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# Psychological care in a COVID-19 Intensive Care Unit: psychologists' experiences

## *Atenção Psicológica em uma Unidade de Terapia Intensiva COVID-19: experiências de psicólogos*

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### Abstract

#### Objective

This study sought to understand the interventions of hospital psychologists in the COVID-19 Intensive Care Unit (ICU), to identify the difficulties experienced by these professionals, and describe the emerging emotional impacts on them.

#### Method

Participating in the research were nine psychologists, aged between 25 and 44, who worked in intensive care units in public and private hospitals for an average of 15 months. Narratives were analyzed using qualitative content analysis.

#### Results

Two thematic categories were revealed: emotional impacts and their implications on mental health and professional practice; and psychological practices in the COVID-19 Intensive Care Unit: possibilities and challenges

#### Conclusion

The intensification of mental health impacts on healthcare professionals, including psychologists, was evidenced, leading to changes in care practices, such as virtual visits and interventions with staff members.

**Keywords:** COVID-19; Hospital Psychology; Intensive Care Units.

### Resumo

#### Objetivo

Conhecer as intervenções dos psicólogos hospitalares na Unidade de Terapia Intensiva COVID-19, identificar as dificuldades vivenciadas por esses profissionais e descrever os impactos emocionais emergentes nos mesmos.

**Método**

Participaram da pesquisa 9 psicólogos com idade entre 25 e 44 anos, atuantes em unidade de terapia intensiva durante o tempo médio de 15 meses, em hospitais públicos e privados. Os relatos foram analisados através da análise de conteúdo qualitativa.

**Resultados**

Desvelaram-se duas categorias temáticas: impactos emocionais e suas implicações para a saúde mental, -para a prática profissional e práticas psicológicas na UTI COVID-19: possibilidades e desafios.

**Conclusão**

Foi evidenciada a intensificação dos impactos para a saúde mental dos profissionais de saúde, incluindo o psicólogo, o que ocasionou mudanças nas práticas assistenciais, como as visitas virtuais e as intervenções com os colaboradores.

**Palavras-chave:** COVID- 19; Psicologia Hospitalar; Unidades de Terapia Intensiva.

This study stems from the questionings raised from the experience of a psychologist working in an Intensive Care Unit (ICU) and focuses on the experiences of the intensive care psychologist in the COVID-19 ICU.

In January 2020, the World Health Organization (WHO, 2020) declared the COVID-19 epidemic a public health emergency of international concern, and in March 2020, it was categorized as a pandemic, given its spread across all continents (WHO, 2020). The emergence of the pandemic caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), etiological agent of Coronavirus Disease 2019 (COVID-19), posed a challenge for psychology in extreme situations. This challenge was described by Vasconcelos and Cury (2017) as an exercise in seeking the construction of new actions while confronted with unusual human contexts that are potentially generating intense suffering and abrupt changes in lifestyle.

According to Faro et al. (2020), the COVID-19 pandemic established itself as a critical social crisis, increasing concerns about mental health. Moreover, it is one of the most irrefutable global public health adversities, affecting virtually the entire planet (WHO, 2020).

As a result, the need for assistance rapidly increased, leading to overcrowding in healthcare systems. This occurred due to the widespread fear of the disease, as well as the severity of some symptoms, particularly respiratory symptoms, which in turn caused chain difficulties in healthcare systems worldwide (Brooks et al., 2020). This overload occurred at all levels of care, but especially at the tertiary level, in various countries across all continents (Peeri et al., 2020).

The Intensive Care Unit is a hospital device designated for the reception and treatment of critically ill patients who present clinical instability or are at risk of vital clinical instability. Therefore, they require high-complexity support with multiple monitoring modalities to sustain life during conditions of extreme clinical severity and the risk of death due to organ failure. Thus, constant surveillance and monitoring (24 hours) and continuous titration of treatment are essential, actions that should be placed under the responsibility of a qualified multidisciplinary team (Conselho Federal de Medicina [CFM], 2020).

According to the resolution of the Brazilian Federal Council of Medicine, a critically ill patient is someone who may experience degradation of one or more vital organ functions, facing respiratory, renal, cardiovascular, metabolic, neurological instability, or pathologies that may lead to the instability of these systems (CFM, 2020).

In the ICU environment, unfamiliar equipment, invasive procedures, constant deprivation, pain, thirst, immobilization, noise, and alarms are inherent to the patient routine. According to

Barth et al. (2016), the environmental aspects of the ICU predispose patients and their families to emotional impacts and can trigger situations that lead to psychopathological changes for the patient, their family, and the healthcare team. Feelings of distress, threat, and perceived risk of death are present, which may trigger helplessness and psychological disorganization.

In this scenario, strategies based on the identification of emotional alterations by the psychologist and/or the healthcare team are essential. When we can adequately detect the presence of possible alterations, they can receive proper attention and management early on. It is important to emphasize that the psychologist's insertion in the intensive care team aims to add his knowledge and skills to the other care services in order to promote a broad support to the patient's life in a biopsychosocial dimension (Sebastiani & Di Biaggi, 2016).

The role of psychologists in the ICU encompasses actions ranging from prevention to palliative care, referrals, and planning for post-discharge. According to Kitajima (2014), the intensive care psychologist has a role alongside the patient, the team, and the family. In general, the following interventions are highlighted: supporting patient reception, minimizing psychological impact, understanding psychosocial aspects, demystifying routines and practical issues, facilitating expressions of affection, and promoting patient-team-family communication. Caiuby and Andreoli (2005) add to this: differential diagnosis, psychological support, environmental management, and complementary techniques.

According to Ministério da Saúde (2020), the COVID-19 pandemic has brought about unprecedented and large-scale epidemiological, social, psychological, and economic damages. In this context, in addition to the terror caused by the high transmissibility of the virus, the symptoms of illness, and the high mortality associated with it, we are also experiencing the impacts of social isolation, essential for containing virus infections. In the face of ICU hospitalization, these impacts have been intensified by the stressful events characteristic of hospitalization and COVID-19, marked by anguish, fear of death and intubation, guilt, embarrassment, lack of knowledge and uncertainties about treatment and prognosis, and isolation from family (Moretto et al., 2021). Thus, both patients and their families, as well as healthcare professionals, including psychologists, have been affected (Caurin et al., 2021).

Considering this, questions have arisen: how did psychologists operate in the intensive care context during a pandemic? What impacts did it have on the mental health of professionals? What supported it and what was its result? Hence, this study aims to uncover the professional and personal experience of psychologists in the COVID-19 ICU. To do so, two thematic categories were explored: emotional impacts and their implications on mental health and professional practice; and psychological practices in the COVID-19 ICU: possibilities and challenges.

## Method

### Participants

This is a qualitative-exploratory study conducted with six women and three men hospital psychologists, aged between 24 and 44 years, working in the COVID-19 ICU for an average of 15 months. Among the nine participants, three had specialization in hospital psychology prior to the pandemic, while the others had specialization in other areas related to health or education. Most worked exclusively in public hospitals, with three having worked in private hospitals. Regarding

theoretical approaches, two are rooted on Gestalt therapy, one on Behavior Analysis, two on Cognitive-Behavioral Therapy, and four on psychoanalysis.

The snowball sampling technique was employed, which is a non-probabilistic technique based on a chain of referrals. Initially, key informants were approached, and then the “seeds” helped to identify the group to be researched, as defined by Vinuto (2014). The sample size was determined based on saturation point. That is, the point at which new interviewees start to repeat content already covered in previous interviews, without adding new significant information to the research (Baldin & Munhoz, 2011). Psychologists who did not sign the informed consent form were excluded.

## Data Collection Procedures

Data collection took place either in-person or virtually, according to the interviewee’s preference, between August and September 2021. A semi-structured interview was used, consisting of two parts: Part A, aimed at collecting sociodemographic data; Part B, addressing questions aligned with the proposed objectives. Part A pertains to the sociodemographic profile, seeking information about the participants’ education and professional experience. Subsequently, the second part of the semi-structured interview was conducted, focusing on the psychological interventions performed and the challenges faced in providing care to COVID-19 patients hospitalized in the ICU. The instrument was created by the researcher. The semi-structured interview combines closed and open-ended questions, allowing the interviewee to discuss the topic without being influenced by common perceptions. Furthermore, it facilitates the approach and ensures that hypotheses or assumptions are covered in the conversation (Minayo, 2010).

## Procedures

Participant selection was conducted using the snowball sampling technique, where contacts were made through telephone based on the referrals provided by each interviewee. The scheduling and execution of the interviews were arranged individually with each participant, based on their preferences and availability. The interviews were recorded, and their transcription was done manually by listening to each interview, pausing and repeating as necessary.

Regarding categorization, it was done based on the interview questions. Considering the potential risks and benefits involved in the research, participants received a copy of the Informed Consent Form, which clarifies, among other aspects, that participation can be terminated at any time and that anonymity will be respected. This research was approved by the University’s Research Ethics Committee (No. 4.687.910).

A qualitative content analysis was conducted. According to Bardin (2011), content analysis is a set of techniques for analyzing communications, and it allows, among other things, to avoid the dangers of immediate understanding. The different phases of content analysis are organized into three chronological poles: pre-analysis, exploration of the material, and treatment of the results. The first phase (pre-analysis) can be identified as an organizing phase, in which a precise work plan is established, with well-defined yet flexible steps. As for the interviews, they are transcribed, compiled, and thus form the research corpus. In the material exploration phase, coding units are chosen. Once this is done, they are classified into blocks that express certain categories, confirming or modifying those initially proposed in the hypotheses and theoretical framework. The third phase of the content analysis process is called treatment of the results – inference and interpretation. In this phase, the researcher takes the raw results and seeks to make them meaningful and valid.

This interpretation should go beyond the manifest content of the documents as the researcher is interested in the latent content, i.e., the meaning that lies behind what is immediately grasped (Bardin, 2011).

## Results and Discussion

### Emotional Impacts and their Implications on Mental Health and Professional Practice

The following aspects stood out in the statements of the interviewees: conflicting/ambivalent emotions, fear (of dying, of transmitting the virus to others), fatigue/exhaustion, and a high death toll. Regarding ambivalent emotions, let's look at the statement: "When suddenly I felt that mix of fear, of wanting to help, of insecurity, of transmitting it to the family, and so on" (P1). On the other hand, P9 brings another fluctuation related to the experiences in their daily routine: "We went from extremes, situations that were emotionally complicated (...) to that extreme of joy, of euphoria when someone is discharged (...) Because the family's appreciation was so great that sometimes we felt like we were a part of it".

In this sense, but relating to social repercussions, P10 said, "Can you imagine how our heads were like? At one point, we were being attacked on the streets because we were contaminating everyone, and then suddenly, everyone wanted to applaud us". Added to this is the ambivalence associated with the repercussions on family dynamics, mentioned by P1: "My husband at the time said that if I went to work, I wouldn't be allowed back home (...) And that caused me a great deal of suffering because I also wanted to be here helping, and at the same time, I felt stuck".

These accounts begin to illustrate the intensity of the emotions experienced in this context, indicating how numerous variables unfolded, abruptly changing daily life, disrupting what was familiar, and contributing to the onset of personal crises. In the face of such a humanitarian and health crisis of enormous proportions, it became urgent to rescue our coping strategies (Folkman, 2012) and build new ones.

Continuing with the participants' statements related to the emotional dimension, let's refer to the fear of getting infected and transmitting the virus: "It was painful for me to know that (...) I could get infected, and not only infect myself but also transmit the virus to other people" (P3). "Many professionals had comorbidities (...) we were in a war zone (...) Anyway, it was completely overwhelming" (P6). With this, we glimpse an extremely intense routine, as expressed by P10: "It was a constant concern. How am I going to go back home? I'm going to infect my family. That stayed with us: I'm going to infect my family! So, there was a whole ritual we had to go through to return home".

According to Oliveira et al. (2020), the mental health of professionals was compromised mainly due to the fear of their own contagion and the fear of infecting family members or friends upon returning from work. In times of a pandemic with an unprecedented historic dissemination, unfavorable working conditions and an extraordinary increase in demands for assistance tend to be intensified.

In the meantime, it is worth highlighting some statements that referred to fatigue/exhaustion: "This life completely changed all of a sudden, this eternal tension, it was 24 hours, there was a lot of worry about both the work and home environment, and in the end, the physical exhaustion was too much" (P10). In response to this, P1 added: "But it was really a tremendous fatigue, my body

tingled, I couldn't get the necessary sleep to rest my mind and body, but I kept going. Exhaustion, I never thought I would need an anxiolytic", explicitly highlighting one dimension of the impact on health through the need for medication.

Finally, P2 reinforces the statements of colleagues and highlights the need to seek support: "It's a very intense pace dealing with frustrations, because through our perspective, we identify many demands that sometimes were not verbalized or requested from us (...) if you don't have support, you can get sucked into that". Corroborating with the participants' accounts, Faquineti (2020) and Jung and Jun (2020) emphasize the enormous psychological impact that the pandemic has caused and will continue to cause on individuals, which is even greater for frontline healthcare professionals due to their exposure to long periods of anxiety, stress, and fear-inducing situations.

Caurin et al. (2021) point out the development of symptoms related to stress, anxiety, and depression among psychology professionals in the pandemic scenario. In this perspective, they think about the difficulties associated with the flow, emergency situations, and contact with patients, as well as the need to adapt quickly to the reality of online attendances for psychological intervention. They also emphasize the need for careful attention to psychologists regarding problems generated by the pandemic, as well as the demand for new studies that consider this panorama (Caurin et al., 2021).

Another recurring dimension in the statements refers to the intense and constant proximity to the risk of death and the numerous deaths experienced in the work context, as mentioned by P2: "There had been four deaths during one shift. So, when I arrived in the afternoon, the whole team was shaken, and then we had three more deaths in the afternoon, and everyone was devastated". Often, the deaths were fast and unexpected: "Sometimes, we would admit the patient, provide care, and the next day the patient would already be intubated. And then sometimes, in the following day, they would pass away" (P4). The loss or threat of loss was constant, present at home and at work:

First, it was when we lost a staff member, and I witnessed the whole process, I was here in the ICU at the time of their death. And then, when my mother was hospitalized due to COVID (...) I started fearing death, it troubled me. Besides the fear, I began to notice that my heart was racing (...) Then it started: forgetfulness, headaches, fatigue, I couldn't sleep well, stress (P1).

While witnessing multiple losses within the same family, P6 questions: "How are we going to cope with the grief of so many losses? Because I think it all happened so quickly, many families lost not just one, but parents, mothers, siblings". Among the various ruptures and changes caused by the pandemic, it is worth highlighting the issues related to death, which, according to Ministério da Saúde(2020), becomes more frequent, closer, premature, and sudden. These factors can hinder the normal bereavement process and lead to significant psychological changes in individuals suffering these losses. In the meantime, the process of bereavement involves unfolding events that increase the risk of exacerbating individual and collective psychological suffering (Ministério da Saúde, 2020).

Furthermore, in line with Oliveira et al. (2020), healthcare professionals, despite regularly dealing with death and dying, generally do not receive training to cope with this phenomenon. This is aggravated by cultural issues and the particularities brought about by the pandemic, such as isolation and impediments in performing farewell rituals in socially recognized ways, considering the organizing effect of these rituals and the extraordinary increase in the number of deaths ( Crepaldi et al., 2020; Ministério da Saúde, 2020).

In this context, there is a challenge in experiencing one's own grief while listening to and

caring for the grief experienced by patients, their families, and colleagues.

Regarding coping strategies, both individual and collective, seen as resources that help professionals in this critical situation, psychotherapy/psychoanalysis, supervision, faith/religion, teamwork, physical activity, exchanges with colleagues from other institutions, courses, and seeking theoretical references were mentioned. Let's look at some statements: "The (psychology) team as a whole had integration, and that certainly made a difference, especially because working in healthcare is very exhausting, as you directly deal with physical and psychological suffering".

The feedback from patients/families and the team, as well as the perception of the effects of the work performed, were linked to the integration and teamwork (multiprofessional and uniprofessional): "We can also see the fruits of our labor. Sometimes, something you do punctually has such a gigantic effect." (P2). Regarding the care of personal matters:

I noticed the approach I was taking when talking to her (the patient), I took that into analysis, worked on it, I went to identify why, what it was that she represented to me. I managed to turn what had affected me negatively in a positive way (P4).

According to Folkman (2012), coping strategies can be defined as cognitive responses manifested through behaviors or thoughts aimed at protecting health from the harmful consequences caused by stress.

In times of crisis, resources (social, physical, and emotional) tend to be depleted, leading to psychological distress, and requires searching for strategies that help minimize the impacts that worsen chronic stress and promote mental health. Therefore, these strategies are crucial for working in stressful environments such as the ICU. Furthermore, the mere insertion of the psychology professional in the hospital does not constitute his effective entry. Specifically, psychology in the hospital is a process that needs to be built daily through attitude, practice, and theoretical, technical, and personal training. Considering the institutional reality, work proposals can be established (Mäder, 2016).

Moreover, working in a hospital means working as a team, and this requires learning. This work demands the development of networking skills (both within and outside the institution), which, in turn, requires listening and communication skills (Mäder, 2016).

Following this line of thought, one of the questions posed to the participants referred to the influences of the experience in the COVID ICU on their professional practice, in view of which the improvement of multidisciplinary understanding and action was highlighted: "For me, it allowed me, for the first time, to truly witness a multidisciplinary team in action." (P2) and "We can look at the intensive care patient in a different way, and the understanding from a multidisciplinary perspective has become even better" (P10); the improvement and significance of humanization: "Regarding practice, the issue of humanization" (P9); and an expansion of possibilities of actions: "Nowadays, we can easily make a video call to the patient and their family members who cannot come, who are in another state and all" (P10).

In addition to greater visibility and recognition of the importance of mental health and the role of hospital/intensive care psychology: "A special focus on the mental health of that patient, on the impact it has on that family (...) Today, people can look at it with a bit more respect and understand the need for a hospital psychologist" (P10).

In this regard, there were reports from psychologists indicating significant changes that

occurred because of the pandemic, especially in terms of a different perspective from management towards the role of psychology in institutions (especially in hospitals), recognizing it even more as necessary and collaborative. There have also been adaptations in the approach to patients (greater openness to the use of technology and virtual care) and an increase in the visibility of psychologists' roles.

## Psychological Practices in the COVID-19 ICU: Possibilities and Challenges

Regarding the challenges highlighted by the participants, we emphasize the feelings of fear, the uncertainties inherent to the context and to the lack of knowledge about the virus, the intensity of emotional reactions, the stigma, the ICU training for dealing with this context being incipient, and the workload burden.

The routines in both work and personal life have undergone radical and abrupt transformations, requiring the reorganization of various aspects, including family and work dynamics, as well as daily tasks like personal hygiene.

Regarding the insertion into the ICU context, P4 mentioned: "It was a challenge. Specifically, I didn't work in the hospital field, and I had just graduated. Let's say I entered during the boom. It was a significant challenge".

According to Gorayeb (2001) in the field of health and hospital psychology, one can speak of a quaternary level of care to delve into the particularities of practices in highly specialized centers, such as an Intensive Care Unit.

This level of care is characterized by preventing the overmedicalization of assistance, iatrogenic effects resulting from unnecessary interventions, seeking to reduce harm through contextualized, individualized, and qualified care practices.

The specificities of psychology's role in these spaces are related to the effects of submission to invasive technological procedures, along with the ethical aspects involved. The high degree of manipulation of life, morbidity, and mortality present in these contexts impacts the processes of subjectivation of the users and their family members (Conselho Federal de Psicologia, 2019).

In addition to the specificities of the context in question, there was a constant search for ways to deal with the particularities of the virus, which were little known at the time. This involved uncertain information about its effects, transmission, and protective measures, which were constantly being updated. At times, a protocol taught in training one day would be replaced by a different one the next day.

It was all so new, there were no studies, there was nothing, so when a patient's oxygen saturation dropped even slightly, we had to intubate that patient (...) Being in the intensive care unit at that time was terrifying. So, we had professionals having anxiety attacks, crying fits... once you entered the ICU, you couldn't leave. You had to stay inside for six hours until another team took over (P10).

Considering this, psychology-related interventions in emergencies and disasters became crucial (Ministério da Saúde, 2020). Among the interventions proposed by emergency psychology is Psychological First Aid, which aims to provide emotional support to individuals who have experienced emergencies and acute events, besides helping individuals cope with the situation and provide a sense of safety, calmness, and hope International Federation of Red Cross and Red Crescent Societies (IFRC, 2020).

The patients, who were affected by sudden losses and changes in multiple dimensions, exhibited many of these impacts on their emotional state: “We were receiving people who were completely bombarded with information from the outside world (...) at a time when they were completely isolated from their families, surrounded by complete strangers” (P1). In other words:

I think never in history have we dealt with so much anxiety as we did during the pandemic. If before, in the normal hospital context, we would have a patient developing anxiety, let's say, after 15 days of hospitalization, now we were receiving patients directly in the emergency department, you know? who were there, on the sidewalk, experiencing anxiety attacks due to the fear of COVID or because they received a COVID diagnosis (P10).

In this regard, Moretto et al. (2021) addresses issues identified in the statements of patients hospitalized due to COVID-19, which help us understand this increase in anxiety. Specifically, distress and insecurity related to the unpredictable nature of the disease, to the limited knowledge about it, and the isolation; fear of intubation and death; embarrassment for having become infected; guilt or fear of having infected others; concern for other loved ones who are hospitalized; and suffering resulting from losses or limitations, as well as intense changes in routine. This situation required psychologists to provide efficient and swift responses, which involved collaboration with other professionals in the development of strategies and the implementation of new care modalities, such as the use of Information and Communication Technologies.

Regarding the workload, as reiterated by the interviewees: “We noticed that the team was very affected due to the work, the long hours (...) the team was very tired, and we were also exhausted, our physical and emotional health was completely affected, due to... umm... this high demand” (P8). It is worth adding: “I was one person responsible for two ICUs, so it was 20 beds, 20 virtual reports, 20 families, and two additional teams. Sometimes we had to deal with a strong feeling of frustration, of not being able to cope” (P2, P4), and “The psychology team, I don't think it was enough to really... we tried our best to attend to all the patients, but it was a huge strain” (P8).

Inadequate staffing brings negative consequences for the quality of care and the quality of work life. Unfortunately, there are no regulations regarding the staffing levels of hospital psychologists, only recommendations from regional technical guidelines considering aspects of the work routine, such as service hours (Conselho Regional de Psicologia de Goiás, 2019). In the ICU setting, Ministério da Saúde (2020) recommends that there should be at least one dedicated psychologist on-site for every 10 beds or quota in the ICU. These psychologists should be available for 12 hours each day, working in six-hour shifts.

According to Branco and Arruda (2020), in the hospital context, patients with severe symptoms of the disease may undergo intubation and subsequent weaning from mechanical ventilation in the ICU, often experiencing negative emotional reactions. According to the authors, feelings of confinement, loneliness, difficulty understanding contact isolation, anger, and perception of stigma in the context of hospitalization are common, especially due to the stigma associated with infectious diseases and social isolation (Branco & Arruda, 2020). Thus, the emotional impacts of isolation, loneliness, and helplessness are amplified (Branco & Arruda, 2020; Ministério da Saúde, 2020).

In response to the intensified emotional reactions, the presence of the psychologist in the COVID-19 area to care for isolated patients was becoming routine. As a result, various strategies and interventions were developed. In addition to the recommendations, especially in the initial moments, psychology in extreme situations, disaster and emergency psychology, along with the

notions of Psychological First Aid (Vasconcelos & Cury, 2017) and the theoretical-clinical frameworks were indispensable, assisting in interventions and coping with this emergency situation, whether through the phones, information technologies, in the wards, in the corridors, or outside, on the sidewalks of the hospitals.

Among the emerging psychological practices mentioned in the discourse are: large-scale psychological interventions with staff members, virtual visits/exhibiting media, the use of communication technologies for patients with limitations in communication, accompanying in-person visits, environmental interventions and in collaboration with management and continuous education sectors, participation in lectures and training sessions, team and intersectoral meetings, and participation in hospital committees.

Moretto et al. (2021) highlight the importance of psychologists as mediators between patients and families who are unable to be present, especially in end-of-life situations, considering the limitations or absence of farewell moments and funeral rituals.

As for the psychological interventions with the staff, Ministério da Saúde (2020) suggests alleviating the confrontation of the pandemic through the promotion of institutional strategies of offering mental health care, identifying and building health protection factors.

According to Moretto et al. (2021), the pandemic of the new coronavirus presented an unprecedented challenge for Hospital Psychology. The authors emphasize that initially, this challenge was mixed with feelings of helplessness and powerlessness. However, “the urgent need to care for people calls us to deal with what we already knew in order to face what we didn’t know, and together we moved forward” (Moretto et al., 2021, p. 42).

Regarding the theoretical foundations used in the interventions, the following aspects were highlighted: studies in the field of hospital psychology, specifically in the ICU context: “With the patient, the ICU patient, I observed many aspects related to, for example, delirium, brief psychotherapy, cognitive stimulation” (P6); the pursuit of deepening/developing listening skills within the theoretical framework; seeking courses and materials related to coping with COVID-19: “FIOCRUZ also offered some training and talked about psychologists in the ICU (...) so that was one of the things that gave me more preparation, greater support” (P4); and the studies involving specific diagnoses and vocabulary used by other professional and cross-disciplinary categories: “Training sessions were even conducted on how to enter the ICU, what we should and shouldn’t have in that environment, training on how to use PPE” (P6).

P1 stated: “As the days went by, a whole dynamic of action was developed in the face of COVID-19, with schedules, seeking training like the one from Fiocruz, with the help of residents who always brought a lot of material and discussed it”. This required a lot of study and exchange, as stated by P2: “It was the most exchange that I had ever experienced, of being there and seeking supervision, seeking professors, you talk to one person, then to another, to colleagues, often being on social media”.

The courses and materials from Fiocruz (Ministério da Saúde, 2020) mentioned by the participants were designed to assist professionals in coping with the challenges faced in mental health and psychosocial care during the pandemic, and to provide them with quick responses (Ministério da Saúde, 2020).

Other publications were also fundamental in this scenario, such as the one from the Brazilian Conselho Federal de Psicologia (CFP, Brazilian Federal Council of Psychology), dated March 24, which requested that managers provide, preferably, Information and Communication Technologies for

conducting professional work remotely during the pandemic period, according to Circular Letter No. 40/2020/GTec/CG-CFP (CFP, 2020).

The recommendations published by the Brazilian Society of Hospital Psychology on March 21 provided guidance for psychologists conducting in-person therapy in hospitals, including technical recommendations and guidance on the psychologist's protection and their own mental health (Ministério da Saúde, 2020; Sociedade Brasileira de Psicologia Hospitalar, 2020).

Hospital psychology, intensive care psychology, and emergency and disaster psychology. Currently, only Hospital Psychology is a recognized specialty by the Federal Council of Psychology. The other two fields have been strengthening their presence and highlighting their necessity and particularities (Schneider & Moreira, 2017; Vasconcelos & Cury, 2017).

This pandemic has brought to light existing needs and generated new ones, and it is also the responsibility of research to give these issues a voice. Therefore, we discuss areas that still lack studies but have shown promise in facing the pandemic. The experiences discussed in this study emphasize the need to expand investigations in the context of COVID-19.

## Conclusion

The ICU context, which is inherently demanding, has become even more so. More distressing, more distant from the families, and more uncertain in terms of prognosis. Faced with this tragic yet inevitable reality, filled with uncertainties, fear, and deaths, it was necessary to unite and seek renewal, courage, and hope. Thus, the participants, after engaging in this struggle, recognized the ongoing negative psychosocial impacts marked by complications in the bereavement process, feelings of guilt, fear, and helplessness, numerous losses in the family setting, significant changes in the economic reality, physical and mental exhaustion, with lasting consequences that we still must deal with and for which we must reorganize ourselves personally and collectively.

The psychosocial impacts have affected everyone. However, the way and the intensity with which certain groups were affected varied. Healthcare professionals witnessed this hardship closely and did not retreat in the face of such suffering; they experienced it and persevered. Psychologists, within their specificities, helped to minimize and cope with this suffering, always emphasizing and valuing the fact that health is not achieved alone or without theoretical and technical support.

Thus, new possibilities of action were built, a better relationship with the team was developed, and another step was taken towards a better understanding of their role within the intensive care units. In addition, there was an increased perception of the value of their work. The complexity of the disease, dealing with the unknown, shed light on a well-known but rarely experienced need: teamwork, the role of each professional, and the institutions for the delivery of holistic, comprehensive, humane, and safe care.

In conclusion, this study helped document and discuss the interventions of psychologists working in COVID-19 ICU settings, as well as contributed to the improvement of hospital/intensive care psychology's role in the ICU. At the same time, it highlights the need for further development in terms of mental health care for hospital/intensive care psychologists, as well as for their specialties in acting within this specific context, especially in times of collective crises. The pandemic is still not over. Nevertheless, it has already left lasting marks and irreparable losses that we must address.

Regarding the limitations of this study, it is worth noting that the topic is complex and allows for various approaches and further exploration. The intention was not to exhaust the discussion on

the topic, but to discuss and explore a very specific aspect. As a result, new perspectives for further research are opened, both in expanding the discussion to a macro context and delving deeper into the raised issues.

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