MENTAL HEALTH IN PRIMARY HEALTH CARE: AN EXPERIENCE REPORT ON OCCUPATIONAL STRESSORS IN A BASIC HEALTH UNIT

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Abstract: This experience report originates from a university extension project developed between August and December 2024, aimed at analyzing occupational stress and stressors experienced by healthcare professionals at the Dr. José Ramos Neto Basic Health Unit, in Eunápolis, Bahia, Brazil. The extension activity involved students and professors in the health field, integrating education, service, and community through investigative actions with a quantitative and qualitative approach. Data collection included the application of the Lipp Stress Symptom Inventory for Adults (ISSL), as well as a questionnaire on occupational stressors. Fourteen health professionals participated in the study, and the responses revealed that biological risk was the main stressor identified (34.6%),

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followed by the physical structure of the unit (23%). The data also indicated that 28.57% of the participants experienced some level of stress, with the resistance phase being the most prevalent. The extension experience provided a critical reflection on the mental health of professionals in Primary Health Care, highlighting the need for institutional interventions aimed at preventing occupational illness and reinforcing the role of extension activities in promoting social awareness, professional training, and humanized care.

Keywords: Occupational Stress. Primary Health Care. Extension Project. Mental Health. Stressors.

Introduction

Primary Health Care (PHC) is characterized as the main gateway to the health services of the Unified Health System (SUS), encompassing a set of actions aimed at health protection, disease prevention, diagnosis and treatment. In this context, there is a constant flow of care in these health networks, covering low and medium complexity procedures, which makes it essential to discuss the work processes and the relationship between the work environment and the mental health of professionals working in this area (Brasil, 2012).

In the health area, the complexity involved in the responsibility of dealing with lives, combined with the growing demand for care and the need to increase the workload, can cause physical and emotional exhaustion among professionals (Ferreira et al., 2016).

The individual characteristics of the worker, especially his emotional dimension, play a significant role in occupational stress among health professionals. In addition, these professionals still face the stigmatization associated with seeking help for mental health issues in the workplace, which aggravates the confrontation of the problem (Lima et al., 2024).

Occupational stress is a condition characterized by mental and physical exhaustion reactions related to professional practice. Among the main causes, exposure to stressors resulting from work activities stands out, which negatively affect both the psychological and physical aspects of workers.

These situations can be aggravated by inadequate working conditions, such as poor infrastructure and exhausting routines (Damasceno et al., 2023).

In view of this scenario, the high exposure of Primary Health Care professionals to physical, emotional and organizational stressors emerges as a central problem, aggravated by the insufficiency of institutional support and the invisibility of psychological suffering in the work context. Thus, this study aims to analyze the levels of occupational stress and stressors present in the daily lives of workers at the Dr. José Ramos Neto Basic Health Unit, located in the municipality of Eunápolis, Bahia. The investigation is based, above all, on the contributions of Lima et al. (2024), who address the stigmatization of the search for mental health care; by Damasceno et al. (2023), when discussing working conditions and the prevalence of stress in PHC teams; de Faria et al. (2021), when dealing with the emotional vulnerability of community health agents; and Lourenção et al. (2022), who explore the relationship between stress and engagement in primary care medical professionals. Based on these theoretical bases and the extension experience, it is proposed to reflect on the impact of the work environment on the mental health of professionals and the urgency of institutional coping strategies.

Methodology

The present study was derived from a university extension project developed from August to December 2024, with a basic, descriptive nature and quantitative-qualitative approach. Descriptive research aims to study the characteristics of a group or phenomenon, such as the distribution of a population by age, physical and mental health status, among other aspects (Gil, 2008).

The activity was carried out at the Dr. José Ramos Neto Basic Health Unit, located in the municipality of Eunápolis, Bahia. This municipality is located between the federal highways BR-101 and BR-367 and has an estimated population of 113,710 inhabitants (IBGE, 2022).

The sample consisted of 26 professionals from the unit, according to the following inclusion criteria: being a professional who had been working at the UBS for more than six months, performing

the functions of nurse, physician, dentist, nursing technician, community health agent or administrative support, and having agreed to participate in the research by signing the Informed Consent Form (ICF). Professionals who refused to answer the collection instruments were excluded. All participants were guaranteed the reading of the ICF, as well as the confidentiality and anonymity of the data and identities involved.

The objective of the extension action was to identify and analyze the presence and/or level of stress, in addition to the main stressors that affect the mental health of professionals working at the UBS. For data collection, three instruments were used: a sociodemographic questionnaire to characterize the participants; the Lipp Adult Stress Symptom Inventory (ISSL), used to assess stress levels; and a third instrument composed of questions about the stressors perceived in the work environment. The forms were made available through the Google Forms platform, with the aim of expanding adherence and facilitating access for professionals.

The Lipp Inventory is an instrument validated in Brazil and was developed by Marilda Lipp in 1994. It consists of 52 items that must be marked by the participants, in order to identify physical and psychological symptoms associated with stress. The instrument classifies individuals into three phases of stress: in the alert phase, seven or more symptoms are reported in the last 24 hours; in the resistance phase, four or more symptoms that occurred in the last month; and, in the exhaustion phase, nine or more symptoms identified in the last three months (Rossetti et al., 2024).

The collected data were submitted to descriptive analysis, being organized in spreadsheets and presented in absolute numbers and percentages. This systematization allowed a quantitative reading of stress levels, as well as the qualitative categorization of the main stressors reported by the participants.

Analysis and Discussion of Results

Mental health is an inseparable component of human health and an indispensable element in

preserving the integral health of workers (Esperidião et al., 2020). It takes on a meaning related to the "healthy socius", which involves job satisfaction, an expressive daily life, social participation, leisure, equity, in short, quality of life (Filho et al., 1999).

In this sense, the World Health Organization defends the idea that mental health goes beyond the mere absence of any mental disorder, encompassing the broad state of health and can be determined by socioeconomic, biological, and environmental factors (WHO, 2016).

A healthy work environment has a positive influence on the health and well-being of workers, and is a fundamental right of every citizen (article 6, caput, CF/88). This right must be ensured not only by the State, but also by the employing and managing institutions. However, the labor universe sustains conditions that often lead to the weakening of workers' mental health, such as social exclusion, competitiveness, and authoritarian relationships (Lourenção et al., 2022).

Primary Health Care (PHC) is responsible for a set of strategies and actions at the individual and collective levels, which covers health promotion and prevention. Within this network, the Basic Health Units (UBS) and the Family Health Strategy (ESF) are the primary care centers and carry out less complex procedures, such as regular consultations, administration of medications and vaccines, as well as health education activities (Brasil, 2019).

Despite its importance, PHC presents challenges ranging from the low problem-solving capacity of services to chronic underfunding of health, situations that occupy a prominent position among the obstacles to compliance with public policy (Geremia, 2020). In addition, there is fragility in the health care actions of PHC workers and the lack of awareness of these professionals about the importance of occupational health (Silva et al., 2018).

From this perspective, it is valid to recognize that the care activities developed by professionals working in PHC are permeated by challenges, uncertainties, and anguish, which makes them more susceptible to psychological distress and psychological distress (Esperidião et al., 2020). In the analysis of Leite et al. (2014), these professionals face, in their daily lives, specific challenges that can generate stress and overload, negatively impacting their quality of life at work (QWL). Among these

conditions, the lack of understanding on the part of the teams about the objectives of the health policy, the high workload and the lack of preparation to work in the context of the FHS stand out. In addition, the absence of institutional support is also a factor that compromises QWL.

Tenório-Correia et al. (2024) show that PHC professionals, especially those subjected to intense working hours, pressure for goals and limited resources, are often affected by work-related psychological problems. In contexts of prolonged burnout, there is an increased probability of leaves and risk of exclusion from the labor market, which amplifies the social and institutional impact of these conditions.

In accordance with the objectives of the study, a sociodemographic profile of the research participants was drawn (Table 1), with the aim of identifying aspects that could be related to the development of stress.

Table 1. Sociodemographic profile of research participants

Variables	Frequency n(%)
Age	
< 25 years	0
26-35 years old	1(7.1%)
36-45 years old	5(35.7%)
46-55 years old	8(57.1%)
Gender	
Masculine	5(35.7%)
Feminine	9(64.3%)
workload	
Up to 40 hours per week	12(85.7%)
Exceeds 40 hours per week	2(14.3%)
Profession	
Doctor	1(7.1%)
Nurse	1(7.1%)
Nursing technician	2(14.3%)
Dentist	1(7.1%)
ACSs	7(50%)
Administrative agent	2(14.3%)
Total	**14(100%)**

Source: Survey data, 2024.

Of a total of 26 people approached during the survey, 16 responded to the form made available online. In this scenario, one person did not sign the mandatory consent form for the continuation of

the research and another did not agree to answer the questionnaire on stress symptoms presented. Thus, 14 people agreed to participate in the research, resulting in an adherence rate of approximately 53.84%.

From the sociodemographic survey of the 14 professionals working at the Dr. José Ramos Neto Basic Health Unit, there is a predominance of individuals in the 46 to 55 age group. Next, 35.7% are in the age group of 36 to 45 years, while only 7.1% are between 26 and 35 years old.

This profile reflects a group mostly composed of professionals at a more advanced stage of their work trajectory and possibly with previous experiences of insertion in the labor market. This maturity may be associated with greater exposure to risk factors, which may amplify the impact of adverse conditions over time. Studies show that prolonged and continuous exposure to stressors at work can determine an insidious process of occupational stress (Costa et al., 2003), and that length of service and professional experience interfere with the way each person copes with stressors (Tamborini et al., 2023).

As for gender, the survey revealed a predominance of women (64.3%). This data is compatible with the scenario observed in many public health services, in which care functions are mostly occupied by women (Martins et al., 1996).

Several studies relate the gender category to the development of stress. Sadir et al. (2010) cite research by Levi (1999) that found that the combination of being a woman, being overworked, and living in an unfavorable economic situation constitutes an increased risk factor for the development of stress.

In this sense, the World Health Organization (WHO) reveals that, both in emerging and developed countries, women in the workplace generally present greater stress compared to men (WHO, 2007).

Among the participants, there was a predominance of community health agents (50%), followed by nursing technicians (14.3%), administrative professionals (14.3%), nurses (7.1%), physicians (7.1%) and dentists (7.1%). This distribution reflects the multiprofessional structure characteristic of

the UBS's, highlighting the role of the community health agents (CHA).

The ACS's play a crucial role in the consolidation of the SUS, due to their continuous and permanent performance. Its actions prioritize strengthening the bond between team members and the community, promoting initiatives aimed at health. In addition, they carry out activities such as home visits, welcoming, and community actions, and are often engaged in group and community practices (Faria et al., 2021).

Regarding the employment relationship, only 21.4% of the participants reported having some external relationship to the one provided at the Dr. José Ramos Neto UBS, and only 7.1% stated that they felt overloaded with the workload at the UBS. These data contrast with those described in literature studies, which point to high levels of stress related to overload and high workload among primary care professionals (Fernandes et al., 2019).

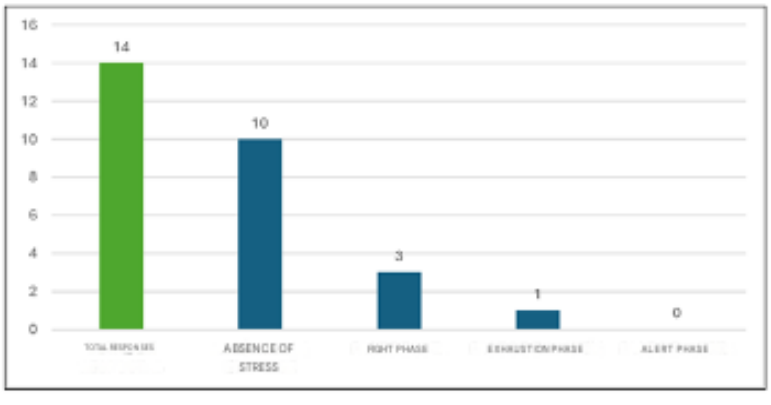
Another relevant aspect identified was the great variation in the weekly workload of the participants, which ranged between 8 and 70 hours per week. About 85% of professionals reported working up to 40 hours a week, while 15% exceeded this limit. According to Lopes (2018), the exhaustive workload can contribute significantly to work overload, culminating in the emergence of occupational stress.

Stress is characterized as the organic reaction to situations that require intense emotional effort; when these situations become constant, physical and psychological changes are triggered that can manifest themselves in headache, malaise, cardiovascular changes and, in chronic cases, burnout syndrome (Damasceno et al., 2023). Occupational stress, on the other hand, refers specifically to psychological tension linked to work; occurs when the individual perceives certain work demands as stressors and, when activating coping mechanisms, experiences negative reactions that compromise their well-being (Paschoal and Tamayo, 2004).

In the present study, the application of Lipp's Stress Symptom Inventory for Adults revealed that 28.47% of the professionals had some level of stress; The resistance phase was the most prevalent, while only one participant was in the exhaustion phase, and none was in the alert phase. Although most

of them were classified as stress-free, the presence of a significant set of symptoms was found that approached the cutoff points of the instrument, which demands attention, as these workers constitute a risk group for the evolution of occupational stress.

Chart 1. Stress Levels



Source: Survey data, 2024.

The symptoms reported by the participants revealed important aspects of occupational health. In the last 24 hours (alert phase), the majority (57.1%) reported muscle pain or tension, followed by stomach pain (28.6%) and other stress-related symptoms (Table 2). This stage occurs when the individual comes into contact with the stressor and is marked by the prevalence of physical symptoms to the detriment of psychological ones (Cordíoli et al., 2019).

The items that make up the questionnaire follow an order of symptom intensity, as it is common for the initial signs of the alert phase to appear mildly and sporadically, disappear and later reappear with greater intensity (Sadir et al., 2010). At this stage, it is essential to identify, minimize or eliminate the stressors present in the work environment, in order to prevent the progression of symptoms. Health promotion actions in the workplace can act as an effective strategy in the prevention and control of occupational stress.

Table 2. Most common symptoms in the alert phase

Most common symptoms of the alert phase among healthcare workers	Frequency n (%)
Muscle tension (muscle pain)	8 (57.1%)
Knot or pain in the stomach	4 (28.5%)
Insomnia, difficulty sleeping	3 (21.4%)
Sudden and transient hypertension	3 (21.4%)

Source: Survey data, 2024.

When extending the time horizon, it is observed that, in the last month (resistance or struggle phase), the most frequent problems were memory difficulties (57.1%) and excessive irritability (35.7%). The development of the resistance phase is associated with the persistence of the action of the aggressive stimulus (Table 3). In this sense, when stressful stimuli become repetitive and chronic, the body response tends to decrease in intensity, being anticipated on a recurring basis. This anticipation, however, can trigger more serious pathologies, such as anxiety. In this phase, the most recurrent symptoms become predominantly psychological (Cordíoli et al., 2019).

Table 3. Symptoms most noted in the fight phase

Most common symptoms of the fighting phase among healthcare professionals	Frequency n (%)
Problems with memories	8 (57.1%)
Excessive irritability	5 (35.7%)
Constant tiredness	5 (35.7%)
Feeling of physical exhaustion	3 (21.4%)
Arterial Hypertension	3 (21.4%)
Emotional Sensitivity	4 (28.3%)
Malaise	3 (21.4%)
Change of Appetite	3 (21.4%)

Sources: Survey data, 2024.

Finally, in the last three months (exhaustion phase), excessive tiredness was reported by half of the participants (50%), followed by irritability without a defined cause (35.7%) and the desire to "run away from everything" (35.7%) (Table 4). In this stage, the symptoms are triggered by a condition of chronic anxiety resulting from the resistance phase and are characterized by the exhaustion generated by adaptive failure in the face of continuous emotional efforts to overcome a persistent stressful

situation. From this perspective, the third phase of stress presents more intense symptoms and can lead to the development of serious diseases, such as cardiovascular pathologies, which, in extreme cases, can result in the death of the worker (Tenório-Correia et al., 2024).

Table 4. Most common symptoms during the exhaustion phase

Most common symptoms of burnout among healthcare professionals	Frequency n (%)
Excessive tiredness	7 (50.0%)
Insomnia	5 (35.7%)
Irritability without apparent cause	5 (35.7%)
Want to escape from everything	5 (35.7%)
Apathy, desire to do nothing	4 (28.6%)
Daily anguish or anxiety	4(28.6%)

Sources: Survey data, 2024.

The survey also revealed that, in relation to the care offered in the territory, 57.1% of the professionals reported that they considered that the UBS where they work does not have sufficient structural, logistical and human resources conditions to meet the demand. This data indicates that structural precariousness and work overload are perceived as sources of stress for the unit's professionals, which requires attention from the municipal management regarding the working conditions offered in the daily routine of primary care.

Regarding the team's reception with the health worker, most of the research participants (64.3%) reported that there was no active listening and moments of care aimed at the professionals who work in the unit. This perception reveals the absence of institutional strategies to welcome workers and, at the same time, the fragility of interpersonal relationships within the team.

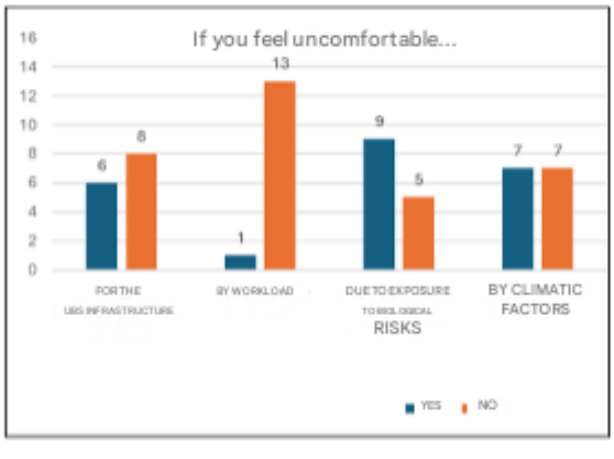
When asked about what caused stress in the unit's daily life, the main answers reported were: "overloaded and unmotivated", "working beyond hours", "exhausting work", "moral harassment and overload", "devaluation", "overloaded with accumulation of functions", "being constantly charged and being treated with ignorance". All these answers reveal important aspects of psychic suffering, and its repetition among the professionals of the unit is an alert for health management.

Participatory management presupposes qualified listening, horizontality in work relationships and valuing the knowledge of all team members. When there is asymmetry in decision-making power, vertical imposition of goals and absence of dialogue, work tends to become sicker. Suffering, in these cases, ceases to be a temporary condition and starts to crystallize as ethical-political suffering, as the worker is prevented from performing a dignified job, which brings him meaning and recognition.

Qualified listening should be understood as an intentional and humanized process, in which the worker not only reports his complaints, but is welcomed in its entirety, considering the multiple aspects that cross his subjectivity and his performance. Promoting spaces for listening and care among professionals from the same team can contribute to the collective coping with suffering, being a tool for strengthening the team and preventing occupational stress.

The absence of listening spaces is also related to the symbolic devaluation of SUS workers. The ideal of user-centered care often disregards the health of those who provide care, which, in addition to being incoherent, compromises the quality of care and the permanence of professionals in the territories. Caring for those who care is, therefore, an ethical and strategic responsibility for the sustainability of the SUS.

Chart 2. Stressors identified by UBS professionals



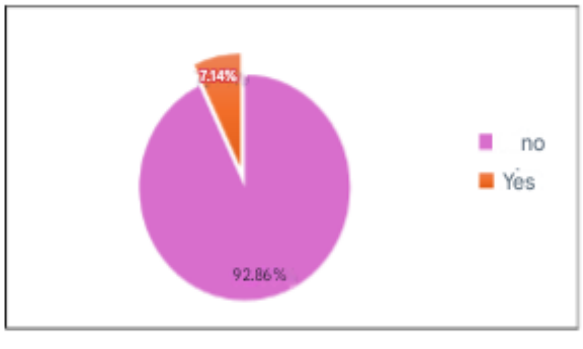
Sources: Survey data, 2024.

During the data collection stage, signs of discomfort were observed on the part of some

participants when addressing the topic of occupational stress. Although the confidentiality of the answers was ensured, some professionals reported insecurity in answering with total frankness, motivated by the fear of possible retaliation in the work environment. This perception points to the presence of manifestations of non-verbalized psychic suffering, suggesting institutional weaknesses in the reception of demands related to the mental health of workers.

It was observed that approximately 93% of the professionals working at the Dr. José Ramos Neto Basic Health Unit reported the absence of institutional psychological support. Psychological support is an essential resource for the identification of stressors and for the development of coping strategies in the work context. It is also noteworthy that 100% of the professionals who presented some level of stress, according to the Lipp Inventory, are part of the group that declared that they did not have any type of psychological support.

Chart 3. Psychological assistance/support



Sources: Survey data, 2024.

This finding corroborates evidence in the literature that indicates the low perception of institutional support in the workplace as an aggravating factor for occupational stress among primary health care professionals. In a study conducted by Tamborini et al. (2023), which assessed the risk of exposure to occupational stress in this group, it was observed that 46.6% of the participants reported not having psychological support at their place of work. These data reinforce the relevance of implementing institutional policies aimed at the mental health of workers, with permanent strategies of care, listening and psychosocial support in the daily lives of the teams.

Final Thoughts

The results of the present report showed the significant presence of symptoms of occupational stress among health professionals working at the Dr. José Ramos Neto Basic Health Unit. Although most participants did not fit into the most critical phases of stress according to the Lipp Inventory, a significant frequency of physical and psychological signs was observed, such as muscle pain, irritability, excessive tiredness and memory difficulties, which indicate a high risk of progression to more severe conditions. The phases of resistance and exhaustion were especially marked, revealing the persistence of stressors in the work environment.

The research also highlighted structural and subjective aspects that contribute to the illness of workers, such as the overload of functions, lack of motivation, the absence of active listening and institutional fragility in the promotion of care for those who care. The lack of institutional psychological support, reported by more than 90% of the participants, associated with the perception of professional devaluation, reinforces the need for strategic actions aimed at mental health in the context of primary care. The scientific literature consulted reinforces that the absence of psychosocial support is recurrent in this field, which can aggravate the ethical-political suffering of health professionals.

Thus, the findings of this study reveal not only a situational diagnosis of occupational stress in a family health team, but also the urgency of public and institutional policies that ensure decent working conditions, qualified listening, and interventions that favor the comprehensive care of professionals. Taking care of the mental health of workers is an ethical imperative for the qualification of health practices and for the sustainability of the Unified Health System in the territories.

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