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Reactions and feelings of health professionals in the care of hospitalized patients with suspected covid-19

Reações e sentimentos dos profissionais de saúde no cuidado de pacientes hospitalizados com suspeita covid-19

Reacciones y sentimientos de profesionales de la salud en la atención de pacientes hospitalizados con sospecha de covid-19

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ABSTRACT

Objective: To understand the reactions and feelings of professionals in the frontline of care for inpatients with suspected COVID-19.
Method: Qualitative approach study with 19 health team professionals from a teaching hospital located in the hinterland of the state of Paraná. Data were collected in March and April 2020. For data analysis, content analysis was used.
Results: Of all professionals, 89.5% were female, 57.8% were between 20 and 30 years old. The following emotions and feelings were highlighted by the content analysis: Motivation; willingness to contribute; feelings of fear, anxiety; obligation; preoccupation with death; sadness; discrimination; isolation; prejudice; uncertainty; and doubts about the future.
Conclusion: The research showed workers' reactions/feelings, which were ambivalent both as a motivating impulse and as self-care, such as in the case of isolation/fear in coping with COVID-19.
Keywords: Emotions. Coronavirus infections. Patient care team. Health personnel.

RESUMO

Objetivo: Compreender reações e sentimentos de profissionais da linha de frente, no atendimento a pacientes internados com suspeita de COVID-19.
Método: Estudo de abordagem qualitativa realizado em hospital do interior do estado do Paraná, Brasil. A coleta de dados ocorreu entre março e abril de 2020, por meio de entrevistas com 19 profissionais da equipe de saúde. Para análise dos dados, utilizou-se a análise de conteúdo.
Resultados: Da totalidade dos profissionais,89,5% eram do sexo feminino e 57,8% com idade entre 20 e 30 anos. Da análise qualitativa, destacaram-se as emoções e sentimentos: motivado pela experiência; medo e ansiedade; obrigação; preocupação com a morte, tristeza; discriminação; isolamento; preconceito; incerteza e dúvidas em relação ao futuro.
Conclusão: A pesquisa evidenciou reações/sentimentos dos trabalhadores revelando ambivalência tanto como impulso motivador e cuidados de si, como de reclusão/temor no enfrentamento do COVID-19.
Palavras-chave: Emoções. Infecções por coronavírus. Equipe de assistência ao paciente. Pessoal de saúde.

RESUMEN

Objetivo: Comprender las reacciones y sentimientos de los profesionales de primera línea en la atención de pacientes hospitalizados con sospecha de COVID-19.
Método: Estudio de un enfoque cualitativo. Participaron 19 profesionales del equipo de salud de un hospital universitario en el interior del estado de Paraná. Los datos se recopilaron en marzo y abril de 2020. Para el análisis de datos, se utilizó el análisis de contenido.
Resultados: Del total de profesionales, 89.5% eran mujeres, 57.8% tenían entre 20 y 30 años. En el análisis cualitativo, destacamos: Motivado por la experiencia; Miedo y ansiedad; obligación; Preocupación por la muerte, tristeza; Discriminación; Aislamiento; Preconcepción; Insomnio; Actividad física, lectura, series de televisión; Incertidumbre y dudas sobre el futuro.
Conclusión: La investigación mostró las reacciones/sentimientos de los trabajadores, revelando la ambivalencia tanto como un impulso motivador y autocuidado, como también el confinamiento/miedo al hacer frente a COVID-19.
Palabras clave: Emociones. Infecciones por coronavírus. Grupo de atención al paciente. Personal de salud.

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INTRODUCTION

During the current pandemic, experienced through the potential contamination of the population with COVID-19, caused by the new coronavirus SARS-VoV-2, the main difficulty for health professionals that provide care in the frontlines, with regard to potential hosts of the virus and/or the disease, is the fact that it is a highly transmissible and lethal virus, leading to the fear of the unknown[1–3].

The new SARS-CoV-2 is one of the main viruses of respiratory diseases outbreaks. At first, it was detected in Wuhan, China, where a high number of patients had a connection to a large market of seafood and animals in the region, a situation which suggested that the contamination happened between animals and people, and animals were the hosts of the virus. However, after an investigation, there was a growing number of patients who theoretically had no connection to the animal market, indicating the dissemination from person to person. Currently, it has been determined that this virus has a high and sustained transmissibility among people[1–3].

The new/unknown generates many feelings in the individuals. Similarly, coronavirus, with regard to the lack of knowledge about the disease and uncertainties, with studies still being developed, leads to subjects that are even more susceptible to the risks of contamination. Therefore, the search for knowledge, as well as the transmission of this knowledge through training and work with the different professional categories, can bring more safety to workers.

It is paramount to highlight that, in addition to the lack of knowledge and to the psychological pressure suffered by health professionals with regard to contamination, they still need safety. The lack of knowledge among the main speakers (health professionals) and their interlocutors (patients and/or families) about clinical states can lead to profound sadness and uncertainties about the future[4].

Considering the above, the objective of this study was to understand the feelings of professionals in the front lines of the attention to patients hospitalized due to suspected COVID-19 cases.

METHOD

Exploratory-descriptive study, with a qualitative approach. Due to the multifaceted character of the theme, we chose to use the qualitative approach, since it is more adequate to the study of human phenomena. A semistructured interview was used for data collection, including open questions related to the reactions and feelings of health professionals, considering the attention to patients with COVID-19 or suspected to have it.

The research was carried out in a university hospital targeted at developing care and teaching, which works as a field of practice for several courses in the field of health and is linked to the Single Health System (SUS) in the hinterland of Paraná, Brazil.

The inclusion criteria for health professionals included those who worked in the COVID-19 ward. The exclusion criteria encompassed those who were on leave for any reason during data collection (vacation, medical leave, maternity leave, documented leave, among others).

The hospital counted on 195 beds, exclusively linked to SUS, attending nearly 2,000,000 people with attention from high to medium complexity in many specialties. Currently, it is a regional health reference to receive severe COVID-19 cases.

The COVID unit is made up of 46 professionals from the multidisciplinary team, distributed in the following professions: 11 nurses, 20 nursing technicians, 10 physicians, and 5 physical therapists, who formed the initial multidisciplinary group of the COVID-19 ward of the hospital.

Data collection took place through a semistructured interview, non-validated, from April to May 2020. The interview was made up by 18 guiding questions, about the following data: age, sex, marital status, professional category, educational level, time working in the institution, type of employment bond, and questions about COVID-19, such as: the definition of coronavirus, what motivated the patient to work in the COVID-19 ward, how have they been dealing with their feelings, how it has impacted their daily lives, expectations with regard to the future, professional practice in the COVID-19 unit, and work in the multidisciplinary team.

After data collection, the interviews were transcribed in full into the software Word®. Data analysis was carried out using content analysis, which is defined as a group of techniques to analyze communication, aiming to obtain, through systematic procedures and objectives that describe the content of messages, indexes that allow for the inference of knowledge related to a certain theme[5].

The ethical precepts related to researches involving human beings, established by Resolution No. 466/12, from the National Council of Health, were considered, and this research was evaluated by the Permanent Ethics Committee for Researches Involving Human Beings from the Universidade Estadual do Oeste do Paraná, and approved under opinion No. 3.323.244.

RESULTS AND DISCUSSION

Considering the objective of understanding the reactions and feelings of professionals in the front line of the attention to patients with COVID-19 or suspected to have

COVID-19, this work used a sample of 19 health professionals in the multiprofessional group of the COVID ward. Its results showed that most participants were women (89.5%), while 10.5% were men. In our sample, 68.6% stated to be single and 31.5% to be married. Similarly, in another study, women were the majority among health professionals, since they are culturally considered to be care providers[5].

The age of the participants in the team varied from 20 to 50 years old, and 57.8% were from 20 to 30 years of age, indicating that the team was very young. Regarding the professional category of members of the professional team, 43% of interviewees were nursing technicians; 24%, nurses; 11%, physical therapists; and 22%, physicians.

Regarding educational level, 73.7% of interviewees had complete higher education; 10.5%, incomplete high school; and 15.8%, complete high school.

Regarding time in this position, most professionals from the institution had been working there from one to six months, with 26.5%; 21%, from seven months to two years; 5.2%, from two years and one month to five years; 21%, from five years and one month to ten years; and 26.3%, from ten years and one month to 20 years. It has been found that, among professionals who work in the COVID ward, their time working in the institution was: below six months (26.5%) and from 10 years and 1 month to 20 years (26.3%). When asked about having another employment bond, 84.3% of interviewers answered no, while 15.7% answered yes.

Considering the results of the qualitative investigation, 12 significant themes of analysis were discovered: motivation; willingness to contribute; feelings of fear, anxiety; obligation; preoccupation with death; sadness; discrimination; isolation; prejudice; uncertainty; and doubts about the future.

Regarding the question that addressed the motivation to work in the frontlines of COVID, 10 out of the 19 professionals highlighted experience as a motivation to work in the fight against COVID-19, as the statements indicate:

> [...] *and I like to learn new things, a new modality of work, and I think that coming now to COVID, we will have an experience as work* [...] (S1).
>
> *Experience, because I know it's a difficult situation* (S2).
>
> [...] *it was kind of a part of the residence, except it wasn't mandatory, but I had to participate to get experience* [...] (S4).
>
> *I always wanted to be in the frontlines of something important, at the time of H1N1 I had an opportunity to participate, I always wanted to participate, no matter what* [...] (S3).
>
> [...] *I wanted to make a difference and I think this is my contribution* [...] (S10).

The behavior was analyzed as one that is provoked and guided by personal goals, and that makes efforts to reach objectives. Human motivation is a psychological process that is intimately related to the impulse or the tendency based on the behavioral persistence of the individual. For example, motivation at work can manifest in the worker who seeks to carry out tasks in a fast and precise way, until predicted and/or expected results can be achieved[6].

Dealing with problems to acquire experience is the best way to deal with the stressors that emerge, not only in the work environment but also in personal life, since it is a positive way to approach and solve a conflicting problem. A study carried out with other populations, including master's degree students in health sciences, corroborates these results, and coping factors focused on the problem were shown to be more reliable when compared to the factor of searching for social support[7].

Regarding the feelings and emotions in the actions taking in the new setting, five categories were found: feelings of fear; anxiety; obligation; preoccupation with death, sadness; and prejudice.

> *What I feel is fear, really, I am afraid of being infected... what we see in the media, we get really scared, due to the number of people infected, so then, I feel fear, anxiety* [...] (S1).
>
> *So, at first I was really afraid, fear, that was really the word... another feeling I had: anxiety, that is also there, anxiety, I had a lot of anxiety before coming here.* [...] (S2).
>
> *When the patient is confirmed, the prejudice is greater because we become afraid of being infected, despite taking all care and using all PPEs* [...] (S3).
>
> [...] *What worries the most is not me, but the family* [...] *The emotional load is very heavy* [...] (S6).

Since ancient times, humans depend on fear for survival. It was, most likely, the most related to prevention among the characteristics of human ancestors. Therefore, risks and imminent danger were, often, avoided due to natural defenses available, with which fear was directly involved. This is an emotion that is present in the daily life of each living being, and its definition was "a feeling of restlessness when confronted with the notion of a real or imaginary danger, of a threat; dread, fear"[8:20], which is in accordance to the anguish experience, that cannot be neglected. Fear, however, is an ally

in the formation of wellbeing. In real or imaginary situations, it prepares the body to deal with extreme pressure and to react against threatening situations. As a psychophysical state, it elaborates reactions capable of provoking actions that would not be normally possible. Fear is constitutive of emotion[8].

Occupational accidents, especially those involving infections by pathogenic agents, are the main cause of the preoccupation of health workers, since they can lead to psychological and physical traumas, or even greater complications, such as disabilities and death. Other feelings also emerge, such as weariness, frustration, anger, and guilt[9].

It is necessary to be attentive to the emotions involved, from the perspective of those who are not a part of this reality, since questions about vulnerability are raised that do not only address physical or mental characteristics, but also integrate emotions and the limits to which a person is exposed[8].

The idea of risk is closer to and should be understood as "the obstacles that were too close for us to remain calm and can no longer be neglected"[9:19]. The dangers of negligence stand out, especially with regard to the absence of credibility concerning the potential risks and the trivialization of emotions that involve them, since it can be understood that "no danger is as sinister, no catastrophe hurts as much, as those whose probability is seen as irrelevant "[9:24].

As in the statement:

> [...] *when it all started, I didn't even believe it was all that* [...] (S2).

Fear constitutes the emotions of human beings and is an essentially subjective emotion. Even if it involves the collective, it stems from assumptions about individual feelings or, more adequately, intersubjective ones, since, normally, this is a relation between subjects or between them and an object, whatever it is[9].

> [...] *sometimes, I feel sad, worried, and the only thing that calms me is to put these people in a prayer, when I'm here inside, I'm praying from them too, so I mean it's complicated, sometimes, I really feel like crying, and, sometimes, even like giving up* (S9).
>
> [...] *at first, I was afraid, but not anymore, though of course we have that bad feeling about the people inside who end up dying, that kind of strange sensation remains* (S7).
>
> [...] *the pressure that comes with these cases, both from the media and due to the high mortality and easy contamination* [...] (S16).

Health professionals frequently have to cope with the death of patients and find it difficult to see it as part of the life of individuals, associating it to failure in the therapy and in their effort to seek a cure. When studying how different societies conceive the health-disease-death process, through time, health professionals have their values and beliefs when confronted with death and the process of dying, as well as attitudes and actions related to daily life questions that influence in their personal and professional lives[10].

Working with the death and grief processes means that health professionals must turn to their own death and to the anguish associated to it; Traditionally, these specialized caregivers have the specific role of curing and defeating death[11].

In the set of disciplines to form the main health professionals, they are not taught how to prepare to losses and grief; their formation is targeted at a cure. When health providers, physicians, nurses, psychologists, get in touch with human finiteness, that can lead to practices and attitudes that are not in line with the technical and professional practices, preventing the process form happening naturally[11].

A study has found that health professionals who are working in urgency and emergency sectors can trigger physical and emotional wear, as well as stress, because the environment in which the multiprofessional team works demands immediate and efficient results in the process of caring. Furthermore, with an increasing risk of death, due to the complexity of the care this environment requires, and associated to personal and emotional factors, stress and depression are triggered. Therefore, stressors must be identified at first, so diseases in the professionals can be prevented and/or minimized[12].

In addition to the reports of exhausting work hours, the natural risks of infection, and the lack of PPEs and of an adequate structure to care for the patients, another problem pointed out by the participants of the research was the prejudice of people with regard to maintaining any type of contact with people in the front lines of the coronavirus fight.

> *We are a bit apprehensive, other workers complain about feeling excluded by the team outside* [...] (S13).
>
> *I get upset, because I cannot say I'm working here, yesterday I got really upset, there was a training session in the hospital and when we arrived at a sector, I heard them saying something like this... Those girls you cannot invite, they are from COVID* (S15).
>
> [...] *you see people treating health professionals who work here with prejudice* (S17).

Prejudice is an unfavorable opinion that is not based on objective data, but motivated by hostile feelings brought forth by judgments made out of habit or from hastened generalizations[12]. Just like discrimination, which can be considered to be a type of behavioral response that is intrinsic to stigma and prejudice, these are negative attitudes with regard to the value of specific social groups, in addition to the clear distinctions between ideas, attitudes or ideologies, and behavioral consequences of discriminatory actions[13].

To cope with the emotional impact brought by the pandemic, participants of the research tried to continue performing some daily activities, as well as developing coping techniques, thus creating defense mechanisms to adapt to stress, a defensive hide in which emotions and feelings were dulled in order to promote distancing from people and anxiogenic situations[14].

The word coping refers to all cognitive and behavioral efforts that are constantly mutable, and control internal and external demands that, often, go beyond a person's resources. As a result, coping mechanisms can change with time, according to the realistic characteristics employed to the stressing factors and contextual demands.

Social isolation impacted in the routine of professionals who work in the COVID-19 ward, which can bring serious prejudices for individuals and society. People who are used to a routine of social experiences can feel the consequences of an abrupt interruption of social interaction. The suspension of the provision of services and the closing of spaces of conviviality, as well as the fact that staying home is mandatory, can trigger anxiety and depression.

> *A lot, I became completely isolated from my family and I know it will be for a long time* (S2).
>
> [...] *I'm becoming alone* (S3).
>
> [...] *not being able to get out anymore* [...] (S11).
>
> *I cannot get out, I have to stay home, if I leave, I myself get worried* [...] (S15)
>
> [...] *I avoid leaving the house a lot, only in cases of extreme urgency, such as going to the market, otherwise I stay home, I only get out to come to work* (S17).
>
> [...] *I didn't use to stay home a lot before, I'm missing physical activities, I think I'll start now, I'll let myself be a little more lose, because I used to always give* [...] (S19).

Some reports are worrying, because, in the group investigated, there may be someone suffering from mental and psychic instability, which can lead to a worsening of their emotional state. In addition to the immediate health impairments, there are economic and social losses.

Social isolation, despite necessary in some situations, such as pandemics and epidemics, tends to provoke crises in the supply of food, medication, and other materials necessary to survival, in addition to leading to economic crises, increasing social inequality, hunger, and unemployment.

> *The routine itself, for people, does not impact so much, the highest impact comes from this emotional load* [...] (S6).
>
> *So, my mood became much worse at home, while at work it's the same* [...] (S10).
>
> *The preoccupation took my sleep away for days, on the first twenty days I had lunch and dinner with the phone on one hand* [...] (S13).

The expectation of participants with regard to the future after this experience was also addressed. Most of them gave answers related to acquiring experience, something discussed in the first question, while three participants seemed uncertain about the future, feeling doubt and uncertainty, according to the statements below:

> *I don't know what to say about the future, this will leave a mark* [...] (S3).
>
> *It is an uncertain future, actually, we don't know what to think, it's a feeling of doubt and uncertainty* [...] (S18).
>
> [...] *And, about personal matters, I think this will be an experience that will mark me for life, both emotionally and professionally* [...] (S16).

Considering the pandemic, one must seek paths that lead to an escape route, especially those related to emotional issues during catastrophes, mainly in one's social life. It is essential to elaborate projects to prevent or minimize the effects caused by the pandemic, reconstructing and recovering the emotional state of health professionals, since they have been under a constant condition of vulnerability due to their actions regarding people infected by a disease with a high death rate. This awareness and this reflection must be targeted at the recovery of a healthier and more safe conviviality between the institution and its workers[8].

It is urgent to identify, recognize, and establish the weakness of the other in decision making, since suffering and fragility are common themes. It is necessary to consider the inclusion of others, the relations, the different feelings, as well as what will come and what actions can be planned with the existential care of these professionals in mind. Therefore, considering the reflection about the uncertainties, doubts and, especially, the fear of the future and resilience, society must have confidence and act when confronted with risk.

To this end, being reflective implies in recognizing the health professionals and trusting organization practices. It is, therefore, paramount that preexisting fears are overcome, such as those related to an open, uncertain, and unpredictable future, which generates fear that makes all equal in the weakness, and strangely vulnerable when confronting the risks.

CONCLUSION

The feelings of professionals in the front lines of the attention to patients hospitalized due to suspected COVID-19 cases were understood, whether they were intrinsic or resulting from extreme or risky situations.

Furthermore, this research aimed to aid those involved in the fight against COVID-19 to see how important it is for them to recognize their own feelings, in emotional and social particularities, disconnecting them from crises or daily situations, so that this understanding can minimize problems resulting from the pandemic in daily life and for the post-pandemic future. Another objective was understanding the real emotions involved, through care and through several guiding actions, considering the hypothesis of seeing the individual as a focus, with preventive measures regarding the eminent risks of situations of extreme stress.

The results of this research exhibited the reactions/feelings of workers, unveiling their ambivalence both in the way they encouraged and motivated care for the workers themselves, and encouraged reclusion/fear in coping with COVID-19, thus cooperating for health workers to have a more detailed perspective about the reality of facing COVID-19, considering that they are dealing with feelings such as fear, anxiety, obligation, preoccupation with death and sadness, discrimination, isolation, uncertainty, and doubts with regard to the future.

Therefore, the research reached its objective, unveiling the emotions and feelings of these professionals and collaborating, in some way, for health institutions to seek the development of policies of emotional health care, through actions of appreciation, respect, encouragement, and healthy coexistence among professionals and the institution, to fight against the negative effects that can affect people after the pandemic.

REFERENCES

1. Agência Nacional de Vigilância Sanitária (BR). Nota Técnica GVIMS/GGTES/ANVISA nº 04/2020: Orientações para serviços de saúde: medidas de prevenção e controle que devem ser adotadas durante a assistência aos casos suspeitos ou confirmados de infecção pelo novo Coronavírus (SARS-COV-2). Brasília, DF: ANVISA; 2020 [cited 2020 Jun 10]. Available from: https://www20.anvisa.gov.br/segurancadopaciente/index.php/alertas/item/nota-tecnica?category_id=244
2. Cui J, Li F, Shi ZL. Origin and evolution of pathogenic coronaviruses. Nature Rev Microbiol. 2019;17(3):181-92. doi: https://doi.org/10.1038/s41579-018-0118-9
3. De Wit E, van Doremalen N, Falzarano D, Munster VJ. SARS and MERS: recent insights into emerging coronaviruses. Nature Rev Microbiol. 2016;14(8):523-34. doi: https://doi.org/10.1038/nrmicro.2016.81
4. Quintana AM, Kegler P, Santos MS, Lima LD. Sentimentos e percepções da equipe de saúde frente ao paciente terminal. Paidéia. 2006;16(35):415-25. doi: https://doi.org/10.1590/S0103-863X2006000300012
5. Silva AH, Fossá MIT. Análise de conteúdo: exemplo de aplicação da técnica para análise de dados qualitativos. Qualit@s Rev Eletron. 2015 [cited 2020 Jun 10];17(1). Available from: http://revista.uepb.edu.br/index.php/qualitas/article/view/2113/1403
6. Trettene AS, Ferreira JAF, Mutro MEG, Tabaquim MLM, Razera APR. Estresse em profissionais de enfermagem atuantes em Unidades de Pronto Atendimento. Acad Paul Psicol. 2016 [cited 2020 Jun 10];36(91):243-61. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1415-711X2016000200002
7. Alshmemri M, Shahwan-Akl L, Maude P. Herzberg's two-factor theory. Life Science J. 2017;14(5):12-6. doi: https://doi.org/10.7537/marslsj140517.03
8. Pereira SS, Teixeira CAB, Reisdorfer E, Vieira MV, Donato ECSG, Cardoso LA. The relationship between occupational stressors and coping strategies in nursing technicians. Texto Contexto Enferm, 2016;25(4):e2920014. doi: https://doi.org/10.1590/0104-07072016002920014
9. Tavares LMB, Barbosa FC. Reflections on fear and its implications in civil defence actions. Amb Soc. 2014;17(4):17-34. doi: https://doi.org/10.1590/1809-4422ASOC473V1742014
10. Fernandes MA, Silva JS. Sentimentos e emoções de trabalhadores de enfermagem frente a acidentes de trabalho: uma revisão integrativa. Rev Pre Infec e Saúde.2017;3(2):45-52. doi: https://doi.org/10.26694/repis.v3i2.6208
11. Zygmunt B, Raud R. A individualidade numa época de incertezas. Zahar; 2018.
12. Magalhães MV, Melo SCA. Morte e luto: o sofrimento do profissional da saúde. Psicol Saúde Debate. 2015 [cited 2020 Jun 10];1(1);65-77. Available from: https://psicodebate.dpgpsifpm.com.br/index.php/periodico/article/view/7/5
13. Bezerra FN, Silva TM, Ramos VP. Occupational stress of nurses in emergency care: an integrative review of the literature. Acta Paul Enferm. 2012;25(spe 2):151-6. doi: https://doi.org/10.1590/S0103-21002012000900024
14. Bacila CR. Criminologia e estigmas: um estudo sobre os preconceitos. São Paulo: Atlas; 2016.

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