruby, a 35-year-old single male nurse with 15 years ICC experience and trained in intensive care, admits that dealing with patients who present with cardiac arrest *"causes a lot of stress"*, since he keeps thinking that they could die on his shift. According to his conception, *"stress is something that results from the accumulation of many things... I think of stress as rushing around, a situation of fatigue and disorder"*. However, ultimately, it is the possibility of the death of a patient that causes him anguish.

The narratives clearly show that talking about stress is a way of elaborating criticism concerning labor relations, of addressing the difficulties of dealing with death, of thinking about critical moments in which they encounter intense interventions in bodies - the threshold moments between life and death. This criticism is concentrated in the bodies, in their manifestations, in their sensations, in positions, in body techniques. Thus, the body is transformed into a means to substantiate this criticism. Or rather, when talking about stress, the criticisms are inscribed in the body.

As mentioned earlier, in this article we avail ourselves of Michel Foucault's analysis, due to his attempt to understand the intricate relationships between body and power. Foucault is important, because using his theory permits the elaboration of certain questions concerning body and nursing. According to Costa, Souza, Ramos and Padilha (2008), in the field of nursing, Foucault's work has allowed us to appreciate different facets of the practice of this profession from new perspectives. Foucauldian concepts have had profound implications that help diversify the forms of thinking about nursing as a discipline and as a practice. For Foucault, while the subject is posited in relations of production and meaning, she/he is equally embedded in relations of power. Hence the body is a discursive and non-

discursive construct, a product, an infinitely malleable object of power. At the same time, the body is a territory where the events inscribed therein can be viewed and resisted - a territory of domestication and rebelliousness that can struggle against its own events.

The basic idea of Foucault is to show that power relations are not fundamentally drawn from the field of law, or from violence, nor are they basically contractual, or exclusively repressive. Power produces domains of objects and rituals of truth, productive efficiency, strategic richness and positivity. Thus the body emerges as a central element for power, not to torture or mutilate it, but to improve and train it. When Foucault contemplated the mechanics of power, he was thinking of its capillary form of existence, the point where power encounters the very granule of the individual, affects their bodies, is inserted in their gestures, their attitudes, their discourses, their learning, and in their everyday lives. The individual is not the other of power, an external reality, which is annulled by it; he/she is one of its most important effects. In actuality, the things which assure a body, gestures, discourses and desires, are identified and constituted as an individual as one of the first effects of power. The individual is an effect of power and, simultaneously, or due to the fact of being an effect, a transmission center. Power flows through the individual it constitutes.

For the type of power that produces bodies and generates life, Foucault stipulated two levels of operation: discipline and regulatory controls. Discipline is a "general formula" that modernity discovered to work bodies, to train them, to distribute them in space and regulate them in time, in order to make them more efficient, predictable and obedient. Therefore, discipline implies a political anatomy of the body. It acts on the body, in order to control forces, to extract from it, on one hand, an increase in economic strength and, on the other, a decrease in political strength. In corporeal terms, discipline is the technical unit by which the strength of the body is, with minimal onus, diminished as a political force and maximized as a useable force. This process ensures the submission of forces and bodies. In short, disciplines cultivate the docility and utility of the body through the use of schedules, the application of collective training and exercises, and the implementation of a detailed global surveillance



technology. If in discipline, power focuses on the body-as-machine, in the pole of regulatory controls, power acts upon the species-body. The objectives of these technologies are biological phenomena. They are questions of the order of birth, of mortality, of diseases. Foucault named this biopolitics, which does not act directly on individuals, but rather seeks to achieve a global effect through a set of multiplicities. Thus, life in the nineteenth century became a matter for the State with regard to the birth rate, migration, longevity, and epidemics (Foucault, 1999; 2008a; 2008b; 2008c; 2010).

Considering Foucault's approach, we can confine ourselves to the example of the sick body in a hospital. The journey towards becoming a patient, according to Azevedo (2005), begins with the bath, a symbolization of detachment from everything out there, the other life, which proceeds with wearing the hospital gown, with acts of disposing of your personal belongings, of becoming the object of a medical file and a target for certain assignments, of having no right to private correspondence, of there being a correct place and correct time for every activity - a time for silence and talking, sleeping and eating, even for going without food, of coming and going, and of having responsibilities regarding cleanliness and order in the ward. The examination confers new visibility to the patient's body, as well as enabling its deciphering. From the examination, it is possible to qualify, in order to classify, and, from there, one direction follows, from top to bottom. The examination is considered the most important method of knowing the truth about the patient, given the observation of the minutiae that act upon the patient's life and body. During the examination, the body is verified in a variety of positions. Every detail is evaluated, measured, auscultated, palpated, inspected, and smelt. Likewise, everything is subject to scrutiny: the patient's hygiene, their nutrition, their habits, their facial expressions, their complaints, the coherence of their speech, and their mental state. The hospital is revealed as a constructed body, while at the same time, a body that constructs bodies. It is a world in which the body needs to be fixed in a space so it can be cared for and monitored.

If the control of bodies is mostly directed toward the patient, and if the nurses are part of the hospital machine, it cannot be deduced that they are only in a

position to exercise power over other bodies, as seems to be inferred from their narratives. Our interlocutors told us, through the language of stress, that the practice and techniques learned and arduously developed act upon the bodies of those who should monitor, control and manage. In view of the particularities encountered in the course of this research, we can state that those who work there are affected physically and psychologically. The nursing team, primarily dedicated to the act of caring, faces fatiguing situations expressed in images such as "the fatigued body" and "inadequate working relationships", as mentioned in the previous section. This reveals a scene in which all the professionals complain of constant stress and its physical manifestations, which leads us to inquire about the relationships between body, stress and nursing.

According to Azevedo (2005), the construction of knowledge concerning the body by nursing professionals is centered on a specific body: the sick body. Illness, as understood within the biomedical model of healthcare, is constructed within the medical practice, this being the possessor of legitimacy in the field of knowledge and interventions related to health and disease. According to the author, from the moment the patient enters the hospital, he/she begins to be treated as part of the great hospitalized mass. On admission, he/she ceases to assume certain roles that go beyond the geographical barrier, i.e., separation occurs between the outside world and the world of the hospital.

The outside world is the world of work, of production, of earning wages, of professional fulfillment, of family and the affective and symbolic surroundings, of the roles we play as a father/mother, citizen, community leader; it is the world of life that pulses and moves in various directions, making decisions. It is, in short, a world in which the subject perceives and acts with relative autonomy, freedom of movement and expression. The world of the hospital is the world of disease, the production of new knowledge, where scientific knowledge is superimposed on the knowledge and experiences gained throughout life, it is the world of techniques that allow professionals to touch/manipulate the body, the world of hierarchy, of order and routine, of identification, organized by registration number, ward, bed, pathology. It is a world

of such peculiar organization that, as the individual penetrates within, he/she gains another identity, that of the patient, with a routine marked by the fragmentation of time (visiting hours, examinations, cleaning, wound dressing, feeding) and body, into parts on which techniques and procedures are executed (chest X-ray, abdominal bandage, lumbar puncture, oral hygiene). Work assignments (to detail information related to the conditions of the hospital environment, ensure functionality, organize the care provided, and be a guardian of institutional standards and routines) grant the nurse a power that, most of the time, appears informal, subtle and seemingly invisible, but is, undoubtedly, real (Azevedo, 2005).

The actions of female and male nurses in hospitals are not, however, limited to the exercise of power or practices that exclusively configure the empowered pole of the relationship. Observing reality from their points of view reveals another picture, since the nurses narrated experiences of bodies that, in the act of caring, become ill. In the process of caring for the other body (that of the patient), the body of the caregiver supports intense actions that lead to suffering and illness, evident in Aquamarine's narrative:

*At work I am aware of the responsibility and importance of my function. Our 12-hour shift of intense tasks involves direct patient care actions. In many moments, my body is so tired that I experience physical difficulties. It's as if my shoulders, legs and feet don't want to obey my mind. [So] I draw on my energy reserve, with the thought that I can only rest when I finish the shift. This makes me ill. I end up getting sick.*

Caring involves the caregiver and those who need to be cared for in a mutual action. However, the act of caring also produces illness. The body of the caregiver is then evoked to talk about this ambiguous process.

According to the reports of the female and male nurses, in the caring process, a caregiver's body is faced with a sick body. However, in the act of caring and seeking to produce health, the caregiver's body suffers and becomes ill (Figueiredo & Carvalho, 1999). Turquoise narrates the process: *"Sometimes I feel back pain. The pain comes suddenly. I sleep and wake up with it and it disappears after a few days the same way. My whole body is uncomfortable. It makes me very tense, it gets to where I*

*feel pain down my spine and my head hurts".* Thus, the production of health is itself sick. The caregiver's body exerts its practice faced with the other and itself. The result is not simply healthy bodies. The language of stress, actuated as a way of thinking about the reality of the hospital, thus denounces the suffering and even signals the possibility of nurses falling ill during the healing practices.

The body reveals a singular experience that, upon surrendering to caring, often exceeds its limits. Nurse Aquamarine was emphatic in saying that her body needs care: *"I haven't taken care of my body as I should have. My health screams: Beware! My body takes care of other bodies at the hospital, at home, in the family. I need to take care of it too".*

The nurses narrated a drama in which their bodies, in contact with other bodies, suffer. Pearl affirmed, *"...stress enters the body: it is a state, a feeling, an unpleasant moment. [It is a] moment of anguish, of psychological pressure, that afflicts me and causes me uneasiness, extreme worry and discomfort".* Here, stress is suffering. Jade declares, *"When I'm tired, fatigued, crushed, I can't communicate positively".* She adds, *"My body says stress in every sense, my mind begs me to run away and leave it all behind".* In these moments, she admits feeling the need for someone to listen to her.

Stress, according to Diamond's interpretation, affects the "body and soul". The body is understood as a source of meaning, of signification in the subject-world relationship. Thus, the body is a body that feels, that knows, that understands, that communicates with the other through language, gestures and expressions. This body conducts the interlocutors to receive and send messages with a particular and mutual singularity between the caregiver and those who need to be cared for. In this intense dialogue, the bodies of nurses emerge as instruments of care. The caregiver's body, in the act of caring for the other body, based on the techniques developed, performs an action that is not only technical, but sensitive, involving contact between bodies through touching, looking, listening, and speaking. According to Aquamarine, these actions *"involve the sensitivity of the senses, of subjectivity and of interactive communication between the caregiver and those who need to be cared for".* Diamond speaks of touching, of interaction between bodies in the act of caring: *"The*

*contact that I maintain transcends the technical procedures that I have to perform. I speak with gestures, I pray with them if necessary. ...the beauty is in the ability to touch the suffering other. Involvement is finding our continuity in the other, is recognizing that in this life we will always need someone [and that] there is always someone who needs us."*

The nurses' bodies, as we have said, are thought of as an extension of the patients' bodies. Thus, the characterization of these professionals as mere operators of hospital power over the bodies of patients does not envelop this complex construction, in which bodies are considered in very close, sometimes inseparable, relationships. The caregiver's body is involved in the body that needs care. This "involvement in the other" that Diamond spoke to us about is the very constitution of body.

These caregiver bodies are prepared to act objectively, to act on other bodies "technically and objectively". Aquamarine narrated, for example, the technique of postmortem preparation of the bodies:

*Preparing the body following death is a technical act. Once death is confirmed, the next step is to prepare the body and contact the relatives. All the equipment is turned off, the probes, drains and serum connected to the patient's body are removed. The cleaning process is performed. All body cavities are plugged (nose, mouth, ears, anus, etc.) to prevent the escape of foul odors, blood and secretions. The body is identified with a label containing the name, age, medical record number, bed, sector, date and time of death, and then covered with clean sheets. Identification is attached to the covered body, which is taken on a stretcher to the morgue. It is placed in the cold chamber. The belongings are handed to the family, who are responsible for the removal and burial of the body.*

The recurrent passive voice of the narrative seems to indicate the detachment and objectivity that the act requires. Under these conditions, "preparing the body for the slab", a very common expression in hospitals, is a useful metaphor, which refers to the funeral home's marble slabs arranged in the form of a bed on a cement base, and also indicates the "coldness of the act". Everything happens as if the metaphor, once and for all, indicated the need for objectivity, and that this objectivity is cold, detached from the reality of the

affect and affections (Deleuze, 1968; 1992; 1997; 2007) of the nurses. The metaphor is both a description and a critique. Nurse Solitaire told us a story that exemplifies the complex relationship between the need for objectivity in the technical procedures and the daily task of caring for other bodies:

*The case that was most striking in my career as a nurse happened sometime in 1985-86, with the death of a fellow staff member, a university professor. He was 55 years-old, from Rio, and had come to live and work here. At the time, the ICU was practically next to the SC. I took care of him constantly for about two months. He talked to me a lot, told me many things about his life. I saw the desire in him, the strong will to live. He was cultured and intelligent. He did not drink and had this disease. He presented a very swollen abdomen, like a ball; "water-belly" or hydroperitoneum [abdominal ascites]. The disease had evolved a lot in four months. Besides being stressful, this experience in particular, affected me. My contact with him during the hospitalization was very frequent. He was a terminal patient, and I knew from experience that his case was hopeless. At 2 pm one afternoon on my shift, he died. You get sad about a loss like that. I had to do the postmortem preparation of the body, to send it to the slab.*

Solitaire, who had insisted on the fact that caring for the bodies of the dead should be considered a technical act that the nursing professional is prepared for, ultimately revealed the ambiguity of this process when he had to send this colleague to the slab:

*Despite having experienced other moments of preparing the body, this was the one that struck me most, perhaps because of the interaction I had with the patient. No one is prepared to deal with death. Anyone who says they are is lying. Everyone feels and reacts to death in their own way, based on their own experiences, expressing or repressing their feelings. Caring for and preparing a colleague after death transcends our limitations. This experience happened to me 12 years ago. I've been a nursing professional for 30 years and I still remember. It's precisely our sense of powerlessness in the face of death, since there is nothing more we can do.*

It is, therefore, an intense social drama that blurs the boundaries between objectivity and subjectivity, and Solitaire's narrative shows the involvement of the caregiver with those who need to be cared for. We

believe that the pursuit of concepts of stress among the female and male nurses who practice in the SC and ICC of a teaching hospital located in the State of Paraíba, through ethnographic research, led us to the conclusion that, when talking about stress, these professionals evoked their bodies and certain bodily manifestations; i.e., to discourse on stress, these professionals wove narratives in which the principal element was the body.

What we also want to emphasize in this article is that this process of caregiver involvement with the body that needs care is not exempt from suffering. The statements reproduced here support the idea that the caregiver's body itself needs care. Far from the image of controllers of other bodies, exerting power over patients, our interlocutors seemed to corroborate that the body of the caregiver is also fragile and precarious.

Indeed, the caregiver's body develops affect in the act of caring. The cases of deaths, viewed by analyzing the metaphor of "the slab", for example, reveal this ambiguous process of the act of caring, highlighting the involvement of bodies and denoting the dramaturgy of the nurses' practice. Both the patient's body and that of the nurse feel the hospital machine acting upon them; if on the former, the machine hospital objectifies and reifies (Taussig, 1992), for the latter, it produces a broken, fatigued body. In reality, for the nurses of the Surgical Center and Intensive Care Center of this teaching hospital in the State of Paraíba, stress is a powerful way to narrate the complex relationships between the cared for and caregiver, bodies in contact and work.

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