WORK AND MENTAL HEALTH OF INTENSIVE CARE PROFESSIONALS - A CONCEPTUAL APPROACH

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ABSTRACT

It is understood the work with one of the structures responsible for structuring the identity of the human being. Thus, through work, man modifies his way of acting, thinking and relates to himself and to the world. In health, work is a theme of much discussion with regard to the general aspects of work; however, with little focus on the hospital setting, specifically in the intensive care unit. This theoretical manuscript in the form of an essay aims to analyze the theoretical and conceptual aspects of work and its repercussion on the mental health of workers who work in the intensive care unit setting. After analyzing the pertinent bibliography regarding conceptual, historical and social aspects, its articulation with the conceptions, its complexity in health and its impact on the mental health of workers, specifically in intensive care, was produced. The analysis points to the need to implement strategies that awaken to the elaboration of actions focused on health policy aimed at the promotion, protection and recovery of workers' health in this context of action.

Keywords: Occupational Health. Mental health. Intensive Care Unit.

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INTRODUCTION

Work is configured as one of the components that structure the identity of the human being. Through work, man modifies his way of thinking, behaving and relating to himself and to the world. The development of work involves the performance of multiple activities, but its intentionality, qualification and skills are extremely relevant, making it capable of producing feelings such as pleasure and/or suffering (1).

To understand the work process, it is necessary to consider the objects, agents, instruments, purposes, methods and products. Thus, objects can be understood as something that comes from nature and undergoes changes with the work process; agents are those who transform the objects of nature; instruments are all the tools to modify nature; purpose consists of the reason why work is performed; methods are the actions organized and systematized to achieve the purpose; and finally, Products are the final result of every work process (2).

The object of health work is the human being in its individual or collective dimension. It is a natural being that lives in collectivity and is invested with value (labor power). The means or instruments of work are a set of things (material and non-material) that the worker interposes directly between him and his object of work to obtain the expected result, in this case, prevention, cure or rehabilitation). In health work, there is physical and intellectual expenditure, a product of this human activity, which can be recovered with rest and good nutrition. To carry it out, the health worker makes an intellectual effort, which places him in the category of intellectual workers (3).

Thus, work in the health area is tensioned by situations of psychosocial conflict between the participants in this process (workers and the human beings who are the objects of this work), characterized by a scenario in which numerous situations can contribute to the illness of health workers, this condition is associated with the characteristics of the environment in which this work is carried out.

The hospital environment is considered an unhealthy place, because in this space a type of continuous and uninterrupted work is carried out, which requires work schedules that oppose the circadian rhythm, which establishes demands, routines and controls to which workers are submitted. The journeys are long, the activities carried out require specific knowledge and skills, they are faced with situations that are only observed in times of catastrophes and wars, they live with pain, suffering and death. Recent studies indicate that exposure to adverse experiences at work is considered a risk factor for mental health[4,5].

Among the scenarios that can favor the illness of workers is the Intensive Care Unit (ICU), a complex environment within the hospital that assists patients in critical health conditions. These people with a high degree of dependence require from health workers technical-scientific knowledge and specific skills, performing complex procedures, making quick decisions, constantly evaluating patients and an effort to overcome physical and mental fatigue, performing their activities without jeopardizing the care provided to patients. In addition, there may be a lack of material resources, exposure to biological, ergonomic, physical and chemical risks; In addition to the lack of psychological support, all of this represents a threat to the health of these workers[6–10].

Data from the World Health Organization indicate that mental disorders constitute 13% in the world. They affect about 700 million people and a third of this population does not receive specialized follow-up. In the hospital environment, this illness is associated with workers' exposure to pain, suffering, pressure, responsibility, harassment, violence, conflicts with colleagues and managers, high demands, working hours and shifts, in addition to lack of autonomy[11].

From this perspective, within the health team, physicians and nurses are the professionals most impacted in their work routine in the ICU, as they are responsible for the therapeutic conducts performed with patients hospitalized there, which can trigger mental health problems such as Minor Psychic Disorders (MPD) and *Burnout Syndrome* (BS) (5).

Minor Psychic Disorders (MPD) are described by symptoms such as forgetfulness, difficulty concentrating, decision-making, insomnia, irritability, and fatigue. Somatic complaints such as headache, lack of appetite, tremors, poor digestion, among others, are also common, which demonstrate disruption in the normal functioning of the individual, which can interfere with the performance of their work activities. These effects have repercussions not only on the life of the individual, but also on their families. However, they are not characterized as mental illness, according to the criteria of the ICD-11 (Eleventh Revision of the International Classification of Diseases of the World Health Organization) and/or the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders - 5th edition - of the *American Psychiatric Association*)[12].

Another situation, no less important, but present in the routine of these workers is the Burnout Syndrome (BS). According to the WHO (World Health Organization) in the International Statistical Classification of Diseases and Related Health Problems in its 11th revision (ICD-11), Burnout Syndrome is the result of chronic work stress that has not been successfully managed and that can lead to feelings of exhaustion or depletion of energy, leading to mental exhaustion and reduced productivity. The WHO also defines work-related

diseases as health problems that affect workers after exposure to risk factors resulting from their work activity, which affect their physical and mental health[13,14].

Regarding the clinical picture, there are diversified signs and symptoms that can confound the diagnosis. Among them, fatigue, myalgia, sleep disorders, migraines, hair loss can be listed. In addition, gastrointestinal, cardiorespiratory, neurological and sexual repercussions have already been described in studies. Psychological manifestations have also been reported and are related to memory deficit, low self-esteem, lack of concentration, apathy and aggressiveness. Allied to these factors, BS has repercussions on a higher probability of absenteeism from work[(15,16)].

Due to the scarcity of strategies aimed at protecting mental health in this occupational group, this study is relevant with regard to the production of scientific evidence about the psychosocial and occupational characteristics in the work of medical professionals and nurses who work in Intensive Care Units and the possible repercussions on the mental health of these workers. The results of this study may support the planning and implementation of actions aimed at promoting and protecting health and quality of life for these workers.

WORK - CONCEPTUAL, HISTORICAL AND SOCIAL DIMENSIONS

Work is understood as an essential human activity. It is a process of interaction between man and nature in which man, with his intentional action, measures, regulates and controls his metabolism with nature. By acting through this movement, man seeks to modify it and, in doing so, modifies his own nature. Thus, intentionality is what differentiates human work from the work performed by other animals. The existence of a conscience, a freedom, not just the motivation for survival[17].

In this sense, the intentionality of the work performed by man permeates the need to delineate strategies, aimed at achieving certain objectives. This process of interaction between man and nature provides modification in both, in addition to being the space in which the human being also undertakes a psychic function, linked to the processes that involve: recognition, construction of professional identity, personal and professional gratification and has a subjective construction referring to each individual. **Thus, work activity** can be evaluated as a form of insertion of the individual in society, considering a series of physical, psychic and social aspects that are related to each other[17–19].

For Marx, human labor has two dimensions; abstract labor and concrete labor. "Abstract labor" or quantitative, expenditure of man's labor power in the physiological sense, and in this quality of abstract human labor, produces commodities. On the other

hand, "concrete" or qualitative labor, with the employment of human labor power in a form specifically suited to a purpose and in this quality of concrete labor produces use value. Thus considered, useful labor, which creates use value, constitutes a stimulus that develops the physical and mental capacities of the human being. Work, in this way, comes to be understood as a source of satisfaction and pleasure. Thus, these dimensions of human work must be thought of inseparably (17).

By appropriating and separating the dimensions of human labor (concrete labor/abstract labor), the capitalist production system removes the meaning of work for the worker, the identity of the producer, who no longer identifies with the product of his work, generating alienation of labor. Therefore, alienation is the dissociation between activity and subject, imposed by the capitalist mode of production. The producer no longer identifies with the product of his labor, he becomes an object, he is objectified. Thus, he begins to identify his activity as strange, not belonging to him. In this sense, when the worker no longer identifies with the product of his work, alienation occurs that dissociates the activity and the subject, transforming the work into a commodity[3,17].

For the performance of human work, which consists of the transformation of one object into another, in a previously calculated (intentional) way, it is necessary to use means or instruments of work. These means or instruments are the tools/equipment that help the worker in transforming the object into a product of his work[3].

Thus, for the work to happen, it requires that it be organized, with the planning of the tasks that need to be fulfilled, hierarchized and controlled. It is important to emphasize that in this process, human relationships are regulated and fragmented, which can interfere with people's mental functioning. Thus, the organization of work is divided into two dimensions, one technical and the other social (3,20).

It is understood, then, that in the capitalist mode of production, labor power is bought and sold, it is bought by the capitalist and sold by the worker who, in an alienated way, without perception, converts the purpose of his work into a commodity (17,18).

In this sense, the salaried worker emerges who is born subordinated to the production project elaborated by capital and, thus, constitutes a regime of exploitation that is elaborated and controlled by capital and executed by the worker, with a defined workload, remuneration with temporal periodicity (daily, weekly, monthly, etc.), environment and working conditions determined by capital (17,21).

In view of these considerations, it is understood that the capitalist mode of production is closely associated with the human labor process, requiring the worker to be trained and specialized in carrying out the activities, combined with occasionally inappropriate working

conditions, exhausting working hours, sometimes unattainable goals set to be achieved, disputes among colleagues and circumstances that are linked to exhaustion; leading to physical and mental illness of the worker20.

CONCEPTIONS OF WORK IN HEALTH

In Brazil, the first reflections on the health work process were made by Cecília Donangelo, at a time of technological changes and alterations in the logic of the functioning of health services[21].

Thus, the object of health work is the human being in his/her dimension, individual, the person in his/her biopsychosocial aspects or collectivities of human beings (population groups). Health workers act on people or groups of people, performing prevention, cure, and rehabilitation actions[3,7].

In view of this, the workforce detached by several professionals consolidates health work as essential for the maintenance of human life. This force is performed through a series of individual and collective activities that involve the technical and social division of this work[32].

Health work has some specificities when compared to other human work, as it encompasses not only technique, but also subjectivity and creativity, which are associated with interpersonal relationships and require negotiation. The same assignment performed by different workers causes the mobilization of different knowledge and histories, thus constituting unique and distinct work situations[24].

Studies by Franco and Merry on health work use essential elements for its development, including: the instruments used by professionals to carry out their activities, which are hard technologies, the technical-scientific knowledge that constitute soft-hard technologies and, last but not least, the relationship between people, called soft technologies. These components are used according to the need to produce care, with the logic of using these technologies predominating at times; influencing the work process[25].

The organization of health services is based on the logic of capitalism and the imposition of technological innovations, in which health and especially disease become commodities, observing the growing proletarianization of professionals and precariousness of work, thus requiring increased performance and quality with a decrease in income and social recognition[24].

Allied to this, health work is characterized by the use of specific knowledge related to qualification, requiring its fragmentation among several professionals. With this fragmentation, there is the emergence of the technical and social division of labor,

characterized by the specificity of intellectual knowledge and practice, in which the biomedical model makes the physician the main provider of care, being assisted by other professionals of lower hierarchical status[23].

The division of labor is also effected within the same category, as that of physicians and nurses. In this sense, in nursing this division is perpetuated, with the nursing technicians responsible for activities related to direct patient care and the nurse is responsible for the organization, administration and control of administrative activities, configuring power relations[26].

According to Melo, the division of labor in health causes a fragmentation of care, alienation of workers in relation to the absolute composition of the work process, submission/superiority with regard to the profession with a split in the conception and execution of activities, which has repercussions on different values of remuneration for work; in addition to establishing division and struggles within the same category and between categories of health workers[27].

In this scenario, health care was gradually modified by the capitalist production model, which converted it into another commodity and thus objectified the work of health workers. These workers have a demanding routine of daily coping with pain, suffering and death combined with the requirements imposed by the labor market; thus, they became susceptible to the development of stress, which, in turn, can lead to the development of psychological distress[3,28].

Health work was hierarchized and divided into levels of complexity. This work can be developed at the primary, secondary and tertiary care levels, but the hospital unit is an important employer, characterized as a complex environment, due to the insertion of several members of the health team and the multiplicity of functions performed by each of them[29].

The hospital is characterized as an unhealthy environment, in which the professionals who work there are confronted in their routine with situations such as long working hours, exposure to physical, chemical, biological and ergonomic risk factors, in addition to salaries that are often insufficient[30].

Among the hospital environment, the Intensive Care Unit (ICU) is configured as a place intended for the care of people in critical health conditions who require specialized care in a continuous and uninterrupted way. In this sense, it is a space with the use of high technology and specialized human resources for the care of people in serious health conditions[31].

Working in the ICU is characterized as stressful for the multiprofessional team, as it can have relevant repercussions for the health of these workers, due to peculiarities inherent to the sector itself. Several factors make the ICU a naturally stressful place, as it is a closed environment, with demanding routines, a tiring pace of work, daily coexistence with suffering and death, the need for quick decision-making, in addition to the requirement of specific relational skills for interaction with the family members of hospitalized patients, who in this context, are in altered psychic and emotional conditions[6,8].

In this scenario, the articulation between the actions of the different professionals demands interaction between them, making evident a synchronization in the functioning of the work among the components of the multiprofessional team, so it is essential that the work group is connected in search of a common goal, which in the ICU is the patient's recovery[32].

Despite the joint work of the multiprofessional team, the biomedical model is still perpetuated in hospital units, including intensive care; and the doctor is responsible for leading the team. However, there is a complementarity between the functions of the physician and the nurse. In this way, medical work is more directed to understanding the disease and seeking its cure, so it is focused on the clinic, with the performance of the physical examination, evaluation of the complaints presented, signs and symptoms, so that it can build a diagnostic suspicion and a therapeutic plan. In addition, it makes use of technology to use state-of-the-art tests to conclude suspicions/diagnoses[33].

Nursing work, on the other hand, is not different from that of doctors, is also complex and multifaceted, requiring specific knowledge and skills, and involves several activities performed by this professional. These tasks are often developed simultaneously or not, and can be listed as: assisting the patient under their care, managing the environment in which they are responsible, enabling conditions for the performance of their work and that of other health professionals, teaching by training nursing technicians and auxiliaries[2].

Considering the performance of these professionals in intensive care, several studies point to this scenario as an unhealthy place for the mental health of these workers, thus it is necessary to assess these repercussions, as well as the relevance of early identification of these events to guide individual and collective interventions[7,9,12,34–36].

MENTAL HEALTH OF WORKERS IN THE CONTEXT OF INTENSIVE CARE

MINOR PSYCHIC DISORDERS

The hospital environment can lead to mental distress among health workers, which in turn can progress to absenteeism and the development of mental health problems such

as anxiety and depression. It is important to emphasize that the responsibility of care, difficulties in interpersonal relationships with the multidisciplinary team, emotional exhaustion, among other factors, can have repercussions on the mental health of these workers[4].

Studies indicate that professionals who work in the ICU may suffer in their daily lives with chronic stress, professional dissatisfaction, conditions resulting from factors related to the environment, length of the working day, in addition to a high degree of demand regarding their capacities and aptitudes in the context of intensive care. Such aspects can cause the physical and/or mental illness of these workers, among which we can list Minor Psychic Disorders (MPD) and Burnout *Syndrome* (BS)[7,34].

Minor Psychic Disorders (MPD) are manifested by a clinical picture with symptoms of anxiety, depression or somatization, but cannot be considered a mental illness according to the ICD-11 (International Statistical Classification of Diseases and Related Health Problems) or the Diagnostic and Statistical Manual (DSM-V) of the American Psychiatric Society. These changes have a high repercussion in the area of occupational health and have been characterized as an important public health problem[30,37].

These clinical changes, which may be associated with the appearance of variations related to behavior and emotions, interfere not only in the affected people, but also in their family and their entire support network. Symptoms include difficulty concentrating, decision-making, forgetfulness, insomnia, irritability and fatigue, as well as somatic complaints (headache, lack of appetite, tremors, poor digestion, among others), which have a high cost and impact on quality of life and relationships, with implications for daily activities; which can cause absenteeism and evolution to more severe mental disorders[30].

Several epidemiological studies conducted with intensive care workers have demonstrated the existence of a relationship between the development of MPD and the work performed by these workers. These results are associated with excessive workload, chronic stress, psychic and cognitive overload, night work, absence of rest breaks, and lack of control over work[4,12,37].

BURNOUT SYNDROME

Another frequent problem among workers is the Burnout Syndrome (BS), first described in 1974 by psychoanalyst Herbert Freudenberger. This problem is related to unfavorable situations in the work environment and is manifested by three dimensions: emotional exhaustion, depersonalization, and low personal fulfillment[38].

According to the WHO in the International Statistical Classification of Diseases and Related Health Problems in its 11th revision (ICD-11), Burnout Syndrome is the result of chronic work stress that has not been successfully managed and that can lead to feelings of exhaustion or depletion of energy, leading to mental exhaustion and reduced productivity. The WHO also defines work-related diseases as health problems that affect workers after exposure to risk factors resulting from their work activity, which affect their physical and mental health[14].

To measure SB, Maslach and Jackson (1981) developed the *Maslach Burnout Inventory* (MBI), which had its version adapted and validated by Tamayo (1997) in Portuguese. The MBI is composed of 22 questions about feelings and attitudes that encompass the three fundamental dimensions of the syndrome, professional exhaustion is assessed by nine items, depersonalization by five, and personal fulfillment by eight. The 22 questions have a seven-point scale, ranging from 0 to 6, identifying one of the three dimensions independently, each of the dimensions. For emotional exhaustion, a score ≥ 27 indicates a high level; from 17 to 26 moderate level; and ≤ 16, low level. For depersonalization, a score ≥ 13 indicates a high level, from 7 to 12 moderate, and ≤ 6, a low level. The score related to ineffectiveness goes in the opposite direction to the others, since a score from zero to 31 indicates a high level, from 32 to 38 a moderate level, and ≥ 39, a low level[39].

Occupational stress affects about 70% of the Brazilian population and 30% of this contingent suffers from BS, directly harming the work of these people, due to its high prevalence, configuring itself as an important public health problem. In this sense, many studies have been directed to this theme in the health area[40].

Burnout *syndrome* is characterized as a series of physical and psychological symptoms (bad mood, difficulty in individual relationships, absence from work, insomnia, lack of appetite, low productivity, fatigue, myalgia, hair loss, migraine, impact on the digestive, neurological and sexual system). Psychological symptoms are highlighted as lack of concentration, apathy, memory deficit, low self-esteem and aggressiveness. The Burnout situation also implies a greater probability of absenteeism by the affected professionals. Thus, it has been configured as an important public health problem, as it has a direct impact on health workers and patients cared for by these professionals[15].

From this perspective, the intensive care setting, due to its physical characteristics, work pace, need for rapid decision-making, and severity of the patients' clinical condition, has been listed as a favorable place for its development. In addition, the professionals who work in this unit live with constant emotional changes[41].

The ICU's multidisciplinary team is composed of doctors, nurses, nursing technicians, physiotherapists, psychologists, and nutritionists. In this sense, the health professionals who are at greater risk of developing BS are physicians and nurses; due to the similarity of responsibilities and functions within the sector[15,41].

Studies show that the worsening of symptoms of mental illness, including BS, has increased in the face of the COVID-19 pandemic. The exhaustion presented by these professionals was associated with a new context of uncertainties, deaths, fear, among other factors[39,41,42].

Also in relation to the worsening of mental illness situations among health professionals in the context of COVID 19, Brazil revealed that the pandemic favored the mental illness of those who worked in direct care for infected patients. According to the survey carried out by Fiocruz, the main alterations reported in the daily lives of health professionals were sleep disturbance (15.8%), irritability/crying, frequent/disturbances in general (13.6%), inability to relax/stress (11.7%), difficulty concentrating and slow thinking (9.2%), loss of satisfaction in career or life/sadness/apathy (9.1%), negative feeling of the future/negative thinking, suicidal (8.3%) and change in appetite/change in weight (8.1%)[43].

In addition, it is relevant to mention that cases of mental illness in workers and their leave are often underreported, but studies point to the severity and urgency of investing in actions that contemplate these workers is paramount[44].

Thus, studies are needed to estimate the occurrence, investigate the factors associated with these diseases; in addition to enabling strategies to minimize the repercussions of these events on mental health among workers who work in Intensive Care Units.

FINAL CONSIDERATIONS

This study contributes as a theoretical contribution to health researchers, broadening their view of the theoretical, historical and social dimensions related to work, how work happens in the health dimension and what is its impact on the mental health of health workers, particularly in the ICU.

Thus, it is relevant to mention that the theoretical contributions presented here may support the planning and implementation of actions aimed at promoting and protecting health and quality of life for these workers.

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