Revista Brasileira de Enfermagem
REBEn

THEMATIC ISSUE:
WORK AND MANAGEMENT IN NURSING

ORIGINAL ARTICLE

Care model for Primary Care workers: Convergent Care Research

Modelo de cuidado aos trabalhadores da Atenção Básica: Pesquisa Convergente-Assistencial

Modelo de cuidado a los trabajadores de la Atención Básica: una Investigación Convergente-Asistencial

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How to cite this article:
Lucchese R, Ramos CB, Carneiro LMS, Brito RP, Vera I, Paula NI, et.al. Care model for Primary Care workers: Convergent Care Research. Rev Bras Enferm [Internet]. 2019;72(Suppl 1):80-7. [Thematic Issue: Work and Management in Nursing]. DOI: http://dx.doi.org/10.1590/0034-7167-2017-0625

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Submission: 10-03-2017 **Approval:** 03-10-2018

ABSTRACT

Objective: To verify the application of the Operative Group as a care tool for the workers of Primary Health Care, with a view to the constitution of mental health care at work. **Method**: Convergent Care Research as a research process and health workers as subjects. The intervention strategy as a proposal to accommodate the mental suffering of the worker was the Operative Group. **Results**: Two categories emerged: "Evidence of Suffering at Work" and "Group Learning: Group Reception by the Group". **Final considerations**: The use of the Operative Group has been assertive in providing the subjects with a space for listening to adversities in the work environment and active learning of reality, reflection and confrontation of basic fears, development of a pro-change project through peer and active learning of reality.

Descriptors: Nursing; Health Personnel; Qualitative Research; Mental Health; Primary Health Care.

RESUMO

Objetivo: Verificar a aplicação do Grupo Operativo como ferramenta de cuidado aos trabalhadores da Atenção Básica em saúde, com vista à constituição de assistência à saúde mental no trabalho. **Método**: Pesquisa Convergente-Assistencial como processo de investigação e trabalhadores da área da saúde como sujeitos. A estratégia de intervenção como proposta de acolhimento do sofrimento mental do trabalhador foi o Grupo Operativo. **Resultados**: Emergiram duas categorias: "Evidências do sofrimento no trabalho" e "Aprendizagem em grupo: acolhimento do grupo pelo grupo". **Considerações finais**: O uso do Grupo Operativo demonstrou ser assertivo ao proporcionar aos sujeitos um espaço de escuta das adversidades ocorridas no ambiente laboral e aprendizagem ativa da realidade, reflexão e enfrentamento dos medos básicos, desenvolvimento de um projeto pró-mudança por meio da cooperação entre os pares e aprendizagem ativa da realidade.

Descritores: Enfermagem; Pessoal de Saúde; Pesquisa Qualitativa; Saúde Mental; Atenção Primária à Saúde.

RESUMEN

Objetivo: Verificar la aplicación del Grupo Operativo como herramienta de cuidado a los trabajadores de la Atención Básica de Salud, con miras a la constitución de asistencia a la salud mental en el trabajo. **Método:** Investigación Convergente-Asistencial como proceso de investigación, y trabajadores del área de la salud como sujetos. La estrategia de intervención como propuesta de acogida del sufrimiento mental del trabajador fue el Grupo Operativo. **Resultados:** Se plantearon dos categorías: "Evidencias del sufrimiento en el trabajo" y "Aprendizaje en grupo: acogida del grupo por el grupo". **Consideraciones Finales:** El uso del Grupo Operativo demostró ser asertivo al proporcionar a los sujetos un espacio de escucha de las adversidades ocurridas en el ambiente laboral y aprendizaje activo de la realidad, reflexión y enfrentamiento de los miedos básicos; además, el desarrollo de un proyecto pro-cambio por medio de la cooperación entre los pares y el aprendizaje activo de la realidad.

Descriptores: Enfermería; Personal de Salud; Búsqueda Cualitativa; Salud Mental; Atención Primaria de Salud.

INTRODUCTION

The sickness of professionals working in the health sector is increasingly present in the context of services, especially those linked to the Brazilian Unified Health System (SUS - *Sistema Único de Saúde*), becoming one of the main causes of work conflict due to psychic and physical damages, interfering in the worker's quality of life. It is emphasized that the frequent occurrence of occupational diseases in this population affects the psychosocial dimensions alone or in comorbidities[1].

In the "psychic" dimension, there is a prevalence of Common Mental Disorder (CMD) in Primary Care workers (which can reach 22.9%), high values when compared to other categories of workers or common population[2]. Other findings of unhealthy conditions among professionals were the presence of depression, stress, Burnout syndrome, mental exhaustion, anxiety, CMD and emotional disorders[3]. Depression is highly disabling for the practice of the profession, with a marked reduction of labor practices. As for physical aspects, there were complaints of pain in the legs, in the back, paresthesias in lower limbs, rhinitis, insomnia, lumbago, drowsiness, varicose veins, urinary infection, repetitive strain injury, systemic arterial hypertension and allergies[3].

As triggering factors of complaints or the process of illness, there is work overloading, excess of activities with continuous efforts, environment that leads to stress, uncertainty in the service, poor working conditions and lack of financial support. The latter has a negative impact on the personal resources to be applied in health rehabilitation and improvement of the worker's living conditions[4]. With the same predictive weight, there are experiences of pressure suffered in the work environment[5].

Thus, a hostile context is unveiled; of excessive responsibilities; little time for planning; severe collections of resolutions; dissatisfaction with the profession; professional prestige; low payment; double daily journeys; difficulties of coexistence between the team; high psychological demand; temporary employment situation; lack of autonomy in relation to the service provided; and decreased productivity[2]. Above all, the demands and challenges posed to professionals about the concepts proposed by the SUS[6] that do not always resonate with professional training.

Reception of the mental suffering of professionals is extremely important, as excessive stress on the health team, emotional and physical exhaustion is notorious. There are several macrossocial factors that corroborate this situation, inherent in the historical processes built in the relationship between the SUS's organizational infrastructure and the fragility of actions that welcome Primary Care professionals. These include those who emerge from professional-community interaction, with a high demand for interpersonal relationships, mobilizing more suffering through direct contact with social inequality and difficulties in seeking attention to health needs; others are at the macro level with precariousness about SUS, regarding its fragmented operationalization, resource cuts and clearing threats. However, the macro context is not taken into account and it focuses more attention on the health professional, so that complex techniques can be used as means of overcoming the challenges posed in daily life, causing anguish, withdrawal and becoming submissive to the profession[7].

OBJECTIVE

To verify the application of the Operative Group as a tool of care for the workers of the Primary Health Care, with a view to the constitution of mental health care at work.

METHOD

Ethical aspects

The research was derived from a matrix project titled "*Análise da Atenção em Saúde Mental e constituição da rede no Sistema Único de Saúde no Sudeste Goiano*", was approved by the Committee of Ethics in Research with human beings of the *Universidade Federal de Goiás*, of the National Health Council *(Conselho Nacional de Saúde*) 466/2012. All individuals signed an Informed Consent Form.

Type of study

We adopted the Convergent Care Research (CCR), considered as a qualitative research with a high affinity with the practices of Health Care[8], in tune with the action research in which the researcher has immersion in the researched setting and intervenes to transform the situation[9].

Theoretical-methodological framework

It should be noted that in this investigation the theoretical framework of the Operative Group (OG) was used to replace the intervention stage of reality, considering its internal mobilization condition and redefinition of relations with itself, with the other and with the context[10]. The occurrence was described among the CCR stages in the following paragraphs.

Methodological procedures

The research process addresses a given reality and the subjects involved, advancing with an intervention in this context, proposing the constitution of knowledge and practices in Health, especially in Nursing. The theoretical construction of health care is what CCR aims to do, it requires a path with five well-defined, interrelated and feedback paths, namely: design, instrumentation, research, analysis and interpretation[9].

Study setting

The study setting comprised the conception phase, according to the CCR, and was developed from the research project mobilized by the relationship of professors of the Mental Health area of a Federal University with the management of Primary Care (PC) of the Municipal Health Office (SMS - *Secretaria Municipal de Saúde*) in a medium-sized Municipality and of economic and social relevance in the Central region of Brazil. The research problem was due to the need for reception of the team of professionals working in the PC, since the complaint about the management was that the team presented fragility of relations, conflicts and lack of motivation.

Based on the problem above, the topic was defined and what had already been published was studied. Thus, the second phase

of the CCR was continued. Because it was the involvement of a research group that already worked in the region, it was thought of an extended project focused on Mental Health Care, in which one of the objectives covered aspects of mental health of the worker.

Data source

We worked on the planning of the research project with the choice of CCR methodology that would include an intervention and construction of knowledge in the area of Health Care. We defined as an intervention the accomplishment of OG to receive interpersonal relations in health work in PC and group technology approach as a tool in managing with people. For that, it was chosen as subject of research professionals of higher level who acted in the PC of the municipality, regardless of the time or type of bond. Those excluded from the OG period were excluded.

Collection and organization of data

The data were obtained in synchrony with the instrumentation phase methodological decisions were taken. The first one was in relation to OG technology, conducted by the theoretical-methodological framework of Pichon-Rivière[10]. The groups were planned with the support of the SMS, which granted physical space and release of the professional to participate in the schedule of the work activity. The groups were held in ten meetings during from August 28 to September 25 of 2015, with an average duration of two hours each.

In the first OG, the objective of the contract[10] was established in which the norms, schedules, objective and operationalization of the intervention project were established. To identify the mental health condition of the participants, the Self-Reporting Questionnaire (SRQ-20) was applied to track a group of non-psychotic mental disorders, such as insomnia, fatigue, irritability, forgetfulness, concentration deficit and depression. There are 20 yes vs. no questions and the positive score for CMD probability is ≥ seven yes responses, with validation in Brazil, disseminating in the evaluation of mental conditions of workers within the PC[11], as in other sectors[12]. These findings corroborated with the construction of the interventional OG.

The remaining OG followed the structure of intervention of 30 minutes previous, with triggering theme, mobilizer of the session, reading the chronicle of the previous group, session development and closure. It is noteworthy that in this last stage there was the collective construction of the most relevant points discussed during the development. The ten OG counted on the coordination of the researcher and of two undergraduate observer students, all with experience in the theoretical-methodological framework of OG. The observations were made in field notebooks and the session recorded in audio. This material composed information for the performance of the chronicles, which are a synthesis of the group setting.

Work steps in Operative Group

This moment corresponded to the phase of scrutiny of this CCR. The themes of ten OG and strategies that led the sessions were established, taking into account the results of the SRQ-20. From this emerged the empirical material that had been analyzed in the sequence. It should be noted that after each session, an analysis of the group setting was performed for the creation of the chronicle, which aided in the process of analysis of the next phase. It also guided the elaboration of the triggering themes of the subsequent OG, that is, each session was guided by themes elaborated during the intervention process, demonstrating the characteristics of feedback, flexibility and continuity between the meetings. Chart 1 presents the themes and strategies for mobilizing the discussions. As identification, the letter G was used to identify the "group" and the numbering sequenced in Arabic numerals to indicate the session number with the triggering title of the meeting.

Chart 1 - Triggering themes applied in the Operational Groups held with professionals, Central Region, Brazil

Triggering theme of the Group (G)	"Explicit task" strategy	Objective
G1 – Presentation	Objects bag	Promoting presentation through an object
G2 – Group concept (PICHON-RIVIÈRE, 2009)	Choice of pictures or magazine headlines that would have meaning to you	Addressing current feelings and thoughts
G3- The challenges of everyday life in Primary Care	Kneading the sheet and in doing so, remember that situations that displease you	Addressing unpleasant and current feelings and thoughts
G4 - The challenges of everyday life in Primary Care	Cut the paper and build something with the fragments	Reflecting on troubleshooting ways
G5- Professional team relationships	Survey of weakness and potentiality of the team that I work in	Reflecting on the team
G6- Teamwork strategies	Assembling the work team - drawing	Reflecting on the performance of each in the team
G7 - Living with you and like others	Reflective Poem "I'm not you, you're not me"*	Listening therapeutically to the other
G8- Criativity and improvisation	Choice of objects from a basket and creating stories	Encouraging confrontations
G9- Changing the course of history	Group anxiety survey	Reflection on future expectations
G10- Group closing	Video projection of previous meetings	Promoting review of interventions and evaluation of the process

*Note - *FREIRE, M. Educator. Paz e Terra. p.95-96, São Paulo State, 2008.*

Analysis and interpretation of data

The phase of analysis and interpretation of the data occurred simultaneously to the performance of the OG. First the sessions were transcribed in their entirety, they went through the analysis of group opening, group setting development, main explored aspects and closure (such observations traditionally make up a chronicle). For the pre-analysis, the thematic content analysis[13] was used, which summarily consists of the pre-analysis steps identified by the floating reading with material exploration and the corpus of the research. The Registration Unit (RU) were abandoned, their grouping and formulation of the hypotheses precursors of the thematic categories. The coding of RUs in G1, G2, G3... representing the OG, followed by P1, P2, P3..., representing the professional participant. From the thematic analysis process, two categories emerged: "Evidence of Suffering at Work" and "Group Learning: Group Reception by the Group". Once the material was organized, the inferences and interpretations of the data.

RESULTS

The subjects that participated in the study were women (96.2%) (SD 3.7, 95% CI 88.5-100) with a mean age of 31.65 years (SD 35.57, 95% CI 30.31-33.00), 19 (73.1%) were nurses, 2 (7.7%) nutritionists, 2 (7.7%) physicians, 2 (7.7%) psychologists, 1 (3.8%) dentist. The mean in months of profession time was 87.48 (SD 50.96, 95% CI 69.56-108.59). The prevalence of CMD probability was 42.3% (95% CI 23.1-61.5).

Categories

The first thematic category "Evidence of Suffering at Work" was perceived during the ten OGs that reinforced the need to receive the adversities of daily work in PC and that may justify in part the mental suffering of each worker, especially for the group searched. This grouping of RU emerged from the process of analysis that identified aspects of suffering in relations with management and local administrative policy, and of frustrated demands in the daily work.

> *I think it's not just our problem, ... our health is greatly impaired by politics, it hinders the proper development of itself, ... I think SUS is an exemplary model of health, if it works, if to be valued in Brazil, ... it's just the patient and we who are screwed up...* (G5:P1)

> *When you are acting well, nobody recognizes, no one comes to compliment, just to get attention, they complain about you, ... recognition never, more critical always, we recognize, we know when we act right, only we want the other to see it too.* (G4/P8)

> *I compare nursing to a cow, gives milk, meat, and when there is nothing to do with it anymore, goes there and slaughter it, and still eats you! I feel like a cow, doing what they have to do, accommodate, eating, and getting fat.* (G9:P1)

> *Often, the patient arrives with the request for mammography and has returned many times and has no way, has no vacancy, the problem is not his, it is also mine, it is all over the nursing team. Another example: the glass has been broken for 30 days, and when the thief comes in, it's me who has to keep doing police report, which distresses me. What distress me the most is that my service does not bring me a little pleasure, I go there forced, I go because I have to go, I do not have the pleasure to work, as I have had, in other situations, which today are not the that I'm experiencing.* (G9:P7)

> *He sends me a call, then he cuts you off, for a vaccine campaign, then I called my agents and they went to work for me, otherwise, I would have worked like a donkey*. (G4:P5)

> *First, I do not think I live in a glass house, if one comes late, and I arrive too, what am I going to tell him? Can I do it but he cannot? We both have to work eight hours. They are playing in the unit, people who do not know how to do anything, who are not prepared, they have commissioned positions, their godfathers are the mayors...* (G5:P4)

> *I got sick and asked to leave, because of a commissioned position, a meeting that I had, everyone asking me to stay ... so I said this is a hierarchy of power, and I'm disenchanted with nursing today, you have a bond with the community, and no use, I'm also a bankruptcy, then I asked for another type of service, no hierarchy of power you have no opinion.* (G5:P6)

> *It is typical of the management of the municipality, one hindering the other, rather than one helping the other through the city, but not, one is hindering the other.* (G6:P11)

> *It is very complicated, because there is always this thing debating inside of us, since newly graduated is more difficult, that doubt remains, the responsibility.* (G3: P8)

> *I took my Premium license, and then I stayed five years, I got a dislike of nursing, I loved waking up early to work, until they left me in another basic unit, for three months, but my God ... one day I saw an intern girl and I said: you are too naïve to major in a course like this, I will tell you my life, I sat with her and I told, and I asked 'Do you want it for you? Chang your course'.* (G5:P5)

> *...as a health professional, your home may be upside down but you have to be well, our mission is very difficult, we have to try to help the other, to understand, sometimes we make a pre-trial. The question of the house I did, I was watching yesterday on television, the boy from Syria, I built a home, a family here, it's a complicated time, if we do not try to help the other, who will help? I'm starting now, but it's really hard work.* (G4:P10)

> *...the daily pressure is very great, but I do not know where we are going to stop, we work in the SUS, the majority of the population depends on the SUS, and what is the future of public health? The health system does not have proper investment; it has no contests to register the workers. What would be for us without health care, people are ending the SUS, when I say people I say workers and population.* (G5:P6)

> *It is desperate to see SUS be undermined in resources and people...* (G5:P7)

The second category "Group Learning: Group Reception by the Group" was formed by the expressions of qualitative leaps by the members of the group, promoted by elaboration of some

conflict difficulties, reflections on the practice in health and the own behavior of the group context. The RU that makes up this category are the following:

> *Nobody wants to talk, so I'm going to talk, no one was wanting to tell a story, their story, to expose something of their personal life, other people had to force the colleague to do, and after it started by spontaneous free pressure, there everyone went interacting, I'm feeling afraid in the group, that the staff is afraid to speak, to talk, to speak what they should not, or to speak some truth to someone, or else they want to close themselves.* (G7: P3)

> *My expectation is always to remember what I have been meant to be, I graduated to be different, and to make the difference, and I'm not doing, after that group I intend to go back to being what I was meant to be.* (G8:P2)

> *I also found it very good because I saw that I am not the worst person in the world, that I do not suffer alone ... I was closer to people who did not have much proximity and I am going to miss a lot, because I count on the fingers the days of Friday to arrive at the meetings.* (G10:P9)

> *I'm going to miss it too, it makes me want to cry. I will miss the learning, because it has brought us closer, so before saying that I do not know anyone, I know everyone I am here for everyone, only me as a nutritionist I think everyone is working as a team and, I will miss.* (G10: P10)

> *When you proposed the group, I thought, what are we going to do? But now I want to thank you all for collaborating in my life and that of my colleagues...* (G10: P7)

> *We feel very abandoned in this last time, there is no meeting, there is no union, there is nothing, and so on your part of the university, you want it to be a different work, only you listen to our difficulties, everyone complains, but you do not, you hear us, we were feeling abandoned, ... a way to soften the abandonment a little, we are all needy here.* (G10: P5)

> *I got the political paper, and I started thinking about bad things, it was easy to tear* (referring to group activity)*, I thought about the problems, the national issue, the violence, the health, we've been observing in the dissatisfaction, frustration, in question of profession, recognition, but as a health professional we have to reorganize ourselves.* (G4:P10)

> *Even more in the profession that we choose is dealing with people, we just take it, even keeping it far as brings good things, and bad things, we get loaded, heavy days, and there are days that we bring good, happy things. We end up reflecting what we are in life, in the middle am I, and outside a little of each one.* (G3:P1)

> *I even apologize because I think I complained too much, unfortunately, everything that happened to me was the group's own, when I wanted to vent, you always listened to me. I already started to do with my friends at the Monday meeting as we are doing here today, I am very unmotivated I do not want to speak because I only complain. The groups that I coordinate have improved a lot, but I have never done it like here, on Monday I have already done ... I just do not have the observer, I have to fix the observer, but for me it was very good, enriching, thank you very much and sorry for anything and sorry for the vent.* (G2:P6)

DISCUSSION

Regarding the prevalence of the possibility of CMD found in this investigation, it was higher than those reported by studies with the general population attended in PC (from 31.47% to 41.6%)[11,14-15]. A study conducted with nursing professionals in a hospital identified the probability of CMD of 35.0%[3], which points out that the possibility of CMD among health workers is a reality to be faced, regardless of the complexity of care , it was considered vulnerability to illness due to depression, anxiety and somatotropic disorders[3,11]. Recalling that CMD has been shown to be a strong predictor for other specific occupational pathologies, such as Burnout Syndrome[16].

The causes of illness at work can be multiple, and without the pretension to exhaust the subject, stand out some conditions that could have corroborated with this situation, through which the subjects of the research revealed. The dissatisfaction was strongly reported and, like another study, the lack of recognition mobilized feelings of suffering, negatively reinforcing the actions carried out on a daily basis. Increased frustration leads to a painful, tiring, and unpleasant health-making, eroding relationships with you and with others[17].

The great prevalence of work dissatisfaction in the health area is due to the difficulty of coexistence in the team, great demands for work, low remuneration, lack of professional recognition, precarious materials to carry out the work, service patterns out of the reality of the same, lack of encouragement, lack of interaction with other services, disinterest among colleagues, maladministration among others[17]. The results of the work are little determined by the one who executes it, being much more conditioned by external demands, which makes it an activity that does not always promote the fulfillment and personal and social satisfaction[18].

Management aspects have also been approached, such as coexistence with commissioned positions and managers who are not qualified to perform the function for which they are appointed, due to political influences and positions sponsored, without any technical skills or preparation, which hampers work and leave the professionals dissatisfied and indignant, reflecting the displeasure in the work environment, loss of meaning and resolution of health actions[19]. The dissonances between the ideas of the health system and the daily reality in PC are reflected in the lack of motivation, and are also related to rates of turnover and conflicts with management. It creates, then, a work environment of insecurity about what is accomplished, with the feeling of loss of control of the activities that they perform[2].

The excessive labor demand of the healthcare model proposed by the SUS is incompatible in most cases, with the number of professionals, physical structure of the environment, equipment and supplies made available to PC. Focusing on management problems, these are predominant paradigms, low qualification for the population reception, centralization in the biomedical model, disorganization in the rotation of activities proposed for professionals and high bureaucratic demands. The above-mentioned problems are a consequence of party-political influence, as well as the inadequate titling of people sponsored for leadership positions[19], which contributes nothing to the consolidation of

SUS principles and directives. Besides that political and economic actions at the end of the second decade of the 21st century have imposed radical sanctions on public services, all in the name of the recovery of Brazil's growth, thus, in a setting that the majority of the Brazilian population depends on SUS to take care of their health[6] is expected to suffer more suffering and illness, both workers in the area, and the citizen.

Consequently, it is suggested that conflicts, disintegration of the team and the suffering of health workers may originate from the disqualification of managers who are not or do not feel prepared to perform the position for which they were selected. Thus, it does not come from optimum conditions for the functioning of services and teams, so it is not possible to resolve the day-to-day problems of the sectors[2,19], in addition to arousing feelings of non-ownership, margin and in lesser value of the projects of management[18].

Another dimension reported by the subjects in the OG was the difficulty of separating what is personal from what is professional. Health workers have a very interrelated relationship between their personal lives and work, because of their own practice, because they deal with emotions and experiences of complex moments, of the individual, and of the community, which are often sick, fragile, facing treatments and barriers in health services. In this environment, the professional feels mobilized and becomes more vulnerable when added to this condition, besides having multiple jobs, considering the physical and psychological wear and tear, reflecting the poor quality of the service provided[4], as well as losses in professional relations, in the follow-up and in the daily evaluation of the health work and in the own technical-scientific condition of performance[3].

Proceeding, although the average time of action of the subjects was high, during the GO was identified the space for the manifestation of anxiety of some newly trained professionals. This sensation permeated the health work, mobilized basic fears before which one does not have mastery and experience[20], at the same time that wants to face the situation and to change[20]. Professionals who have just graduated receive major challenges and responsibilities, generating discomfort and sometimes feelings of inability to care for others because of the lack of experience. Frequent fears are the error, and the insecurity to perform certain technical procedures. The fear increases when faced with the difficulties of adaptation that the profession brings[21]. This situation requires attention and space for reception, since it can determine both assertive confrontations, resistance and stagnation of learning[10].

All these aspects add up to the precariousness of the health service and become real problems to do in health, with great potential to generate mental suffering of the professionals and, sometimes, to the development of mental and behavioral disorders. The greatest indicators of this illness are the absenteeism of working days with successive withdrawals from activities[1] and reduced ability to exercise daily activities and even the profession in general[5].

In the meantime, it is observed that during the sessions of OG, the group members occupied the space to expose their difficulties in the work and, when this occurred, re-significances emerged. In the group setting, the dialectical performance was analyzed, allowing the construction of a bond between the members, be they of edification or conflicts, as long as they are solved within the collective environment, enabling a development and envelopment in the group's relations[10]. A group is made as a group as individuals build links with each other, the other becomes significant, being a sophisticated technology to share experiences and knowledge, constituted by a purpose of similar interests.

In this meeting, the need for change is projected, which recruits in each individual the training of reflection and mobilization, in the quest for autonomy[20], during this exchange, the subjects showed the insecurity in exposing themselves in a group, both in relation to of work for oneself; moments identified as pre-task. When individuals subjectively resisted the group insertion, the contact with the other and with them, resulting in restlessness, concern and fear of loss of identity, feelings are generated and an act opposite to the task[18,20].

Generally, this phenomenon deals with the antithesis and precedes the task, which represents the essence of OG work. Group work is when group members organize themselves towards their goal or intention, they allow themselves to live beyond what is known, share their anxieties, and seek methods for them to be nullified or elaborated[18,20]. In the case of the group researched, the initial resistance was in relation to the construction of belonging, and that was to feel part of the group, to share problems, anxieties, modifications and mutual acceptance[22].

Still in relation to the emergence of feelings, this identified with the transferential network, because the moments that have already lived have surfaced so that the group could approach it collectively, constituting a reproduction of situations, reformulating processes of personal and group confrontations, which indirectly interfere in life. There is talk of redefinition of the defensive positions adopted by the individual at the beginning of the OG, related to fear, insecurity, resistance, authority, dominance. In the course of the groups, this resistance is broken by the task[23], due to the movement of pro-opening to the new one and overcoming the stereotypes[20]. It becomes aware of its historicity and contextualize its doing, so that it is possible to open other possibilities, including to think about their reality[10].

Some factors that have been addressed during the OG sessions may constitute personal protection and promotion of mental health; one of them was the learning space that represents the main therapeutic resource of the OG because it promotes learning in the sense that people are able to reconstruct processes that are sick in the way of life and relationships. The conditions generated by the OG are: to listen, to reflect and to know more about oneself and the other, increasing the capacity for cooperation, communication and relevance of actions, which allows coping and overcoming the distortions of learning reality[10].

OG aims to distinguish the group problematic, providing dialogue, problem-situation exposition and confrontation construction, considering the peculiarities of each individual, weakening factors that contribute to depersonalization[24]. It is observed that by the speeches of the professionals, there was reflection on the condition itself and the aspects of its identity were rescued. In this sense, to approach their own conflicts and to elaborate feelings, if it led to the understanding of the problems of others, better adaptation to the environment and new learning situations[10].

Individual and collective reflection are relevant factors for the development of OG participants, link building and change project, and are aligned with the maturation process. Likewise, it encourages technical dimensions through the learning and construction of knowledge, especially related to group work, reception and listening strategies[24]. The OG is an assertive strategy for the improvement of working conditions, with indicatives in the confrontation of physical and psychological suffering in the work environment[22], with unfolding in the capacity to solve problems and benefits in the relationships of professionals in their interactional network extra group.

This phenomenon occurs once the group process causes transformation through dialectical and dynamic actions between the paralyzing forces of fear and those that are driven by the need to change, to advance[10,20]. A rich environment that enables members of the group to develop schemes to manage their own desires and the other, benefiting beyond personal life as well as social life[25].

Therapeutic listening has great potential to be built among group participants[25]. To give voice to the suffering of the colleague gave rise to the collective feeling of not being alone, of being welcomed, which represented an exercise of cooperation between the subjects of the study. Much was due to the factor of social inclusion of the individual, contextualized in the relationship with the neighbor and/or society, reflecting in his psychic life. This being a way of visualizing the reality, be the own or with the aid of the other, constituting, thus, a relation of trust between both. In the interaction of the members, emotions, experiences and knowledge were shared which facilitated social and group interaction. Emphasizing the particularities of each individual, working a therapeutic listening, not only between the coordinators of the group, but also from the members, collaborating in the respective life and in the others[20].

Study limitations

The limitations of the study were related to the subjects and the methodological approach, which reflected a given reality and not generalization of the results. Also, when the suggestion of a mental health care tool guided by the Pichon-Rivière framework was used, since it requires professionals trained with such fundamentals, restricting its application in other contexts with a lack in this training. However, it is believed that group interventions should be guided by technical-theoretical frameworks, in order to guarantee interventions that promote therapeutic listening, autonomy, critical reflection of reality and learning as means of overcoming.

Contributions to the sector of Health

The present study revealed as the main finding the theoretical-practical constitution of mental health care of working professionals in PC, conducted by the OG. To that end, it was methodologically guided by the CCR, starting with the application of the instrument to identify the possibility of illness of PC workers, SRQ-20, which was reinforced by the first thematic category of content analysis on the evidence of the mental suffering. Also, following the CCR stages, the subjects' reality was intervened with the group approach of OG as assertive technology in the reception of the suffering identified by both SRQ-20 and the thematic analysis.

FINAL CONSIDERATIONS

The results of this CCR reinforce the vulnerability to the mental illness of the active professional of PC and guide the constitution of mental health care for them. The application of OG as a proposal of reception of the mental suffering of the worker of the PC was assertive, because it provided the professionals a space of listening to the adversities of the day to day work, reflection and confrontation of the basic fears, development of a pro-change through peer cooperation and active learning of reality.

As a proposal of care for the mental health of the professional applying OG, points out their systematization and operationalization, such as the establishment of the objective contract that directs group membership; the understanding of the group pre-task, as a moment of antithesis inherent in confronting the basic fears; the work centered on the task as an instrument of overcoming stereotypes and elaborating pro-change projects. In this context, the role of the feedback of previous OG sessions is considered important, through group chronicles, since they allowed the follow-up of the intervention process, respecting the scope of continuity.

Finally, the characteristics of the elaboration of the intervention themes that have not been plastered since the beginning of the method are highlighted, since it risks to be based only on the SRQ-20 results. Taking into account that in the course of the period, analyzes of the sessions had space for approach in the following meetings and that the group movement itself was protagonist of the intervention.

This study provided a theoretical-practical contribution to the care of the worker's mental health in the PC, and the nurses in this environment are included as members of a team, also points out the OG as an instrument and assertive conduct of the multidisciplinary actions and with the community itself. It is suggested, then, the OG as a construction of the care to the mental health of the workers of the nursing team.

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