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Repercussions of violence on the mental health of workers of the Family Health Program

ABSTRACT

OBJECTIVE: To describe forms of external and indirect violence that affect the mental health of workers of the *Programa Saúde da Família* (Family Health Program), as well as the strategies developed by these workers to enable their work and to be psychologically protected.

METHODS: Qualitative study on the *Programa Saúde da Família* work process, performed in the cities of São Paulo, Ribeirão Preto and Embu (Southeastern Brazil) in 2005. Theoretical approach of psychodynamics of work, which proposes the formation of reflection groups with workers, was employed. Subjective aspects of work, situations of psychological suffering and strategies used by workers to deal with suffering and continue to work were sought to be identified.

RESULTS: The Program's work organization exposed workers to the following: situations of violence, invisible at times; feeling of impotence in the face of precarious situations; lack of acknowledgement of efforts made; lack of borders between professional and personal aspects; intense experiences of social and domestic violence; fear of risk of exposure; feeling of moral and physical integrity being threatened; and fear of reprisal. Situations of psychological suffering resulting from violence in the workplace were observed. These became more intense in the *Programa Saúde da Família* due to regular contact with situations of violence that cause fear and a feeling of vulnerability.

CONCLUSIONS: Psychological repercussions caused by violence in the workplace, not always expressed in the form of psychological disorders, were observed in situations of intense suffering. Workers develop strategies to minimize suffering, protect themselves psychologically and continue to work; and seek to create solidarity and protection networks with the population, aiming to reduce vulnerability. With the experience gained, they learn to detect high-risk situations, avoiding those they believe to be threatening.

DESCRIPTORS: Health manpower. Program Family Healthcare. Psychological Stress. Professional exhaustion. Satisfaction at the Job. Health Worker. Mental health. Violence. Qualitative Research.

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INTRODUCTION

Since the late 1980s, violence has been the second general cause of death in the Brazilian population.[20] According to the Pan American Health Organization (PAHO), "violence, due to the number of victims and magnitude of organic and emotional sequelae it causes, has acquired an endemic nature and become a public health problem in several countries."[11]

Mortality rates are only the "tip of the iceberg", when compared to morbidity indices and their impact on society and health services, where the number of

hospitalizations due to violence is six times higher than that of deaths.[1,4,18]

European Union studies[a] reveal that 4% of the economically active population affirms having suffered some form of violence in the workplace and that high-risk environments are concentrated in the service sector (health, transportation, retail market and education).[13,15]

Theoretically, work violence, or violence *of* work, is associated with deterioration of work conditions and the new productivity paradigms, which increase workers' exposure to the risk of accidents and diseases. On the other hand, violence *in* the workplace involves a relationship with superiors, colleagues, clients and the public when performing tasks.[3,5] Wynne et al[23] (1997) includes incidents associated with abusive behavior and threats or attacks, which imply explicit or implicit risk to workers' safety, well-being and health, in the concept of violence in the workplace. Psychological violence is understood as forms of verbal aggression, threats, intimidations, psychological abuse and insults.

In a bibliographic review, Santos Junior & Costa Dias[14] mentioned two forms of violence in the workplace, according to the Occupational Safety & Health Administration in 1995: external violence, when committed by someone who is not associated with the worker or when committed by clients/users, including some type of professional relationship between the aggressor and worker; and internal violence, when committed by someone who is associated with the workplace, whether they are a colleague, superior or subordinate.

Indirect violence is included in these two types of violence, occurring when the worker, by performing their tasks, experiences situations of great misery, associated with lack of resources to resolve them and the impotence to propose alternatives. In addition, the concept of indirect violence considers disqualification of work performed, impossibility of performing it with quality, and also situations that force workers to act against their will and values, violating their psychological integrity and, consequently, human dignity.[16] Indirect violence can result from experiencing, interacting with, and witnessing situations of external violence, which means direct or indirect contact with victims of violence or aggressors.

To discuss violence in the workplace is a complex task, once it requires defining the workplace and the concept of violence, in addition to establishing a causal connection between work and violence. When work is performed in outdoor environments, such as streets, distinction between workplace and route, a decisive factor to analyze these events, becomes difficult.

These forms of violence become more intense in services such as the *Programa Saúde da Família* (PSF – Family Health Program), which, in its implementation, privileged areas that are at a higher social risk, and created strategies that foresee close contact between the health team and the population served, as well as service in outdoor environments and in the users' own homes, factors which increase workers' vulnerability. Thus, high-social risk areas are those that also increase violence.

The PSF began in the 1990s in Brazil, and it was the Ministry of Health's main strategy to organize primary care.[7] However, the PSF did not help teams to develop instruments to deal with the complexity of these new practices, because qualification, support and backstage strategies were not organized during their implementation. The PSF follows health care comprehensiveness and regionalization, presupposing good relationship between the team and the community and focusing on the family. The interdisciplinary team is one of its foundations to make work operational, "facilitating the development of a comprehensive individuals/family approach and the understanding of different factors that interfere with the health-disease process."[2] Each team has at least one general practitioner, one nurse, one nursing assistant and six health community agents, and is responsible for between 800 and 1,000 families living in its area on average.

The present study aimed to describe forms of external and indirect violence that affect the mental health of workers of a family health program, as well as the strategies they develop to enable their work and to be psychologically protected.

METHODS

This study was part of the research project entitled "Assessment of the *Programa de Expansão e Consolidação da Saúde da Família* (PROESF – Family Health Expansion and Consolidation Program) – for the development of assessment studies – Southeastern Region – 3".[b] This project aimed to analyze the factors that comprise the complexity of primary care, especially in terms of the PSF/Brazilian Southeastern Region.

The cities of São Paulo, Ribeirão Preto and Embu were selected for this study based on sociodemographic data and certain PSF implementation results, such as: PSF consolidation in several regions, implementation time,

presence of complete teams and epidemiological profile diversity. The administrative sub-region of Pirituba was selected in São Paulo, with 413,120 inhabitants, 23 PSF teams distributed among eight *Unidades Básicas de Saúde* (UBS – Basic Health Units); Ribeirão Preto has 550,480 inhabitants and 23 PSF units distributed in nine UBSs; and Embu, 244,642 inhabitants, six UBSs and eight PSF teams. PSF coverage in these locations reached 18% of the population at that time.

Psychodynamics of Work, also denominated Work Clinic, proposes an investigation and intervention method for work situations. Given the complexity of the object and its objectives, the study of the relationships between pleasure and suffering in the workplace, Psychodynamics of Work belongs to the field of qualitative research[21] and, in general, seeks to grasp individuals' perception, understanding and participation, as well as aspects related to the problems investigated.[12] In Psychodynamics of Work, such phenomena refer to the psychological impact of the work process and to the subjective relationships established in it. The peculiarity of this method differs from focus groups, once group reflections are defined by their transforming nature, resulting from the work process being reclaimed by participants. Thus, it could be said that Psychodynamics of Work is involved in the research-action approach.[19]

Psychodynamics of Work recommends understanding subjective work aspects from reflection groups, a privileged space to turn individual experiences into group reflections. These groups, comprised by workers directly involved with the situation analyzed, enable a general view of defensive strategies and mechanisms, established by individuals to protect themselves from suffering caused by work.[9,10]

The Psychodynamics of Work method involves five stages: a) pre-research; b) demand reconfiguration; c) project presentation to workers and identification of volunteers to participate in the groups; d) reflection groups; and e) return and validation of a preliminary report prepared by researchers.[7] The final report subsequently becomes public material, as previously agreed.

To carry out the stages foreseen by the Psychodynamics of Work, a management group was formed, comprised by researchers, coordinators and health unit managers. The proposal was presented to the workers involved, according to the professional categories comprising the PSF team. A total of four homogeneous reflection groups were formed, organized with each of the PSF team professional categories: doctors, nurses, nursing assistants, and community health agents. Each of these had the participation of three researchers, responsible for session coordination and recording.

All workers were invited to participate in the groups. Participation was representative of all units involved and defined on a volunteer basis.

Group processes lasted 24 hours on average, distributed in up to six weekly sessions, and sought to preserve the time required for a Psychodynamics of Work action and minimize interference in service routine (Table 1).

After reflection groups, a preliminary report was prepared and subsequently presented to each of the groups in validation sessions.

Next, the two other participating cities were analyzed. The reports prepared in Pirituba were the methodological resource used to begin group discussions, organized according to the same criteria adopted in the first stage, as shown on Table 2.

These discussions occurred in a single session, after reading the report from Pirituba. One month after the end of each group's initial reflection process, preliminary reports were presented in group sessions for validation. The final reports were subsequently made public among the remaining workers and managers of all regions.

From the reading and analysis of the reports obtained in the three cities, passages that mentioned violence in the workplace were emphasized, paying attention to discourse antagonisms and repetition.

The study was approved by the *Faculdade de Medicina da Universidade de São Paulo* (University of São Paulo School of Medicine) Ethics Committee. All participants signed an informed consent form.

RESULT ANALYSIS

The most expressive and recurrent themes identified in the reports enabled the establishment of the following analytical categories: impotence in the face of precarious situations; lack of acknowledgement of efforts made; lack of borders between professional and personal aspects affecting non-working time; intense experiences of social and domestic violence; fear of risk of exposure; feeling of moral and physical integrity being threatened; and fear of reprisal.

Regular, intense, and prolonged interaction with users, as occurring with PSF teams, causes an impact on these workers. This interaction humanizes work and enables a critical view of users and their context of life, but it also has a strong psychological impact, which is expressed in the impotence experienced in the face of situations of extreme material precariousness: *"We weren't prepared to bear and understand the problems and give guidance. You go into a home, see all that misery, listen to all those problems and don't know where to start. You got to work on everything... We give it a try"*.

Table 1. Characterization of participating groups in Pirituba. City of São Paulo, Southeastern Brazil, 2005.

Workers' categories	n	Sessions	Interview (in hours, including validation)
Doctors	6	6 of 4 h	24
Nurses	4	5 of 4 h	20
Nursing assistants	10	5 of 4 h	20
Community health agents	16	5 of 4 h	20
Total	36	21 of 4 h	84

The context of life of the communities served by the *PSF* exposed its workers to regular social violence, as they witnessed situations of aggression directly, and also intense misery, indirectly. Workers saw themselves in the face of situations that involved conflicts and forms of violence that caused them to feel ethical dilemmas in terms of how to adequately intervene in each case, such as experiencing situations of disrespect towards others and the law, or that involved private cases of domestic violence.

As members of society, community health agents and their families are exposed to a greater feeling of vulnerability to violence, once they witness high-risk situations and meet people involved with such. Thus, they reported fear of the risk and ambivalence when they had to decide, alone, to approach a home where someone supposedly involved with aggression and/or drug traffic lived: *"The woman gets beaten and tells no one, but me. She goes into her house, something comes up, some fight, and we're there already. We can't visit someone alone. I'm afraid"; "You know that area is dangerous, there's 'pedágio' (Portuguese for 'toll', meaning money the population is forced to pay to be*

Table 2. Characterization of participating groups in the second stage of research. Cities of Ribeirão Preto and Embu, Southeastern Brazil, 2005.

City/category	n	Sessions	Interview (hours)
Ribeirão preto			
Doctors	5	1	4
Nurses	4	1	4
Nursing assistants	7	1	4
Community health agents	16	1	4
Total	32	4	16
Embu			
Doctors	3	1	4
Nurses	3	1	4
Nursing assistants	6	1	4
Community health agents	17	1	4
Total	29	4	16

protected against criminals), curfew, things get ugly there. So, why did you go there?".

To minimize such exposure to violence, health community agents establish individual and group defense strategies, which enable them to deal with high-risk situations by creating a protection and solidarity network in the community. They adapted to create ways to enable their work to be performed. They avoided learning about high-risk situations, exchanged information about the area where they worked, customs, habits, and "forbidden and allowed" places, aiming to create protection and prudence strategies: *"The only way is to keep your distance and pretend you know nothing; it's better not to know where the danger is, or not to remember a face; depending on the mood, we know when to go into some house or not."*

If exposure to violence affected community health agents primarily, fear would be frequently reported by the whole team, and it was associated with the fear of reprisals by users known to be violent and dissatisfied with the service offered. On the other hand, the team felt offended concerning their own integrity, because they had to remain silent in the face of situations of domestic violence or even disrespect for others.

The contradiction between the effort made to maintain the health of population and the problems and deaths witnessed caused intense suffering and a feeling of loneliness: *"It touches me when someone's murdered and this happens every week!"; "not to have someone to share this with"; "we measure his pressure countless times, but we can't get him to care for himself more, nor to stop beating his wife".*

The team seeks to minimize indirect violence with strategies and actions that transcend their professional role. Workers organized fund raisers to buy medication and food or to help with home expenses; and used their own networks to speed up care for patients considered to be in a serious condition. However, these actions become sources of suffering, as they cause doubts and conflicts. They feel they receive little comfort, not having someone with whom to share these dilemmas, and end up facing situations where the invisibility and partial reach of their actions result in lack of acknowledgement of efforts made.

The team mentioned the difficulty in remaining absent and working according to a logic that did not enable the population's demands to be met. To control one's own involvement, establish limits between health actions and social actions, and interact in situations for which they do not feel prepared were part of these workers' usual dilemma: *"You can't deal with it, solve these social problems, the poverty, the women who get beaten up…"; "I took the child home, because it got badly beaten, I wanted to adopt it, but my husband*

didn't accept it, this is about drawing the line... this line works in theory, but, in fact, you get involved".

The continuous contact of the team with the users creates situations for which there are no pre-defined procedures. The several levels of violence witnessed by these workers cause them to become a target of this same form of violence. The situations they experience in their work routine makes them feel lonely and vulnerable when performing their work, regardless of their professional category.

Immersed in the routine of misery and submitted to a logic of work which is not functional at times, workers feel responsible for the several cases under their care. The team mentions the "lack of barriers" between professional and human involvement, once they are in direct contact with people's intimacy: *"The limits (of involvement) are very subtle... we often pitch in to buy medicine..., to take a child home is beyond (the limits)"; "I couldn't, I'd stay awake, I couldn't sleep, I began to draw the line... when the child died, I went to the funeral and burial..."; "I couldn't sleep well for several weeks, I know the murderer, the one who was murdered, I know the family, I know everyone".*

This lack of barriers causes dilemmas, according to what is reported by one of the doctors: *"Is the doctor's desire to cry in the face of problems that can't be resolved normal?"* Another example is given by a nursing assistant: *"Should professionals go to funerals? And in such cases, should they go as professionals or as people?"; "The moment you humanize care, you become human, I help more if I have an impartial, technical approach".*

CONCLUSIONS

The observation of the effects of physical violence in the workplace usually leads to accurate actions that seek to minimize or even resolve its causes. In contrast, psychological violence, even when it is direct and expressed by verbal aggression, harassment, and threats to the worker's integrity, is not always evident, once it occurs in an inter-subjective relationship, making it difficult to be detected. At times, it is even neglected, while several contexts of work are assessed.

According to Vezina et al[22] and Dejours,[6] even though severe psychological disorders associated with work can occur, phenomena which are not classic mental disorders, but rather situations of high psychological suffering, whose origin is attributed to the experiences workers have due to work organization, have become more frequent.

According to Heloani et al[8] and Soboll,[17] the experience of psychological violence, due to its subjective nature, must be treated on different levels, especially because of its impact and cost for the worker. The effects of this violence include psychosomatic symptoms and can become manifest as a feeling of distrust, lack of motivation, work becoming meaningless, and low self-esteem, for example. These effects tend to become worse over time, and may lead to interpersonal relationship break-ups, absenteeism, high turnover, sickness, work leaves and, finally, loss of work organization structure.[20]

Violence, in its different forms, as reported by PSF workers, became manifest in the fear of risk of exposure, threat to integrity and fear of reprisal. In addition, feelings of impotence in the face of precarious situations, the invisibility of efforts made, and the lack of barriers between professional and personal aspects, thus affecting non-working time, usually remain hidden.

Even though results indicate a strong trend towards psychological suffering resulting from violence in the workplace, the work process developed by the PSF enables its professionals to have interesting perspectives. To design a system where technical actions and innovative activities can come together and which can lead to improvement in quality of life for the population is an opportunity for professional and personal development that generates professional involvement with others and satisfaction.

The visibility of psychological violence in the workplace and its forms, based on workers' participation, can contribute to develop individual, collective and organizational strategies that make work healthier, enabling workers to perform it, despite the threats and fear they experience.

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