MENTAL DISORDERS AND LIFE SKILLS IN ADMINISTRATIVE HEALTH PROFESSIONALS

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ABSTRACT

Introduction: Work is an important aspect in the construction of people's identity and therefore it is essential to understand its influence on mental health. Studies have pointed out the relationship between the development of life skills and mental health in health workers, and the deficit in these skills can contribute to the development of anxious symptoms, depression, stress and Burnout syndrome. **Objectives:** To evaluate the presence of symptoms of anxiety, depression, stress at work and urinary in health professionals, correlating these data with the development of life skills. **Method:** Collaborators in the health area of a medical specialties outpatient clinic were invited, 20 professionals enrolled and agreed to participate in the research. For data collection, the following were used: Sociodemographic questionnaire and health/disease conditions; Life Skills Scale (EHV); Hospital Anxiety and Depression Scale (HAD); Short version of the "Job Stress Scale" (JSS) and Burnout Characterization Scale (ECB). Descriptive, comparative and correlation statistical analysis of the variables investigated was performed. **Results:** The sample evaluated showed deficient levels in life skills (75%), as well as symptoms of anxiety (80%), depression (45%) and stress (45%). Such positive findings occurred more frequently in individuals with low life skills. 30% of the participants scored on the dimensions of Burnout. **Conclusion:** The high prevalence of mental illness among health workers is consistent with data in the literature. Although no statistical significance was found, most participants with low life skills have symptoms of anxiety and depression, highlighting the importance of conducting more studies to invest in life skills training.

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INTRODUCTION

WORKER'S MENTAL HEALTH AND LIFE SKILLS

Work has undergone several changes in its meaning throughout the history of humanity and, currently, gives rise to the possibility of recognition, social insertion, maintenance of daily needs, among others (SILVA and TABALDI, 2018). Through work, people achieve an income and maintain their basic needs, such as food, health, etc. In addition to being a means of survival, the work function can be considered as a personal identity, since in its construction it involves personal and social aspects, through learning, routine and interpersonal contact. According to Sousa and Silva (2019), work is a means by which the person socializes and, in the process of constructing their identity, manages to give meaning to what they learn and teach.

A worker is an individual who performs a formal or informal activity, to support himself and his family. In order to achieve good work performance, physical and mental health is an essential prerequisite. The term health can be defined as a biopsychosocial and affective well-being, in which people have the right to housing, work, wages, water, food, education and other conditions necessary to ensure health (CNS - NATIONAL HEALTH COUNCIL, 2019). In order to improve the health of workers, the National Policy on Workers' Health was instituted in 2012, in Ordinance No. 1,823. This policy was instituted based on the principles and guidelines of the Unified Health System (SUS). Workers have the right to quality health in their workplace, and it is the duty of organizations, within the factors that are under their control, to develop an environment that allows employees to have their health preserved (MINISTRY OF HEALTH, 2012).

As brought by the CNS, health also encompasses psychological well-being. Mental health influences the way a person thinks, feels, and interacts with the world, the ability to make decisions, build relationships, deal with emotions, among others (WHO, 2022). It is an aspect developed under the influence of several factors, including environmental, biological, social, religious and others. The update of NR-1 (Regulatory Standard 1) that will come into force in May 2026, provides for the identification and evaluation of psychosocial risk factors, in addition to the appropriate management of these risks in the workplace (MINISTRY OF LABOR, 2025). This measure highlights the importance of mental health in the workplace and the need to develop strategies to improve the mental health of employees.

According to Olmos, Nosralla, Grela and Fernandes (2025), stress is an adaptive syndrome that occurs as a result of the breakdown of the individual's internal homeostasis. Zanovello (2012) understands stress as the sum of physical and mental responses caused by specific external stimuli, which enable the individual to face certain conditions of the

environment and the physical and mental exhaustion caused by this process. Workers, regardless of hierarchical level and profession, can be exposed to various occupational stressors that, when not managed, can contribute to illness.

Several authors have shown that health professionals have higher rates of mental illness compared to the general population (TRIGO, TENG & HALLAK, 2007; MARTINS et al, 2009; FERNANDES, SOARES & SILVA, 2018; CARVALHO, ARAÚJO & BERNARDES, 2016). According to Fernandes, Soares and Silva (2018), there are many factors that can contribute to the mental illness of health workers, such as: overload and excessive working hours, compromised sleep and wakefulness patterns, low salaries, more than one contract and work processes, in addition to dealing with suffering and illness of patients. Despite being in a space of care for others, these professionals often neglect their own health. Among health workers, the main psychic symptoms and mental disorders associated with occupational stress are: sleep disorders, use and abuse of psychoactive substances, burnout, anxiety and depression. (RIBEIRO et al, 2018; OLMOS, NOSRALLA, GRELA and FERNANDES, 2025).

Burnout Syndrome is an exclusively occupational phenomenon that affects not only the individual, but also the quality of care offered. There are several discussions in the literature about the validity of this diagnosis, in addition to very different prevalence rates due to the conceptual and methodological heterogeneity of the studies (OLMOS, NOSRALLA, GRELA and FERNANDES, 2025). The most accepted characterization defines the presence of three dimensions: emotional exhaustion, depersonalization, and reduced professional fulfillment (OLMOS, NOSRALLA, GRELA, and FERNANDES, 2025). Several other psychic symptoms can accompany this diagnosis and impact professional performance, job satisfaction, patient safety, and quality of life (OLMOS, NOSRALLA, GRELA and FERNANDES, 2025; PÊGO and PÊGO, 2016; TAUBE, CARLOTTO & CÂMARA, 2024).

Anxiety is characterized by fear and apprehension followed by discomfort or tension from the anticipation of danger or unknown situations, which is part of human experiences, but when manifested in intensity disproportionate to the present or non-existent stimulus, it can indicate symptoms of a mental disorder (SCHMIDT, DANTAS and MARZIALE, 2011). According to Kohl (2025), pathological anxiety is characterized by an exacerbated response to a common stimulus, with an impact on the individual's global functioning. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), 5th revised edition, the different types of anxiety disorders that share characteristics of fear, excessive anxiety, and behavioral disturbances are described (KOHL, 2025; APA, 2023). Several symptoms can be associated such as sweating, tremor, shortness of breath, changes in concentration, insomnia, irritability, restlessness, avoidance, among others (APA, 2023).

Major depressive disorder is a prevalent condition in the general population, being the 10th disease with the most sick leaves according to Social Security data (OLMOS, NOSRALLA, GRELA and FERNANDES, 2025). The main symptoms are sadness and anhedonia, as well as symptoms of fatigue, sleep and appetite changes, guilt, concentration difficulties, and thoughts of death (APA, 2023).

Among the factors associated with mental illness in the context of health workers, some studies have been relating psychological distress with deficits in life skills. Life skills, according to the World Health Organization, can be defined as skills necessary for the person to be able to develop an adaptive and positive behavior that helps to face the challenges and demands of daily life. Life skills are listed in ten domains: Decision Making, Problem Solving, Creative Thinking, Critical Thinking, Effective Communication, Interpersonal Relationships, Self-Knowledge, Empathy, Dealing with Emotions, and Dealing with Stress (WHO, 1997). These are important skills for social, personal and work context, since the individual having these well-developed capabilities can better deal with daily challenges and contribute to a healthier work environment, which benefits both employees and organizations.

Resende et al (2022), in a study carried out at the Mental Health Care Service of Employees of the Faculty of Medicine of São José do Rio Preto/Fundação Faculdade Regional de Medicina de São José do Rio Preto (FAMERP/FUNFARME), demonstrated that the dimension of dissatisfaction with work in the Burnout construct, anxiety, and depression were inversely correlated with satisfactory levels of life ability. In addition, a significant score for the sphere of emotional exhaustion of Burnout was associated with deficient performance in the dimensions of "critical thinking" and "dealing with emotions" in an instrument to assess life skills. A study by Dionísio-Lucânia (2021) demonstrated that there are important impacts related to interventions carried out with life skills training in health professionals, such as a reduction in symptoms of mental disorders and good development in life skills domains. Thus, developing life skills with health employees can be a beneficial strategy to improve quality of life, physical and mental health, to increase productivity, reduce medical costs and improve the care offered to patients.

In view of the above, the present study aimed to characterize the clinical and sociodemographic profile of employees in the administrative area of a health service; assess the presence of symptoms of anxiety and depression, stress at work and burnout; measure life skills and correlate these skills with the presence of symptoms of anxiety, depression, and burnout.

METHODOLOGY

STUDY DESIGN AND LOCATION

This is an observational, cross-sectional research, with a survey and correlation of variables based on quantitative analyses. Data collection was carried out in a high-complexity hospital in the interior of the state of São Paulo, Brazil.

PARTICIPANTS

Employees from the administrative area of health of an outpatient clinic of medical specialties, men and women, aged between 18 and 60 years, were invited. For this research, 20 vacancies were made available and the professionals who signed up and accepted to participate in the research were drawn to compose two groups.

INCLUSION AND EXCLUSION CRITERIA

Inclusion criteria: Be a collaborator in the administrative area of health who worked in the outpatient clinic of medical specialties.

Exclusion criteria: Employees who had a health condition that made it impossible to respond to the evaluation instruments were excluded.

INSTRUMENTS

For data collection, a questionnaire with sociodemographic questions and health/disease conditions, prepared by the researchers (Appendix 1), was used. Self-applicable and easy-to-understand instruments were also used, which are listed below:

Life Skills Scale (EHV): Scale to assess Life Skill (EHV) (DIONÍSIO-LUCÂNIA, 2015). The scale has 10 questions that aim to assess self-knowledge, interpersonal relationships, empathy, ability to deal with feelings, ability to deal with stress, effective communication, critical thinking, creative thinking, decision-making and problem solving. The response scale is of the *Likert type,* of five points, ranging from 1 (never presents the ability) to 5 (always presents the ability). If the answer is from 1 (never) to 3 (sometimes) it is indicative of not having a good development of the skill evaluated. If the answer is 4 (almost always) or 5 (always) it is indicative of having a good development of the observed life skill. The maximum score of the instrument is 50 and the minimum is 10 points. The closer to 50 points, the greater the presence of HV demonstrated by the individual.

Hospital Anxiety and Depression Scale (HAD): composed of 14 items arranged in two subscales, to assess the probability of anxiety and depression. Each of the subdivisions can be indicated from zero to three points with a maximum score of 21 points for each

subscale. The cut-off values are: 0-7 unlikely to have anxiety or depression (in the respective subscales), 8-11 points are correlated with possible anxiety or depression, 12-21 points are correlated with anxiety or depression. The higher the score, the more likely you are to develop an anxiety disorder and/or depression.

Short version of the *Job Stress Scale* (JSS): it is the short version of the Karasek questionnaire that was translated and validated by Alves et al. (2004) It consists of seventeen questions, five of which refer to psychological demands at work, six to the degree of control exercised by the worker over his activity and six to the support mechanisms existing at work (ZANOVELLO, 2012). The scale is divided into three dimensions: Psychological Demand, Control and Social Support, and the "Control" dimension is separated between Intellectual Discernment and Authority over decisions. The total score of the scale ranges from 17 to 68 points, with the average score being 42.5 (Zanovello, 2012). The Psychological Demand count varies between five and twenty points, with twelve and a half being the average. In Intellectual Discernment, the range is from four to sixteen points, and the average score is ten points. The score of the Authority on Decisions dimension varies between two and eight, with an average of five points. And, in Social Support, the score varies from six to twenty-four, with an average of fifteen.

Burnout Characterization Scale (ECB) (Appendix 3): is an instrument composed of 35 statements about feelings and attitudes towards work that encompass the three dimensions of Burnout Syndrome: emotional exhaustion, dehumanization and disappointment at work. Each sentence should be evaluated based on a Likert scale ranging from 1 (never) to 5 (always) (SOUZA, 2011). The assessment of the ECB is based on the answers presented in relation to the dimensions that make up the Burnout Syndrome, and scores higher than P66 in the three dimensions strongly suggest the presence of Burnout (SOUZA, 2011).

ETHICAL ASPECTS

Data were collected after approval by the Human Research Ethics Committee of the São José do Rio Preto School of Medicine/FAMERP (Opinion No. 6,389,420). The participants who accepted signed the Consent Register, as provided for in Resolution No. 510/2016 of the National Health Council, being aware of the risks and benefits of the research, the non-identification, the freedom to withdraw at any time and the confidential nature of the data collected.

PROCEDURES

After approval of the research by the Research Ethics Committee, health employees of the medical specialties outpatient clinic were invited to participate in the research, based on the dissemination of posters attached to the time cards and pantry with information about the research and with the help of supervisors who sent the invitation to their employees through groups on whatsapp and skype applications. The participants who accepted were randomly assigned to compose two groups, each with ten participants, one intervention (A) and one control (B) to participate in a future life skills training.

A meeting was held to present the mental health themes and explain each life skill, the risks, benefits and objectives of the work. After this presentation, the collaborators who agreed to participate received the Consent Record in two copies to sign, one for the participant and the other for the researcher. The Consent Record was kept separate from the evaluation protocol to ensure confidentiality. Then they answered a form with the evaluation instruments. The application of the form was collective and the participants answered individually based on the instructions of the researchers. First, they accepted the Consent Register and then answered the instruments.

DATA ANALYSIS

After data collection, they were spreadsheetd in Excel for descriptive statistical analysis, which was performed from the calculations of the measures of central tendency and dispersion and frequency counts. Correlation analyses were performed using Pearson's correlation test. The correlation coefficients (r) were classified as follows: r = 0.10 to 0.30 (weak); r = 0.40 to 0.60 (moderate); r = 0.70 to 1 (strong).

For all analyses, P value ≤ 0.05 was considered statistically significant. The programs used were *Statistical Package For Social Sciences* (SPSS, IBM, version 24.0), GraphPad Instat 3.10 (2009) and Prisma 6.07 (2015).

RESULTS

The study sample was composed of 20 employees from the administrative sector and general services of the General Outpatient Clinic and Medical Specialties. Table 1 shows the sociodemographic data of the sample.

Table 1. Sociodemographic data

Variables	N - 20	%
Gender		
Male	1	5
Female	19	95

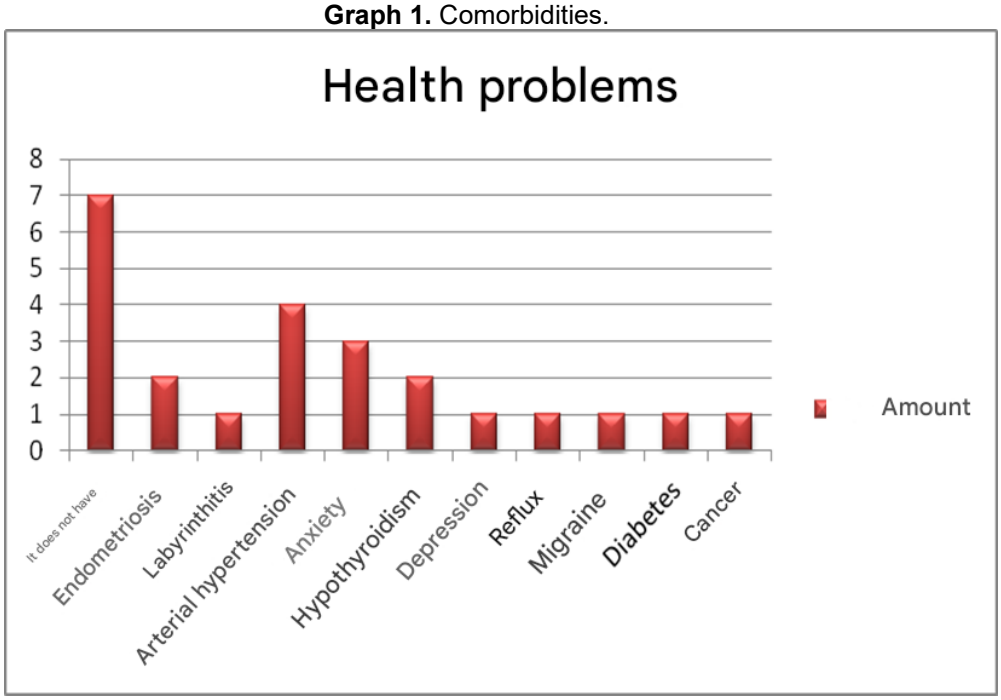
Age		
18-30	8	40
31-40	4	20
41-60	8	40
Profession		
Administrative Assistant	14	70
Administrative Assistant	1	5
Administrative Secretary	1	5
Nursing assistant at work	1	5
Cleaning Assistant	2	10
Doorman	1	5
Marital status		
Married	6	30
Divorced	1	5
Single	11	55
Stable Union	1	5
Widower	1	5
Religion		
Catholic	13	65
Christian	3	15
Evangelical	3	15
No religion	1	5
Schooling		
Complete high school	10	50
Studying Higher Education	3	15
Complete Higher Education	7	35

***N = Number of participants**

The family income of the participants ranged from one to eight minimum wages, the average income represented four and a half minimum wages, and most of the participants declared family income between three and six minimum wages.

Graph 1 presents the data regarding clinical comorbidities reported by the participants. Some participants are treated for more than one comorbidity, so the percentage was analyzed according to the number of responses for each situation declared.

Graph 1. Comorbidities.



The entire selected sample denied using illicit psychoactive substances (n=20). Most of the sample denied smoking (n=19). Regarding the use of alcoholic beverages, 60% (n=12) reported consumption sometimes, 30% (n=6) denied consumption and 10% (n=2) reported frequent consumption of alcoholic beverages. Regarding physical activities, 55% (n=11) denied practicing the activities, 35% (n=7) stated that they do physical activities and 10% (n=2) reported that they sometimes practice the activities. Regarding leisure, 60% (n=12) of the sample stated that they have moments of leisure and 40% (n=8) report that they have these moments sometimes.

With regard to sleep hours, 40% (n=8) of the participants stated that they slept about seven hours per night, 35% (n=7) six hours, 10% (n=2) five hours, another 10% (n=2) eight hours, and 5% (n=1) four hours of sleep per night. Regarding healthy eating, 40% (n=8) stated that they eat healthily frequently, 5% (n=1) denied, and 55% (n=11) stated that they sometimes eat healthy.

LIFE SKILLS SCALE (EHV)

The Life Skills Scale was used in order to identify the level of each life skill, perceived by the participants, There are 10 life skills described by the World Health Organization (WHO, 1997), as already described, the closer to "50 points" the greater the presence of life skills. It was observed that 75% (n=15) of the participants scored below 40 points, implying that there is little applicability of each life skill in their daily lives. It is then considered that 75% of the sample has low life skills.

HOSPITAL ANXIETY AND DEPRESSION SCALE (HAD)

The scores obtained by the participants indicated that most of the participants (80%, n=16) had possible or probable anxiety, while the symptoms of depression have lower indications (45%, n= 9) for a possible disorder.

JOB STRESS SCALE (JSS) - SHORT VERSION

The evaluation of the scale occurs based on the association between the dimensions. If the individual has low psychological demand, low control and low social support, he can be considered a passive worker, with no stimulation of the development of new skills, which can be harmful to the worker's mental health. If it is an individual with high psychological demand, with low control and low social support, there is also a potential for exhaustion in the worker, culminating in occupational stress for having to perform their activities without having organizational autonomy and without social support.

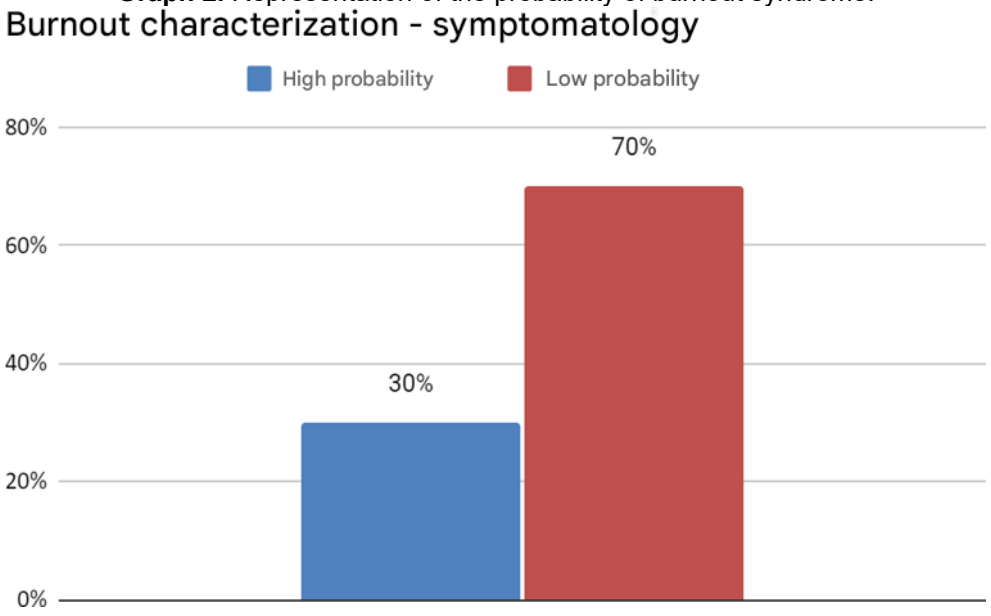
If the individual has high psychological demand, with high control and high social support, we can say that the subject is in an active job, where he can use his skills, have autonomy to organize himself and perform the necessary activities (ZANOVELLO, 2012), which is the ideal scenario for work fulfillment.

In the present evaluation, it was identified that most of the participants (55% (n = 11) had a low level of stress. It should be noted that 25% (n = 5) had a medium level and 20% (n = 4) had a high level of stress.

BURNOUT CHARACTERIZATION SCALE (BCB)

In the data analysis, it was possible to perceive that 30% (n = 6) of the selected sample had a high probability of Burnout Syndrome, while the other 70% (n = 14) had a low probability (Graph 2).

Graph 2. Representation of the probability of burnout syndrome.



CORRELATION BETWEEN EHV AND OTHER VARIABLES

Table 2 presents the data regarding the correlation between Life Skills and the other variables. No statistical significance was found between the variables.

Table 2. Correlation between life skills, sociodemographic data, ECB, HAD and JSS.

Correlations	"r" (Pearson)	R squared	P (two-tailed)	Significant (alpha = 0.05)
EHV vs. EHV Identification form				
Age	-0,3397	0,1154	0,1428	In
Hours of sleep	-0,09944	0,009889	0,6766	In
Offspring	-0,2523	0,06367	0,2832	In
Household income	0,1522	0,02316	0,5339	In
Time in the company	0,07637	0,005833	0,7489	In
Schooling	-0,1354	0,01834	0,5691	In
EHV vs. ECB				
Exhaustion	-0,3067	0,09409	0,1884	In
Dehumanization	-0,4037	0,1629	0,0776	In
Disappointment at work	-0,3716	0,1381	0,1067	In
EHV vs. HAD				
Depression	-0,1522	0,02317	0,5218	In
Anxiety	-0,03023	0,000914	0,8993	In
EHV vs. JSS				
Psychological Demand	-0,07849	0,00616	0,7422	In
Control	-0,104	0,01083	0,6624	In
Social support at work	0,2142	0,04588	0,3645	In

DISCUSSION

Considering the demographic profile, although the invitation to participate is open to all employees of the outpatient clinic, enrollment was mostly made by female individuals. This data may be related to the fact that women seek mental health information and support more frequently. (JUNIOR, PAULA AND ZAMPIERI, 2021; RISCZIK, 2019; OLIVEIRA, LUCENA-SANTOS AND BORTOLON, 2013). In addition, several studies highlight the higher prevalence of common mental disorders in women, despite biases such as greater ease of symptom identification, stigma and resistance to seeking help (SANTOS AND SIQUEIRA, 2010). Filho et al (2023), in a study carried out based on data available at the Department of Informatics of the Unified Health System (DATASUS) identified that cases of work-related mental disorders are prevalent in women, with a higher prevalence in people between 30 and 49 years old. Thus, the majority of women seeking to participate in the study is consistent with the descriptions in the literature.

It was possible to observe the presence of symptoms of mental disorders, especially anxiety, in 80% of the sample, data that are in line with the literature. In Brazil, data from the Ministry of Social Security and Social Assistance (MPS) show a high incidence of mental illness in the working-age population, representing the third leading cause of absence from work in the country (SOUZA AND BERNARDO, 2019). Ribeiro et al (2019) found a high prevalence of anxiety disorders as a cause of sick leave and the high demand for high costs with sick pay. In a study carried out by Resende et al (2022), in the outpatient clinic responsible for the psychiatric care of employees of this same institution in the early months of the pandemic, 44.9% of respondents had a confirmed diagnosis of anxiety disorders.

It is worth mentioning that lifestyle habits also influence psychic symptoms. In the sample, it was observed that alcohol consumption, sedentary lifestyle and unhealthy eating, along with few hours of sleep, were all predisposing factors for mental illness. Some studies have already highlighted the protective effect of physical activity on the occurrence of mental disorders (DILÉLIO et al, 2012). Sampaio, Oliveira, and Pires (2020) investigated empathy, depression, anxiety, and stress in health professionals, identifying that lifestyle, when unhealthy, is a predisposing factor for the development of mental disorders.

Regarding the ECB assessment, although 30% of the sample had suggestive symptoms, it is important to emphasize that 80% of the sample had possible or probable symptoms of anxiety and 45% had possible or probable symptoms of depression. For the diagnosis of Burnout to be established, it is essential that the psychological suffering is due exclusively to occupational stress and that the diagnoses of anxiety or depressive disorders

are excluded (WHO, 2019). Thus, more detailed studies are needed to assess the presence of Burnout Syndrome in this sample of employees.

Occupational stress levels were not high, with more than 50% of the sample exposed to low levels of stress. Despite this, 20% of the sample reported a high level of stress according to JSS results. This is an important piece of data, since chronic and unmanaged occupational stress contributes to mental illness. Marcelino and Araújo (2015), in a study carried out with professionals from medical specialty centers, found a significant prevalence of occupational stress and common mental disorders among these employees. High demand and low control over work were positively associated with the presence of common mental disorders in health workers, with a difference between genders, with a greater impact among women (Campos et al, 2020). Araújo, Graça and Araújo (2003) highlight that aspects related to the psychological demand of work are more strongly associated with high prevalence of minor psychic disorders than aspects related to control. It is also noteworthy that mental disorders have a multifactorial cause, with the influence of structural work issues and organizational climate (SCHUTZ et al, 2023). These data reinforce the importance of a better understanding of the stress to which these employees are subjected at work and intervention strategies.

In the descriptive analysis of the results, deficit in life skills was prevalent. Participants with less presence of life skills in daily life had greater symptoms of anxiety, data that corroborate the research carried out by Carvalho (2018). These results are also in line with the research carried out by Dionísio-Lucânia (2015) which, in addition to indicating impairments in mental health, indicated a correlation between low life skills and depression, anxiety and stress, and it can be reflected that a lower level of life skills can increase the presence of symptoms of mental disorders in health workers.

Although the statistical analysis carried out did not find statistical significance between the correlations that the study aimed to discuss, the data discussed so far highlight the presence of mental health impairments in individuals who had low life skills. According to Rodrigues (2021), the higher a person's level of self-knowledge, the greater their ability to analyze the issues that affect their health and consequently they can have a better development in the skills to deal with these factors in order to maintain quality health. According to the study by Dionísio-Lucânia (2021), the improvement of life skills brought satisfactory results, preventing negative behaviors and promoting mental health. Life skills training allows the individual to better deal with everyday situations, increasing self-efficacy, favoring their self-esteem and well-being.

Further research evaluating the relationship between these variables is essential to understand in more detail the role of life skills in the prevention of mental illness and to structure interventions for the training of these skills in the entire work environment.

An important aspect to be considered in this research is that the scale used to assess life skills has not yet been validated, but no other possible instruments were found for this objective that match the profile of the selected sample. This factor may have influenced the results obtained in this study. Validation studies of this scale are essential to understand whether life skills are captured accurately and reliably with this instrument. In addition, the sample size may have impacted the correlation between the variables. Another important aspect is that the selected sample was mostly employees from the administrative scope of the institution, and it is interesting that other studies evaluate employees from different positions and professions within the institution.

CONCLUSION

Mental illness in health workers is a reality and causes damage both to the individual and to the care offered and also to the organizations. In the selected sample, a high prevalence of symptoms suggestive of mental disorders, especially anxiety, was observed. Although it was not the majority, medium or high occupational stress was reported by 45% of the sample. The deficit in life skills was found in 75% of the sample studied. There was no statistical significance in the correlation between the variables, which may be related to the sample size and the instruments used. Life skills training can have an important impact on improving quality of life, work performance, and the prevention of mental disorders.

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