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ORIGINAL ARTICLE

Suffering and defense mechanisms: an analysis of the work of Primary Health Care nurses

Sofrimento e mecanismos de defesa: análise do trabalho de enfermeiras na Atenção Primária à Saúde

Sufrimiento y mecanismos de defensa: análisis del trabajo de enfermeras de la Atención Primaria de Salud

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ABSTRACT

Objective: To analyze the suffering and coping strategies of nurses working in Primary Health Care considering the psychodynamics of their work. **Methods:** Descriptive study with a qualitative approach, carried out with 11 nurses working in Primary Health Care. Data were collected through semi-structured interviews, systematized, and interpreted using Bardin's content analysis method applied to recurrent themes. **Results:** The suffering factors related to work in Primary Health Care are difficulties with management, the fragile structure of the health support network, and conflicts with the users. Defensive strategies to minimize these difficulties are the support of hierarchical superiors, the empowerment of the community and users, and communication between team members. **Final considerations:** It is important that there be changes in the organization of this line of work to improve the workers' health. **Descriptors:** Stress, Psychological; Defense Mechanisms; Mental Health; Primary Health Care; Nurses.

RESUMO

Objetivo: Analisar o sofrimento e os mecanismos de defesa de enfermeiros atuantes na Atenção Primária à Saúde à luz da psicodinâmica do trabalho. **Métodos:** Estudo descritivo com abordagem qualitativa realizado com 11 enfermeiras atuantes na Atenção Primária à Saúde. Os dados foram coletados mediante entrevista semiestruturada, sistematizados e interpretados utilizando-se a análise de conteúdo de Bardin na modalidade temática. **Resultados:** Os fatores de sofrimento relacionados ao trabalho na Atenção Primária à Saúde são as dificuldades com a gestão, a estrutura fragilizada da rede de apoio à saúde e os conflitos com os usuários. As estratégias defensivas para minimizar essas dificuldades são o apoio dos superiores hierárquicos, o empoderamento da comunidade ou dos usuários e a comunicação entre os membros de equipe. **Considerações finais:** É importante que haja mudanças na organização do trabalho para que melhorias sejam alcançadas na saúde dos trabalhadores. **Descritores:** Estresse Psicológico; Mecanismos de Defesa; Saúde Mental; Atenção Primária à Saúde; Enfermeiras e Enfermeiros.

RESUMEN

Objetivo: Analizar el sufrimiento y mecanismos de defensa de enfermeros actuantes en la Atención Primaria de Salud a la luz de la psicodinámica del trabajo. **Métodos:** Estudio descriptivo con abordaje cualitativo realizado con 11 enfermeras actuantes en la Atención Primaria de Salud. Datos fueron recolectados mediante entrevista semiestructurada, sistematizados e interpretados utilizándose el análisis de contenido de Bardin en la modalidad temática. **Resultados:** Factores de sufrimiento relacionados al trabajo en la Atención Primaria de Salud son las dificultades con la gestión, estructura debilitada de la red de apoyo a la salud y conflictos con los usuarios. Las estrategias defensivas para minimizar esas dificultades son el apoyo de los superiores jerárquicos, el empoderamiento de la comunidad o de los usuarios y la comunicación entre los miembros de equipe. **Consideraciones finales:** Es importante que haya cambios en la organización del trabajo para que mejorías sean alcanzadas en la salud de los trabajadores. **Descriptores:** Estrés Psicológico; Mecanismos de Defensa; Salud Mental; Atención Primaria de Salud; Enfermeras y Enfermeros.

INTRODUCTION

The workplace plays an influential role in an individual's life, being it where one spends a substantial part of their time, capable of affecting the worker's and their family's relationships. This setting can interfere in the professional's mental health, since its routine, planning, organization, and duties, also taking into account the relationships with co-workers, are capable of causing emotions of pleasure and/or suffering in the worker[1]. When sources of suffering are present, work may appear distressing to the individual, and this condition can cause illnesses if excessive and frequent[2].

Thus, work manifests a duality: as a form of suffering, it can gradually drive the subject to despair; or it can instead be subverted to become pleasurable[3]. Several factors can contribute to the suffering at work, such as precarious and insufficient material resources, inadequate organization, high workload, and a lack of commitment[4-5].

Suffering at work can only be witnessed through defense mechanisms employed by the worker to endure the aggressions imposed by the organization of work, leading them to strengthen themselves to the point of resisting the organization's demand, configuring the psychic protection of suffering[6]. The analysis of the psychodynamics of nurses work in Primary Health Care (PHC) can help to identify the factors that cause suffering and indicate coping strategies that can help in the challenges of daily life.

Nurses deals daily with pain, suffering, death, and often a feeling of powerlessness in the face of reality[7-8]. Once the worker's expectations are upset by the reality imposed by the work organization — where there is usually a lack of professional recognition, rigid management, and relational problems —, then suffering and dissatisfaction arise. So, when coping mechanisms fail, illness emerges in the form of pathological suffering[9].

The propensity to psychic suffering is intrinsically linked to relationships and working conditions, especially the lack of human and material resources and work overload[10-11]. Health professionals see themselves as participants of a collective that seeks strategies to deal with suffering, individually and collectively, to transform it into positive experiences. In this context, situations that promote cooperation and solidarity are the most effective[12].

The insertion of nurses in PHC through the Family Health Strategy (FHS) should bring new meaning to the practice of care, given the variety and complexity of the actions developed by this professional. In this sense, the nurse becomes an agent of social transformation in defense of the population's health[13]. However, this is exactly one of the biggest challenges for these professionals, since the accessibility and coverage of public health care are intrinsically related to a country's administrative, economic, and social capacity. This places developing countries in a vulnerable situation, facing a lack of adequate infrastructure and material resources, lack of qualified professionals, and geographic and economic barriers[14].

From this perspective, suffering at work can lead to physical symptoms of emotional cause and illness. Investigating the subject can promote changes in the work activities of nurses who experience this kind of distress, strengthening coping mechanisms and bringing positive experiences to the work environment, improving their quality of life.

OBJECTIVE

To analyze the suffering and coping strategies of nurses working in Primary Health Care considering the psychodynamics of their work.

METHODS

Ethical aspects

The development of the research implied the requirements of Resolution No. 466/12, which regulates research involving humans[15]. For this purpose, the project was submitted to Plataforma Brasil (Brazilian online database containing research involving humans) and forwarded to the Research Ethics Committee of the Universidade de Pernambuco's (UPE) [University of Pernambuco's] Hospital Complex – Hospital Universitário Oswaldo Cruz (HUOC) [Oswaldo Cruz University Hospital] / Pronto-Socorro Cardiológico Universitário de Pernambuco (PROCAPE) [Pernambuco University Cardiac Emergency Room] and approved. Prior to data collection, the participants were fully informed about the research and signed the Informed Consent Form. To preserve their anonymity, the interviews were coded (E1 to E11) according to the order in which they were held.

Theoretical-methodological framework

To systematize and interpret the collected data, we used Bardin's content analysis method applied to recurrent themes[16]. Data analysis was based on the theoretical framework of the psychodynamics of work, proposed by Chistophe Dejours[9].

Study scenario and type

Descriptive study with a qualitative approach, using the Consolidated Criteria for Qualitative Reporting Research (COREQ) as the main methodological tool. It was conducted in the 7th Health District (HD) of the 3rd Administrative Region – Northeast, comprising 13 neighborhoods associated with the City Hall of Recife, the capital of the state of Pernambuco. The health care network of the 7th HD consists of 17 Family Health Units (FHU), 48 Family Health Teams (FHT), 3 Family Health Support Center Teams (FHSCT), 3 Traditional Basic Units (TBU), in addition to other health agents and services; serving 188,538 inhabitants[17]. This study is part of the global project entitled "Pleasure and Suffering of Primary Care Nurses In Light Of Work Psychodynamics".

Methodological procedures

The sample consisted of 11 nurses who work in the Basic Health Units of the 7th Health District, chosen regardless of gender, age, and length of service. Nurses who had been working in the PHC for less than a year were also included. Those unable to participate during the period of data collection were excluded. The collection was carried out between April and August of 2015. The research project was presented at the Health Units for the invitation and scheduling of interviews, according to the interviewees' convenience.

The data collection instrument was developed by the authors and consisted of a semi-structured interview script containing closed questions to characterize the sample and the following guiding questions: What factors cause suffering in your work in Primary Care? What defensive strategies do you and/or the team apply to face the feelings of suffering at work?

Then the study worked on the following emerging categories: themes related to suffering in the work of nurses working in Primary Health Care; and the individual or collective strategies used by them to face suffering at work.

The interviews were conducted by one of the researchers, and the criterion used to define the sample size was the saturation of collected data, that is, when speeches began to be repetitive, the sample was considered sufficiently representative.

Data Analysis

The material collected throughout the interviews was recorded to be transcribed and analyzed. Data regarding the characterization of the sample were described by their frequency. The data referring to the guiding questions of the interview were analyzed using Bardin's content analysis technique[16].

The data analysis process consisted of three steps. The first step, a preliminary analysis, consisted of skimming the transcripts in order to operationalize initial ideas and become familiar with the content. The second phase, exploration of the material, searched for words and sets of words that were meaningful for the research, then classified them into categories. Based on the recurrence of themes and the presence of units of meaning, it was possible to identify and classify the speeches. In the final stage of content analysis, the treatment and interpretation of results was done in order to achieve the objectives of the study[16]. Thus, as a result, two categories were systematized. The first comprises the factors that cause suffering for the nurse working in PHC and has the following subcategories: (1) Problems with management, (2) Deficiencies of the Health Care Network, and (3) Difficult relations with the users/user aggressiveness. The second category refers to coping strategies to deal with suffering in the work of PHC nurses; and presents the following subcategories: (1) Communication between team members, (2) Community/users empowerment, and (3) Asking superiors for support.

RESULTS

The study sample consisted of 11 nurses, with a mean age of 40.72 years and a median of 37 years. As for religion, seven were catholic; two, protestant; one, agnostic; and one, spiritist. Regarding marital status, five were married or in a stable union, three were single, two were divorced, and one chose to not answer. Almost all interviewees (n = 10) declare having completed some specialization course. The average length of education was 16 years and a median of 11 years, ranging from 8 to 27 years. Nine of them were graduates from federal or state public universities; and two, from private colleges.

The average length of professional experience in the sample was 16.5 years, ranging from 8 to 27 years. The average time working in Primary Health Care was 13.8 years, ranging between 6 and 23 years, with all of them having worked exclusively in the public health system, and most of them (n = 6) working exclusively in Primary Health Care.

Based on Dejour's framework, two categories emerged during the data analysis, which were organized into the two themes presented below.

Suffering causes of nurses working in Primary Health Care

We grouped all the content related to the experiences of mental suffering and distress experienced by nurses in PHC. In the study, there were numerous reports of experiences of suffering and distress that occurred in their work environment. The units of meaning were organized into thematic units, resulting in the subcategories that emerged from this category.

Problems with management

In this study, inadequate, ineffective, and vertical management, with difficulties in problem-solving and maintaining healthy relationships, showed up as a reason for suffering and hardship for the nurses working in the PHC. In such a setting, harmonious work management is essential to minimize distress.

> *These administrative issues make me suffer at work* […] *We have a good team, with people that help each other, it is the structural issues, from outside, the management, that causes me the most suffering.* (E1)

> *Management… management is a problem, you know? I'm not saying local management, of our unit, it's the district management, the municipality management* […] *it makes it all more difficult.* (E2)

> *There is a lack of structure and proper management.* […] *we have some frustrating situations, for example, tomorrow there will be a community meeting, that was scheduled more than a month ago. It was supposed to be a meeting with the medical staff, the health district managers, and the local community; and just today, the district told us they won't participate anymore, do you understand? That is what I'm talking about, things we could do and end up not doing due to lack of logistical support… that really frustrates me a lot.* (E3)

> *We have a patient with multidrug-resistant tuberculosis* […] *he needs injectable medication* […] *then we realize there are no syringes left to use* […] *the patient cannot buy it himself and he can't do without the medication* […] *so you stop and think: "My God, in what conditions am I working in?"* (E4)

> *In daily practice, I think that what frustrates us is not being able to perform the work to the standards we would like, because of administrative and management reasons, this greatly upsets any professional and I realize that this doesn't happen only to the nursing team* […]. (E6)

> *If we had better conditions,* […] *a complete team… right now there's a shortage of doctors, we're almost a year without a doctor.* (E7)

> […] *There was a single room for the whole team! So, in the morning, only I could work there, the doctor had to wait until afternoon*

and vice-versa. We had to come up with some way to work outside the unit. (E9)

Deficiencies of the Health Care Network

The shortcomings of the Health Care Network (HCN) were cited by nurses participating in the research as a major obstacle in providing care to the community. The population health is compromised by the incomplete care service caused by the shortage of specialized professionals, as nurses alone are not able to fulfill all needs of care in a health system, which is a reason for great suffering and dissatisfaction for them.

> *What causes me pain is, mainly, when we leave a patient unassisted for any reason, because we were unable to perform an exam, or because we were unable to reach a specialist; and when we can, it takes a long time to do something that is of ultimate urgency* […]. (E5)

> […] *there are many disappointments, but it is beyond our control, the patients' first point of contact. I think this is more of a lack of political will, because the network's difficulty to provide complete treatment is depressing* […] *you have difficulty referring a patient to a specialist, the treatment is abandoned, or it takes way too long* […]. (E6)

> *I was getting sick for real, these situations at work were draining me in a way that I really had to seek help: I had symptoms such as social isolation, difficulty talking to people, irritability* […] *all because of the inefficiency of the service and the structure of the health system, of the system's management, we run into many issues of ineffectiveness. We, in Primary Care, may even be able to do something, but after that, they need another level of care, and this level does not work as well as the Primary Care, and it ends up unresolved* […]. (E11)

Difficult relations with the users/user aggressiveness.

The research participants claim that violence suffered from part of the users trigger feelings of fear, suffering, and distress in the work environment, being especially oppressive for female workers.

> *We have a community leader here that targets me, he doesn't like me, and he's already said that one day he's going to get me fired. He came here one time looking for trouble, disrespected me, yelled at me* […] *I even cried at work because of this, I even had trouble sleeping at home, because of the anguish, anxiety. You are poorly treated in your workplace by a community member who just complains about problems that are not your fault.* (E1)

> *We had a very aggressive user in the area, who use to attend the service for changing wound dressings* […] *and I said: "Hey, I need to take a look at that wound!" He then started kicking chairs, kicking everything around like he was possessed, calling me all the terrible names on earth, and the Community Health Agent (CHA) came to defend me; she is a black woman and he started calling her horrible slurs, it was so terrifying that we called the police, because he didn't want to leave and was tearing up the place, cursing and threatening us* […]. (E2)

> *We often deal with some very aggressive people, you know? So, they're the problematic users who do not understand how we work here in the Family Health Unit service… as I said, we have been working here for a long time, and there are still users who come here just to make trouble.* (E3)

> […] *When I fall out with a patient* […] *unfortunately, it makes me feel very bad, it leaves me sick, crying. Unfortunately, this happens, and it is one of the situations that makes me most depressed.* (E4)

> […] *It was unsafe for us, there was a lot of stress, there was a lot of tension* […] *I ended up on leave because of the pressure… I developed a health problem* […] *I was constantly attacked and I got sick, because I felt vulnerable, I felt unprotected and I slowly got ill, I had to leave, and as I couldn't get transferred, I decided to just quit the job.* (E5)

Coping strategies used by nurses working in Primary Health Care

We grouped all the content related to the development of coping strategies, individual or collective, experienced by nurses in PHC.

All nurses in the study reported different ways of coping with suffering in their work environment. The units of meaning were organized into thematic units, resulting in the subcategories described below.

Communication between team members

The interviewed nurses reported the use of dialogue to mediate conflicting situations in the work environment as the main individual and collective defensive strategy, in meetings held at the workplace. The majority said it was one of the best strategies to deal with problems, both personal and work-related.

> *I think we can do a good job because we're a tight team, we have a well-developed work process, we plan what we're going to do, and that's why our team is unusual, everyone likes each other, there's no fighting* […]. (E3)

> *I don't go telling anyone what they should do: I first talk to the doctor, to the health agents, and we'll check together what is best for the team so that we can work well* […]. (E5)

> *Communication, colleagues support each other. We have a lot of meetings, so when problems arise, we talk and try, within our reach, to find a solution. There are things we can make a little better* […]. (E7)

> […] *if there's a problem with a specific person, I always call that person to talk* […] *if I have a problem with them, about our work, our job, that person has something to complain about me, I try to sit down and talk to see what is going on, listening to the other side to see if we can solve it somehow.* (E8)

> *When I see that there's something wrong or something with our doctor or our resident that isn't working, we try to solve it as a team, and sometimes I think it's more helpful to talk directly to them first; if we can't solve it like this, then I take it to the team meeting* […]. (E9)

Community/user empowerment

Many of the nurses reported finding, within the community, the support they need to solve the health unit's problems or even difficulties with management. Using dialog and health education

as a coping strategy strengthens affective bonds and develops in the people a social awareness of their rights, empowering them.

In strengthening social participation, professionals look for partners to fight together for the Primary Care cause, as we will see in the interviewees' speeches:

> *We report the problems,* […] *talk,* […] *encourage the community to call the ombudsman, we take the social issues to the council, in the community meeting, tell them what the work is, how it can be done, how can it improve, so we can find some partners in this search for improvements* […]. (E1)

> *We also hold community meetings* […] *because we need to keep the community updated* […] *to introduce the new doctor, to inform that something in the schedule changed, and the flow of reception that exists throughout city hall.* (E3)

> *We try to talk to find the best solutions for the community, for the aggressiveness, for the community's desires, making clear what we can do and what we cannot do, what is out of our reach and what we can solve.* (E5)

> *When it's something that anguishes me and I can't solve the problem with the patient, I try to see that patient again, talk to him again, or go to their house to do an active search to see if it was my orientation failure* […]. (E9)

> […] *always communicating with the team and the community, we are always going out on the street, making appointments with the health agents,* […] *we struggled so hard for this health unit for almost three years, for years we asked for the construction of this unit, and now it's built.* (E10)

Asking superiors for support

In the search for collective mobilization, in order to minimize suffering or to transform it into positive situations, the interviewees turn to social/professional support from their hierarchical superiors.

> […] *what is within our reach and what we can solve, we try to solve here by ourselves, but what is not possible, we forward to the district, the problem is transferred to the district because we need their help.* (E5)

> […] *we sit and talk a lot* […] *we try to solve it and when we see that we have not achieved our goals, we call management, this way we have been able to get a good partnership with management* […] *they listen to us, and we report all our difficulties.* (E7)

> *We have a nurse who is the unit's manager. When there is a problem with the reception, with the pharmacy, with the observation staff, we try to bring it up to the manager so she can help us solve it… I usually do it like this* […]. (E9)

DISCUSSION

The results showed that the sources of suffering related to the work process reported by nurses are difficulties with the municipal management, the fragile structure of the HCN, and conflicts with users. At the same time, they point out that the strategies used to minimize these experiences of suffering are the support of superiors, the empowerment of the community, together with communication between team members. Despite identifying sources of support, these are sometimes not enough to prevent the stressful factors from impacting the physical and mental health of nurses working in Primary Health Care.

It is noted that the sample comprised exclusively of women, demonstrating their great presence in the profession. Another study carried out with nurses also found a predominance of females. This finding may be related to the historical context of the profession, exercised prominently by female members[18].

It is observed that the organization of work is responsible for the increased psychological demand on the workers, and when this starts to interfere with their psychic functioning, mental suffering arises. More and more workers are required to think critically, give precise answers, make quick decisions, work as a team and push forward, but this same work organization imposed by the institution will not always give workers the needed conditions to perform so many duties[9].

Work is not a simple activity, and in all types of work, suffering can occur. When workers can see meaning in their work and obtain recognition, this suffering can turn into personal achievement and identity for the individual. However, when the work environment cannot provide such conditions, psychological distress persists, bringing serious consequences to the individual's health[19].

It is observed in the speech of the participants that problems related to Primary Care management can prevent professionals from carrying out their work fully and competently, as the worker performance is limited due to poor management conditions and organization of tasks, feeling powerless in the face of the situation.

Although Primary Care is considered the main reorganization strategy of the health network, its management is still considered inefficient and it is still far from having adequate cooperation between individuals to establish participatory management, perpetuating a Taylorist management system, which aims only at increasing productivity at the expense of providing humanized services, with welcoming and qualified listening to users[20].

Difficulties with management are also reflected in another triggering factor of frustration and suffering in nurses: the discontinuity of care caused by shortcomings of the HCN. Studies show that, in addition to the professionals' lack of knowledge about the correct flow of referrals or services that support users, a serious problem in comprehensive care is a reason for dissatisfaction among professionals[21-22]. This is one of the main causes of negative feelings, such as insecurity, lack of motivation, and powerlessness, in nursing staff professionals at a Psychosocial Care Center, according to a study carried out in the state of Amapá[23].

Another aspect pointed out by this study as a factor of suffering is the poor relationships and aggressiveness of the users of the unit, which was also identified in a study carried out with hospital nurses in São Paulo[24]. In the health sector, women are the main victims of acts of violence, and the profession most affected is nursing, then, as the workforce of nursing is mostly composed of women, these professionals face increased vulnerability[25-26].

In a study carried out with nurses, it is revealed that 94.6% of professionals report having been victims of violence in the workplace[27]. As a reflection of this situation of violence, professionals may exhibit reduced performance, decreased satisfaction with work, and fear

about the occurrence of similar situations with them. Consequently, this scenario ends up affecting workers' mental health[28].

In addition to the distress and anguish experienced by these professionals, other health consequences can result from violence, such as depression, reproductive problems, alcohol and drug abuse, heart disease, and risky sexual behavior. Still, violence can have major economic impacts, as evidenced by absenteeism, loss of human capital, and lack of financial investments[29].

To counter suffering and illness, workers build strategies to face these negative work experiences[3]. This is relevant because, as evidenced in a meta-analysis carried out with the sample of nurses, stressful factors and negative experiences promote fatigue and exhaustion[30].

As defense mechanisms against factors that cause a mental breakdown, nurses report using communication and dialogue with the team. Professionals use interpersonal dialogue as a means to defend themselves from situations that are out of control, sharing ideas and solutions to problems; and also, to create a harmonious environment, where people seek mutual affection, understanding, and respect[31-32]. Despite this, problems often do not come from within the team, but from the organization of work, which ends up causing strain on the team.

Cooperation is a great motivator for workers, as it is sustained by the willingness of people to work together and share experiences and, also, to collectively overcome contradictions and counterpoints, which are inherent to the essence of work organization. The need for a space for talks and exchanges is essential to minimize distancing and conflicts and strengthen bonds[32-33], according to a study carried out with hospital nurses[24].

A research carried out with nursing professors reports the exchange of ideas as a collective mobilization strategy to deal with problems[11]. In another investigation, carried out with employees of a public foundation, it was found that the absence of dialogue and exchange between peers and superiors creates barriers between people, which impairs collective problem solving[34].

Another important aspect is the empowerment and participation of communities and users in strengthening and consolidating Primary Care. In this sense, it is necessary to look at popular movements as protagonists of actions to transform their realities, from the perspective of emancipation. It is up to the professional to direct the community towards co-management of the health system, considering popular knowledge, seeking solidarity in relationships and policies, through an inclusive perspective based on the ethics of justice[35].

The exchanging of experiences of pleasures and sufferings, of behaviors and practices, is an object of study of the psychodynamics of work, and the organization of work and its social relations are also part of its scope[33]. Social participation in Primary Care is needed in its work process, so the reports of success in the struggles for improvements in the conditions and organization of work in the health units described by the interviewees will only gain reinforcement if all actors are involved in the processes of change and improvement. For this, it is necessary to consider that professionals and users share the same reality.

Another aspect pointed out in this study as a defense mechanism for situations that cause suffering was the support of hierarchical superiors. It is observed that the organization of work is described as its division, task content, hierarchical system, command model, and power relations. Responsibilities also cause psychic demands that can lead to workers becoming ill. The participation of hierarchical superiors in the work process goes beyond delegating tasks: it is up to them to make the judgment of usefulness and recognize the work performed by their subordinates[24].

According to the framework of Dejour, this act of recognition by the superior is essential, being directly related to the suffering inflicted on the worker, as this suffering is intrinsically linked to recognition. That is, recognition is what will give utility and identity to the role performed by the individual, and the opposite can bring negative consequences to the worker's health[33].

According to a study carried out with nurses from public hospitals, social support has attenuating effects on the psychic demand, making clear the need for superiors to provide workers with social support[36]. A good relationship between professionals is seen as a factor capable of producing satisfaction in the work environment and should be the goal of the entire team, as, in addition to reducing possible conflicts, it optimizes the quality of care provided[1].

A study carried out with nursing workers reports that, when supported by their superiors, they present personal well-being in carrying out their work and lower levels of stress[37]. On the other hand, studies refer to socio-professional relationships with hierarchical superiors in which they have low conflict resolution capacity for denying the worker's freedom of expression and for adopting punitive practices in their actions as a reason for suffering and distress[35,38].

The adoption of punishment and the castration of freedom in the work environment by superiors is rooted in perversity, violence, and in ideological processes linked to "manliness", imposed on those who are dominated. Such behaviors generate a feeling of helplessness on the worker, who often performs their function based on fear of reprisals, causing work performance to greatly deviate from what would be considered ideal, which will bring serious consequences to the organization of work, to workers' mental health, and to the assistance provided to the user[39].

Study Limitations

The study is limited by the fact that it occurred only with one professional category and only with professionals who worked in the Family Health Strategy, preventing it from achieving a broader view of reality.

Therefore, the results cannot be generalized to the context of professionals inserted in PHC in other places of work and from other professional categories.

Contributions to the field of nursing, health, or public policies

It is considered that the study contributed to the understanding that workers' health is a topic to be debated in all social fields; and for the perception that the worker is a living part of the system. This professional can be affected by their environment and working conditions, such as remuneration, work overload, inflexible employer, lack of recognition from their superiors and peers, and so many other things that can affect their mental health and make them ill. And since the individual cannot be dissociated

from the environment in which they live, they can compromise the whole environment around them if in a pathological state.

If this is a health professional, such as a nurse, the risks are increased, as the psychological distress, in addition to putting their health at risk, can also compromise the care they provide to the population.

The study also subsidized strategies adopted by the professionals in order to defend themselves from negative factors.

FINAL CONSIDERATIONS

The study showed that the factors associated with the suffering of nurses working in Primary Health Care are the difficulties with management and users, in addition to the fragility of the Health Care Network. With the reports, it was observed that such factors can affect the health of these professionals.

When considering the Psychodynamics of Work Theory, it was possible to better understand how the circumstances experienced by the nurses cause psychological distress, as well as which defense mechanisms were used to deal with the difficulties. From this perspective, the search for help from hierarchical superiors, empowerment of the community/users, and communication among team members stood out.

Given the context presented, it is perceived the need for change in the organization of work in order to promote the health of nurses and a work environment favorable to health. The results create a resource capable of contributing to the health of professionals and, consequently, to the care provided to patients treated in Primary Health Care by bringing data that may be similar to other realities and by exposing the need for changes in the context of work that strive for the establishment of healthier relationships in the workplace.

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