LUMEN ET VIRTUS

Evaluation of the mental health conditions of workers of the family health strategy in the municipality of Campina Grande – PB

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ABSTRACT

Mental disorders are considered a serious public health problem, so that, according to the Pan American Health Organization (PAHO), one billion people in the world have some type of mental disorder. Approximately 15% of workers suffer from some type of mental disorder, which is one of the main causes of years lived with disability and absence from work. The objectives of this study were: to investigate the mental health conditions of workers of the Family Health Strategy (FHS) in Campina Grande – PB and to identify the prevalence of Common Mental Disorders (CMD) among workers. This is an observational, descriptive, quantitative, cross-sectional research, carried out with FHS workers from the Medical Residency Program in the Municipality of Campina Grande – PB, between October 2023 and January 2024. The structured tools "Sociodemographic Questionnaire", "Occupational Questionnaire" and "Self Report Questionnaire" (SQR-20) were used. The mean age of the participants was 41.5 ± 11.3 years, most of them Community Health Agents, female, married, with up to two children and per capita income greater than 2 minimum wages. The overall prevalence of CMD was 43.5%, being present in all professional categories, and more frequent among social workers (100%), but without statistical differences. The study identified that professionals have a high prevalence of psychic disorders, especially female professionals.

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INTRODUCTION

Mental disorders are considered a serious public health problem, so that, according to the Pan American Health Organization (PAHO), one billion people in the world have some type of mental disorder, in addition, about 15% of workers suffer from some type of mental disorder, with anxiety and depression being the most prevalent (PAHO, 2022; WHO, 2003).

In view of the high incidence of mental disorders in workers, the WHO, together with the International Labor Organization (ILO), published, in 2022, a practical guideline with specific measures aimed at protecting the mental health of workers. This document includes measures for prevention, promotion, protection and support of mental health, through key interventions, such as: remodeling of work environments to minimize psychosocial risks; training of managers in mental health and ensuring that work can adapt to the physical and mental capacities of workers (WHO, ILO, 2022).

Although they do not constitute a nosological entity per se, CMDs negatively influence workers' health, causing psychological distress and potential social and economic impacts, so that they are responsible for a high portion of absenteeism at work, a drop in productivity, and a high demand for health services (Parreira et al., 2017).

Nevertheless, few studies are dedicated to research on the mental health of Primary Health Care (PHC) workers. This study aims to identify the profile of the mental health of PHC professionals in the basic health units (UBS), where the residents of Family and Community Medicine (FCM) work, of the Medical Residency Program of the Municipal Health Department in Campina Grande – PB, as well as the social, demographic and occupational characteristics, so that we can correlate which socio-occupational and demographic variables predispose to mental illness.

The workers of the Family Health Strategy (FHS) are in daily contact with the realities of the communities in which they are inserted in their work context, being continuously exposed to conditions of intense care demands, many of them of high complexity, added to the pressure for the resolution of the situations presented, even in the face of scarcity of resources, which limits the capacity of the health teams to act in the territory. The sum of these factors can precipitate the mental illness of workers, especially in those who do not develop strategies to cope with conflict situations in the workplace.

Knowing the prevalence of mental illness among workers, as well as the most vulnerable groups of workers, allows us to foster planning to outline specific measures to promote and protect mental health, rescuing workers' productivity and minimizing the socioeconomic impacts that their illness represents.

THEORETICAL FOUNDATION

THE FAMILY HEALTH STRATEGY

The Family Health Program (FHP) – now called the Family Health Strategy (FHS) – launched by the Federal Government in 1994, aimed at the reorganization of Primary Health Care in the country, through measures that, in line with social movements and health conferences, seek to ensure universal and comprehensive access to health, following the precepts and guidelines of the Unified Health System (SUS) (Brazil, 2000).

Thus, the Basic Health Units (UBS) were created, which constitute the users' first contact with the health system. The UBS are structured by multiprofessional teams – the family health teams – compulsorily composed of a physician (preferably a specialist in family health), a nurse (preferably a specialist in family health), a nursing technician and a Community Health Agent, which may be added to oral health professionals: dentist and oral health assistant (Brasil, 2012).

Family health teams work with a defined number of people, the enrolled population, in a geographically limited area – the territory. Through promotion, prevention, recovery and rehabilitation actions, they ensure comprehensive health care for citizens in their different life cycles (Brasil, 2012).

Thus, after the implementation of the ESF, there was a significant improvement in the health indicators of our country. Among these, the following stand out: the reduction in hospital admissions for ambulatory care-sensitive conditions (ACSC), reduction in infant mortality, expansion of vaccination coverage, and reduction in mortality from infectious and parasitic diseases (DIPs), thus highlighting the importance of primary care and the ESF program for the Brazilian health system (Gusso et al., 2019; Pinto et al., 2018; Ribeiro et al., 2020).

This study was carried out in Campina Grande, where the UBS are the main scenarios in the territories where the 30 residents of the Family and Community Medicine Medical Residency Program promoted by the Municipal Health Department work, together with the health teams and preceptors.

PSYCHIC DISORDERS IN FHS WORKERS

PHC is characterized by low technological density, where less equipment and technologies are used, but it deals with complex problems. Since health and illness are multifactorial phenomena resulting from the interaction of factors that are not purely biological, but influenced by social, psychic, affective, cultural, environmental and spiritual determinants (CONASS, 2007).

The work process in PHC requires that the professionals working in it be highly specialized, capable of applying their structured knowledge to solve the most frequent and relevant problems in their territory, understanding illness as a complex and multifaceted phenomenon. Thus, it is the

responsibility of the FHS worker to use soft technologies as a way to ensure the bond and longitudinality of care (Coelho et al., 2009; Guimarães et al., 2019).

According to Carreiro (2013), FHS workers should be responsible "for evaluating the health indicators in their area, recognizing the reality of the families under their responsibility, identifying and developing strategies to cope with the most common health problems and developing educational actions", complex actions that demand a great expenditure of energy and time, and when insufficient, they awaken the feeling of powerlessness and favor the psychic illness of these professionals.

Work in PHC takes place in a work structure that is still fragile in several aspects, it is perceived that issues related to precarious work, low pay, overload of activities, risk of contamination by biological materials and risk to physical integrity may be associated with an increased risk of developing psychic disorders (Barbosa, 2012; Carreiro, 2013).

In addition to the care routine of professionals, other factors are added, such as: lack of professional recognition, overload due to the demand for productivity/problem-solving, scarcity of physical resources and basic supplies, insertion in unhealthy environments and dangerous communities with great social inequalities, and these together can also predispose to the professional's mental illness (Carreiro et al., 2013; Moreira et al., 2016).

Recent studies have shown that FHS professionals have varied and often underestimated levels of psychological distress. Such suffering is expressed in different ways, with Common Mental Disorders being the most observed – nonspecific symptoms such as discouragement, anguish, nervousness and irritability.

At different times, the authors Goldberg et al., 1994; Guirado et al., 2016; Parreira et al., 2017, highlight Common Mental Disorders (CMD), characterized as a set of nonspecific signs and symptoms, such as irritability, fatigue, insomnia, difficulty concentrating and memorizing, which are a complex mixture of psychic and somatic symptoms that are quite prevalent in our population of workers, and can also affect health professionals.

Although nonspecific and non-pathological symptoms, but which generate psychological distress, are the most common, some studies indicate that severe psychological disorders such as Burnout syndrome, characterized by physical and emotional exhaustion, may also be present in FHS workers (Lima et al., 2017; Trindade et al., 2010).

METHODOLOGY

This is a descriptive observational study, with a quantitative and cross-sectional approach, carried out with workers of the Family Health Strategy in the city of Campina Grande – PB, where the Family and Community Medical Residency Program (PRMFC) is working.

The Self-Reporting Questionnaire (SQR-20), originally developed by Harding et al. (1980) and already validated in Brazil by Mari and Williams (1986), was used as an instrument for data collection. Secondarily, data related to age group, age, gender, education, marital status, professional category, length of service, workload, and family income were collected using a questionnaire prepared by the author.

The choice of the SQR-20, created by the World Health Organization (WHO), as a data collection tool was due to the fact that it is an instrument frequently used to assess the presence of common mental disorders in specific populations, such as workers. In addition, this questionnaire has already been translated, tested and validated in the Brazilian population (Santos et al., 2010).

In addition, they corroborate the fact that this is a self-administered questionnaire, composed of 20 yes/no questions, which deal with four variables: I: Depressive Mood – Anxious; II: Somatic Symptoms; III: Decrease in Vital Energy; IV: Depressive Thoughts (Guirado et al., 2016).

The cut-off point used in this study – for suspicion of mental disorder – was 7 points (for men and women), with a sensitivity of 68% and specificity of 70.7%, as described by Santos et al. (2010).

The sample of workers selected for this study was by convenience. Thus, workers who were present in the UBS that are part of the PRMFC in the municipality of Campina Grande – PB at the time of the visit carried out for the application of the questionnaires were selected.

To calculate the representative sample size of the population of workers in this study, the formula for calculating the sample size to describe qualitative variables in a finite population was used (Miot, 2011):

Figure 1 - MIOT's formula for sample size calculation for the description of qualitative variables in a finite population.

$$n = \frac{N \,.\, \delta^2 \,.\, (Z\,\alpha/2)^2}{(N-1) \,.\, (E)^2 \,+\, \delta^2 \,.\, (Z\,\alpha/2)^2}$$

Source: Miot, 2011.

Where N represents the size of the population (N = 250), p – proportion of favorable results of the variable in the population (p = 19.7%, according to Moreira, 2016), q – proportion of unfavorable results of the variable in the population (q = 80.3%, according to Moreira, 2016), Z α/2 – value of the confidence level (Z α/2 = 95%) and E – standard error (E = 5%). Thus, we obtain a value of n = 123 workers. Therefore, the sample of this study can be considered representative of the target population.

Regarding the analysis of the SQR-20 questionnaire, two (2) workers were excluded from the study because they had filled out the form incompletely.

A total of 34 physicians, 14 nurses, 15 nursing technicians, 3 pharmacists, 4 pharmacy assistants, 4 dental surgeons, 5 oral health assistants, 1 social worker and 44 community health agents answered the questionnaire satisfactorily.

This study included 124 PHC workers in the city of Campina Grande – PB, who were distributed in 25 family health teams in a total of 16 FHUs. All the workers evaluated were part of health teams with resident physicians in family and community medicine from the Medical Residency Program of the Municipal Health Department (SMS) of the municipality.

The data collected through the application of the questionnaires were included in tables of the Microsoft Excel program for Windows (version 2019) and submitted to a descriptive statistical analysis through the calculation of absolute frequencies (FA) and relative frequencies (RF). Subsequently, the comparative analysis of the data was carried out through the use of the statistical analysis software Jamovi in its version 2.4.11.0. The chi-square test and Fisher's exact test were used (when the expected frequencies were less than 5).

Only workers from Basic Health Units with residents of Family and Community Medicine in the city of Campina Grande – PB who consented to participate in this research by signing the Informed Consent Form were included in this study. Workers who did not consent to participate in the study and those who filled out the collection instruments incorrectly were excluded from this study.

This research was approved by the Research Ethics Committee in accordance with opinion No. 6,203,699, issued on July 27, 2023, as it complies with the ethical and legal guidelines established by Resolution No. 466/2012 of the National Health Council.

RESULTS AND DISCUSSION

The PRMFC takes place in 16 UBS, totaling 25 teams composed of physicians, nurses, dentists, pharmacists, social workers, nursing and oral health technicians, pharmacy attendants and community health agents who were selected as the target population of this study. The teams do not have the same profile of professionals, as they vary depending on the territory they assist.

Of the total of 250 workers who made up the target population working in the UBS, 126 workers were not present in the health units at the time of data collection, for different reasons that were not listed at the time of the visit. Thus, 124 professionals were included in this research, thus representing 49.6% of the target population.

Regarding sociodemographic characteristics, most workers were female (75%), with a mean age of 41.5 ± 11.3 years. 56.4% were married or with a partner and had up to two children (50%). 75% had a per capita income higher than two minimum wages at the time (R$ 1320.00). Regarding

education, 62.9% had completed higher education and 1.6% (2 workers) reported a complete postgraduate course (Master's degree) (Table 1).

Table 1 - Distribution of Family Health Strategy workers, according to sociodemographic variables in the municipality of Campina Grande, PB, 2024 (n = 124).

Variáveis Sociodemográficas	n	%
Sexo (n = 124)		
Feminino	93	75
Masculino	31	25
Idade (anos completos) (n = 124)		
Até 30 anos	28	22,5
31 a 35 anos	18	14,5
36 a 45 anos	26	21
> 45 anos	52	42
Escolaridade (n = 124)		
Ensino Fundamental	-	-
Ensino Médio	17	13,7
Ensino Técnico	29	23,3
Ensino Superior	78	63
Estado Civil (n = 124)		
Solteiro(a)	51	41,1
Casado(a)	70	56,5
Viúvo(a)	3	2,4
Filhos (n = 124)		
Nenhum	46	37
1 – 2	62	50
> 2	16	13
Renda familiar (n =124)		
Até 2 salários mínimos	31	25
Mais de 2 salários m.	93	75

Source: Santos et al., 2024.

Among the occupational variables, the largest portion of the participating workers were Community Health Agents (35.5%), with a weekly workload of up to 40 hours (81.4%) and with more than 10 years of work at the institution (53.2%) (Table 2).

Table 2 - Distribution of Family Health Strategy workers, according to occupational variables in the municipality of Campina Grande, PB, 2024 (n = 124).

Variáveis Ocupacionais	n	%
Categoria Profissional (n = 124)		
Técnico(a) de enfermagem	15	12
Técnico(a) de saúde bucal	5	4
Cirurgião Dentista	4	3,2
Enfermeiro(a)	14	11,3
Médico(a)	34	27,5
Farmacêutico(a)	3	2,5
Auxiliar de Farmácia	4	3,2
Agente Comunitário de Saúde	44	35,5
Assistente Social	1	0,8
Carga Horária Semanal (n = 124)		
40h por semana	101	81,5
> 40h por semana	23	18,5
Tempo de trabalho na instituição (n = 124)		
Menos de 6 meses	-	-
6 meses a 5 anos	43	34,7
6 anos a 9 anos	15	12,1
Maior ou igual a 10 anos	66	53,2

Source: Santos et al., 2024.

Regarding the mental health of workers, it was observed that the prevalence of Common Mental Disorder (CMD), according to the cutoff point adopted (7 points), was 43.5%, with a variation from 25% (among dental surgeons) to 100% (among social workers). No statistically significant difference was found between the presence of CMD and the categories evaluated (p = 0.804) (Table 3).

Table 3 - Prevalence of common mental disorders among workers in the Family Health Strategy, according to professional category. Campina Grande, PB, 2024. (n = 124).

Categoria Profissional	Total	Ausente		Presente		p*
		N	%	n	%	
Técnico(a) de enfermagem	15	11	73,3	4	26,7	0,804
Técnico(a) de saúde bucal	5	3	60	2	40	
Cirurgião Dentista	4	3	75	1	25	
Enfermeiro(a)	14	7	50	7	50	
Médico(a)	34	20	58,8	14	41,2	
Farmacêutico(a)	3	2	66,7	1	33,3	
Auxiliar de Farmácia	4	2	50	2	50	
Agente Comunitário de Saúde	44	22	50	22	50	
Assistente Social	1	0	0	1	100	

*Teste exato de Fisher.

Source: Santos et al., 2024.

In the population studied, cases of CMD were more frequent in female workers (44/93 or 47.3%), married workers (34/70 or 48.6%), between 36 and 45 years old (13/26 or 50%), with complete higher education (37/78 or 47.4%), with > 2 children (9/16 or 56.2%), family income < 2 minimum wages (18/31 or 58%), with working hours greater than 40 hours per week (11/23 or 47.8%) and length of work in the service greater than or equal to 10 years (30/66 or 45.4%).

Data on the prevalence of CMD are shown in Tables 4 to 11.

Table 4 - Prevalence of CMD among workers in the Family Health Strategy, according to gender. Campina Grande, PB, 2024. (n = 124).

Gênero	Total		Ausente		Presente		p*
	n	%	n	%	n	%	
Feminino	93	75	49	52,7	44	47,3	0,143
Masculino	31	25	21	67,7	10	32,2	

*Teste qui-quadrado.

Source: Santos et al., 2024.

Table 5 - Prevalence of CMD among workers in the Family Health Strategy, according to marital status. Campina Grande, PB, 2024. (n = 124).

Estado Civil	Total		Ausente		Presente		p*
	n	%	n	%	n	%	
Solteiro(a)	51	41,1	31	60,8	20	39,2	
Casado(a)	70	56,5	36	51,4	34	48,6	0,229
Viúvo(a)	3	2,4	3	100	0	0	

*Teste exato de Fisher.

Source: Santos et al., 2024.

Table 6 - Prevalence of CMD among workers in the Family Health Strategy, according to age group. Campina Grande, PB, 2024. (n = 124).

Faixa Etária	Total		Ausente		Presente		p*
	n	%	n	%	n	%	
Até 30 anos	28	22,6	15	53,6	13	46,4	
31 - 35 anos	18	14,5	10	55,5	8	44,5	0,789
36 - 45 anos	26	21	13	50	13	50	
>45 anos	52	41,9	32	61,5	20	38,5	

*Teste qui-quadrado.

Source: Santos et al., 2024.

Table 1 - Prevalence of CMD among workers of the Family Health Strategy, according to schooling. Campina Grande, PB, 2024. (n = 124).

Escolaridade	Total		Ausente		Presente		p*
	n	%	N	%	n	%	
Ensino Médio	17	13,7	9	52,9	8	47,1	
Ensino Técnico	29	23,4	20	69	9	31	0,299
Ensino Superior	78	62,9	41	52,6	37	47,4	

*Teste qui-quadrado.

Source: Santos et al., 2024.

Table 2 - Prevalence of CMD among Family Health Strategy workers, according to the number of children. Campina Grande, PB, 2024. (n = 124).

Número de filhos	Total		Ausente		Presente		p*
	n	%	n	%	n	%	
0	46	37,1	26	56,5	20	43,5	
1 – 2	62	50	37	59,7	25	40,3	0,519
>2	16	12,9	7	43,7	9	56,3	

*Teste qui-quadrado.

Source: Santos et al., 2024.

Table 3 - Prevalence of CMD among Family Health Strategy workers, according to family income. Campina Grande, PB, 2024. (n = 124).

Renda Familiar	Total		Ausente		Presente		p*
	n	%	n	%	n	%	
<2 salários mínimos	31	25	13	41,9	18	58,1	0,06
>2 salários mínimos	93	75	57	61,3	36	38,7	

*Teste qui-quadrado.

Source: Santos et al., 2024.

Table 10 - Prevalence of CMD among workers in the Family Health Strategy, according to workload. Campina Grande, PB, 2024. (n = 124).

Carga Horária	Total		Ausente		Presente		p*
	n	%	n	%	n	%	
<40h por semana	101	81,4	58	57,4	43	42,6	0,647
>40h por semana	23	18,6	12	52,2	11	47,8	

*Teste qui-quadrado.

Source: Santos et al., 2024.

Table 11 - Prevalence of CMD among workers in the Family Health Strategy, according to length of service. Campina Grande, PB, 2024. (n = 124).

Tempo de Serviço	Total		Ausente		Presente		p*
	n	%	N	%	n	%	
6 meses – 5 anos	43	34,7	25	58,1	18	41,9	0,894
5 anos – 9 anos	15	12,1	9	60	6	40	
>/= 10 anos	66	53,2	36	54,5	30	45,5	

*Teste qui-quadrado.

Source: Santos et al., 2024.

Among the cases of professionals with CMD, it was evident that 81.5% occurred in females, aged over 45 years (20/54 or 37%), with complete higher education (37/54 or 68.5%), married or with a partner (34/54 or 63%), with 1-2 children (25/54 or 46.3%), per capita income greater than 2 minimum wages at the time (36/54 or 66.7%), with working hours of up to 40 hours/week (43/54 or 79.6%) and with time working in the same institution greater than or equal to 10 years (30/54 or 55.5%).

This study included 124 PHC workers in the city of Campina Grande – PB, who were distributed in 25 family health teams in a total of 16 FHUs. All the workers evaluated were part of health teams with resident physicians in family and community medicine from the Medical Residency Program of the Municipal Health Department (SMS) of the municipality.

At the time of data collection, it was found that there were 121 family health teams in the city of Campina Grande. In this study, we represent 20.7% of the municipality's teams (CODECOM, 2023).

At the time of data collection, all family health teams were in accordance with the minimum necessary training established by the Ministry of Health: a general practitioner in training in family

and community medicine, a generalist nurse or specialist in family health, a nursing technician and 4 to 6 community health agents (CHA) (Brazil, 2012). Other professionals such as social workers, pharmacists, dentists, pharmacy assistants and oral health technicians were also included, since they are also PHC workers, but were not equally part of all the teams evaluated.

Regarding the characteristics of the population studied, we observed a predominance of female professionals (75%), possibly as a result of the process of feminization of health-related professions in Brazil (Matos et al., 2013).

The authors Braga, Moreira and Ribeiro also observed that women and professionals with a higher workload and lower pay get sick more, as well as those who are married and have children, a probable reflection of the physical and mental overload of the double workday (Braga et al., 2010; Moreira et al., 2016; Ribeiro et al., 2011).

It is noteworthy that the professionals in this study have, in general, more than 45 years of age (45%), completed higher education (63%) and more than 10 years of professional experience in the service (53.2%). These data reveal an experienced population with a high level of education, factors that positively impact the quality of the service provided by the teams (Camelo, 2008).

A high prevalence of CMD (43.5%) was observed among the workers studied. This result was similar to that found by Braga et al., in a study carried out in Botucatu, SP, revealing a prevalence of 42.6% of CMD among PHC workers in this municipality. However, it was much higher than that found in three other studies: Moreira et al. found a prevalence of 19.7% among professionals in the city of Santa Cruz do Sul, RS; Dilélio et al. and Barbosa et al. found a prevalence of 16% of CMD in professionals from the South/Northeast regions and the municipality of Feira de Santana, BA, respectively.

Regarding gender, it was observed that, of the total number of workers studied, women had more CMDs than men (47.3% vs. 32.2%) and, among professionals with CMD, there was a higher prevalence of women when compared to men (81.5 vs. 18.5%), which is in line with the studies by Braga et al. (2010), Moreira et al. (2016), where the predominance of CMD occurred in females. Despite this difference, this result was not statistically significant ($p = 0.143$) (Table 6).

This result may be a reflection of the process of female emancipation, in which women began to occupy more vacancies in the labor market without, however, getting rid of domestic occupations and family care (functions culturally still assigned to women), in order to accumulate functions and suffer from work overload, generating factors predisposing to physical and mental illness (Lages et al., 2005).

Married professionals also had a higher prevalence of CMD, as shown in Table 5 and as also described in the studies by Barbosa et al., Moreira et al. When analyzing married professionals, we observed that, when comparing married men and women, the prevalence of CMD is higher in women

(54.9% vs. 31.6%; p = 0.083), which is, therefore, another indication of the burden generated by the double shift of female work (Table 12).

Table 12. Prevalence of CMD among married Family Health Strategy workers, according to gender. Campina Grande, PB, 2024. (n = 70).

Gênero	Total		Ausente		Presente		p*
	n	%	n	%	n	%	
Feminino	51	72,8	23	45,1	28	54,9	0,083
Masculino	19	27,2	13	68,4	6	31,6	

*Teste qui-quadrado.

Source: Santos et al., 2024.

Regarding the professional categories, although we did not find a statistically significant difference in the association with CMD (p = 0.804), we observed a great variation between professions (25% among dental surgeons and 100% among social workers). This variation can be explained by the small number of professionals in these areas who were part of the research (Table 3).

In relation to medical professionals, we found a high prevalence of CMD (41.2%), much higher than what was reported by Moreira et al. (14.3%); Dilélio et al. (15%); Barbosa et al. (17.4%) and Braga et al. (33%). This difference can be explained by the occupational characteristics of the physicians who participated in this study. In this study, 34 physicians were evaluated, with a predominance of resident physicians (24 resident physicians and 10 preceptor physicians). Thus, the medical population in this study is made up of young physicians (19/34 or 55.9% up to 30 years of age) who have little professional experience (24/34 or 70.6% with less than 5 years of professional experience) – these factors, in association, may have contributed to these professionals having a greater predisposition to mental illness, although without statistical significance (Tables 4 and 5).

Regarding the family income of the professionals, we observed a variation in the prevalence of CMD in this sample. Professionals with an income of less than 2 minimum wages had a higher prevalence of CMD (18/31 or 58%) than professionals with an income of more than 2 minimum wages (36/93 or 38.7%), but without statistical significance (p = 0.06) (Table 13), a result similar to that found by Braga et al. and Moreira et al. This difference can be explained by the degree of motivation of the professionals, since motivation at work can be related, among other factors, to the remuneration of the professionals (Batista, 2005).

Table 13. Prevalence of CMD among workers in the Family Health Strategy, according to family income. Campina Grande, PB (n = 124).

Renda Familiar	Total		Ausente		Presente		p*
	n	%	n	%	n	%	
< 2 salários mínimos	31	25	13	41,9	18	58	0,06
>2 salários mínimos	93	75	57	61,3	36	38,7	

*Teste qui-quadrado.

Source: Santos et al., 2024.

It is important that the comparison of the results obtained in this study with those of other studies, with similar methodologies and use of the same instrument (SQR-20 questionnaire) may be impaired by the cut-off point used. In our study, 7 "yes" answers to the questionnaire were used as the cut-off point, as suggested by Harding et al. (1980) for both sexes, while in some of the studies mentioned above, the cut-off point varied according to gender, being 5/6 points for men and 7/8 points for women, as suggested by Mari and Williams (1986) in the Brazilian validation study.

Another factor that must be taken into account is the difference in the populations analyzed. In our study, only PHC workers were included, while other studies included professionals from health centers and reference centers. Our study included only health care workers, while other studies included administrative workers.

In addition to these limitations, the possible biases of this research are highlighted. First, sample selection for convenience generates a potential selection bias. In this study, only the medical residency units were analyzed, whose sample of physicians is composed mostly of resident physicians, many of whom have recently graduated, young and with little professional experience. These professionals, given their characteristics, are more vulnerable to mental illness since, due to their inexperience, they have fewer strategies to cope with conflict-situations in the work environment.

A second limitation is the methodological delimitation of this study. Cross-sectional studies do not allow us to confirm the cause-and-effect relationship, since risk and outcome factors are present concomitantly at the time of data collection. Thus, in this type of study, we are left with the possibility of raising hypotheses.

CONCLUSION

Through the present study, we identified a high prevalence of psychological distress suggesting common mental disorder (CMD) in the professionals of the medical residency health units

that make up the PHC in the city of Campina Grande – PB, as well as describing their sociodemographic and occupational profile.

We found that among professionals with CMD, women are more vulnerable to the development of psychological distress when compared to men, as well as married professionals with children. This result reflects our model of social organization, where women are overloaded with their double workday.

In this context, we emphasize the importance of continued care for Primary Care professionals, who are vulnerable to the development of CMD, and, therefore, it is necessary to create public policies aimed at promoting and protecting the mental health of these workers, developing spaces for listening and speaking, as well as professional appreciation policies.

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