

## DEFENSIVE STRATEGIES OF FAMILY HEALTH TEAMS TO SUFFERING IN THE WORK\*

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**ABSTRACT: Objective:** to analyze the defensive strategies that Family Health team professionals use to protect themselves from suffering at work, from the perspective of Work Psychodynamics. **Method:** This qualitative, descriptive and analytical study was carried out in three Health Units of the South of Brazil, which were intentionally selected, from October to December 2012. All the members of the teams participated in the study, totaling 68 professionals. The information was collected through observation and collective interviews and analyzed according to Bardin, with two categories emerging: collective and individual defense strategies. **Results:** in the first category, the professionals highlighted the sharing of work issues in meetings and, as individual strategies, denial, rationalization and recognition. **Final considerations:** the professionals sought strategies to cope with the suffering caused by their work using internal and collective resources to confront it and transform the work into a source of pleasure and health.

**KEYWORDS:** Nursing; Family Health; Worker's health; Health Assessment.

### ESTRATÉGIAS DEFENSIVAS DE EQUIPES DE SAÚDE DA FAMÍLIA AO SOFRIMENTO NO TRABALHO

**RESUMO: Objetivo:** analisar quais as estratégias defensivas que profissionais de equipes de Saúde da Família utilizam para se proteger do sofrimento no trabalho na perspectiva da Psicodinâmica do Trabalho. **Método:** trata-se de estudo com abordagem qualitativa, descritiva e analítica, realizado em três Unidades de Saúde do sul do Brasil, que foram selecionadas intencionalmente, nos meses de outubro a dezembro de 2012. Participaram do estudo todos os integrantes das equipes totalizando 68 profissionais. As informações foram coletadas por observação e entrevistas coletivas, analisadas conforme Bardin, emergindo duas categorias: estratégias coletivas e individuais de defesa. **Resultados:** na primeira categoria, os profissionais apontaram o compartilhamento do trabalho em reuniões e, como estratégias individuais, a negação, a racionalização e o reconhecimento. **Considerações finais:** os profissionais têm buscado estratégias de enfrentamento do sofrimento provocado pelo próprio trabalho utilizando-se de seus recursos internos e do coletivo para enfrentá-lo e transformando o trabalho em fonte de prazer e saúde.

**DESCRIPTORIOS:** Enfermagem; Saúde da Família; Saúde do trabalhador; Avaliação em Saúde.

### ESTRATEGIAS DEFENSIVAS DE EQUIPOS DE SALUD DE LA FAMILIA ACERCA DEL SUFRIMIENTO EN EL TRABAJO

**RESUMEN: Objetivo:** analizar las estrategias defensivas que profesionales de equipos de Salud de la Familia usan para protegerse del sufrimiento en el trabajo bajo la perspectiva de la Psicodinámica del Trabajo. **Método:** es un estudio de abordaje cualitativo, descriptivo y analítico, realizado en tres Unidades de Salud del sur de Brasil, seleccionadas intencionalmente, en los meses de octubre a diciembre de 2012. Participaron del estudio todos los integrantes de los equipos totalizándose 68 profesionales. Se obtuvieron las informaciones por observación y entrevistas colectivas, analizadas conforme Bardin, resultando dos categorías: estrategias colectivas e individuales de defensa. **Resultados:** en la primera categoría, los profesionales apuntaron el compartir del trabajo en reuniones y, como estrategias individuales, la negación, el razonamiento y el reconocimiento. **Consideraciones finales:** los profesionales vienen buscando estrategias de enfrentamiento del sufrimiento provocado por el propio trabajo utilizándose sus recursos internos y el colectivo para enfrentarlo y transformando el trabajo en fuente de placer y salud.

**DESCRIPTORIOS:** Enfermería; Salud de la Familia; Salud del trabajador; Evaluación en Salud.

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## ● INTRODUCTION

Family Health (*Saúde da Família* - SF) is a strategy of reorientation of the healthcare system of the Brazilian Nation Health System (*Sistema Único de Saúde* - SUS), which seeks better comprehension of the health-disease process and integral and continuous care for families from an ascribed area<sup>(1)</sup>. It is therefore characterized as work that requires a collective construction from the professionals. The work in the SF requires the incorporation of new knowledge and the commitment to guarantee the practice based on the consideration of subjectivity, on the establishment of bonds and on responsabilization of the care. This model requires a practice of organization of the activities, involving relationships that can cause suffering. Therefore, the professionals seek strategies to confront these situations, as it is understood that, in order to be in solidarity with the suffering of the other, it should be possible for the health workers to negotiate their desires with the organizational needs, avoiding suffering<sup>(2)</sup>. In this confrontation, defense strategies can be collective or individual. The collective strategies refer to how workers organize themselves when there is the common goal of eliminating the negative cost that the work imposes on them. In order to be used, these strategies require the existence of cooperation among the workers - trust and solidarity - that allows them to arrive at a common product and promote a public space of discussion so that they can collectively express their suffering<sup>(3)</sup>. Individual strategies are mechanisms that workers use, often unconsciously, to negate their own suffering and the suffering of others in the work or to rationalize (avoidance and euphemization of the anguish, fear and insecurity experienced in the work) the suffering and the human cost in the work<sup>(4)</sup>.

The current context of public policies has led to the dismantling of the work collectives of the SF teams, a lack of solidarity and trust between groups and a weakening of professional social links. This hampers the ways of organizing the work and leaves a marked void in the constitution process of the subject - which is always relational - interdicting the collective space of talking<sup>(5)</sup>. Therefore, there is tension in the healthcare practice between the traditional clinical model and the preventive-promotional actions that are prioritized in the work of the SF teams. It can be observed that the fragmented practices of the biomedical model, with the reductionist formation of the professionals, still make it difficult to horizontalize their actions in the field and perform work articulated with the community<sup>(5)</sup>. Furthermore, the coexistence with these two models, coupled with the lack of preparation of the professionals, who have long had their practices focused on the biomedical model, has motivated conflict and caused difficulties in changing to new practices. Among the difficulties, different models and thoughts, lack of management support, a population still dominated by curativism<sup>(6)</sup>, violence, fear and resilience in the development of the care and care limitations<sup>(7)</sup> can be highlighted. Thus, the question arises: how do the professionals of the SF teams confront the suffering that comes from the work quotidian? This study sought to analyze the defensive strategies that Family Health team professionals used to protect themselves from suffering in the work, from the perspective of Work Psychodynamics.

The aim of this study was to provide support for the reflection about the work of the professionals of the SF teams studied, seeking to contribute to the better organization of the work in these spaces, to the construction of actions that reduce work suffering and to include, in the work process, actions that also provide pleasure for the worker.

## ● METHODOLOGY

This is a qualitative, descriptive and analytical study carried out in three Health Units (HUs) of Rio Grande do Sul state in the south of Brazil, which were intentionally selected, with the theoretical and methodological reference of Work Psychodynamics (WPD)<sup>(8)</sup>. Following the steps of the methodology, a pre-study was carried out focused on searching for a more generalized idea about the work context and the relationship between pleasure and suffering. This stage was carried out with workers from the multidisciplinary team of 12 HUs that compose the Community Health Service of a hospital group. From the analysis of the results of the data from the workers who participated in the pre-study, the following teams were selected for the qualitative stage: the HU that, in the pre-study, presented the lowest risk of

work-related illness; the HU with a moderate risk and the HU that presented the highest risk of illness related to the work. The workers of these three HUs constituted the sample for the qualitative step.

Primarily, contact was made with the Community Health manager of the institution and the respective coordinators of the HUs, then the invitation to participate in the study was sent to the professionals. The criteria for participation in the study were: inclusion of all the professionals of the Family Health teams who were working at the time of the data collection and those who had links with the institution, with a period of service of more than six months and that agreed to participate in the study, totaling 68 professionals. Those professionals that were on holiday, on sick or maternity leave and those on leave for training were excluded.

The HUs were identified with the letters A, B and C. A total of 13 professionals participated From HU-A, 30 from HU-B and 25 from HU-C, including nurses, nursing technicians, physicians, dentists, psychologists, oral health technicians and a social worker. The data were collected from clinical observation of the work process and collective interviews, between October and December 2012. Clinical observation is essential in this type of study and should be based on the discourses of the participants of the session, according to the Work Psychodynamics method<sup>(8)</sup>. Following the steps of the proposed method, collective interviews were conducted with the subjects. The purpose of the interview is to allow the evaluator to enter into the perspective of the other, seeking to apprehend feelings, thoughts and intentions<sup>(9)</sup>. Twenty hours of observation were carried out in each HU, following an adapted previous itinerary<sup>(10)</sup> that contemplates nine items: type of service performed; individual care; urgent and emergency actions; participation in meetings; report actions; groups with users and family; expressions of suffering in the work of the team; and defense strategies. These observations were performed in the morning and afternoon shifts, totaling 60 hours of observation, with the findings recorded in a field diary and identified by the letter "O" - observation - plus the date and shift in which it was performed.

The collective interviews with the SF teams were divided into two moments. In HU-A, two meetings were held: one for the presentation of the study and another for the collective interview. In HU-B and -C, a single meeting was scheduled divided into two moments: the first for the presentation of the study and the latter for the performance of the collective interview. The collective interview allowed the participating professionals to speak freely about the proposed theme, guided by the following questions: regarding the time working in Family Health; what factors cause pleasure in your work and what situations cause suffering in the work? How does each person deal with this? The collective interviews lasted two hours and were identified with the E specification plus the letter, according to the HU, such as EA, EB, etc. The participants requested that their professional categories not be identified in the transcript of the interview, since in some cases the professional was represented by a single person in the HU.

The analysis of the data was performed after the transcription of the interviews in full and the organization of the field notes using the Content Analysis method, based on the theoretical framework of Work Psychodynamics<sup>(8)</sup>, with three fundamental stages (pre-analysis, exploration of the material and treatment of the results obtained and interpretation)<sup>(11)</sup>, operating with two categories: "collective defense strategies" and "individual defense strategies". The ethical precepts of CNS Resolution 466/2012<sup>(12)</sup> were followed and the project was approved by the institutional Research Ethics Committee under authorization number 11-140. The subjects agreed to participate in the research through the signing of the consent form.

## ● RESULTS

The workers of the SF teams that participated in the pre-study totaled 153 subjects, the majority, 121 (79.6%), being female, with a mean age of 43 ( $SD=10.76$ ) years, married ( $n=73$ ; 48.3%), of the professional category of Nursing Assistant ( $n=39$ , 26.2%) and with post graduate degree in 50% ( $n=76$ ) of the sample. Regarding the periodic medical examination, 10 (6.6%) professionals had not performed it in the previous year and nine (6%) had more than three periods of sick leave in the year due to work-related health problems.

A total of 68 workers participated in the qualitative stage, including nurses, nursing technicians, physicians, dentists, psychologists, oral health technicians and a social worker. The workers of the SF teams studied highlighted the sharing of work issues in the meetings as the main collective coping strategy, with the denial of the suffering, rationalization and recognition for the work emerging among the individual defense strategies.

### Collective defense strategies

The sharing of work issues in meetings promoted cooperation and solidarity among the workers and gave them a space of discussion to share their anxieties and thus alleviate the burden of the work, as expressed in the following statements:

*The management council I think is fundamental in our work because it gives support to the leadership. We can better distribute the workloads [...] what appears, as the best of the Unit, is the question of the socioprofessional relationship. I think we have an internal mechanism of sustainability that helps to keep the suffering a bit more under control. It is not a matter of not getting sick, but making sure it does not get to a maddening dimension. (EA5)*

*Sometimes we become weak, even running the risk of becoming sick when these internal relationships become fragile, but I think this is an important differential that we have. [...] And I think it is a source of some protection because it does not come from the outside, it comes from within. We sustain ourselves with our thing. (EC6)*

*Sometimes, you cannot solve that [...] and we sort of deal with it, I think dividing. We try to talk and share with the other person [...]. (EC4)*

In the spaces for reflection, discussion and organization of the work, there can be sharing, doubts can be resolved and catharsis promoted, which leads to a different form of confrontation/transformation of the suffering and reorganization of the work, that is, by sharing the issues of everyday life, the group collectively constructs strategies to protect against the suffering of the work.

*[...] we end up helping each other and don't lose our focus. There was a moment when several people on the team supported the sector, distributing tasks, so much so that the people who came to do extra work here said: "there in my unit it is not like this, I have to do it alone". (EA7)*

*I think affection is what provides some of the balance in the stress. I think it appears in communities where conviviality is better, affection is a good mediator. We have the potential to recover, to recreate ourselves. I really like working here. (EB5)*

In the workers collective, the individuals can have their demands negotiated with greater political power, as well as establishing a network of social support.

### Individual defense strategies

The individual strategies were used, by the workers of the SF teams, to confront the work suffering. Through the reports, it was evident that the participants used *denial* as a strategy to alleviate their suffering, when they "disconnect" from the work, compensating for the fatigue with leisure activities and other activities that give them pleasure, such as gymnastics, sports, reading and outdoor walking.

*For me, sometimes it's a bit heavy, but I have ways to cope, [...] I'm going home. I try not to think, I don't know, I manage to survive, despite the difficulties that sometimes appear [...] I'm going home, I'm going to the gym, I'm going to make a different salad. (EA1)*

*[...] I do sport, I like to read, I have a dog that I go to the park with, I'll read my book. It's a time to try to get it out of my head because I end up taking a lot of the work home. (EA5)*

*I sing, I do gymnastics, I do tapestry, which I think is health for my life. I only work in this job, the ways that I've arranged to be healthy. (EC4)*

These forms of defense alleviate anxiety and enable an internal reorganization so that the professionals are able to confront the demanding psychic load of their work.

Rationalization is another protection strategy also used to control the suffering:

*So, I think the positive side of this is being able to value the positive things in my life and perhaps minimize my problems a little more. (EC8)*

*[...] there were times before, when I was younger here, I suffered a lot, when I got home, I cried because I was not able to solve it [...] today, I am more experienced, both at work and in age, so I think I can do it differently and not upset myself so much. (EA7)*

Rationalization as a defense, to comprehend their work, implies the professionals give a more positive meaning to their experiences, seeking to reverse the negative impression of what causes them anguish and suffering. Recognition of the work of the professional by others also constitutes a source of pleasure helping to subvert the stress.

*[...] I think feedback is something that can alleviate it. Positive feedback, if someone gives us a positive response, either in relation to the patient or in relation to the relationships. I think it helps us with the overload of the difficulties of the space. (EB5)*

The community health agents reported that they could now perceive their work as being recognized by both the team and the users (O - 14/09/12). They remembered, however, that previously this was not so, as they felt devalued and that they were invading the space of attributes of other professionals. Recognized for what they do, the workers subjectively mobilized themselves, becoming enthusiastic and more engaged in the work, strengthening their personal investment. When the professionals cannot resignify their work through individual strategies for coping with suffering and the collective strategies fail, sickness develops. During the collective interview, the weight that the psychic burden conferred on the worker prior the appearance of a physical symptom was reported.

*[...] we get in conflict with each other and we won't work well. You do not feel like coming here. I even looked for a psychiatrist [...] I came here and got sick. My blood pressure was 180/110 mmHg. (EB6)*

Another report revealed that the psychic burden of work went beyond physical damage by interfering with the social life.

*[...] I see that my work today has too many repercussion in my personal life, it takes a lot from my life, from my desires. (EA9)*

The statement expresses that suffering due to the work can affect the social life of the worker and can be identified as isolation and difficulties in family and social relationships. Through the individual or collective defensive strategies, the HU workers confronted the suffering trying to modify what made them suffer.

## ● DISCUSSION

Work expresses production, affectivity and resistance in its organization, because the professionals work not only for themselves, but also for others, and in this sense, the collective relations appear as central in the defense of/coping with suffering<sup>(13)</sup>. In the work collectives, the professionals associated, identified and supported each other to confront suffering. In this way, they sought to resignify their work and reaffirm the importance of the socio-professional relations as "source of a certain protection" and a way to keep the suffering a little "more under control". In other words, sharing issues at meetings was characterized as an opportunity for the workers to express themselves, to listen and to relate to others. In order to create this space for discussion, identification with another colleague is an essential reference of the social localization of a worker<sup>(3)</sup>. The sense of work subjectively organizes the identity structure of an individual. The collective space is created by the establishment of cooperative relations among the members and the manifestation of mutual trust and recognition that can only be solidified in the effective relationship with the other and not as a result of a simple grouping of workers<sup>(3)</sup>.

In addition to collective strategies to confront the suffering of the work, the professionals used individual strategies, even if they sometimes constitute social and cultural practices implanted in the relationships with the others. These are individual tactics that have been gaining strength with the weakening of the work collectives. Increasingly, the professionals denied or rationalized the suffering through a dynamic alienating them from the organization of the work<sup>(3)</sup>. In one study, the author pointed out that protection defenses can arise from the unpredictability and suffering of work and, to confront this, workers perform activities outside work, as a compensatory form of pleasure, renounced in the work environment<sup>(13)</sup>. In another study, it was observed that the workers studied used the rationalization defense mechanism as a coping strategy for stress, seeking to control the suffering experienced<sup>(14)</sup>.

In this sense, protection strategies are important for the alleviation of suffering, since work articulates health, when it is related to the confrontation of work pressures, and disease, when the desire of the production overcomes the desire of the worker<sup>(15)</sup>. Thus, the defensive strategies should not be taken as alienation from the work, but as a momentary defense that will strengthen workers in attempting to transform suffering into pleasure. The workers understood the valorization of their lives as a strategy that could resignify the suffering in the work. That is, it is the moment in which the subjects appropriate their own suffering to resignify it, overcome it and transform it to produce pleasure. In this way, it becomes an anticipated action regarding the concrete conditions of the organization of the work, considering the emancipation of the subjects, in which recognition is one of the provocative ways of transforming suffering in the work<sup>(14)</sup>.

From the perspective of Work Psychodynamics, the production of psychic burdens is not quantifiable, since this refers to the subjective experience of the work and in this it differs from the other burdens that physically affect individuals<sup>(16)</sup>. In view of this, a heavy psychic burden can also affect the social life of the professional, for example, producing insensitivity towards friends, desire to be alone, conflicts in family relationships, impatience and even aggression toward other people<sup>(15)</sup>.

Suffering in the work should have a creative role in increasing resistance and strengthening personal identity, thus signifying a possibility for making workers find strategies to deal with it in a creative way and change the situations that cause, at some point, pathological suffering. This mobilization depends on the margin of freedom offered to workers to adjust their personal needs to the work situations<sup>(17)</sup>. It has been argued that the space for discussion, participation, cooperation and solidarity of workers in their work processes is recognized as necessary, especially to strengthen individual and group beliefs in changes and their effective contributions to modifications in the everyday situations of the work that cause suffering<sup>(18)</sup>.

## ● FINAL CONSIDERATIONS

The SF team professionals felt motivated by their work and its organization. They also recognized themselves as subjects of a collective and sought strategies to confront the suffering of the workplace, using individual and collective resources to cope with it, seeking to transform it into opportunities for pleasure, which could preserve health. However, it became clear that it was necessary to create and maintain processes of cooperation in the organization of the work, to minimize suffering and to validate the recognition of the professionals, as an important part in carrying out the work of the HUs.

The workers studied evaluated, as a collective defense strategy, the sharing of work issues at meetings that promote cooperation and solidarity among the workers and that allow the reflection, discussion and reorganization of the work, thus, resignifying it. In the same way, they used individual strategies in which negation and rationalization were mechanisms that alleviated suffering because they disconnected from the work, compensating with leisure activities and other skills that give them pleasure.

This study presents, as limitations, the participation of professionals with employment restricted to a group of HUs of the city unlike the other health districts of the region. As contributions for health service managers, the importance and the need for more democratization in work relations are highlighted. In this, the spaces of talking and listening in the work of the HU are opportune tools, enhancing and stimulating the involvement of the professionals with the organization of the work, as well as mobilizing

the subjectivity, the autonomy and the confrontation of the suffering and the search for pleasure. Furthermore, they contribute to the disruption of exclusively biomedical practices and collaborate for the construction of collective practices that consider the family in its sociocultural dimension in the production of health. Further studies on the subject are suggested in order to strengthen managers and health professionals to resignify the work by recognizing these workers as subjects and not only as instruments in a health promotion "factory".

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