Experiences of nursing professionals of the Rioja Health Service (Spain) on their mental health during the COVID-19 pandemic.

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Abstract

Background: The global pandemic of COVID-19 has intensified the psychological impact on healthcare personnel, manifesting itself in terms of stress, emotional well-being, and use of coping strategies.

Objective: The aim is to explore the psychological impact on nurses during the COVID 19 crisis

Methods: A qualitative descriptive phenomenological study was carried out using interviews and written narratives with a sample of 36 nursing professionals (workers of the Riojan Health Service) in the year 2021 to know in first person the emotional management and their coping strategies during the first months of the COVID 19 pandemic.

Results: After the analysis, three themes were obtained: (T1) Perceived emotions, (T2) Stressors, and (T3) Coping strategies. Nursing professionals exposed on the front line to COVID-19 experienced feelings of frustration and fear that affected their mental health, making decision-making and emotional management difficult.

Conclusions: The COVID-19 pandemic has had a psychological impact on healthcare professionals. Early interventions can help mitigate the long-term effects of mental disorders with targeted interventions that promote resilience and psychological support and strengthen the health system's capacity to meet future challenges and ensure quality care.

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Keywords: Coping strategies, coronavirus, Covid-19, mental health, nursing, Stress.

1. Introduction

The outbreak of the COVID-19 pandemic in 2020 had a societal impact that has been reflected in research on the repercussions in different areas. An unprecedented increase in research in this area has been observed (1-3). Pandemics, being inherently disruptive and challenging, generate

significant psychological distress, causing widespread panic and fear in the population. This impact goes beyond the individual level, resulting in psychological flares, including depression, panic, and anxiety disorders (4,5), which persist both during and after the health crisis (6). The constant exposure to high-stress situations, the emotional burden of coping with illness and loss of life, and the uncertainty surrounding the safety of themselves and their loved ones have contributed to a profound impact on the mental health of those who have been in the first care of such patients. (7).

During previous epidemic episodes, healthcare professionals have experienced acute stress disorders, anxiety, adverse psychological effects, mood disorders, and post-traumatic stress disorders (PTSD), along with short- and long-term psychosocial consequences in the general population (8). Meta-analyses have found prevalences of anxiety (31.9%, 95% CI, 27.5-36.7), depression (33.7%, 95% CI, 27.5-40.6), and post-traumatic stress symptoms (23.9%, 95% CI, 14.01-33.76) (9,10).

Nurses, in particular, have faced significant emotional burdens and mental health challenges in performing their duties (11,12). Emotional exhaustion and physical fatigue from coping with illness and death, exposure to traumatic situations, fear of contagion, complex decision-making, and the need to support patients and families under exceptional conditions, coupled with uncertainty about their safety and that of their loved ones (5), have characterized their work experience during the pandemic. These factors have created a substantial psychological burden.

Additionally, the lack of adequate recognition and support has sometimes led these voices to feel silenced. Many health professionals have had to make significant adjustments in their daily lives, compromising their health and psychological well-being due to physical and mental exhaustion (13). This has led to an increase in temporary sick leave, which, in many cases, has resulted in permanent departures from the profession.

In this context, attention has focused on nurses' psychological challenges, highlighting the urgency of providing them with psychological care (14). The psychological impact on health personnel has manifested in stress, emotional well-being, and coping strategies (4,15). Professionals who had direct

contact with patients affected by COVID have been found to have experienced higher levels of anxiety compared to those who did not (16).

Healthcare professionals often prioritize patients' needs over their own, sometimes unaware of or relegating their care needs (17). Healthcare organizations are responsible for caring for the population's health and the staff who provide that care. It is imperative to emphasize the importance of providing adequate support and resources to preserve the mental health of healthcare professionals, enabling them to continue their vital work (18). This comprehensive approach benefits both healthcare personnel and the quality of patient care.

Although many studies have addressed these aspects from a quantitative approach (19-22) few have explored the first-person mental health-level experiences of health professionals directly involved in the care of patients with COVID-19 (23-25). Qualitative research, focusing on open-ended questions, brings additional value to conventional quantitative epidemiological methods, as its nature focuses on the "what" and the "how." This lack of detailed exploration justifies our study's need to address this gap by inquiring into the experiences of health professionals coping with the complexity of the pandemic. (26).

This study explores the psychological impact on nurses during the SARS-CoV-2 crisis. Understanding their mental well-being is crucial for developing effective interventions and occupational health policies, strengthening their preparedness and emotional well-being for future health crises. The narrative experiences of professionals offer valuable insights for designing strategies to mitigate risks to their mental health.

2. Methods

Design

A qualitative descriptive phenomenological study was conducted, which allows us to learn about and explore people's experiences of a phenomenon in the first person (27). Descriptive phenomenology has the closest connection to Husserl's original conception. It focuses on creating detailed descriptions of the specific experiences of others, seeking to unravel the underlying meaning of participants' experiences, emphasizing the importance of capturing the essence and uniqueness of individual experiences in the context of the phenomenon being studied (28).

Research team

Before starting the study, the researchers conducted a reflection exercise. They inquired about their position on the event under study, and their beliefs and motivations openly exposed to the rest of the team. The team comprised 12 researchers, seven men and five women. All of them had experience in health sciences research, and two had experience in qualitative studies (E. G.-C; A. T.-R). None of the investigators had any previous clinical relationship with the participants, nor did they know each other before the study. In addition, the study protocol was audited by an external investigator.

Participants

Purposive sampling was conducted based on a previous study (20) that included 605 nursing professionals recruited on the frontline of care during the COVID-19 pandemic. From this population, participants interested in contributing to this qualitative study are selected to explore in detail their experience during the health crisis (29). Participants were chosen for their ability to contribute meaningful information and respond reflectively to the research questions, allowing for a deeper understanding of their experiences. In total, 36 individuals agreed to participate in the study.

To select the participants, contact was established with the health service of La Rioja, which informed the professionals of the opportunity to participate in the research. The inclusion criteria

focused on registered nurses and nurse auxiliaries who provided direct care to patients diagnosed with COVID-19. The characteristics of the sample are detailed in Table 1. Data collection was carried out between June 19 and August 6, 2020, until data saturation was reached (30), achieved with 36 participants. There were no dropouts.

Table 1. Participants characteristics (n = 36).

Data collection.

The researchers developed a semi-structured interview script after conducting a comprehensive review of the relevant literature (31), which consisted of two main sections. The first section addressed demographic aspects of the professionals, such as age (in intervals), gender, marital status, number of children and dependents, work details such as professional category, type of contract (either permanent or temporary), and years of experience. The second part of the interview consisted of open-ended questions designed from the existing literature (Table 2), focusing on the participants' lived experiences. The COVID-19 pandemic has accelerated the need to explore alternative methods for data collection in qualitative nursing research. Due to the context of the outbreak, some interviews were carried out in person and others through a written space via telematic means (32). The in-person interviews were audio recorded with an average duration of between 35 and 45 minutes. The written narratives recorded 10.097 words. Two researchers conducted all interviews (I.S.-A; P.DP.-H), and confidentiality was ensured by consecutively numbering each interview and removing identification from the transcripts. Transcripts were emailed to participants for verification and correction, if necessary.

Table 2. Interview Questions

Data analysis

An inductive thematic analysis was conducted, which involved identifying more descriptive content for coding with the help of the qualitative analysis software ATLAS-ti 23. These were then reduced and grouped to identify the most coded categories (33). In this process, categories were created

separately for each reflective narrative. Joint meetings were held to merge the analysis results and represent the participants' perspectives. In the face of possible discrepancies, the identification of the theme was based on reaching a consensus among the research team members. Data saturation was observed during the analysis, as they were repeated and did not provide new information. In the transcription phase, the audio and written narratives were transcribed verbatim for later interpretation. In this part of the analysis, alphanumeric codes were used to anonymize the participants (Table 1).

Rigor and quality criteria

Guidelines established by the Consolidated Criteria for Reporting Qualitative Research and COREQ Standards for Reporting Qualitative Research were adhered to when conducting the qualitative study (34). The quality criteria applied in this study included specific techniques and procedures to ensure the findings' credibility, transferability, trustworthiness, and confirmability (35). To ensure credibility, researcher triangulation was employed, with two researchers analyzing each interview. Subsequently, team meetings were held to compare and contrast analyses, identifying emerging categories and themes. Transferability will be ensured by including detailed descriptions of the study and sharing characteristics of the researchers, participants, contexts, sampling strategies, and data collection and analysis procedures. To ensure confidence in the results, an external researcher (R.J.-V) audited and evaluated the study's research protocol, focusing on methods and design. In addition, confirmability was promoted through investigator triangulation, encouraging reflexivity through reflective reporting and a clear description of the rationale for the study.

Ethical considerations

This study was conducted in accordance with the Data Protection Regulation (EU) 2016/679 of the European Parliament and the Organic Law 3/2018 on data protection. Information was treated confidentially and anonymously, as the data were dissociated. The study was approved by the ethics committee of the CEimLAR of La Rioja (reference PI 416). Informed consent and permission to

record the interviews were obtained from all participants. The data collected were used solely for transcription and interpretation within the context of this study.

Results

Demographic data

The final sample was 36 participants, of whom 35 were women. Most study subjects (60.25%) were over 46 years old. Regarding the professional category, there was an equal distribution between registered Nurses and nurse Auxiliary. Regarding labor experience, 75% of the participants had more than ten years of experience in the health field. On a personal level, 27.8% of the participants reported having children or family members in their care (Table 3) (Table 3).

Table 3. Demographic Information.

Themes

Three thematic blocks with their categories were identified: (T1) perceived emotions, (T2) stressors, and (T3) coping strategies, see Table 4.

Table 4. Themes and categories.

Theme 1: Perceived Emotions

The participants addressed a variety of emotional situations that were manifested in a cross-cutting manner in the topics addressed, which complicated the data analysis from a single perspective.

Among the most prevalent emotions in the narratives was the professionals' frustration at not being able to provide more effective support to their patients. One of the participants expressed: "*...we all had the feeling of not doing enough...*" (P4), while another described the emotional impact of witnessing heartbreaking situations: "*It was tough to see people alone and very sick. And you go around again after a while, and you find them dead or on the ground disoriented. That's the most*

frustrating thing." (P16). The limitation of not being able to establish closer contact with the sick, as is common in nursing practice, generated added feelings of frustration: "*...to highlight several things, which for me are the 'worst' and which have affected me the most: the 'barrier' when treating a COVID patient, which made your work most of the time insufficient*" (P18).

Frustration also emerged as a result of helplessness in the face of the inability to provide adequate care due to work overload: "*...we did not get the tasks done on time and felt that we were leaving patients completely stranded and alone*" (P15). Additionally, there was evidence of unease caused by some citizens' lack of responsibility and awareness regarding the pandemic: "*Maybe we could have done more. I feel frustrated and annoyed at this new situation and the irresponsibility of citizens towards us, the health professionals.*" (P9).

The participants revealed the deep imprint that fear left on their work experience, evidencing the perception of personal threat and the intensity of fear at the possibility of putting their lives at risk during their work performance. One participant expressed: "*I have experienced this situation as dangerous; never until now have I had the feeling that I could lose my life in my work*" (P27). This fear has transformed how they face their profession and rethink how they deal with the fear that has invaded them: "*We have experienced something that has changed us. We have seen death, extreme suffering, and fear up close. At the moment, everyone's lives have been turned upside down. It will be difficult to return to how we were before and remove the fear*" (P19). The emotional impact transcended the work environment, affecting daily life and generating difficulties in interacting with the private environment: "*To this day, it is still difficult for me to go out on the street and interact with other people. I only feel calm and safe at home...*" (P13). The connection of fear with the spread of the virus among close personnel and the painful loss of acquaintances added to the sense of anguish and fear: "*The situation generated fear in me as I saw more than 90% of the personnel in my team become infected. Pain when I met people I knew who died*" (P6). This feeling sometimes caused

a dissociation between professionalism and inner reality: "*I thought that the next day I would go to war and those applauded would stay at home protected. I have never felt like a heroine because I would not have shown up at the hospital if I had been given the choice. That was my fear*" (P2). These reflections offer a more complete and closer view of the emotional complexity that health professionals face in their daily work.

The professionals shared experiences that highlight the deep sadness that permeated their work life, revealing a great emotional connection with their patients: "*...sometimes I felt like crying for certain situations of some patients. Most of those who died, died ALONE.*" (P 16), heartbreaking situations of significant emotional impact of witnessing the death of patients without the company of their loved ones; evidencing the persistence of a sadness that has not yet been overcome either physically or mentally: "*It has been a tough and sad stage in my working life. Although I wanted to be there and not somewhere else, at that time. I'm still not over it, neither physically, nor mentally.*" (P 1) not even time after: "*I had never cried so much after a working day and to this day there are times when I still cry just like that, for no apparent reason.*" (P 5)

The work experience was marked by emotional loneliness, an onerous burden to bear by not being able to share significant moments with loved ones: "*It has been tough, especially on an emotional level, not being able to be with your closest loved ones and your true friends.*" (P 8). Uncertainty became a constant, generating anxiety due to the lack of clarity in the protocols and insecurity in executing tasks: "*Almost no day you could go calmly knowing what you were going to do and how you were going to do it.*" (P 4).

Anxiety was present in the stories through bad dreams, insomnia, and a permanent state of alertness: "*Constant dreaming, waking up at night several times..., a constant state of alertness. Palpitations, anxiety...*"(P 22).

The accounts of some participants reveal a lack of motivation, which in specific cases led them to question their continuation in the nursing profession: "*I have lost my vocation, my empathy for the patient. I had the feeling of little support... and little recognition for the effort made*" (P 28).

Despite the challenges, rewarding and grateful moments were highlighted, where the emotional connection with patients was especially significant: "*I cry a lot.... I see in my head the anguish of some people who have later passed away, and of others who have come through it gives me a lot of tenderness and satisfaction.*" (P 16)

As adaptation and learning took hold, satisfaction made its way among the professionals. "*With much effort, we are coming out...very saturated, but with the satisfaction of having done the job well.*" (P 29).

Theme 2: Stressors

Emotion-triggering situations among participants reveal common patterns contributing to their experiences' complexity. These shared events, when recalled, arouse intense feelings, underscoring the deep emotional connection to the events experienced.

The insecurity caused by the lack of information and communication, especially in the early stages of the pandemic, was a constant in creating an atmosphere of nervousness and stress: "*I was quite disconcerted by the information that was continuously given, I think it made people more nervous, it gave the feeling of not having things clear, there was no communication between spokespersons*" (P 24). This insecurity also added to the disorganization, lack of knowledge of how to deal with the disease, and the lack of training of professionals in the face of such an exceptional situation. "*...the lack of training and ignorance of the disease made for months of real chaos and brutal emotional impact.*" (P 19).

Another primary concern that was very present in the participants' accounts was the fear of contagion. The initial fear of facing the virus and caring for COVID patients generated insomnia and anxiety: "*The first month was horrendous. The fear of getting infected... overcame me. Sleepless nights, but literally praying because the next day I had to take care of COVID patients*" (P 13)," *I'm afraid of going back to the ICU and getting infected again. I don't want to be isolated from my family and friends again. I feel sad and guilty*" (P 22). In addition, the reality of seeing colleagues and acquaintances become infected and pass away added additional layers of distress: "*The situation generated fear in me as I saw more than 90% of the staff in my team become infected. Pain when I met people I knew who died*" (P 6).

Fear of infecting loved ones also manifested itself as an additional emotional burden. Preventive measures included the decision to isolate themselves from family to protect vulnerable loved ones: "*I had to stop going to take care of my elderly parents at their house (my mother suffering from Alzheimer's disease) for fear of infecting them*" (P 14). The fear of infecting family members, especially those in risk groups, generated constant concern and, in some cases, drastically modified family dynamics: "... *the greatest fear I had was not about infecting myself but about infecting my family and not being able to continue having my relationship with my children and parents and especially the day-to-day life with my husband, who is a person at risk and not knowing whether I could be contaminating him or not*" (P 25).

The personal and family dimension of the experience during the pandemic is revealed as an additional burden. Some participants expressed the problematic choice of isolating themselves from the family to protect vulnerable people: "*I decided to isolate myself from my family because of the vulnerability of a relative in my husband's care for three weeks. That led to weaning my 18-month-old son, I had a terrible time*" (P 12), producing a significant impact on their lives and intensifying the experience at work:" My parents tested positive and were both hospitalized. I am an only child. It

has been challenging to reconcile work and hospitalized parents whom you cannot see" (P 18). Returning home, a space that should provide relief becomes a challenge and an added overload: "... *much stress also arriving home with uncertainty, small children and alone at home... and with school homework*" (P 21). The impossibility of seeing children for long periods becomes a reality shared by many professionals: "*I, like many of my colleagues, have had to stop seeing my child for two months*" (P 24). Modifications in daily life are highlighted as examples of extreme adaptations necessary during the pandemic: "*Many colleagues have had to modify our lives to be able to offer a service during this pandemic. In my case, I moved into a house all by myself so as not to put my loved ones at risk and so that they would not experience so closely the terrible situation we have seen every day in the hospitals*" (P 27).

Finally, the emotional impact of not being able to say goodbye to a loved one, in this case, the mother of a participant illustrates the personal tragedy that some professionals faced: "...*very difficult to know that your mother is dying and not being able to visit her..... in the end she died without saying goodbye to her...*" (P 30). This experience reflects the complexity and emotional consequences of dedication to the profession in crisis. The combination of these and other less frequent factors detonated not only the professionals' work sphere but also their personal and private spheres, seriously affecting their physical and mental health.

Theme 3: Coping Strategies

Participants shared valuable coping strategies in the face of the challenges of the pandemic, highlighting solidarity as an essential pillar. In the face of the overwhelming magnitude of the situation, collaboration among colleagues proved crucial: "*The helplessness of the patients. I thought I wouldn't be able to. But then... we got organized, and everything went much better. We made a team*" (P 10). The unity in the work proved to be a strength, allowing an effective response and generating a feeling of achievement: "*We worked as one, and that brought us closer together, and we*

did it very well, without collapse, being able to cope with the situation; that was a boost" (P 8).

Teamwork emerged as another vital strategy. Despite the harshness of the fight against the pandemic, the cohesion of the staff contributed to creating a humane and satisfactory work environment: "*The fight was tough, but the teamwork and the high number of colleagues we had for the performance of our duties created a very humane and satisfactory work environment*" (P 2). The mutual support within the team counterbalanced fear and uncertainty: "*I was afraid of being infected by my family, fear of the unknown, sorrow for not being able to help my patients more, sadness for so many deaths we saw, I was lucky to work with a great team, and that helped me*" (P 21).

Resilience and empathy emerged as fundamental elements in the coping narrative. Insecurity and emotional burden were alleviated by finding support among colleagues who shared the same experience: "*The uncertainty of working there was sometimes overwhelming, we found strength in colleagues who were in the same situation, and we leaned on each other*" (P 11). Adapting to an unprecedented care routine was fundamental to overcoming adversity: "*I think definitively this situation has changed us in one way or another; for better, for worse... or both in a sense, it has taken us out of the care routine to face something never seen before*" (P 27). The willingness to alter their personal lives for the benefit of society highlights the extraordinary dedication and shared sacrifice: "*We have sacrificed quite a bit because we felt the situation deserved it*" (P 27).

Professionalism and vocation were comforting elements, and despite the confusion and fatigue, the crisis reinforced in many participants their vocation in the profession: "*It has been chaotic and unexpected, but at the same time, it has comforted me as a person and professional, making it very clear to me the strength of vocation in this profession and how important it is*" (P 4). The satisfaction of a job well done has also been a constant in the discourse of the participants: "*It has been a hard stage, but I am happy because I have been up to the task physically and professionally; what has gone through our heads for us remains*" (P 14).

Taken together, these coping strategies highlight the resilience and adaptability of health professionals, underlining the importance of collaboration, solidarity, and vocation in times of crisis.

3. Discussion

The study highlights the complex emotions experienced by healthcare professionals during the COVID-19 pandemic. Frustration is constant due to the feeling of powerlessness to effectively support patients, compounded by restrictions on establishing close contact and an overwhelming workload (36). Fear also plays a prominent role in altering work outlook and personal life. Sadness is intensely manifested, especially when witnessing the death of patients in solitude. These findings are aligned with previous research highlighting the severe emotional impact on healthcare providers, including intensive care nurses. (37,38) Emotional loneliness, uncertainty, and demotivation are common, exacerbated by unclear protocols and organizational dysfunction (39). Lack of information and communication initially contributed to insecurity and anxiety among healthcare professionals, compounded by a lack of preparedness to address the disease. However, amidst these challenges, rewarding moments of connection with patients emerge that provide satisfaction. Amid adversity, resilience and learning offer a glimmer of hope for coping. These findings are consistent with previous research highlighting the burden of care, lack of resources, and limited understanding and treatment of the virus as crucial factors in the distress experienced by healthcare professionals. (40,41)

The fear of contagion represented a significant emotional burden for healthcare professionals and their loved ones, leading to difficult decisions such as family isolation to protect the most vulnerable (42). Other studies indicate that fear is a natural reaction to threats, and a lack of knowledge characterizes the current experience of COVID-19 (43,44). This lack of knowledge triggers feelings of loss of control, concerns about one's own and loved ones' health, and social isolation (45). The personal and family impact of the pandemic, combined with work-related stresses, forced some professionals to make painful decisions, such as separation from loved ones to protect their health.

The continued threat of further outbreaks has left healthcare workers exhausted and vulnerable. Consequently, it is critical to implement psychological support measures and provide timely interventions for those presenting with psychological symptoms due to the overwhelming workload experienced during the COVID-19 crisis. (43) This recommendation builds on previous research highlighting the importance of caring for healthcare workers' mental health during crises (43). Providing the necessary support is essential to ensure the comprehensive well-being of these professionals, recognizing the value of their care work and ensuring they have adequate resources to meet future challenges (20).

The nursing professionals in our study demonstrated a strong sense of professional duty and purpose and a deep commitment to the well-being of patients. Despite the various adversities caused by the pandemic, they strived to deliver the best possible care to provide quality care (20). These vocational and professional values motivated them and provided a solid focus to continue their work. This dedication reflects individual resilience and nurses' commitment to excellence in health care during difficult times (46). However, studies have found that participants' low resilience to the work environment and conditions led to burnout and mental fatigue (47).

As found in previous research, peer interactions and teamwork emerged as fundamental elements to sustain the well-being of professionals (20) as a protective factor, especially during the most challenging periods of the pandemic. These dynamics provided support and companionship in the workplace and served as a safe space for expressing thoughts and emotions personally (48).

Strengths and limitations

One of the limitations of our study was about the idiosyncrasy of nursing professionals in our country since it should lead us to estimate the results of differences by sex with certain reservations due to the sample distribution with 97.2% of women versus 2.8% of men.

Another limitation of the study was the impossibility of maintaining physical contact with the participants due to the restrictions of the pandemic in 2021, so written narratives were made and it

was not possible to complement the data obtained with the non-verbal communication of the participants. This restriction also led to the inability to provide direct emotional support during the research process.

Conclusions

The COVID-19 pandemic has illuminated the psychological impact on nursing professionals. Emotions such as frustration, fear, anxiety, and stress were identified, profoundly affecting their emotional well-being and ability to provide adequate care. The scarcity of resources, overwhelming workload, and pervasive uncertainty significantly contributed to these negative experiences.

It is recommended that specific interventions be implemented to mitigate these effects and promote resilience, including psychological support programs, promotion of self-care, and provision of adequate resources and training. These measures are not only crucial during the current pandemic but also for future health crises. By recognizing and addressing the emotional challenges of nursing professionals, we can strengthen the health system's ability to meet future challenges and ensure quality care for all.

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Author Contributions

E.G.C-B., A.T.R. designed the study; P.D.P.H., and I.S.A. collected data; R.J.V., R.R.D.V., P.K. S.G.F. and V.M.I.-M. organize the data; A.M.S., E.C.S., and V.G.C. contributed to the discussion. All authors had read and approved the manuscript.

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Table:

1. Table 1. Participants characteristics (n = 36).
2. Table 2. Interview Questions
3. Table 3. Demographic Information.
4. Table 4. Themes and categories.

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Supplementary Files

Figures

Participants characteristics (n = 36).

Participants	Age	Sex	Marital status	Professional category	Labour experience (Years)	Type of employment relationship	Head in charge	Number of children
P 1	>50	Woman	divorced	Registered Nurse	>10	Civil servant	no	two
P 2	46-50	Man	married	Nurse Auxiliary	>10	Not Civil servant	no	two
P 3	46-50	Woman	single	Nurse Auxiliary	>10	Civil servant	yes	none
P4	36-40	Woman	married	Registered Nurse	>10	Not Civil servant	no	two
P5	36-40	Woman	married	Registered Nurse	>10	Not Civil servant	no	two
P 6	26-30	Woman	single	Registered Nurse	0-10	Not Civil servant	no	none
P 7	46-50	Woman	married	Nurse Auxiliary	>10	Not Civil servant	no	one
P 8	46-50	Woman	married	Registered Nurse	>10	Civil servant	no	one
P 9	>50	Woman	married	Nurse Auxiliary	>10	Civil servant	no	two
P 10	26-30	Woman	single	Registered Nurse	1-5	Not Civil servant	no	none
P 11	26-30	Woman	single	Nurse Auxiliary	0-10	Not Civil servant	no	none
P 12	>50	Woman	married	Nurse Auxiliary	>10	Civil servant	no	two
P 13	46-50	Woman	married	Nurse Auxiliary	11-15	Not Civil servant	no	two
P 14	46-50	Woman	separated	Nurse Auxiliary	11-15	Not Civil servant	no	two
P 15	46-50	Woman	married	Nurse Auxiliary	>10	Civil servant	yes	one
P 16	>50	Woman	married	Registered Nurse	>10	Civil servant	yes	one
P 17	26-30	Woman	single	Registered Nurse	0-10	Not Civil servant	no	none
P 18	<25	Woman	single	Registered Nurse	1-5	Not Civil servant	no	none
P 19	>50	Woman	single	Nurse Auxiliary	>10	Not Civil servant	no	one
P 20	26-30	Woman	single	Registered Nurse	1-5	Not Civil servant	no	none
P 21	26-30	Woman	single	Registered Nurse	1-5	Not Civil servant	no	none
P 22	36-40	Woman	married	Registered Nurse	>10	Civil servant	no	one
P 23	>50	Woman	married	Nurse Auxiliary	>10	Civil servant	yes	two
P 24	>50	Woman	divorced	Registered Nurse	>10	Not Civil servant	yes	one
P 25	26-30	Woman	single	Registered Nurse	11-15	Civil servant	no	none
P 26	46-50	Woman	divorced	Registered Nurse	>10	Civil servant	no	two
P 27	36-40	Woman	married	Registered Nurse	>10	Civil servant	no	two
P 28	46-50	Woman	married	Nurse Auxiliary	>10	Civil servant	no	one
P 29	>50	Woman	married	Nurse Auxiliary	>10	Civil servant	no	two
P 30	26-30	Woman	married	Nurse Auxiliary	>10	Not Civil servant	no	none
P 31	36-40	Woman	single	Nurse Auxiliary	1-5	Not Civil servant	no	one
P 32	46-50	Woman	married	Nurse Auxiliary	1-5	Not Civil servant	yes	two
P 33	46-50	Woman	married	Nurse Auxiliary	>10	Not Civil servant	yes	none
P 34	>50	Woman	married	Registered Nurse	>10	Civil servant	yes	two
P 35	>50	Woman	married	Registered Nurse	>10	Civil servant	yes	two
P 36	>50	Woman	married	Nurse Auxiliary	>10	Civil servant	yes	two

Interview questions.

How has the frontline experience of dealing with a pandemic affected you psychologically?
What changes have you noticed in your mental health since the pandemic began?
What strategies have you used to manage your work-related stress and anxiety during the pandemic?
What measures do you think could be implemented to improve the emotional support and mental health of nursing professionals in crises such as the COVID-19 pandemic?

Demographic information.

		Registered Nurse (n)	Auxiliary Nurse (n)	**Total (N,%)**
Sex				
	Men	0	1	1 (2.8%)
	Women	18	17	35 (97.2%)
Age				
	<25	1	0	1 (2.8%)
	26-35	6	2	8 (22.2%)
	36-45	4	1	5 (13.9%)
	46-55	2	9	11 (30.6%)
	>55	5	6	11 (30.6%)
Laboral experience (Years)				
	1-5 years	4	2	6 (16.7%)
	6-10 years	2	1	3 (8.3%)
	11-15 years	1	2	3 (8.3%)
	>15 years	11	13	24 (66.7%)
Dependents in my charge				
	yes	4	6	10 (27.8%)
	No	14	12	26 (72.2%)

Themes and categories.

	Themes (T)	Categories
T1	Perceived Emotions	Frustration, fear, sadness, loneliness, uncertainty, gratitude, anxiety, demotivation, satisfaction.
T2	Stressors	Insecurity, lack of communication, fear of contagion and of infecting others, lack of knowledge of the disease, and difficulty living with the family.
T3	Coping Strategies	Solidarity, teamwork, resilience, empathy, professionalism, vocation