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WOMEN ON THE FRONT LINE OF COVID-19: IMPACTS ON MENTAL HEALTH AND SUBJECTIVITY

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Abstract: The present study sought to analyze the impacts that the pandemic context generated on the mental health and subjectivity of women who worked on the front lines of Covid-19, understanding the material and subjective conditions to which these workers were subjected. The methodological procedure used in this research is qualitative and exploratory. Seven individual interviews were conducted with a semi-structured script, containing open and closed questions. Regarding the profile of the participants, they had an average age of 49 years, self-declared white, with formal employment, belonging to a high socioeconomic level and had a high level of schooling. The collected data were analyzed under the precepts of hermeneutic-dialectic analysis, with the formation of five categories of analysis to facilitate the identification of shared meanings and own meanings expressed in the speeches. With regard to the results, the interviewees verbalized about the intense workday, the reconciliation between the domestic sphere and the productive sphere, the fear of contamination and transmission of the virus, the feeling of impotence in the face of deaths, the feeling of loneliness in relation to some family members and friends and the presence of solidarity among the professional teams. That said, it was noted that, although they belonged to a high social class and were supported by the institutions in which they worked, the pandemic situation generated psychic and physical suffering in the women in question.
Keywords: Women; Pandemic; Health professionals; Mental health; Work.

INTRODUCTION

Work accompanies humanity since its beginnings, being resignified depending on the context and historical moment in which it is inserted. This contradictory process, through which men materially build society and self-produce, corresponds to a structuring factor in the relationships between subjects, and between these and the world. By contributing to the constitution of subjectivity and expression of identity, experiences in the sphere of work are intimately related to the health of individuals.

Faced with an increasingly globalized world and under the aegis of a neoliberal model, work appears as a form of adaptation to the world market. This way, it became a mediated activity for the production of value to the capitalist, being emptied of meaning and losing its power to guarantee social inclusion and protection. (ANTUNES, 2000).

> And in this market game, workers are exposed to risks that compromise their health and often their lives. Thus, the combination of technological advances, unpredictable acceleration of economic, social and cultural processes, the flexibilization of rights, put human beings in play in their various dimensions, individual and social. (MENDES et.al, 2005, p. 4).

In view of the violent nature of neoliberalism, today, the modes of oppression experienced by the working class find extremely complex forms of expression. They replaced the whip, the supervisor and psychological tests with the illusion of integration and participation (HELOANI & CAPITÃO, 2003, p.107).

These new forms of labor relations are strengthened through the individualistic and naturalizing ideology, which attributes to the subject the responsibility for his own success and failure. This self-referentiality generates a paradoxical freedom that, due to the coercive structures that are inherent to it, turns into violence (HAN, 2010, p.30). In other words, an individual was created subject to the interests of the market, who contributes to the perpetuation and reproduction of neoliberalism by introducing, in his subjectivity, the ideas and images of reality formulated by this system. This way,

the art of governing is placed both in the macrostructural field and in the field of subjectivities (FONSECA & SILVA, 2020, p.62).

However, recently, labor relations have undergone major shocks. In December 2019, in the city of Wuhan, China, the first cases of COVID-19 were identified. It corresponds to an acute respiratory infection caused by the SARS-CoV-2 coronavirus, potentially serious, highly transmissible and globally distributed (MINISTRY OF HEALTH, 2021). In Brazil, along with this health crisis.

> [...] it came the worsening of the political crisis, the accelerated fall towards the bottom of the well of economic recession and unemployment, the increase in insults to institutions, new threats to the environment and the exacerbation of authoritarian speeches and gestures, with the right to explicit flirting with militarism or a civil war. (AGUIAR & XAVIER, 2020, p. 47).

In this context, the situation of the workers worsened even more. According to Antunes (2020, p. 114) "the lethality of the capital pandemic is stamped in its acute tragedy in relation to work: if they go to work, they become contaminated; if they remain in isolation, they will not have the minimum resources to survive.".

In the case of health service workers, the issue was more critical. As pointed out by Almeida (2020), these professionals found themselves facing a scenario of simultaneous installation of problems. Added to this was the situation of scarce resources, the increase in the number of absences from work due to health reasons, the growth in the number of patients, excessive working hours and, consequently, an increase in levels of tiredness. Furthermore, in addition to the high chances of contamination, there were a series of experiences of losses and frustrations, which often turned into profound psychic suffering.

At this point, a gender perspective is needed. According to an article made by UN Women (2020), females accounted for 70% of the workforce on the front lines of the social and health sector during the pandemic. In addition to being in direct contact with the fear and disasters generated by the virus, women also face historical challenges related to gender.

These challenges can be understood through the notion of sexual division of labor, which presupposes the existence of social places demarcated according to gender, limiting women to the domestic sphere. According to Hirata and Kergoat (2007), apart from the separation between male and female work, this phenomenon is characterized by the principle of hierarchization, in which there is an appreciation of male activities and subalternization of the so-called female functions.

As a justification for this asymmetrical relationship, the biological discourse was used, based on the existence of natural instincts that restrict the female sex to roles of social submission and care.

> This work is marked by pain, oppression and illness, especially in view of the naturalization of the subordinate position that women occupy in society and in the hierarchy of the traditional family structure, which leads them to exhaustion in the face of the care required by all family members (MACÊDO, 2020, p.189).

In this sense, women have a triple workday: paid, domestic and care, which implies a lack of time for self-care and the need to support the high load of physical and emotional stress (GUIMARÃES & DAOU, 2021, p.127). Due to social isolation, with the closure of day care centers and schools, domestic and care tasks intensified, producing an overload of women.

Based on the foregoing, it is undeniable to state that women health professionals who worked on the front lines of Covid-19 found themselves in a situation of extreme

vulnerability during the pandemic period, expressing the social tensions generated by neoliberalism, by the Covid pandemic -19 and by historical gender inequality. For this reason, a qualitative research was carried out seeking to understand the impacts that the pandemic generated on the mental health and subjectivity of this group and, thus, give voice to these invisible women.

METHOD

The methodological procedure used in this work was a qualitative exploratory one, in which "attitudes, beliefs, behaviors and actions were worked on, seeking to understand the way people interpret and give meaning to their experiences and the world in which they live." (MINAYO et.al, 2005, p.74).

Seven individual interviews were carried out, with the prior preparation of a semi-structured script, based on information gathered from the reading of already published materials. This script contained open and closed questions in order to guarantee fluidity and respect for the authenticity of the interviewee's speech, allowing him to express elements of his subjectivity.

The study was publicized on the researcher's social networks and the participants made themselves available voluntarily, which justifies the concentration of workers belonging to a high social class. The participants were contacted and invited to participate in the research via WhatsApp and, subsequently, the interview was scheduled through the Google Meet platform. The choice of the virtual medium was due to the recommendations of health agencies and the preference of the participants.

The data collected in the interviews were grouped into five thematic categories and analyzed under the assumptions of the hermeneutic-dialectical analysis, following the steps proposed by Minayo (2014): pre-analysis, material exploration, treatment of the obtained results and interpretation.

The Scientific Initiation research project was approved by the Ethics Committee of `` Pontifícia Universidade Católica de São Paulo``.

RESULTS ANALYSIS: THEME CATEGORIES

In this research, seven women health professionals were interviewed who were between 25 and 59 years old, with an average age of 49 years old, self-declared white, with formal employment, belonging to a high socioeconomic level and had a high level of schooling, that is, complete higher education, postgraduate and master's degrees. As for professional activities, two were physiotherapists, two were psychologists, one was a doctor, one was a nurse and one was a nursing technician.

Therefore, women spoke of a specific social place, not corresponding to the totality of experiences of health professionals in Brazil during the pandemic.

From listening to the interviewees and intensive reading, five analytical categories were built, which grouped similar contents.

MATERIAL WORKING CONDITIONS

In the pandemic, as pointed out by Almeida (2020), health professionals were faced with a catastrophic scenario. These workers lived daily with:

> [...] precarious working conditions, resulting from the scarcity of resources and materials or characteristics of the organization of health work that involve a high workload, prolonged working hours, work in shifts and difficulty in taking breaks and resting. (HELIOTERIO et. al., 2020, p. 04).

According to the authors, the interviewees discussed the material obstacles encountered during the pandemic:

> *"The volume of work was also quite high, we had around 10 to 15 visits in the afternoon. So, it was pretty tight." (G.Q.S.)*

> *"There were 17 beds for 50 people. A team that had 3 people for 50 people (...) I continued working only within my institution, but I extended the hours. Many professionals worked 2 jobs, this is routine. What we saw were many professionals working in three, so it ended up becoming an opportunity to earn extra money and try a new professional opportunity, with that came the fatigue." (R.H.M.)*

At the same time, initiatives created by the institutions were mentioned, such as moments of decompression, to provide support to workers and alleviate the damage caused by the pandemic.

> *"We had a lot of support from the hospital to offer these kinds of moments of decompression. We had these moments, having a place to go to rest, do other things, leave that environment for a while and then return." (R.C.E.)*

After stating this, the reports reveal that, although with a certain support from the institution, the context of the pandemic demanded excessive workloads from these workers, leading to physical and mental exhaustion, as mentioned by Lai et al. (2019).

CONCILIATION BETWEEN THE PRODUCTIVE SPHERE AND THE DOMESTIC SPHERE

Regarding the experiences of the interviewees in the private sphere, they were divided between those who had someone to help with the housework and those who lived alone. To illustrate, two lines were chosen to represent each of the situations:

> *"I had someone to help around the house, but the workload was too great. I worked 12 hours a day, in this context of a war scenario. Good thing I had someone to handle the housework. (...) There wasn't much more time or energy left to do other things." (G.Q.S.)*

> *"I live alone, which is something that helps in a way. (...) as I spent practically the whole day outside, I had little housework, there was no one to help me, but the institution gave us a lot. I had all my meals there, I didn't have to cook." (R.H.M).*

In this sense, for some of these women, the fact of not having children demanded less in terms of non-remunerated tasks. Furthermore, those who were mothers had teenage children, which means that, because they have more autonomy, not only do they need less care when compared to children, but they also have more conditions to help with household chores.

In addition, it is essential to insert the speech of these women in the social context to which they belong. In Brazil, reproductive work in upper- and middle-class families continues to be carried out mostly by black domestic workers (GUIMARÃES & DAOU, 2021, p.122). This points to the need, described by Nogueira and Passos (2020), to racialize the phenomenon of the sexual division of labor, since women are a heterogeneous group, in which race and class determinants add to gender oppression.

THE FEAR PANDEMIC

Faced with a stressful scenario, fear appears as a possible reaction. In the context of the Covid-19 pandemic, fear of death manifested itself as fear of the unknown. According to Jorge, Mello and Nunes (2020, p. 586): "The invisibility of the virus fades the feared object and at the same time makes it omnipresent, producing the characteristic suffocation of anguish.".

That said, the new coronavirus corresponded to an invisible threat, since, in addition to the lack of knowledge of its biological mechanisms, it was not directly observable, generating uncertainties regarding lethality and transmission. Therefore:

> [...] knowledge about possibilities of reinfection, high prevalence of cases among health professionals and high transmissibility of most strains of the virus, but partial ignorance, added to fake news, feeds the imagination, feeding back the feeling of fear, also among professionals. (HORTA et. al, 2022, p.30).

In addition to fearing their own contagion, these health professionals feared the infection of their family, co-workers and other friends, experiencing uncertainty and labelling, reluctance to go to work and high rates of resignation. (PRADO et.al, 2020, p.7).

With regard to the interviewees, the feeling of fear appeared in the speeches in three forms: the fear of contracting the disease, the fear of transmitting the disease and the fear of changes at work. These forms are expressed in the following speeches:

> *"I think the biggest difficulty was when we started to see the team itself, the employees, starting to get Covid. People very close to us, doctors friends intubated. This emotionally disrupted the team. So knowing that any time could be one of us, people started to think that very close friends are going through this and how are we going to survive this." (R.C.E.)*

> *"I could even die, but I don't want to let the people I love, in my house, my family, transmit a disease because of my occupation." (S.T.S.)*

> *"At work it was a change of everything. First, my unit was closed, I didn't know where I was going (...) I asked if I could evaluate wounds and they decided right away that I would just do that. For me it was a very good change, despite all the stress, seeing my colleagues change everything, the fear. The fear of change is very fearful." (C.C.S.)*

For these women, the hospital space was meant, explicitly or implicitly, as a place of risk, in which more direct contact with the virus left professionals more exposed to contracting the disease and possibly transmitting it to other people. Furthermore, uncertainty about the future of work due to changes within the institution also generated fear in the participants. In these cases, the hospital environment was shown to enhance fear.

On the other hand, a woman expressed the opposite:

> *"At that initial moment I was not afraid, because I felt more protected in the hospital than anywhere else. There I knew where the danger was and how to defend myself against it. And out there you never knew." (R.H.M.)*

For her, the hospital appeared as a safe place, while she had greater control over the virus, greater knowledge about the people with whom she lived daily and had more resources to protect herself.

LOSSES IN EVERYDAY LIFE

According to HORTA et. al (2022, p.30), "[...] fear can be increased by confirming factors, such as the loss of a loved one, or signs of compromised health.". That said, the fear related to the context of the pandemic, among other forms, materialized in the losses of both human lives and routines, social relationships and financial stability.

With regard to the interviews, the participants reported having experienced loss of team members, relatives and patients:

> *"I almost lost my father in this last year of the pandemic because of Covid. I find it very difficult to have to continue working in a context like this, with a very important person almost leaving." (F.S.R.)*

> *"It was very heavy because there were deaths every day, I remember weekends when I was the only psychologist at the hospital and then I would look for a patient to visit and when I arrived in the room he had just died. He was going to look for another one, the other one had also died. It was a job where I had to constantly deal with the issue of death, it was very difficult (...) The things we witnessed were very bad. We saw human beings in the worst*

of their conditions. Dealing with these images, witnessing this was impactful." (G.Q.S.)

"It was sad to see patients dying, very serious. Known to people who died. I had an employee of mine who passed away. A lot of people nearby got sick." (C.C.S.)

The constant losses leave marks on the psyche of health professionals. As described by Lóss et.al (2020), the inexorability of the risks of the disease can make these professionals feel fragile, presenting a feeling of impotence, since they have no control over events. See the following statements:

"The team also had a very large emotional part, far beyond the lack of knowledge about the disease, the treatment, making mistakes and getting it right at the beginning of what was good or not for the patient. We suffered with the patients this anguish of what is happening in the world, people are dying and we cannot help, people are suffering in here and we cannot help either." (R.C.E.)

"For me it was a moment, in the second wave, when the demand for assistance was greater than my operational capacity. At that moment I had to make choices, they are very difficult choices, because I questioned myself a lot (...) it hurt me, not being able to do everything I wanted for everyone with the quality I wanted, with the dedication I had. It was the moment when I felt like I wobbled in the pandemic, I felt like I wasn't going to make it." (R.H.M.)

"There was a moment when there was actually a shortage of medication to perform the intubation, which made everyone desperate. We are dealing with lives, we make the promise to try to safeguard that life and knowing that there was no vaccine yet or it was only available, in the beginning, to health professionals. You were vaccinated, but you saw your relative or someone's relative being hospitalized, because you haven't managed to get the vaccine yet." (R.M.C.G.)

In conclusion, it is possible to state that, in some cases, the frustration of losing someone touches on personal issues, bringing psychological suffering to health professionals. This can be explained through the accountability historically attributed to health workers for caring for others. And when the preservation of life cannot be guaranteed or expectations are not met, responsibility becomes guilt.

LONELINESS AND SOLIDARITY

The title of this category was due to the contradiction present in the experiences of health workers. At the same time that they were stigmatized by society, they built very strong bonds within the team.

With regard to the interviews, the distance from close family members and the creation of bonds with other health professionals were addressed in the following ways:

"All this very difficult scenario I had to either keep to myself or talk to the colleagues who were there by my side. It was something I avoided bringing into the house because people wouldn't know how to deal with that information (...) what I did was create very strong bonds with people who were in the same reality as me. That's what helped me keep my head on straight, because we ended up sharing how hard it was, how scary it was. That ended up relieving a little." (G.Q.S.)

""I also feel a lot of solidarity between the professional teams (...) the solidarity was also immense in the relationship between the teams and the patients (...) with my husband it was very difficult, because if I prepared the food, he didn't eat. So, everyone made their own preparations. We did separately, we ate separately. I didn't sleep with him for two years, me in one room, him in the other (...) we wanted to survive, and I saw myself as a potential vector." (S.T.S.)

That said, throughout the pandemic, because they are in direct contact with the virus on a daily basis, this professional category has been stigmatized. Many people considered health professionals to be potential

transmitters of the virus. Furthermore, an internalization of this stigma by the workers themselves was noted. Regarding this topic, Nascimento and Leão (2019) stated:

> Internalized stigma (..) is a direct consequence of social stigma, in which there is an internalization of the stigma suffered, that is, the individual, when aware of the negative stereotypes associated with his circumstance, agrees, applies and reproduces these unfavorable beliefs about himself, disrupting his quality of life and social interaction. (NASCIMENTO & LEÃO, 2019, p.110).

Therefore, it is worth emphasizing the clarity of the internalization of the stigma present in the following excerpt from the speech of participant S.T.S: "we wanted to survive, and I saw myself as a potential vector.". In this, the interviewee demonstrates acceptance of social distancing, understanding herself as a risk factor for her husband.

Finally, the speeches demonstrated the centrality of sharing experiences for the feeling of acceptance in the face of the pandemic context. Sharing feelings and anxieties with other professionals who are also experiencing the same thing promoted a bond of solidarity between these workers, favoring the psychic elaboration of the impacts generated by this very difficult moment.

CONCLUSION

As pointed out by the interviewees in dialogue with the literature, the women who acted on the front line in the fight against the coronavirus appeared as a group extremely affected by the situation. The successive dismantles in the health area and the consequent precariousness of work in this sector, gender inequalities and the effects of neoliberalism were enhanced with the advent of the Covid-19 pandemic.

Therefore, even belonging to a favorable social class and with the support of the institutions in which they worked, work, for these professionals, walked towards illness. They found themselves facing long working hours, lack of resources, low pay, loneliness, high risks of contamination, direct contact with death, fear of the virus, among other factors.

However, despite being in a similar context, the meanings attributed to the experiences were unique. This way, the life story of each woman influenced the way each one apprehended and dealt with reality.

In this sense, the phenomenon of being a woman, a health professional, on the front lines of Covid-19 is multi-determined. For this reason, it is neither possible nor interesting to exhaust its potentialities and forms of manifestation. That said, it is worth emphasizing the limitation of this work, since the gender focus alone appears to be insufficient to address this issue, and it is essential to consider the influence of other social markers, such as race and class.

Therefore, it is considered essential to encourage new research that seeks to critically study this topic in order to help build protection policies for these professionals.

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