TEXTO & CONTEXTO enfermagem

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MENTAL WORKLOAD AND SOCIAL SUPPORT IN PRIMARY HEALTH CARE WORKERS

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ABSTRACT

Objective: To analyze the relationship between mental workload and social support in Primary Health Care workers.

Method: This is a quantitative cross-sectional survey with healthcare professionals from Primary Health Care in Rio Grande do Sul, Brazil. Data were collected online between July 2021 and April 2022, using the questionnaire with sociodemographic, employment and healthcare profile information; Job Stress Scale; and Subjective Mental Workload Scale. Data were analyzed with descriptive statistics, Spearman's correlation, chi-square or Fischer's exact test (with statistical significance established at $p<0.05$) and internal consistency using Cronbach's alpha coefficient.

Results: The largest group of workers had an adequate mental workload (48.7%) and there was a prevalence of low social support (57.6%). Mental load had a significant association with having time for leisure ($p<0.001$) and satisfaction with work ($p=0.028$). Furthermore, satisfaction with work had a significant relationship with social support ($p<0.001$). Furthermore, social support had negative and significant correlations with mental load in the health consequences ($r=-0.377$; $p<0.001$) and work characteristics ($r=-0.192$; $p=0.008$) dimensions.

Conclusion: Workers with a high mental workload have a lower perception of social support, which may have an impact on their health, considering work characteristics. Furthermore, aspects of satisfaction and leisure activities should be promoted as a way of promoting quality of life at work.

DESCRIPTORS: Primary Health Care. Social Support. Mental Workload. Health Personnel. Work.

CARGA MENTAL DE TRABALHO E O APOIO SOCIAL EM TRABALHADORES DA ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO

Objetivo: analisar a relação entre a carga mental de trabalho e o apoio social em trabalhadores da atenção primária à saúde.
Método: trata-se da pesquisa transversal quantitativa com profissionais de saúde da Atenção Primária à Saúde do Rio Grande do Sul, Brasil. Os dados foram coletados *online* entre julho de 2021 e abril de 2022, por meio dos seguintes instrumentos: questionário com informações sociodemográficas, laborais e perfil de saúde; *Job Stress Scale*; e Escala Subjetiva de Carga Mental no Trabalho. Analisaram-se os dados com estatística descritiva, correlação de Spearman, teste Qui-Quadrado ou Exato de Fischer (com significância estatística estabelecida em p<0,05) e consistência interna usando o coeficiente Alpha de Cronbach.
Resultados: maior contigente de trabalhadores apresentou carga mental de trabalho adequada (48,7%) e houve prevalência de baixo apoio social (57,6%). A carga mental teve associação significativa com o ter tempo para lazer (p<0,001) e satisfação com o trabalho (p=0,028). Ainda, satisfação com o trabalho obteve relação significativa com apoio social (p<0,001). Ademais, apoio social teve correlações negativas e significativas com a carga mental nas dimensões consequências para a saúde (r=-0,377; p<0,001) e as características do trabalho (r=-0,192; p=0,008).
Conclusão: os trabalhadores com alta carga mental têm menor percepção de apoio social, o que pode repercutir na saúde, considerando as características do trabalho. Ainda, os aspectos da satisfação e as atividades de lazer deveriam ser promovidos como forma de promoção de qualidade de vida no trabalho.

DESCRITORES: Atenção primária à saúde. Apoio social. Carga mental de trabalho. Pessoal de saúde. Trabalho.

CARGA DE TRABAJO MENTAL Y APOYO SOCIAL EN TRABAJADORES DE ATENCIÓN PRIMARIA DE SALUD

RESUMEN

Objetivo: Analizar la relación entre carga de trabajo mental y apoyo social en trabajadores de atención primaria de salud.
Método: Se trata de una encuesta cuantitativa transversal con profesionales de la salud de la Atención Primaria de Salud de Rio Grande do Sul, Brasil. Los datos se recopilaron en línea entre julio de 2021 y abril de 2022 a través de un cuestionario con información del perfil sociodemográfico, laboral y de salud, Job Stress Scale y Escala de Carga Mental Subjetiva en el Trabajo. Los datos fueron analizados con estadística descriptiva, correlación de Spearman, chi-cuadrado o prueba exacta de Fischer (con significación estadística establecida en p<0,05) y consistencia interna mediante el coeficiente alfa de Cronbach.
Resultados: Un grupo mayor de trabajadores tenía una carga de trabajo mental adecuada (48,7%) y prevalecía un bajo apoyo social (57,6%). La carga mental tuvo asociación significativa con tener tiempo para ocio (p<0,001) y satisfacción con el trabajo (p=0,028). Además, la satisfacción con el trabajo tuvo una relación significativa con el apoyo social (p<0,001). Además, el apoyo social tuvo correlaciones negativas y significativas con la carga mental en las dimensiones consecuencias para la salud (r=-0,377; p<0,001) y características laborales (r=-0,192; p=0,008).
Conclusión: Los trabajadores con alta carga mental de trabajo tienen una menor percepción de apoyo social, lo que puede repercutir en su salud, considerando las características del trabajo. Además, se deben potenciar aspectos de satisfacción y actividades de ocio como forma de promover la calidad de vida en el trabajo.

DESCRIPTORES: Atención Primaria de Salud. Apoyo Social. Carga de Trabajo Mental. Personal de Salud. Trabajo.

INTRODUCTION

Primary Health Care (PHC) as the primary level of the health care system consists of a consolidated and effective strategy in its way of organizing and operating the system's gateway, with emphasis on comprehensive and resolute function of these services on the most common health problems[1]. Thus, in some circumstances, PHC workers face risks and suffer from influences of the work process, making them subject to physical and mental exhaustion and unfavorable conditions that put their health at risk due to interaction with their work environment[2].

Concerning PHC professionals' work, due to the peculiarity of users' and community's health situation, it can be a stressful environment for healthcare teams[3]. Thus, it is believed that worker health can be seen through the relationships of individuals at work, as this determines the feeling of pleasure or suffering, considering work conditions and organization[2].

In this context, it is worth highlighting the importance of providing an adequate working environment for PHC workers. A fact that justifies the relevance of this study with an emphasis on workers' perspective on the impact of their health in this context, mainly in relation to the repercussion of mental workload (MWL) and social support.

Thus, MWL consists of a multidimensional construct resulting from the interaction between task cognitive demands, person and situation characteristics. And among its causes are task characteristics, work rate, functions to be performed, degree of autonomy and interpersonal interaction[4–5].

One of the considerable aspects of PHC workers is associated with their commitment to territorial work and the health of the population in the community. However, task characteristics, the time these workers have for work, psychological demands, other aspects and their harmful effects on health make up a psychosocial environment that can generate MWL, with tendencies towards mental overload or underload[6]. Therefore, it is believed that low social support could further enhance the development of the consequences of MWL.

Thus, it should be noted that worker health can be directly associated with the institutional support received by workers at work, in which the greater the support, the lower the occupational stress, resulting in improvement in mental health, with reduced risk of developing psychological problems[7]. On the other hand, low social support has an intrinsic relationship with disruptions at work, as this can increase the risk of people being affected by stress and illness[2].

Social support comprises the level of social interaction present at work, trust in the group, assistance in task development by co-workers and supervisors in the context of organizations[8]. Furthermore, support is associated with aspects of social relationships that provide a decisive factor in experiences of satisfaction and success at work as well as an effect on people's physical and psychological health[1]. Therefore, it presents itself as an important resource in the process of facing adverse situations[1].

It is important to pay attention to whoever performs work, taking into account the way they do it, the conditions in which this work is performed, considering the different historical-social contexts[9]. In this regard, the development of this study can enable knowledge of the facts associated with MWL and its relationship with social support.

Therefore, the question arises: What is the relationship between MWL and social support among PHC workers? From this, the research aimed to analyze the relationship between MWL and social support in PHC workers.

METHOD

This is a cross-sectional study with a quantitative approach, guided by the STrengthening the Reporting of OBservational studies in Epidemiology (STROBE).

The study was carried out in PHC, with healthcare workers from the PHC and Family Health Strategy (FHS) units of the 33 municipalities of the 4th Regional Health Coordination (RHC), whose headquarters are located in the city of Santa Maria/RS, covering the municipalities in midwestern Rio Grande do Sul. Healthcare workers from the city Ijuí, located in northwestern Rio Grande do Sul, which has 06 PHC and 15 FHS, were also included[10]. These regions were included for convenience, due to the research network of the members involved in the project.

Healthcare workers were nurses, doctors, dentists, nursing technicians, nursing assistants, dental technicians, dental assistants, community health workers (CHW), administrative workers (office assistant, secretary, receptionist, warehouse worker) and others who work in PHC (nutritionists, speech therapist, psychologist, social workers, pharmacists, health surveillance agent).

As an eligibility criterion for participants, all primary care workers from the municipalities that make up the primary care of the 4th RHC and the city of Ijuí, who provide assistance to users, were included. Workers away from work for any reason during the data collection period were excluded.

The minimum sample size calculated based on the number of items in the instruments used and a finite population of 2,460 workers was considered. Based on structural equation calculation, with a sampling error of up to 10%, the minimum sample was 128 participants. This procedure guarantees a representative sample of the population in order to minimize and control possible selection biases, providing all workers targeted in the research with the same chance to participate in the study.

Data collection took place from July 2021 to April 2022, through voluntary completion of the instruments using an online form available on Google Forms, accompanied by the Informed Consent Form. Before starting the research, we obtained approval from the Research Ethics Committee and authorization from the municipal health departments. This data collection approach was adopted due to the overall health crisis due to the COVID-19 pandemic, which made it impossible to carry out in-person research.

To access healthcare professionals, contact was established through phone calls, emails and instant messages via application. This information was provided by the municipal health departments of the respective municipalities. From these interactions, the purpose of the research and its relevance were informed. All participating units were contacted persistently, with no limit on the number of attempts.

To characterize the sample, the sociodemographic, employment and healthcare profile characterization questionnaire was used, containing variables relating to sex, age, marital status, children, number of children, position, highest level of education, length of training, job tenure, sector (unit), time working in the current unit, whether they have another employment relationship, feeling satisfied with work, intention to leave work, carrying out physical activity and time for leisure.

The Job Stress Scale (JSS) – Demand-Control and Social Support Model was used to assess social support. JSS originally created by Karasek[11], with a reduced version adaptation[12], later translated and adapted into Portuguese[13]. JSS is made up of 17 items and aims to assess stress in the work environment. In this study, only questions from the social support dimension were used, such as items 12,13,14,15, 16 and 17, assessed using a 4-point Likert scale ranging from "completely disagree (1)", "disagree more than agree (2)", "agree more than disagree (3)" and "completely agree (4)". Cronbach's alpha coefficient for this dimension achieved in this study was 0.82.

The Subjective Mental Workload Scale (ESCAM), developed by Rolo, Diaz and Hernandez in Spain, is a multidimensional scale to assess MWL[14]. The version used in this research was the one that had content validity by Cerdótes, for Brazilian Portuguese, to assess MWL in PHC workers[15].

This version contains 20 items, distributed across five dimensions, namely: Cognitive demands and task complexity; Task characteristics; Temporal organization; Work rate; Health consequences. All dimensions containing a Likert scale (1-5). The ESCAM Cronbach's alpha coefficient achieved in this study was 0.65.

Regarding analysis, data were generated in a Microsoft Excel version 7.0 spreadsheet and transported for statistical analysis in the Statistical Package for the Social Sciences (SPSS) version 21.0. Qualitative variables were described using absolute (n) and relative frequency (%). Quantitative variables by measures of mean position, median and dispersion and interquartile range.

The correlation between quantitative variables was performed according to Spearman's correlation coefficient, when the data were asymmetric using the Kolmogorov-Smirnov Test. In relation to verifying the association between levels of social support, MWL and sociodemographic, labor and healthcare profile qualitative variables of workers, the chi-square or Fisher's exact test was used. Workers were analyzed in two groups, based on education, such as high school and higher education, to generalize the results.

For all statistically significant associations, a significance level of 5% was taken into account, i.e., when p-value was less than 0.05. For internal consistency analysis, the Cronbach's alpha test was used.

In relation to the MWL level, the cut-off points for each dimension were obtained using percentiles (25 and 75). MWL (overload) was high when values exceeded the 75th percentile; adequate/balanced, when values were intermediate to the 25th and 75th percentile; low (underload), when values were below the 25th[14] percentile. Previously, the response scores obtained on the items of each dimension were summed, then they were divided by number of items that make up each ESCAM dimension.

As for social support dichotomization, median was used, in which the social support score ranged from 6 to 24 points, where the higher the score, the greater the professional's social support in their work environment[13]. High social support was considered for a score equal to or above the median and low support for a score below the median (19).

The research was approved by the *Universidade Federal de Santa Maria* Research Ethics Committee, considering the ethical and legal aspects of research involving human beings under Resolution 466 of December 12, 2012 of the Brazilian National Health Council.

RESULTS

From the sample of 191 PHC healthcare workers, they were distributed in the positions of CHW (33.5%), nurses (25.7%), nursing technicians (13.6%), doctors (7.9%), administrative (6.3%), dentists (3.7%), dental assistant (1.6%) and others (7.9%). There was a predominance in the study sample for the role of CHW, followed by nurses. The data showed that the majority of workers were female (89.0%), had a partner (80.1%), had children (74.3%) and had a mean age of 43 years. The highest prevalence of complete training was graduate studies (35.6%), followed by elementary or high school (35.1%).

Concerning work variables, there was a predominance of professionals who do not have another employment relationship (85.9%), satisfied or very satisfied with their work (77.5%) and with no intention of leaving work (82.2%). In relation to the healthcare profile variable, the majority do not practice physical exercise (55.0%) and have time for leisure (49.2%).

As for training time, the median was 8 years. Regarding job tenure in PHC and in the unit, the mean was, respectively, 12 years and 6 years.

In relation to MWL levels by ESCAM dimensions and workers' overall mental workload (OMWL) level, a larger contingent of workers was identified with an adequate MWL level (48.7%). By dimensions, it was found that, for cognitive demands and task complexity, work characteristics, work rate and health consequences, a higher percentage of workers found, respectively, with adequate MWL: 46.1%, 42.4%, 44.0% and 49.2%. As for the temporal organization dimension, there was a prevalence of healthcare workers with MWL (42.9%) (Figure 1).
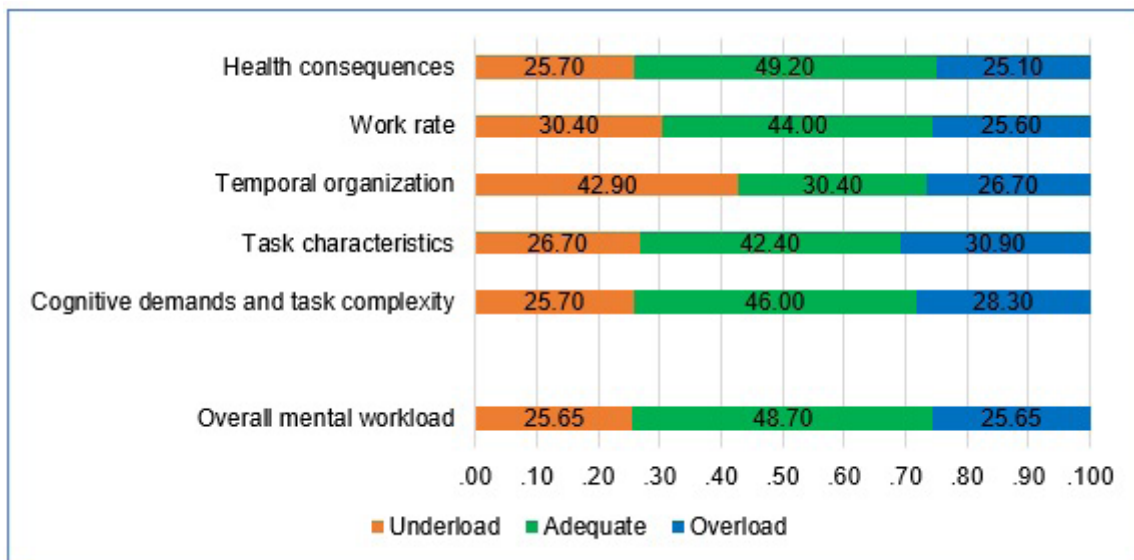

Figure 1 – Distribution of healthcare workers in Primary Health Care according to the level of overall mental workload and ESCAM dimensions. Santa Maria, RS, Brazil, 2022. (n=191).

According to Table 1, there is a statistically significant association between having time for leisure and adequate OMWL (p<0.001). Other associations found were between position (higher-level workers) and adequate OMWL (p=0.001) and between being satisfied or very satisfied with work and adequate OMWL (p=0.028).

About the level of social support, there was a predominance of workers with a low level of social support (57.6%). Furthermore, 42.41% had high support.

According to Table 2, it was evident that there was a statistically significant association between higher complete education (postgraduate) and low social support (p=0.012). Satisfaction with work had a statistically significant association with social support (p<0.001), as dissatisfied/neutral workers have low social support (90.7%).

Table 1 – Association between mental workload and sociodemographic, work and health variables of healthcare professionals in Primary Health Care. Santa Maria, RS, Brazil, 2022. (n=191).

Variable	Overall Mental Workload (OMWL)						*p
	Underload		Adequate		Overload		
	n	%	n	%	n	%	
Sex							
Female	41	24.1	83	48.8	46	27.1	0.270
Male	8	38.1	10	47.6	3	14.3	
Marital status							
With partner	36	23.5	75	49.0	42	27.5	0.311
No companion	13	34.2	18	47.4	7	18.4	
Children							
Yes	39	27.5	66	46.5	37	26.1	0.522
No	10	20.4	27	55.1	12	24.5	
Higher complete training							
Elementary or high school	22	32.8	34	50.7	11	16.4	0.089
Undergraduate degree	16	28.6	24	42.9	16	28.6	
Graduate degree	11	16.2	35	51.5	22	32.4	
Position							
Higher-level workers	13	15.1	42	48.8	31	36.0	0.001
Mid-level workers	36	34.3	51	48.6	18	17.1	
Unit type							
Basic health Unit	11	19.6	25	44.6	20	35.7	0.105
Family Health Strategy	38	28.1	68	50.4	29	21.5	
Other employment relationship							
Yes	6	22.2	13	48.1	8	29.6	0844
No	43	26.2	80	48.8	41	25.0	
Intention to leave work							
Yes	4	11.8	19	55.9	11	32.4	0.118
No	45	28.7	74	47.1	38	24.2	
Job satisfaction							
Dissatisfied or neutral	6	14.0	20	46.5	17	39.5	0.028
Satisfied or very satisfied	43	29.1	73	49.3	32	21.6	
Practice of physical activity							
Yes	24	27.9	44	51.2	18	20.9	0.393
No	25	23.8	49	46.7	31	29.5	
Amount of physical exercise (n=86)							
1 and 2 times	12	30.0	21	52.5	7	17.5	0.669
3 and 4 times	9	24.3	19	51.4	9	24.3	
5 or more	3	33.3	4	44.4	2	22.2	
Time for leisure							
Yes	30	31.9	54	57.4	10	10.6	0.000
No	3	25.0	3	25.0	6	50.0	
Sometimes	16	18.8	36	42.4	33	38.8	

*p= Pearson's chi-square.

Table 2 – Association between social support and sociodemographic, work and health variables of healthcare professionals in Primary Health Care. Santa Maria, RS, Brazil, 2022. (n=191).

Variable	Social support				p*
	Low		High		
	n	%	n	%	
Sex					
Female	101	59.4	69	40.6	0.148
Male	09	42.9	12	57.1	
Marital status					
With partner	92	60.1	61	39.9	0.154
No companion	18	47.4	20	52.6	
Children					
Yes	81	57.0	61	43.0	0.794
No	29	59.2	20	40.8	
Higher complete training					
Elementary or high school	43	64.2	24	35.8	0.012
Undergraduate degree	23	41.1	33	58.9	
Graduate degree	44	64.7	24	35.3	
Position					
Higher-level workers	48	55.8	38	44.2	0.653
Mid-level workers	62	59.0	43	41.0	
Unit type					
Basic health Unit	32	57.1	24	42.9	0.936
Family Health Strategy	78	57.8	57	42.2	
Other employment relationship					
Yes	17	63.0	10	37.0	0.542
No	93	56.7	71	43.3	
Intention to leave work					
Yes	22	64.7	12	35.3	0.355
No	88	56.1	69	43.9	
Job satisfaction					
Dissatisfied or neutral	39	90.7	4	9.3	0.000†
Satisfied or very satisfied	71	48.0	77	52.0	
Practice of physical activity					
Yes	45	52.3	41	47.7	0.183
No	65	61.9	40	38.1	
Amount of physical exercise (n=86)					
1 and 2 times	21	52.5	19	47.5	0.451
3 and 4 times	21	56.8	16	43.2	
5 or more times	03	33.3	06	66.7	
Leisure time					
Yes	47	50.0	47	50.0	0.100
No	07	58.3	05	41.7	
Sometimes	56	65.9	29	34.1	

*p = Pearson's chi-square.
†Fisher's exact test.

In relation to MWL and social support, analyzing the correlations, it was observed that social support does not correlate with cognitive demand and task complexity (p > 0.05). As for the other MWL dimensions, negative and significant correlations were identified, i.e., the greater the social support, the lower the mental load of the individuals studied (r = -0.2687). Among the significant correlations, the health consequences (r = -0.3771; p<0.001) and work characteristics (r = -0.1916; p=0.008) dimensions stand out (Table 3).

Table 3 – Correlation between social support and mental workload in healthcare workers in Primary Health Care. Santa Maria, RS, Brazil, 2022. (n=191).

Subjective Mental Workload Scale dimensions	Social support	
	r	p*
Cognitive demands and task complexity	-0.0347	0.634
Task characteristics	-0.1916	0.008
Temporal organization	-0.1667	0.021
Work rate	-0.1435	0.048
Health consequences	-0.3771	0.000
OMWL	-0.2687	0.000

*Spearman's correlation test.

DISCUSSION

Given the adequate overall mental workload evidenced in PHC healthcare workers in this study, a result was found in the literature that differs from the findings of this investigation, in which the perception of OMWL level of Chilean PHC healthcare workers showed a high level of mental load[6].

Thus, it is highlighted that, for work to generate health and well-being, workers need to be exposed to appropriate mental demands so that they can develop stimuli for warming up and activation, conditions that provide workers with the opportunity using less effort to perform tasks and maintain energy to promote health, learning, knowledge and experiences[5].

On the other hand, it is noteworthy that the imbalance of task demands, workers' capabilities and characteristics, i.e., MWL due to both underload and mental overload, can generate worker discouragement or frustration in their work environment, causing the appearance of mental and physical illnesses[5]. For this reason, the importance of maintaining adequate MWL to guarantee a safe work environment is reinforced[6].

With regard to social support, the PHC healthcare workers participating in this research had a low level of social support, a similar finding was verified in the study with Chinese healthcare professionals[16]. Furthermore, a cross-sectional survey of FHS workers showed low social support[17]. Thus, according to the findings of this investigation, there was a fragility in social interaction between PHC healthcare workers in their occupational spaces, a fact that can generate several disturbances in the psychological state of those who work and, consequently, negatively impact the quality of care provided. Furthermore, a low level of social support can cause problems for the body's health and mind as well as favor the emergence of harmful effects for professionals and unbalancing health[18].

Furthermore, the low level of social support may be an indication of the impacts of the health crisis due to the COVID-19 pandemic that was being experienced at the time of data collection. It is known that much of managers' attention was directed to hospital settings, and PHC units also had difficulties in adapting to this period, whether due to restriction of activities to assist the population, implementation of new protocols, or due to the absence of some workers due to being a risk group,

thus increasing team demand. This context, consequently, may have resulted in a lower level of social interaction for workers with less support. Added to this is frustration and fear of an unknown disease, resulting in team overload[19].

On the other hand, it is noteworthy that a high level of support among co-workers and bosses in the occupational space can make professionals more committed to organization and mitigate the loss of productivity[16].

In this study, a statistically significant association was found between higher completed training and low social support. It is inferred that professionals with a higher level of education tend to deal with greater demands due to the academic degree with a significant basis and technical-scientific knowledge in relation to matters involving comprehensive and quality care for users. Therefore, this can generate the perception of less support in their work, a fact that represents a risk for occupational problems, in addition to the development of individualized and isolated work activity to overcome existing excessive demands, leading to a decrease in social interaction[17].

It was evident that dissatisfied/neutral workers found themselves with low social support. Felício highlights that factors related to job dissatisfaction, such as workers' relationship with their supervisor and conflict with supervision, can have negative emotional repercussions on social interaction, which justifies the perception of professional dissatisfaction[20].

Hence, it should be noted that job satisfaction represents an aspect that can impact health, professionals' lives and occupational space, contributing to increased productivity and efficiency as well as physical and mental health maintenance[21]. Therefore, it is necessary to strengthen interpersonal relationships in the workplace, as this can mitigate wear and tear and promote professional satisfaction at work[18].

Still in this study, workers satisfied with their work present adequate OMWL, indicating that, satisfied with their job functions, they are likely to perceive the appropriate mental load. Therefore, this result is close to the finding of a study by Jiménez-Figueroa, Riquelme, carried out with private sector workers in Chile, in which it was found that when professionals feel satisfied with their work, this reduces their mental overload, thus avoiding psychological problems, such as depression, stress and others[22].

Furthermore, this study revealed that professionals with time for leisure have adequate OMWL, converging with the data obtained by Flores, Bull and Gil, who identified that providing time for workers to rest can help improve work performance and employee healthcare worker[23]. Likewise, the importance of providing workers with the opportunity to take breaks or the possibility of alternating between jobs that require excessive demands stands out, with a view to recovering from the fatigue generated by the type of role they perform. Therefore, it is reinforced that professionals must be given the opportunity to take breaks freely when they feel the need[5,23]. Furthermore, adequate rest outside of work for energy recovery is essential to avoid emotional fatigue[24].

With respect to the relationship between MWL and social support, this research identified that when workers have high social support they tend to perceive a good MWL in the task characteristic and health consequences dimensions. It is known that the issue of work overload and excessive demands in PHC is a reality, which even makes it difficult to implement the principles recommended by the Brazilian Health System (SUS – *Sistema* Único *de Saúde*)[25].

As a result, providing high social support to workers can help them cope with exhaustion, in addition to preventing them from falling ill or having negative impacts on their health[13].

Therefore, it is believed that exhaustion generated by work can be avoided by high social support. This support was identified as an occupational characteristic that provides protection against psychological problems, as it can mitigate the chance of workers developing depression, serve as a

resource capable of promoting individual and collective mental well-being in the workplace, in addition to being a potential promoting the transformation of suffering into pleasure and well-being[21,18,26].

Thus, Deng *et al*. highlight that healthcare organizations must emphasize social support promotion by implementing actions with the purpose of increasing the interpersonal relationships of workers with their co-workers and supervisors, in addition to offering working conditions and opportunities for professionals to improve their relationships at work and mitigate occupational adversities[27].

Concerning the limitation of this study, due to social isolation due to the COVID-19 pandemic, data collection had to be adapted to the virtual model, which made face-to-face contact with PHC healthcare workers impossible, thus making it difficult to engagement and awareness of workers to participate in the research. Even though the minimum sample has been reached, new studies could expand the sample in order to deepen the analysis of factors associated with MWL and social support.

It is hoped that this study will encourage other researchers to develop research with a qualitative approach, aiming to deepen and better subjectively understand professionals about aspects related to their health found in the study.

CONCLUSION

PHC healthcare professionals demonstrated an adequate OMWL. However, a low level of social support was observed in a significant part of this group. When social support is scarce, this indicates a lack of social interaction in the workplace, which can create a conflicting climate and have a negative impact on worker quality of life and well-being.

In view of this, the importance of developing intervention strategies to improve the situation is highlighted. These may include implementing long-term programs, creating support groups and promoting continuing health education actions related to interpersonal skill development. Such measures aim to increase the level of social support and promote a safer working environment.

Furthermore, position, job satisfaction and leisure time were verified as aspects associated with mental load in healthcare workers. Likewise, greater completion of training and job satisfaction are associated with social support. Furthermore, the relationship between social support and MWL was identified, in such a way that social support was the factor associated with mental load in healthcare workers, having a positive impact when it is high, i.e., impacting the balance of mental load.

Workers with a high MWL have a lower perception of social support, which can have an impact on their health, considering work characteristics. Furthermore, aspects of satisfaction and leisure activities should be promoted as a way of promoting quality of life at work.

This study can contribute to constructing knowledge in favor of workers' health due to the existence of few studies that evaluate social support and MWL concomitantly in the context of PHC, since other scales for mental load validated for the country measure with a focus on ergonomics and for the industry sector with an emphasis on assembly lines.

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