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Family Health Support Center: suffering from the perspective of psychodynamics of work*

Núcleo Ampliado de Saúde da Família: o sofrimento na perspectiva da psicodinâmica do trabalho

Núcleo Ampliado de Salud de la Familia: el sufrimiento desde la perspectiva de la psicodinámica laboral

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ABSTRACT

Objective: To analyze the work process of the Family Health Support Center and identify the repercussions on professionals' quality of life at work. **Method:** A descriptive-exploratory qualitative case study conducted with workers from Family Health Support Centers. The content analysis technique was used to analyze the resulting empirical material in the light of the theoretical reference of Work Psychodynamics. **Results:** Twenty workers participated in the focus groups. This study discusses the category of 'suffering' by the chosen theoretical perspective, which derives from interpersonal relationships and teamwork, the feeling of not belonging, lack of infrastructure for work, violence and vulnerability present in the territory. **Conclusion:** Group union and collaborative integration among workers can be strategies for the minimization of suffering at work in the context of the Family Health Strategy.

DESCRIPTORS

Family Health Strategy; Health Personnel; Work; Interpersonal Relations; Stress, Psychological; Occupational Health.

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INTRODUCTION

The proposal of the Family Health Support Center (Portuguese acronym: NASF – *Núcleo de Apoio à Saúde da Família*) in the context of public policies focused on strengthening Primary Care (PC), in particular the Family Health Strategy (FHS), has brought numerous challenges and possibilities of reflection on its forms of organization, action and resolution in the daily practice of services and health professionals.

The NASF, currently named Family Health Support Center Primary Care (Portuguese acronym: NASF-AB), was created with the objective of supporting the FHS teams in the redefinition, qualification and resolution of primary care, in addition to collaborating in the organization of health care networks by expanding the coverage and scope of health care actions in the Brazilian National Health System (Portuguese acronym: SUS – *Sistema Único de Saúde*)[1].

Since its implementation in 2008, the NASF-AB contributes to the confrontation and resolution of the most prevalent clinical and health problems in the various territories in accordance with its guidelines that estimate a performance based on the expanded clinic and interdisciplinary team work in co-responsibility with the FHS. The NASF-AB has the matrix support as theoretical-methodological reference, in which a 'specialist' professional, who holds a certain nucleus of knowledge from its training, supports other professionals with different training nuclei in order to increase the performance effectiveness[2].

Despite the advances and transformations in health care observed in several contexts that include the NASF-AB, there are intrinsic and extrinsic issues to this team that negatively impact the proposal effectiveness and the quality of life in the work of these professionals. Among them, can be mentioned the difficulties of performing matrix support, teamwork and shared actions. In addition, NASF-AB professionals resent the lack of recognition for the work they do.

Peer recognition is a judgment about work done, a symbolic retribution that "can gain meaning in relation to subjective expectations and self-realization", and capable of transforming suffering into pleasure[3]. Without recognition, the desire and commitment to action diminish, and there is a tendency toward demobilization that leads to suffering. This may be directly linked to work organization, but may also be the result of unsatisfactory interpersonal relationships and dysfunctional teams[4].

Several studies involving workers' health are limited to investigating interventions for improvement of productivity and working conditions. There is need for studies that seek to reveal workers' subjective perceptions about work and the symbolic aspects involved[5].

Thus, the aim of this study was to analyze the work process of the NASF-AB by identifying the repercussions on professionals' quality of life at work and the perceptions about situations generating stress and suffering.

METHOD

Type of study

This is a descriptive-exploratory qualitative case study. The recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed and the theoretical-methodological framework of Collective Health and hermeneutic-dialectic were adopted. Given the complex reality contained in the dynamics that permeates the object, qualitative research provides a deep understanding of perceptions and representations of the subjects involved in the research, and the hermeneutics seeks to apprehend the hidden meaning with a view to the interpretation of work processes resulting from a social and historical process[6]. The study is based on the theoretical reference of the psychodynamics of work by Christophe Dejours for the analysis of the process and organization of work in the NASF-AB, and of situations generating stress and suffering from the distance existing between the estimated work and the actual work[3].

Population

The study was conducted in a Social Health Organization of the eastern region of the city of São Paulo, which has a management contract with the São Paulo City Hall. Twenty NASF-AB workers selected for convenience participated in the study. Subjects had previously been assessed through the Lipp Adult Stress Symptom Inventory[7] that was applied by a psychologist, and is aimed at detecting the presence of stress. There were 38 NASF-AB professionals with stress symptoms, but at the time of the telephone call invitation for participation in the focus groups, 18 were unavailable due to vacation, work leaves or disengagement from the institution.

Data collection

For the focus groups, was used a script with seven guiding questions, a field diary, and audio recording for data collection. Between June and August 2014, were conducted three focal groups called G1, G2 and G3 in a room at the participants' workplace, with an average duration of 1h40min each.

Analysis and processing of data

The recording of the focus groups was transcribed, and the resulting material was read repeated times with the aim to develop empirical categories. For the treatment of the material, was used the content analysis by Bardin[8] that includes the steps of pre-analysis, exploration of the material and treatment of results for the production of senses and meanings based on inference and interpretation. The meaning nuclei were constructed by considering the central and relevant ideas present in the testimonies[6].

Ethical aspects

All ethical aspects were observed in the study, which was approved by the Research Ethics Committee of the School of Nursing, University of São Paulo under number 205.892 and by the São Paulo Municipal Health Department under number 597.535-0. The subjects agreed to participate in the study by signing the Informed Consent form.

RESULTS

The use of the analytical category 'The suffering at work', from the theoretical point of view of Christophe Dejours led

to the identification of six meaning nuclei, namely: 1) actual work versus estimated work: resistance to the NASF-AB proposal and lack of understanding of their role; 2) the immediate and curative culture of the user, the FHS and the management; 3) the profile, the overload and the identification with work; 4) interpersonal relationships and teamwork; 5) the feeling of not belonging and the lack of infrastructure for work; 6) violence and vulnerability in the territory.

In a previous article, were approached the first three meaning nuclei[9], and in this article were focused the others.

Interpersonal relationships and teamwork

When analyzing intersubjectivity in teamwork, the limits and exhaustion, as well as the stress and conflicts generated in interpersonal relations in the work routine were evident, especially in moments of team meeting. Motivation for work was also related to the dynamics and interaction between teams. The lack of involvement, commitment, cooperation and communication was also mentioned as a source of suffering. These difficulties were present between the NASF-AB team and the FHS team, between the NASF-AB and the management of the Basic Health Units (Portuguese acronym: UBS – *Unidades Básicas de Saúde*) and within the NASF-AB team itself.

(...) teamwork is ambiguous: at the same time that the team is stronger (...) this helps, this also gets in the way, because when there is a person who is not in the mood, in the 'vibe' of doing the work as it has to be done, that person is the odd one out in the team, and this makes work very difficult (...) (G3).

(...) the dynamics of workflow, of co-workers is much more exhausting. Sometimes I really feel that the same commitment of colleagues is missing (...). There is no way you can do for yourself and for the other always (...) (G3).

I think that relationships wear out a lot (...) I have to work with people who are not giving themselves for work, not doing the way they should and you want to make things work properly, then it does not happen. I think this is a factor that has been making me exhausted lately (...) (G2).

Although there is a discourse of integration and alignment, the dispute and the inequality of power between the NASF-AB and FHS teams is visible, as well as the difference of maturity among professionals. The weight of working in a team with professionals of different backgrounds as in the NASF-AB is evident. The statements also highlighted the importance of the bond between workers.

Three aspects impact on the quality of NASF-AB. I guess it's a bit based on bonding, how much we work on bonding with the population, this will have results in our work ... how much we depend on the bond with the Strategy in order to make the work process function and how much we need bonding within the team to be able to speak everything in an aligned way in the face of difficulties (G1).

People's emotional maturity is what most impacts in the relationship, what most disturbs. It's not even the technical issue because I can get to a nurse (and say) that I'm having technical problem, go to a doctor, to a team and discuss something that can be improved, but if that person cannot separate (...) One has to understand it's a professional thing, there's no personal criticism (...) This impacts a lot. So, I think our maturity to be able to work is very important, not only to assist, but to deal with the colleague (G1).

(...) 'cause we have other factors that also influence, such as interpersonal relationships (...) We have a coordinator, in some units there is one, two managers, each with a different thought. We have to be flexible enough to be able to fit in every unit, every team meeting, every nurse, every doctor. I think this is really a small problem that generates a bit of anxiety (G1).

The different dynamics and characteristics present among professionals in the UBS were explicit in the testimonies about team meetings. For NASF-AB workers, this is the most stressful activity that negatively impacts professionals' quality of life. The posture of superiority of some workers was also mentioned as an obstacle in the process of team interaction.

(...) the team meeting is very stressful (G2).

Some days you wake up and you remember: - 'Yikes, today is the meeting with team four' (G2).

They're a team that don't get involved, don't discuss the case in advance, are not open to any suggestion of collective construction that you propose (...) (G1).

(...) you can speak very calmly or you can act as if you were a consultant, you know? (...) I am a consultant and then, I come with my nose up and I will point out other people's mistakes. And sometimes I think some professionals pose themselves that way, above good and evil. You're doing a job, and it creates a bad atmosphere that is hard to change, you know? (G2).

The feeling of not belonging and the lack of infrastructure for work

The suffering of NASF-AB workers was also evident in testimonies, as they did not feel integrated to the UBS. They have the feeling of invading the space of the FHS team when they use the rooms and other resources of the UBS. Infrastructure limitations that affect everyone, particularly physical structure limitations, have an even greater impact on the work of the NASF-AB team and make it more difficult.

(...) we do not build together. Sometimes, I see the NASF-AB worker far away, apart, doing (the work) in his small room (G1).

What impacts is the possibility of doing some things, but not having the space, not having a more organized structure for this, then you have to improvise beyond what's possible and this is a stressful factor (G1).

(...) it's the space, it's the material you have to get, it's the chair you have to look for. You waste a lot of time organizing a space, and people don't understand you need a space. The other person sharing space with you doesn't like it either. Then, the other must understand your work too (…) (G1).

It's bad when people's non-belonging gets to the point of them being a victim of violence, of theft and the others are not because they have a structure, lockers, room and that environment, you know? (G2).

(...) because there is a feeling of 'devaluation' too, right? Because you are doing a job that is not being valued at all. It seems like you are there begging to do one thing that is your job, and is important (G3).

In order to deal with such limitations, are often used the resources and spaces in the territory. However, some of them are unhealthy for the development of health actions, have no accessibility and cannot be considered as an extension of the UBS.

I feel we need to improve the structural part, not all units (have) *availability of rooms for groups ... Service in the community, we establish partnerships (...) many of the churches, community centers that we use,* (but) *there is a precariousness in the matter of hygiene, water, restrooms, and it's difficult. So that makes it difficult for us to actually do a health promotion job in a space where sometimes we don't even have a bathroom to use (...) We don't guarantee accessibility for all patients, in many places there are stairs only (...) hence how is it going to be accessible for wheelchair patients, the elderly, those with some kind of limitation?* (G3).

The impossibility of responding to management requests given the lack of infrastructure was also mentioned.

What stresses me is that I don't have structure for things that are asked for, I cannot do it, right? They demand things they don't have that are physically not possible, or people are not prepared to do, they don't find their place (G1).

The violence and vulnerability in the territory

For some workers, violence and vulnerability in the territory influence the quality of professional life by resonance in their social role, although for most this aspect in itself is not paralyzing or causing suffering. The exhaustion and suffering identified relate to responsibility - which in most cases is attributed exclusively to NASF-AB - to notify to the various competent bodies regarding the various forms of violence, negligence and abuse in the territory, such as the Guardianship Council, the Police Station for the Elderly, Public Ministry, among others.

(...) the responsibility we are given of responding to an ombudsman, filling out a spreadsheet, something that is not ours (...). So we have this same weight to respond, lawsuits, go to the courthouse, respond to the lawsuit, and considering we don't even follow them up, right? We are not directly responsible for that family ... I guess this also generates a bit of anxiety (G1).

(...) when you work in a group, violence against children, the most extreme cases, no matter how you try to separate things, you cannot differentiate from your social role (G2).

(...) choosing to work in the NASF-AB means being in that region closer to vulnerability (…) (G1).

(...) for example, if I'm a social worker in the Public Security Department, there I explain the conduct and it ends there. Not here, we have the follow-up. So I think in case of negligence, the case of violence becomes heavier because of that, you know? The patient is closer to us ... sometimes we get a much worse case of violence and I'm very close to him. So that ends up affecting, sometimes it messes with us (...) (G1).

DISCUSSION

Teamwork is understood as a guideline of great relevance for the consolidation and implementation of the work process in the FHS, since it promotes coordination of knowledge with a view to interdisciplinarity. It must occur "through a communicative and horizontal interaction" that seeks integrality of health care[10]. However, interpersonal relationships and teamwork can be viewed from a perspective of aggregating value, pleasure and new knowledge to professional practice, or from another that is negative and generates stress and suffering.

Relational difficulties in teamwork are present among NASF-AB workers, and between these and FHS teams, and vary according to the UBS and the profile of the supported team. In this study, as well as in others related to NASF-AB, there were obstacles in teamwork experienced in daily routine, such as lack of involvement, cooperation, commitment and communication, which affect the quality and resolution of actions[11-12].

Regardless of differences between the FHS and NASF-AB teams, the dynamics of interdependence requires the development of skills and the incorporation of new tools such as negotiation, articulation, facilitation, observation and listening for performing work in the perspective of the matrix support.

In the present investigation, team meetings were considered difficult and the cause of great suffering because of the clash between professionals, and this compromises the reach of consensus and agreements for the development of individual and collective therapeutic common projects between teams. However, these spaces were valued as potent for learning, exchange, planning of actions and case discussion[13-14].

Teamwork needs to be organized based on the integrality of care and from users' needs. To this end, the multiplicity of conditions involved in health care performed by all members of the team must be recognized[15].

A study about professionals' common field of practice in the FHS highlights the challenge of constructing collaborative and interdisciplinary practices in the face of contradictions between the logic of professionalization derived from specific and specialized training, and the logic of interprofessionality focused on service needs and the population's health[16].

These contradictions are materialized in the daily practice of a more individual and specific than shared performance before the clash and power struggle between the various professionals influenced by the construction of social and historical identities of professions and their ways of acting, and who still need to move forward for the consolidation of interprofessionality in the routine of the NASF-AB and the FHS.

In spite of the apparent integration, the work routine of each professional in the FHS remains segmented, and power relations are evident, since NASF-AB workers consider that FHS professionals are the "task organizers of everyday work"[17].

The diversity of training, profile and characteristics of professionals with whom NASF-AB workers relate on a daily basis requires resilience, patience, flexibility and proactivity both in team meetings and in the development of work as a whole. However, workers' flexibility can often gain another connotation in team dynamics regarding power disputes, which affects integration and cooperation between them. Even without this apparent intention, the devaluation of the NASF-AB team from the prioritization of actions and interventions of the FHS is perceived by workers, which reinforces the feeling of not belonging to the UBS.

The feeling of devaluation is evident in the excerpts, and shows how fragile are the recognition mechanisms **in** work and **by** work by the teams of FHS and the service management, and how much workers are susceptible to demotivation, suffering, alienation and consequently, illness or work abandonment.

From the perspective of Dejour[3], the recognition originating from performing the work is an indispensable condition for maintaining workers' creative and subjective mobilization. This recognition is fundamental for the prevention of a possible alienation because of contempt and devaluation. Without recognition, workers lose the notion of social utility, and consequently, there is demotivation, commitment of the professional identity and of the sense of work for self-realization. On this condition of the NASF-AB worker, a study[18] identified that "This ambiguity of relationships, the invisibility of their work, the feeling of no place and not belonging, resulted in the difficulty of being recognized by their actions and contributions. Such conditions hindered the construction of their own identity".

Although solidarity and cooperation are evident in the context of nursing work[19], these mechanisms are more present among NASF-AB workers than between these workers and FSH team members, who do not seem to understand the work done by those workers and the need to share spaces and actions in a collaborative way. The same was also observed in another study with speech therapists of the NASF-AB[20].

Testimonies also demonstrate the precariousness of working conditions because of lack of infrastructure. The shortage of rooms and other resources necessary for the development of work and the need to improvise were identified as elements generating exhaustion and suffering, which corroborates other findings regarding their influence on the quality of professional life of NASF-AB workers[11].

Several studies related to NASF-AB and PC also reported the lack of infrastructure related mainly to the physical area and the necessary instruments and inputs for work[11,17,21-22]. There were times when professionals purchased material with their own resources to use in their practice as a way to perform work, given the lack of infrastructure[23].

The use of community spaces for developing collective actions is quite frequent in an attempt to minimize difficulties related to infrastructure. However, such sites are often unsuitable and even unhealthy and do not present safety or hygiene conditions, which compromises the quality of care.

The impossibility of performing daily work as requested by management because of the lack of space and the feeling of not being accepted, arouses feelings and psychic manifestations that generate stress and suffering. Furthermore, NASF-AB workers are often obliged to give in and accept conditions that do not fit their way of seeing and doing work, and this results in moral distress[24].

Another visible source of suffering in the speeches concerns the violence and vulnerability of the territory to which every PC professional is exposed. Violence is understood as external and indirect to health services, since the violence dynamics in the territory is part of workers' routine, just as the care to victims and aggressors, but it can become direct when workers suffer some harm[25]. Although there was no consensus among NASF-AB workers, for some of them, violence and vulnerability in the territory can generate stress and impact on the quality of professional life given the constant exposure, and this fact was also identified in another study[11].

In the context of this study, the greatest impact on workers' quality of life was a result of exposure to the poor social and living conditions of the population, which is involved in risks and vulnerabilities of various kinds. Although some workers have been the object of theft and robbery in the UBS itself and in their area of coverage, this does not stop them, neither prevents them from staying at work.

Violence-related suffering was much more frequently associated with notifications made in defense of children, women and the elderly, victims of violence, abuse or neglect, and these are mostly considered as responsibility of NASF-AB by the FHS teams.

As for repercussions of violence on workers' mental health, the results revealed a feeling of powerlessness before situations of precariousness, fear of risk of exposure and threatened integrity, as well as contamination of personal spaces, as found in another study[25].

In the present research, as in another study on family health[25], the preoccupation with professionals' exposure was evident, mainly of community health agents who live in the territory, regarding notifications of violence that were dilemmatic situations between teams. Workers experience a strong tendency towards psychological suffering by the context itself and by the ethical dilemma between right and wrong, between report and connivance, which can also be characterized as moral suffering, and if prolonged, can generate feelings such as fear, anguish, anxiety, insecurity and differences of opinion that may compromise professionals' effectiveness and cause physical symptoms.

In hospitals, the analysis of nursing's moral suffering demonstrated that its main generating situations are related to lack of team's competence, disrespect to patient autonomy and inadequate working conditions. Moral suffering is more present in environments where there are no team meetings,

where dialogue with managers is not favored, and where there is no investment in continuing education[26].

NASF-AB workers also seem to experience moral suffering to some extent given the exhaustion at meetings and in teamwork, feelings of not belonging, violence and vulnerability experienced on a daily basis, lack of formal spaces for dialogue and agreement with managers and the institution, which leads them to gather forces and routinely adopt various forms of confrontation. In a publication about the book 'The Banalization of Social Injustice' by Dejours[27], it was shown that "over time, workers lose hope and come to the conclusion that efforts, dedication, goodwill, good relationships with colleagues and producing the maximum for companies/institutions have not contributed to establishing a balanced relationship of pleasure-suffering".

The limited number of participants from a single institution can be considered a limiting factor of the study. However, given the complexity of the social and health needs of the collective in the different spaces where the FHS and NASF-AB teams work, even with a large investment, they may never be able to respond fully to what is demanded of them, which will certainly result in some degree of frustration and suffering of workers. Thus, it will always be necessary to invest in individual and collective strategies of defense in order to face suffering and its transformation into pleasure. This is necessary, because in the world of work there will always be external impositions and confrontation between people that may cause suffering. However, work can also favor human development, social recognition and be a source of satisfaction and pleasure[3].

CONCLUSION

In view of the above, and with the background of dialectical contradictions between the determined work of the NASF-AB expressed in its guidelines and the actual work, the process of construction and reconstruction of group and horizontal, cooperative and collaborative integration between NASF-AB and FHS workers remains a challenge in the sense of minimizing suffering at work. This will only be possible from a deep rescue of the work purposes of both teams, a connection to motivation and mutual identification through collective spaces for reflection and continuous redevelopment of the sense of work and defensive strategies against suffering.

RESUMO

Objetivo: Analisar o processo de trabalho do Núcleo Ampliado de Saúde da Família e identificar as repercussões na qualidade de vida no trabalho dos profissionais. **Método:** Estudo de caso descritivo-exploratório, de abordagem qualitativa realizado com trabalhadores de Núcleos Ampliados de Saúde da Família. O material empírico resultante foi submetido à técnica de análise de conteúdo e analisado à luz do referencial teórico da Psicodinâmica do Trabalho. **Resultados:** Participaram dos grupos focais 20 trabalhadores. Neste estudo discute-se a categoria dejouriana *sofrimento*, que deriva das relações interpessoais e do trabalho em equipe, da sensação de não pertencimento, da falta de infraestrutura para o trabalho, da violência e da vulnerabilidade presentes no território. **Conclusão:** A grupalidade e a integração colaborativa entre os trabalhadores podem ser estratégias para minimizar o sofrimento no trabalho no contexto da Estratégia de Saúde da Família.

DESCRITORES

Estratégia Saúde da Família; Pessoal de Saúde; Trabalho; Relações Interpessoais; Estresse Psicológico; Saúde do Trabalhador.

RESUMEN

Objetivo: Analizar el proceso laboral del Núcleo Ampliado de Salud de la Familia e identificar las repercusiones en la calidad de vida en el trabajo de los profesionales. **Método:** Estudio de caso descriptivo exploratorio con abordaje cualitativo, llevado a cabo con trabajadores de Núcleos Ampliados de Salud de la Familia. El material empírico resultante fue sometido a la técnica de análisis de contenido y analizado a la luz del marco referencial teórico de la Psicodinámica del Trabajo. **Resultados:** Participaron en los grupos focales 20 trabajadores. En este estudio, se discute la categoría dejouriana *sufrimiento*, que deriva de las relaciones interpersonales y del trabajo en equipo, la sensación de no pertenencia, la falta de infraestructura laboral, la violencia y la vulnerabilidad presentes en el territorio. **Conclusión:** La grupalidad y la integración colaborativa entre los trabajadores pueden ser estrategias para minimizar el sufrimiento en el trabajo en el marco de la Estrategia de Salud de la Familia.

DESCRIPTORES

Estrategia de Salud Familiar; Personal de Salud; Trabajo; Relaciones Interpersonales; Estrés Psicológico; Salud Laboral.

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