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**Original Article**

# STRESSING FACTORS AND COPING STRATEGIES OF HOSPITALIZED PATIENTS FOR TREATMENT OF WOUNDS

*FATORES ESTRESSORES E ESTRATÉGIAS DE COPING DE PACIENTES HOSPITALIZADOS EM TRATAMENTO DE FERIDAS*

*FACTORES ESTRESSORES Y ESTRATEGIAS DE AFRONTAMIENTO DE PACIENTES HOSPITALIZADOS EN TRATAMIENTO DE HERIDAS*

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This is an explanatory study with a quantitative approach, which aimed to analyze the coping strategies adopted by 40 patients hospitalized in regional hospitals located in the cities of Sousa and Cajazeiras (PB), while undergoing treatment for wounds. The data collected through a script of semi-structured interview were analyzed using the Statistical Package for Social Sciences (SPSS) version 16. One verified that 59.4% of the patients showed a decrease in their self-esteem, pointing the pain (55,1%), the impaired sleep and rest (18.4%) and inability to work (12.2%) as the main stressing factors that come during hospitalization. To deal with this situation and minimize their psycho-socio-spiritual suffering, one used mainly coping strategies focused on religiosity (average of 3.6), followed by strategies focused on the problem (3.5%); on social support (3.1%); and on emotion (1.8%). One noticed that religious beliefs acted as cognitive mediators for the interpretation of events in a positive way.
**Descriptors:** Adaptation; Nursing; Wounds and Injuries; Hospitalization.

Estudo explicativo, com abordagem quantitativa, que objetivou analisar as estratégias de coping adotadas por 40 pacientes hospitalizados nos Hospitais Regionais sediados nos municípios de Sousa e Cajazeiras (PB), submetidos a tratamento de feridas. Os dados coletados através de um roteiro de entrevista semi-estruturado foram analisados através do *Statistical Package for the Social Sciences* (SPSS) versão 16. Verificou-se que 59,4% dos pacientes apresentaram diminuição da autoestima, apontando a dor (55,1%), o sono e repouso prejudicado (18,4%) e a impossibilidade de trabalhar (12,2%), como principais fatores estressores advindos da hospitalização. Para lidar com tal situação e minimizar seu sofrimento psico-socio-espiritual, utilizaram principalmente estratégias de coping centradas na religiosidade (média de 3,6), seguidas de centrado no problema (3,5%); no apoio social (3,1%); e na emoção (1,8%). Percebe-se que as crenças religiosas funcionaram como mediadoras cognitivas para interpretação dos eventos de maneira positiva.
**Descritores:** Adaptação; Enfermagem; Ferimentos e Lesões; Hospitalização.

Estudio explicativo, con enfoque cuantitativo, cuyo objetivo fue analizar estrategias de afrontamiento adoptadas por 40 pacientes hospitalizados en Hospitales Regionales en las ciudades de Sousa y Cajazeiras (PB), Brasil, sometidos a tratamiento para heridas. Los datos recogidos a través de guión de entrevistas semiestructuradas fueron analizados mediante *Statistical Package for the Social Sciences* (SPSS) versión 16. Se encontró que 59,4% de los pacientes mostró disminución de la autoestima, señalando el dolor (55,1%), alteración del sueño y resto (18,4%) e incapacidad para trabajar (12,2%) como principales factores estresores que viene con la hospitalización. Para hacer frente a esta situación y minimizar el sufrimiento psico-socio-espirituales, utilizan como principal estrategias de afrontamiento la religiosidad (media 3,6). Se observa que las creencias religiosas actúan como mediadores de la interpretación cognitiva de los acontecimientos de manera positiva.
**Descriptores:** Adaptación; Enfermería; Heridas y Lesiones; Hospitalización.

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## INTRODUCTION

Care to patients suffering with wounds has become increasingly a topic of debate in hospital practices, because in the common sense, many people think that the treatment of wounds is something simple, that does not require specialized interventions, and that anyone could act in this situation, which is not true.

Dealing with people suffering from acute or chronic wounds, suggests that health professionals adopt in their practice, besides technical knowledge, psychological, spiritual, physical and environmental resources, in the perspective of a holistic approach to the treatment. The nurse has always excelled in the patients' physical care, however, emotional needs have been focused only recently in the professional-patient relationship.

The implications of a hospitalization for patients, especially those suffering from wounds, be it a short or long term, have been reported as negative, since they tend to abandon their habits and customs to adapt to new schedules and routines, have to trust people considered to be unknown and to undergo invasive procedures[1]. All of this influences their well-being, triggering the physical and spiritual suffering, as well as the appearance of emotional reactions essential for human survival, such as fear, grief and helplessness.

Besides facing considerable changes in their well-being, those patients are still forced to experience the sensation of pain, which is one of the triggering factors for the development of psychological stress during hospitalization. Studies on the effects of stress in the disease process have been developed since Hans Selye conducted research related to the so-called General Adaptation Syndrome (GAS), in which the stress response was characterized by physiological reactions in the body, before external demands that damaged its homeostasis[2].

Stress can be understood as a non-specific response of the body to any demand made to it. Currently, many authors recognize human stress reactions as a set of physical, psychological and social reactions of the adjustment of the individual before a stimulus (situation) that causes excitement or strong feeling, both positive and negative[2].

One of several lines which seeks to understand how people cope with stress is the cognitive scale, which is based on the theory of facing (coping), a strategy that uses the individual not necessarily conscious, to get the most information about the events and internal conditions (psychic) to proceed in order to reduce stress responses and keep the organic balance[3].

Studies on coping have become more systematized, when Lazarus and Folkman (1984) defined it as a set of strategies to deal with something that is perceived by the individual as an imminent threat, as a burden to their cognitive and behavioral abilities at the moment. Coping includes strategies adopted by the individual to adapt to a stressful situation; includes cognitive, behavioral and emotional responses that aim to manage the crisis, reduce or tolerate the demands created by the situation[4].

In the cognitive perspective, the process of coping involves four main concepts: (a) interaction that occurs between individual and environment, (b) its function is to manage the stressful situation, and does not control it, (c) it presupposes the notion of evaluation, that is, how the phenomenon is interpreted and cognitively represented in the mind of the individual, and (d) constitutes a mobilization of efforts, through which individuals will undertake cognitive and behavioral efforts to manage internal and external demands that arise from their interaction with the environment[5-6].

Considering function as the aim the strategy serves, the process of coping has two functions, namely coping focused on the problem and coping focused on

the emotion. In the first case, the person seeks to engage in the management or modification of the problem or situation that causes stress in order to control or deal with the threat; they are generally active strategies of approach in relation to the stressor, such as problem solving and planning. In the second case, there is a regulation of the emotional response caused by the stressor that the person faces and it may represent the removal or remedial actions in relation to the source of stress, such as denial or avoidance[7].

There are other coping strategies centered on religiosity and seeking of social support. In the first one, some people when faced with suffering and challenge through a stressful situation are driven beyond their capacities to experience a dynamic process of coping, in which, religious beliefs and practices are inserted. On the other hand, coping focused on seeking social support, represents items with content that have as meaning the look for instrumental, emotional or information support as coping strategies of the situation causing stress[8].

Knowing the importance of recognizing the needs of biological, emotional, social and spiritual needs of patients hospitalized for treatment of wounds, the questions that guided this study emerged: What are the problems faced by patients being treated for wounds during the hospitalization? What strategies were used to solve the problems identified? What did they feel when they were faced with such problems?

Hospitalization is an unpleasant experience, which determines loss processes, regardless of the length of stay, requiring adjustments to changes in their daily lives, whether for short or long term. The patient may withdraw into a cold, impersonal and threatening environment, and it is not an option but a necessity, often in emergency, under an atmosphere of expectation and even fear[9].

Thus, the importance of this study is justified by the need of broader knowledge on the issue involving the psychological aspects of hospitalized patients who experience problematic wounds. It is expected that by elucidating the referred question, one can favor reflections for nurses and other health professionals who work with clients suffering from wounds in order to provide an individualized and quality care of their physical and emotional needs. It is worth highlighting the need for further research in this area given the scarcity of studies published nowadays.

Given the problems elucidated, the present study sought to identify stressors and analyze coping strategies taken by hospitalized patients for treatment of wounds.

## METHODS

This is an exploratory and descriptive study, of quantitative nature, developed in the areas of Medical and Surgical Clinic of the Regional Hospital Deputado Manoel Gonçalves de Abrantes, located in the city of Sousa and in the Regional Hospital of Cajazeiras, located in the city of Cajazeiras, both in the countryside of Paraiba. This choice was due to the fact that they are mid-sized institutions, reference to other micro regions covered by these cities.

The study population comprised all individuals hospitalized for treatment of wounds or even with wounds they had after hospitalization in the period from May to June 2009. Through an accidental non-probability sampling, the sample consisted of 40 of these patients, divided equitably among hospitals. As inclusion criteria one selected patients independent of gender, education, etiology and evolution of the wound; patients over 18 years old with no maximum age limit who agreed to participate in the study and who were hospitalized for more than 24 hours, considering as the

first 24 hours, the moment of adaptation of the patient to the hospital routines/standards.

As an instrument of data collection one used a semi-structured questionnaire composed of 1) Socio-demographic questions, 2) subjective and objective questions aimed at identifying stressors during hospitalization and the social and psychological behavior of patients facing the problems raised; 3) Scale of ways of facing problems (EMEP), instrument built (1985)[11] validated (2001)[10],) adapted to Portuguese (1997)[12].

The EMEP contains 45 items and has four subscales that express cognitions (intrapsychic actions) and behaviors (direct action) to deal with stressful events: (a) coping focused on the problem, corresponding to the strategies aimed at the management and reassessment of the problem, (b) coping focused on the emotion, strategies involving avoidance, denial, unrealistic thinking, blaming, removal of the problem and remedial functions due to the stressor, (c) coping based on the pursuit of religious practices and wishful thinking, and (d) coping based on the look for social support. The answers are given on the Likert scale of five points (1 = I never do this, 2 = I rarely do this, 3 = I sometimes do this, 4 = I usually do this, 5 = I always do this). Scores range from 1 to 5, the highest indicate greater use of particular coping strategy[10-12].

Data collection was conducted in May and June 2009, and the participants, after being informed of the objectives and of the confidential character of the research, completed the questionnaires individually, with the presence of the researchers for any clarification that was necessary on the issues. There were some cases when it was necessary the reading of the questions and marking the answers, since the operation of reading was impaired.

After the collection, the socio-demographic data were analyzed descriptively, counting the percentage. Subjective data focused on the problem of the study were categorized and the percentages were counted. In EMEP, the results were obtained by the sum of the assigned values in the Likert scale, categorized according to the subscales mentioned in the literature (2001)[10]. The highest average of scores among the four subscales indicated what was the main coping strategy used by the participant.

The research project was approved by the Ethics Committee of the Faculdade Santa Maria located in the city of Cajazeiras (PB) under protocol number 01390109, meeting the requirements of Resolution No. 196/96 of the National Health Council.

## RESULTS

The results showed that the participants were adults (45%), with ages ranging between 22 to 41 years old, males (62.5%), married (57.5%), catholics (80%), and attended elementary school as the highest level of education (60%), with family income below a minimum wage (85%) and the period of hospitalization for about a week (87.5%).

As to the classification of wounds, it was found that 80% of hospitalized patients had lesions of acute progression of various etiologies, such as surgery (52.5%) traumatic (28.5%), pathological characterized as ulcers (9.5%) and iatrogenic (9.5%) being the lower limbs (35.5%), the abdomen (33.3%) and upper limbs (11.6%) the most affected regions.

There were problems arising from the hospitalization (92.5%) such as pain (55.1%), felt mainly during movements (44.2%), all the time (20.9%), and/or during the bandage (13.9%); impaired sleep and rest (18.4%); inability to work (12.2%), fear (6.3%); dependence (4%) and difficulties to perform basic daily activities (4%). When asked about their feelings, they showed decreased self-esteem (59.4%), fear (8.1%) and pain due to such problems (2.7%).

In table 1, one demonstrated the coping strategies, as well as their respective scores, most used by the participants when faced with the problems arising from the period of hospitalization.

**Table 1** - Average scores of participants in the strategies. Sousa and Cajazeiras, PB, 2009.

| Factors / Items | Averages |
|---|---|
| **Factor 1 - Centered on Religion** | **3.6** |
| I dream or imagine a better time than the one I am now | 4.3 |
| I wish I could change what happened to me | 4.1 |
| I cling to my faith to overcome this situation | 4.0 |
| I pray | 3.9 |
| I practice more my religion since I had this problem | 3.3 |
| I hope that a miracle happens | 3.2 |
| I try to forget the whole problem | 2.6 |
| **Factor 2 – Centered on the problem** | **3.5** |
| I insist and fight for what I want | 4.4 |
| I take into account the positive side of things | 4.2 |
| I try to be a stronger and optimistic person | 4.1 |
| I accept sympathy and understanding from someone | 4.1 |
| I concentrate on the good things in my life | 4.0 |
| I will leave this experience better than I entered in it | 3.9 |
| I tell myself how much I have already managed | 3.6 |
| I focus on something good that can come from this situation | 3.6 |
| I keep on remembering that things could be worse | 3.5 |
| I find different solutions for my problem | 3.4 |
| I know what must be done and I am increasing my efforts to be successful | 3.3 |
| I try not to act so hastily or follow my first idea | 3.3 |
| I'm changing, becoming a more experienced person | 3.3 |
| I try to avoid that my feelings interfere in the other things in my life | 3.2 |
| I try not to close doors and leave exits open to the problem | 3.1 |
| I change something so that things end up working out | 3.1 |
| I made a plan of action to solve my problem and I am following it | 3.0 |
| I see the situation in stages, doing one thing at a time | 2.9 |

According to the table 1, the most used coping strategies for hospitalized patients undergoing wound treatment correspond to the ones centered on religiosity, which showed overall average of 3.6 points.

The other strategies used by participants were presented in Table 2.

**Table 2** - Average scores of participants in the coping strategies. Sousa and Cajazeiras, PB, 2009.

| Factors / Items | Averages |
|---|---|
| **Factor 3 - Focused on Social Support** | **3.1** |
| I talk to someone to get information about the situation | 3.6 |
| I talk to someone who can do something to solve my problem | 3.3 |
| I talk to someone about how I am feeling | 3.1 |
| I ask for advice from a relative or a friend who I respect | 2.9 |
| I try to keep my feelings to myself | 2.4 |
| **Factor 4 - Centered on Emotion** | **1.8** |
| I wish I could change how I feel | 3.4 |
| I think and have desires about how things could happen | 2.7 |
| I feel bad for not being able to avoid the problem | 2.3 |
| I fight with myself, I keep talking to myself what I should do | 2.1 |
| I realize that I brought the problem to myself | 2.1 |
| I blame myself | 1.9 |
| I try to get away from people in general | 1.6 |
| I refuse to believe that this is happening | 1.6 |
| I find out who else is or was responsible | 1.5 |
| I look for someone to blame for the situation | 1.5 |
| I demonstrate anger towards the people who caused the problem | 1.4 |
| I blame others | 1.4 |
| I think of fantastic or unreal things (like a perfect revenge or finding a lot of money) that make me feel better | 1.4 |
| I think people were unfair to me | 1.3 |
| I work off the anger on other people | 1.2 |

## DISCUSSION

All the variables relevant to the profile of the participants are relevant in the context of coping because they are dynamically influencing the strategies that individuals should take to reduce their suffering, in the sense that not only the stressful situation interferes in the strategies adopted, but also the available resources and the responsibility for the event.

Significant changes in the coping strategies may occur to the extent that the individual develops once children, adolescents, adults and the elderly differ in their ways of managing their problems. The skills needed to use coping emerge in different developmental periods, being adolescents and young people the ones who use more coping focused on emotion[13]. Several authors mention that older children tend to seek solutions to problems rather than avoid thinking about them[14]. The age is still important in the treatment of wounds because it influences directly the speed of healing.

One found that most of the participants are males and fit in the economically active and productive age group, which is something to worry about, because the wound can affect directly the functional capacity and quality of life of these individuals.

Wounds when not treated properly account for larger lesions and/or loss of function of the affected region, characterized as a major health problem that involves several factors related to the patient and their external environment, since their genesis is associated directly to the increased length of hospitalization, the risk of complications and costs[15].

Each gender must be analyzed differently from an ecological perspective in response to the expectations about their behavior, since the differences between the genders influence the processes of coping[16]. A study about coping among children and adolescents showed that boys and girls use different forms of coping to administer the same stress. The first generally use more problem-focused strategies, in contrast, girls use more emotion-focused strategies[17].

Considering the problems resulting from hospitalization, one realized that the pain was emphasized as the biggest problem faced during this period. The pain can be understood as the result of a biochemical process in which its context cannot be reported only through this process without including any accompanying subjectivity. The degree and duration of pain that patients can tolerate during their treatment depend on several factors that include cultural and emotional aspects, previous experiences and personal characteristics[18].

After the effective evaluation of pain, treatment strategies should be identified to promote satisfactory relief from it. One of the strategies is the pharmacological option, involving use of analgesics, opioids and anesthetics. Other options can be physiological, including methods of transcutaneous pacing, postural changes, or use of acupuncture points. Alternative measures such as education, relaxation, guided imagery or other choices from the patients may be valid as effective strategies. The treatment plan may consist of traditional clinical or non-traditional, cultural or religious approaches, which can be identified either by the individual, or by the doctor or nurse[18].

Having as its object of study the care given to the patient and not to the disease, nurses should not underestimate the patients' pain considering the reaction presented, but seek to assess and intervene in this situation. They must be prepared to deal with the pain of others and with the fact that the nursing care to be executed can increase the patients' pain.

Other problems faced pertain to harmed sleep and rest and the inability to work. It is known that the

implications of a wound on the work are clear, because such patients experience bigger physical limitations that direct them to another form of managing issues such as the sleeping position, their food habits and thoughts in relation to health.

Also worth mentioning are the other problems listed in order of highest incidence, such as fear, dependency on help and difficulty in performing basic daily activities, given the fact that with the lower limbs affected, comes the fear of the unknown, of the problems already experienced with the restriction in activities considered to be usual.

Regarding the feelings expressed about the problems elucidated, there was a significant decrease in the patients' self-esteem, suggesting the nurses' presence and involvement in the care of these individuals, seeing them in the broadest and complex sense of the term holism, as human beings who have needs, values, fears, anxieties, uncertainties, who are able to feel, think and act, and who need a little more caring, affection, understanding, love and attention.

Feelings of indifference in this situation, fear and pain are important factors that change the physical well-being and spiritual health of hospitalized patients. Complaints of pain can be a way to call attention and they can be serviced by the presence and touch of a professional, family member or friend who is beside them, listening to them and comforting them.

In this context, one highlights the role of the family, considered a key part in the healing process of hospitalized patients, for being the main source of information and emotional bonds with them, helping them cope with the uncertainty and the probable feelings of loneliness permeating this period. This therapeutic relationship can be maximized when there is an interest on the part of health professionals, valuing the affective relationship between family and patient[16].

It should be emphasized, increasingly, the paramount importance of the nursing staff to have a broader perspective, understanding their action beyond the patient, covering also the family, in their planning and care process, so that they have more effective participation in this process and so that it becomes a moment of personal interaction between staff and family, allowing information that guide the establishment of actions centered on their understanding as subjects of the process[19].

In this context of suffering, nurses should adopt strategies to reduce the amount of stress experienced by patients and their families during hospitalization. One of the strategies is the social support, a tool that improves the health and well-being of individuals, as well as acting as a protective factor in different situations.

Thus, one observed that the most used strategy by patients to face the stressors arising from hospitalization was centered on religiosity. Religion can be useful to face the situation because it provides a system of beliefs and a way of thinking about the stressful event that enables people to find knowledge and proposals to deal and understand inevitable events. One also points out that people linked to religious faith report great satisfaction with life, personal happiness and less negative consequences of traumatic events in life compared to people not involved in formal religion, promoting psychological well-being[8].

A study conducted with patients who underwent pre and post-rehabilitation of spinal cord injury, demonstrated that the strategies most frequently used by those in order of biggest importance were focused on the religion, wishful/positive thinking, on the problem and on seeking social support[16]. When assessing the prevalence of religious coping among individuals with different health conditions, the authors mentioned that in hospitalized patients the prevalence ranged from

73.4% to 86%, whereas in patients who were in outpatient treatment, such prevalence was approximately 60% of utilization of religious coping[8].

Analyzing the results of the Scale of Ways of Facing Problem, a study conducted with HIV-positive patients found that the most used strategies were based on wishful thinking and religious practices (average 4.09), followed by problem-focused coping (average 3.71), seeking social support (average 2.93), and coping strategies based on emotion (average 2.36)[20].

Such justifications are consistent with the results found in this study, where 80% of the participants were active in the catholic doctrine. The fact that a person attends religious institutions suggests a group organization, in which the individual will have a support chain with people who share the same beliefs. In regard to self-esteem, religiosity has comparative patterns between self-assessment and self-concept which value people's self-perception. Thus, decreased self-esteem of the participants is justified largely due to how they perceive the situation, whether optimistic or pessimistic, despite being effectively focused on religion.

Then, it is understood that religious beliefs act as cognitive mediators for the interpretation of events in a positive way, which may favor the adaptation and adjustment of the people to their health condition. On the other hand, one should be careful with such interpretations since, for many people, especially those with chronic diseases requiring intense self-care, the attribution of external causality can hinder self-care measures, as the practice have shown that by attributing to God the responsibility for being sick, one stops to take personal responsibility for it[8].

The second strategy used by participants refers to coping centered on the problem, with average of 3.5. Its items that had the highest score represent behaviors of approximation to the stressor, performed by the individual in order to fix it and they also involve active efforts eminently cognitive focused on the reassessment of the problem, seeing it in a positive way. These findings imply that participants struggled somehow to manage or change the problems, or to improve their relationship with the environment, since they insist and fight for what they want.

A study conducted with 21 patients in the postoperative period of mutilating cancer surgery, observed that when faced with cancer and surgery, they developed ways of coping based on the emotion and on the problem. The most used coping strategies were the reflections about the health problem and religious support, when they reported they prayed and made promises as ways to express their faith in God and in saints of the Catholic Church popular in Brazil, to adjust better to the disease situation. This type of resource can provide strengthening of faith and thus provide more optimistic thoughts, decreasing the internal stress due to the stressor[5].

Coping strategies focused on the problem are also related to positive thoughts, represent behaviors of approximation to the stressor, performed by the individual, in order to solve the problem, deal with or handle the stressful situation. This kind of attitude refers to the ability the individuals have to face the real situation in which they are living, it refers to the thoughts and conscious acts, whose objectives are to solve problems and reduce stress[20].

The third strategy adopted by participants refers to coping focused on the pursuit of social support (average of 3.1). This strategy has an important role in promoting physical and mental health for individuals. People who have this kind of support tend to have more trouble dealing with stress.

Social support helps increase adaptive competence through the management of emotions, affective and cognitive orientation and retro-information. The social support relates to the functional aspects of

social relations, linked to the adaptation of its members. The social support that social networks offer reduces isolation and increases people's life satisfaction[20].

Family support is one of the main external resources of the patient to develop coping strategies. While the patients fight against the disease, trying to cope better with stress, the families have an important role in supporting or not the changes that occur with them, avoiding unnecessary stress factors or helping them to deal with it[3].

The last strategy adopted is focused on the emotion (average of 1.8), corresponding to cognitive and behavioral strategies that can fulfill a palliative function in coping and/or result in removal of the stressor. It demonstrates that patients tried to replace or regulate the emotional impact of stress, using emotion as a way to keep hope and optimism, once they realized they were not competent enough to deal with the situation, and they must stand the strain through different affective regulations.

Study conducted with caregivers of elderlies with chronic diseases treated in a School Health Center of a city in the countryside of São Paulo showed that for the conduction of care, those individuals used coping strategies focused on emotion as a way to ease the stressful situation, without, however, getting involved in its resolution[21].

These findings corroborate the results of this study, since the coping strategy focused on emotion corresponds to a defense of the individuals when they avoid confronting the threat, not changing their situation. When coping is focused on emotion, people use emotional or cognitive strategies that change the way they see the stressful situation, getting away from the problem and trying to avoid it. Thus, in order to avoid the stressful situation, the individual may act in several ways, for example, with self-pity or denying the existence of the stressful situation[22].

Coping focused on emotion is sometimes a "cognitive reassessment" because the individual performs a series of maneuvers in order to modify the meaning of the situation, no matter if it is done realistically or with distortion of reality. This type of coping mechanism does not change the situation itself, but makes the individual deal with the emotions and thus maintain a positive self-esteem, hope and well-being[3].

Among some of the roles of health professionals in the care process, identifying coping strategies and their consequent implications for the clinical course of the individual are of fundamental importance for the planning of nursing care[3].

## FINAL CONSIDERATIONS

One knows that the condition of hospitalization causes discomfort, changes in the lifestyle and psychological well-being of patients, especially when there is an impairment of self-image and consequently denial of their health state. Individuals with wounds should be seen in a broader context, as human beings in need of physical, emotional and spiritual care. Their wound should be treated as part of a whole. However, for the satisfactory supply of such needs, professional assistance should consider the new environment in which individuals are inserted, treat them humanly, offering support and information about their health status, and still earn their trust in order to discover their complaints and needs.

In this study, the choice of coping centered on religiosity suggests that faith in God was associated with recovery of strength, hope and confidence that their problem could be solved. The fact that the participants did not give more emphasis to strategies focused on social support, does not mean they did not use them, as many of them in their accounts, said they looked for professional help. In this sense, it is up to health

professionals to review how patients are using their coping strategies, without trying to consider one strategy more effective than another. It is important to remember that all the attempts to help the individuals with wounds during their regular treatment help to regulate psychologically a stressful situation.

As limitations observed in this study, the small sample size may have hindered a more reliable exploration of reality. Difficulties when it comes to stressors, coping and wounds are found through the few published studies on the subject, making it difficult the discussion with bibliographic sources, limiting the discussion of the study.

Thus, it becomes very important to say that the study met the proposed objectives, bringing more than answers, room for reflections focused on the nursing professionals for the elaboration of a plan of active intervention to help patients with wounds to face stress during their treatment and understand better the threat. Thus, the commitment with care is necessary in the full sense of the term, because it implies possible ways to maximize healing, besides promoting education for patients to recover and seize the best ways to deal with moments of instability of physical and psychological homeostasis.

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