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LEVELS OF ANXIETY AMONG PROFESSIONALS IN THE PSYCHOSOCIAL CARE NETWORK OF PATOS – PB

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ABSTRACT

Anxiety, always present in the evolutionary process of human civilization, is a warning sign that enables a person to deal with threats. Within mental disorders, anxiety disorders are the most common and cause considerable functional impairment, constituting one of the main causes of global disability. This study aims to focus on the analysis of the proportion of professionals from the Psychosocial Care Network (RAPS) in Patos-PB who present levels of anxiety, identify triggering factors and suggest strategies to combat the diseases. A quali-quantitative cross-sectional research was carried out with 39 health professionals from the RAPS in Patos-PB, using questionnaires on social profile and the Hamilton Anxiety Scale (HAM-A). Health professionals with higher education were included, excluding those with previous anxiety disorder or from itinerant teams and NASF. The data were analyzed using the Statistical Package for the Social Sciences (SPSS) software, with relative and absolute frequency tests, descriptive tests, Pearson's chi-square, Student's t-test and Pearson's correlation. The sample of 39 professionals, mostly female, single, with postgraduate degrees and specialization, revealed that 69.2% of the participants reported anxious symptoms. The most common coping strategies included physical exercise, deep breathing, and psychotherapy. Symptoms such as agitation, irritability, worry, insomnia, palpitations, and pain were prevalent. About 82.1% of the participants associated work with the anxious state, and 66.7% stated that they did not have team support or coordination to deal with stress and anxiety in the workplace. In addition, 15.4% had moderate anxiety and 10.3% had intense anxiety. This study reinforces the need for public policies aimed at the mental health of RAPS professionals, promoting a harmonious work environment that can provide qualified and healthy care.

Keywords: Anxiety, Work, Health Professionals, RAPS.

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INTRODUCTION

In the evolutionary process of human civilization, anxiety has always been present, leading us to break the limits imposed by our body and putting us at the top of the food chain. "Anxiety is a warning sign; indicates an imminent danger and empowers the person to take steps to deal with the threat" (Sadock et al., 2017, p. 387). With this evolution, a medical area emerged that made an amalgam between the mind and the human body, which came to be called Psychiatry by the Greeks. Within the study of mental disorders and behavioral changes came the so-called Anxiety Disorders. Of all psychiatric illnesses, anxiety disorders are the most common and result in considerable functional impairment and distress. According to Quagliato, Crippa and Nardi (2022, p.782) these "disorders [...] constitute one of the main causes of disability around the world".

In view of this perspective, with the emergence of the Unified Health System, instituted by Federal Laws 8.080/1990 and 8.142/1990, it has in its scope a democratic State and full citizenship as determinants of "health as a right of all and a duty of the State", provided for in the Federal Constitution of 1988. The Psychosocial Support Centers (CAPS), as well as the Psychosocial Care Centers (NAPS), the Mental Health Reference Centers (CERSAMs) and other types of substitute services that have emerged in the country, are currently regulated by Ordinance No. 336/GM, of February 19, 2002 and are part of the SUS network. This ordinance recognized and expanded the functioning and complexity of the CAPS, which have the mission of providing day-to-day care to people suffering from severe and persistent mental disorders, in a given territory, offering clinical care and psychosocial rehabilitation, with the objective of replacing the hospital-centered model, avoiding hospitalizations and favoring the exercise of citizenship and social inclusion of users and their families.

The Psychosocial Care Network (RAPS) was created in accordance with the Ordinance of the Unified Health System No. 3,088 to help people suffering from mental disorders or mental disorders and needs arising from the use of cocaine, alcohol and other drugs. Reissued on May 21, 2013 and suppressed by Consolidation Ordinance No. 3, of September 28, 2017 on the integration of the standards of the Unified Health System network (Brasil, 2017).

Thus, this Network implements services with some axes, such as Primary Health Care (Basic Health Unit, Family Health Strategy and Street Clinic Team), Specialized Care (Psychosocial Care Center - CAPS, Psychosocial Care Center for Children and

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Adolescents and Psychosocial Care Center for Alcohol and Drugs), Urgent and Emergency Care (Mobile Emergency Care Service - SAMU, Emergency Care Unit (UPA) and Stabilization Room), Transitional Residential Care (Reception Units and Therapeutic Communities), Hospital Care (Reference Hospital Service and Psychiatric Beds in General Hospital) and Deinstitutionalization Strategies (Therapeutic Residence Service) and Rehabilitation.

In the municipality of Patos, it is the 6th Health Region of Paraíba and its RAPS comprises around 09 (nine) surrounding municipalities, totaling a population of 150,305 (one hundred and fifty thousand three hundred and five). In this municipality, there is a Regional Hospital of State management (with 331 professionals with higher education in Health), 03 Psychosocial Care Centers, one CAPS 2 Adult, CAPS for children and adolescents, CAPS AD, Multiprofessional Team for Specialized Care in Mental Health (AMENT) Type 2, SAMU, two Emergency Care Units and 41 Basic Family Health Units. Of these, the main ways of serving users of SUS Outpatient Mental Health services are CAPS, UBS and AMENT.

In a scenario in which the work environment becomes more competitive and demanding, several factors can interfere with the illness of health professionals, especially social and individual factors, as well as working conditions, however, the manifestations of suffering can be multifaceted. Corroborating these statements, Fernandes et al. (2018, p. 219) describe that "in general, the high workload combined or not with low pay, work in more than one establishment and employment relationship established by temporary/precarious contract may correspond to the causes of the appearance of some mental disorder throughout life". Moura et al. (2022) add that several factors interfere with the illness of health professionals, where social and individual factors stand out, as well as working conditions, however, the manifestations of suffering do not occur in a unique way for everyone.

Among mental disorders, Anxiety Disorders are one of the most prevalent, as corroborated by Fernandes et al. (2018) are frequent problems when addressing workers' health, as they generate high costs and impact on absenteeism, presenteeism and other work-related aspects, such as reduced performance and workload.

In this sense, it has become important to analyze these conditions and factors in order to establish health policies that offer occupational safety and resources that ensure better health care for this population.

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In analysis of all this, despite having resources, knowledge and access to information, Psychosocial Care teams are not exempt from psychological illness, which can generate consequences for the service and psychosocial clashes, which calls for the need for studies that bring to light statistics about this context of anxiety status in this public.

This research aimed to trace the proportion of members of the RAPS teams in Patos-PB with levels of Anxiety, as well as, through specific actions, to identify the social profile, possible differences between the profiles of the teams, to characterize which team may give indications of being more vulnerable to mental illnesses, to analyze triggering factors and to suggest strategies to combat these problems.

In the process of investigation and study, the relevance of this research is presented by the analysis of these biases and the establishment of a parallel between health services, detecting which teams may give indications of a more vulnerable psychological trait. In addition to contributing to the understanding that this public can be, in a way, neglected by public authorities and/or self-negligence. Therefore, this research helps to glimpse massive studies on the subject.

Finally, the entire process of study and research elucidated the lack of public policies aimed at the employees of the RAPS devices, providing the government and the team itself to adopt strategies that favor the development of the work environment. With this, in a harmonious environment, the team can, with greater chance, bring qualified and healthy attention.

METHODOLOGICAL ASPECTS

A quali-quantitative cross-sectional research was carried out in the municipality of Patos-PB, conducted by the RAPS health team, especially the Family Health teams and the Psychosocial Care Centers (CAPS), under the management of the Municipal Health Department. The study included 39 health professionals from the RAPS, specifically from the CAPS and the Basic Health Units (UBS), who answered a questionnaire on social profile, the Hamilton Anxiety Scale and open questions on the same topic. The sample was non-probabilistic, selected according to inclusion and exclusion criteria, involving health professionals with higher education, permanent or contracted. Those with anxiety disorder prior to admission to the current job, itinerant teams, multiprofessional residents, and professionals from the Family Health Support Center (NASF) were excluded.

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The form used allowed the identification of the social profile of the participants, including age, marital status, level of education, profession, length of work and religion. In addition, the Hamilton Anxiety Scale (HAM-A), developed by Max Hamilton and validated in Brazil by Kummer, Cardoso and Teixeira (2010), was applied to assess the level of anxiety of the RAPS teams. The scale, consisting of 14 items divided between anxious mood symptoms and physical anxiety symptoms, is widely used in clinical and academic studies. Anxiety levels according to HAM-A are: None = 0; Mild = 1; Moderate = 2; Severe or Strong = 3; Very severe or disabling = 4. The total score of the scale ranges from 0 to 56, classifying anxiety into levels ranging from no anxiety to intense anxiety, with the following intervals: 0 (zero) absence of anxiety; 1 (one) to 17 points, mild anxiety; 18 to 24 points, moderate anxiety; and 25 to 56 points, intense or intense anxiety. Open-ended questions were also included, allowing the interviewees to express their perceptions in a more subjective way, giving a qualitative dimension to the study.

A visit was made to the research sites, with the distribution of questionnaires to the participants. A numerical draw defined the Basic Health Units covered, as well as the three CAPS in the municipality. The data were statistically analyzed, considering both quantitative and qualitative perspectives, and presented in comparative tables and graphs.

The research instruments strictly followed the ethical procedures established by Resolution No. 466/12 of the National Health Council, which regulates ethics in research involving human beings, ensuring the privacy, autonomy and dignity of the participants. The guidelines of Resolution No. 580/18, which applies to research in the Human and Social Sciences, were also observed. All the procedures adopted, including obtaining informed consent, sought to ensure the protection and confidentiality of the participants, in addition to ensuring transparency and clarity in the communication of the objectives and procedures of the research. This study considered the Institutional Authorization Term (TAI), and the request for exemption from the Informed Consent Form (ICF) was sent to the Ethics Committee.

The research took into account possible biases arising from the participants' psychological state, workload, and external factors, such as personal, cultural, and economic issues. To mitigate these factors, the forms were distributed at the end of the day, when it was expected that the participants would be calmer. Respondents also had the option to take the questionnaire home, allowing for more careful reflection before answering.

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Despite the challenges, the survey faithfully captured the emotions and impressions of the participants about the work environment and the challenges faced. Among the benefits of the study, a better understanding of anxiety stands out, allowing greater awareness of the condition, identification of its prevalence and analysis of triggering factors. These data will provide important information for the formulation of policies and interventions aimed at the mental health of health teams.

The data were analyzed using the Statistical Package for the Social Sciences (SPSS) software, version 25. Relative and absolute frequency measures and descriptive tests of measures of central tendency (mean) and dispersion measures (standard deviation) were used. Pearson's chi-square tests for independence (2x2 and 2x4) were performed for comparisons and prevalence calculations for each group. In addition, Student's t-test and Pearson's correlation were used to compare measures and correlations between variables. The effect size between the groups (Student's t-test) was calculated using Cohen's d. Statistical significance was $p < 0.05$.

RESULTS

The present study evaluated a sample of 39 professionals from the Psychosocial Care Network of Patos – Paraíba. The mean age of the participants is 36.85 (SD=9.21) years and the mean age of 10.33 (SD=6.86) years in the profession. The categorical data are described in Table 1. The sample is composed mostly of professionals who work at the UBS (30.8%) and CAPS I (30.8%), female (69.2%), single (53.8%), nurses (28.2%), with a postgraduate degree (76.9%) and specialization or additional training (94.9%), follow some religion (82.1%) and are Catholic (71.9%).

Regarding anxiety symptoms and aspects related to the work environment, most reported feeling anxiety (69.2%) and the most used strategies to cope with anxiety are: physical exercise (48.7%), deep breathing (23.1%), psychotherapy (20.5%), practicing some religion (23.1%) and other preferences (38.5%). Around 15.4% of the professionals were being treated for Anxiety Disorder before taking up their current position.

In addition, the most cited symptoms associated with anxiety were: agitation (25.6%), irritability (33.3%), worry (25.6%), insomnia (30.8%), palpitations (30.8%) and pain (20.5%). 82.1% of the participants associated work with the anxious state and 66.7% stated that they did not have team support or coordination to deal with stress and anxiety related to the

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work context. About 15.4% had moderate anxiety and 10.3% were classified as having intense anxiety.

Table 1. Description of categorical data (n=39).

Variables	Absolute Frequency (F)	Relative frequency (%)
Establishment		
UBS	12	30,8
CAPS 2	6	15,4
CAPS I	12	30,8
CAPS AD	9	23,1
Gender		
Male	12	30,8
Female	27	69,2
Marital status		
Single	21	53,8
Married	17	43,6
Widow(er)	1	2,6
Current profession		
Doctor	5	12,8
Nurse	11	28,2
Psychologist	5	12,8
Social worker	3	7,7
Nutritionist	2	5,1
Physical Educator	2	5,1
Dentist	4	10,3
Psychopedagogue	2	5,1
Physiotherapist	2	5,1
Speech-Language Pathologist	2	5,1
Pharmacist	1	2,6
Schooling		
Complete higher education	9	23,1
Postgraduate studies	30	76,9
Specialization or additional training		
Yes	37	94,9
No	2	5,1
Follow some religion		
Yes	32	82,1
No	7	17,9
Religion		
Catholicism	23	71,9
Evangelical	5	15,6
Spiritism	4	12,5
Do you feel anxious?		
Yes	27	69,2
No	3	7,7
Sometimes	9	23,1
Strategies for coping with anxiety		
Deep breathing		
No	30	76,9
Yes	9	23,1
Physical exercises		
No	20	51,3
Yes	19	48,7
Go out		

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No	35	89,7
Yes	4	10,3
Listening to music		
No	34	87,2
Yes	5	12,8
Watch movies and series		
No	38	97,4
Yes	1	2,6
Psychotherapy		
No	31	79,5
Yes	8	20,5
Antidepressants		
No	35	89,7
Yes	4	10,3
Shift focus		
No	38	97,4
Yes	1	2,6
Other preferences		
No	24	61,5
Yes	15	38,5
Religion		
No	30	76,9
Yes	9	23,1
If you have an anxiety disorder, were you already undergoing treatment before taking up your current position?		
No response	32	82,1
Yes	6	15,4
No	1	2,6
Anxiogenic symptoms		
Agitation		
No	29	74,4
Yes	10	25,6
Irritability		
No	26	66,7
Yes	13	33,3
Racing thoughts		
No	32	82,1
Yes	7	17,9
Worry		
No	29	74,4
Yes	10	25,6
Exaggerated expectations		
No	38	97,4
Yes	1	2,6
Insomnia		
No	27	69,2
Yes	12	30,8
Palpitations		
No	27	69,2
Yes	12	30,8
Pain		
No	31	79,5
Yes	8	20,5
Tiredness		
No	34	87,2
Yes	5	12,8

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Gastrointestinal symptoms		
No	34	87,2
Yes	5	12,8
Food or shopping compulsions		
No	36	92,3
Yes	3	7,7
Shortness of breath		
No	36	92,3
Yes	3	7,7
Fear		
No	38	97,4
Yes	1	2,6
Memory and concentration disorders		
No	32	82,1
Yes	7	17,9
Do you think your job causes anxiety?		
Yes	32	82,1
No	4	10,3
Sometimes	2	5,1
No response	1	2,6
Do you think that the team or coordination of your work supports employees to deal with stress and anxiety?		
Yes	10	25,6
No	26	66,7
Sometimes	2	5,1
No response	1	2,6
Hamilton Scale Rating (anxiety levels)		
Mild anxiety	29	74,4
Moderate anxiety	6	15,4
Intense anxiety	4	10,3

Source: Survey data, 2024.

The results point to a proportion of perceived anxiety among the professionals who work at the BHU (75.0%), if the work environment is considered. Regarding anxiogenic symptoms such as agitation (29.6%), racing thoughts (18.5%), exacerbated expectations (3.7%), pain (29.6%), tiredness (14.8%), compulsions for food or shopping (11.1%), shortness of breath (11.1%) and fear (3.7%), were more prevalent among professionals working at the CAPS (Table 2). On the other hand, symptoms such as irritability (41.7%), worry (33.3%), insomnia (41.7%), palpitations (41.7%), gastrointestinal symptoms (16.7%) and memory alterations (33.3%) were found to a greater extent in professionals at the UBS. Regarding work perceived as causing anxiety, there was a prevalence of 91.7% among professionals working at the BHU. In addition, 91.7% do not receive support from the team or coordination and 83.3% have mild anxiety.

A statistically significant difference was observed between care units and pain as a symptom related to anxiety ($c2(1) = 4.473$, $p < 0.034$, $f = 0.339$). No significant differences were found between the care units and the other variables presented (Table 2).

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Table 2. Distribution of prevalence and association between care units and anxiogenic symptoms in the work context.

Variables		CAPS n (%)	UBS n (%)	P-value(a)
Do you feel anxious?	Yes	18 (66,7)	9 (75,0)	0,486
	No	3 (11,1)	0 (0,0)	
	Sometimes	6 (22,2)	3 (25,0)	
*Agitation	No	19 (70,4)	10 (83,3)	0,392
	Yes	8 (29,6)	2 (16,7)	
*Irritability	No	19 (70,4)	7 (58,3)	0,462
	Yes	8 (29,6)	5 (41,7)	
*Racing thoughts	No	22 (81,5)	10 (83,3)	0,889
	Yes	5 (18,5)	2 (16,7)	
*Concern	No	21 (77,8)	8 (66,7)	0,463
	Yes	6 (22,2)	4 (33,3)	
*Exaggerated expectations	No	26 (96,3)	12 (100,0)	0,499
	Yes	1 (3,7)	0 (0,0)	
*Insomnia	No	20 (74,1)	7 (58,3)	0,326
	Yes	7 (25,9)	5 (41,7)	
*Palpitations	No	20 (74,1)	7 (58,3)	0,326
	Yes	7 (25,9)	5 (41,7)	
*Pain	No	19 (70,4)	12 (100,0)	0,034**
	Yes	8 (29,6)	0 (0,0)	
*Tiredness	No	23 (85,2)	11 (91,7)	0,576
	Yes	4 (14,8)	1 (8,3)	
* Gastrointestinal symptoms	No	24 (88,9)	10 (83,3)	0,632
	Yes	3 (11,1)	2 (16,7)	
*Food or shopping compulsions	No	24 (88,9)	12 (100,0)	0,229
	Yes	3 (11,1)	0 (0,0)	
*Lack of ar	No	24 (88,9)	12 (100,0)	0,229
	Yes	3 (11,1)	0 (0,0)	
*Fear	No	26 (96,3)	12 (100,0)	0,499
	Yes	1 (3,7)	0 (0,0)	
*Memory changes	No	24 (88,9)	8 (66,7)	0,095
	Yes	3 (11,1)	4 (33,3)	
Does work cause anxiety?	Yes	21 (77,8)	11 (91,7)	0,661
	No	3 (11,1)	1 (8,3)	
	Sometimes	2 (7,4)	0 (0,0)	
Does the team or coordination offer support to deal with stress and anxiety?	Yes	9 (33,3)	1 (8,3)	0,173
	No	15 (55,6)	11 (91,7)	
	Sometimes	2 (7,4)	0 (0,0)	
Anxiety level	Lightweight	19 (70,4)	10 (83,3)	0,371
	Moderate	4 (14,8)	2 (16,7)	
	Intense	4 (14,8)	0 (0,0)	

Note: *Anxiogenic symptoms. **Statistically significant difference.

The results showed that professionals who perceive anxiety as a result of the work environment had a statistically higher anxiety score (M = 13.62; SD = 8.15) than professionals who do not see work as a source of anxiety (M = 7.50; SD = 1.73) (t(24.488) = 3.641, p = 0.001). It is noteworthy that the effect size of the difference was high (Cohen's d = 0.81) (COHEN, 2013). No statistically significant differences were found between

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anxiety and support to cope with stress, unit of care, gender, marital status, specialization, and having a religion (Table 3).

Table 3. Comparison of the anxiety scale between work anxiety, work support, care unit, gender, marital status, specialization, and religion.

	Average	Standard deviation	p-value
Work-related anxiety			
Yes	13,62	8,15	0,001**
No	7,50	1,73	
Support for coping with stress			
Yes	12,20	7,61	0,773
No	13,07	8,28	
Care unit			
CAPS	13,25	8,64	0,494
UBS	11,33	6,35	
Gender			
Male	15,25	8,85	0,181
Female	11,51	7,44	
Marital status			
Single	11,57	7,73	0,569
Married	13,00	7,48	
Specialization or training			
Yes	12,86	8,12	0,512
No	9,00	4,24	
Religion			
Yes	12,06	7,15	0,475
No	15,42	11,31	

Note: *p ≤ 0,05; **p ≤ 0,01.

Positive and statistically significant correlations of anxiety were found between coping strategies such as going out and listening to music. A higher anxiety score is associated with a greater tendency to go out ($r = 0.32$; $p < 0.04$) and listen to music ($r = 0.48$; $p < 0.00$) as strategies to cope with anxiety. However, there was a low magnitude of effect (Table 4).

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Table 4. Correlation between anxiety and strategies for coping with anxiety.

		Anxiety scale
Deep breathing	Pearson's correlation	0,07
	Sig. (bi caudal)	0,66
Physical exercises	Pearson's correlation	-0,06
	Sig. (bi caudal)	0,70
Go out	Pearson's correlation	0,32
	Sig. (bi caudal)	0,04*
Listening to music	Pearson's correlation	0,48
	Sig. (bi caudal)	0,00**
Watch movies and series	Pearson's correlation	0,15
	Sig. (bi caudal)	0,33
Psychotherapy	Pearson's correlation	-0,08
	Sig. (bi caudal)	0,61
Antidepressants	Pearson's correlation	0,07
	Sig. (bi caudal)	0,66
Shift focus	Pearson's correlation	0,15
	Sig. (bi caudal)	0,33
Other preferences	Pearson's correlation	-0,27
	Sig. (bi caudal)	0,09
Religion	Pearson's correlation	-0,11
	Sig. (bi caudal)	0,49

Note: *p ≤ 0,05; **p ≤ 0,01.

DISCUSSION

The study elucidates data that reveal a worrying picture about the mental health of professionals in the Psychosocial Care Network of Patos – PB, with a proportion of the perception of anxiety reaching 69.2%. As Santos et al (2019) confirm, there are three phases of the stressful process in the occupational environment, and when the last phase arrives, where it is characterized by exhaustion and exhaustion, if the stressor is continuous and the professional does not have strategies to deal with stress, the body depletes its energy reserve. This is when the professional begins to present diseases, with anxiety being one of the possible outcomes. This high rate indicates that most professionals face significant levels of anxiety, compromising their quality of life and efficiency in patient care.

Despite the limitation of studies that link anxiety levels and the health professional, we can relate it to general psychic conditions, such as stress, burnout, depression and anxiety, in an attempt to bring the study closer to others that also result in the mental suffering of these professionals. As is the case of a study with mental health workers from outpatient and partial mental health services in a city in the interior of the state of São Paulo, 36% of the professionals presented manifestations of stress, and 44% perceived themselves to be under stress, and work conditions and interpersonal relationships were the main associated factors (SANTOS & CARDOSO, 2010). In addition, another study pointed out that CAPS professionals from municipalities in the metropolitan region of João

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Pessoa-PB, with 76.92% presenting anxiety levels (SOUZA, 2017). Finally, another study found a high percentage of minor psychic disorders (MPD), such as anxiety and depression, with a dimension of 24.6% of the 85 intensive care nurses interviewed, which corroborates that these professionals are particularly susceptible to MPD (NASCIMENTO et al, 2019). All of this allows us to associate the condition of health work in general as a factor for triggering psychic disturbances.

As Sampaio and Lotufo Neto (2018) postulate, anxiety symptoms can be characterized as an unpleasant sensation, an internal restlessness, an exaggerated concern with the future, accompanied by bodily and somatic sensations, which reflect on the quality of life, occupational, social and academic performance. It is also interesting to note the difference in the proportion of symptoms between CAPS and UBS professionals. At CAPS, where mental health cases are more severe, there is a higher prevalence of symptoms such as agitation and racing thoughts, indicating greater emotional exhaustion. On the other hand, in the UBS, the higher prevalence of irritability and insomnia can be attributed to the high workload and the constant pressure to care for a wide variety of patients.

The coping strategies used by professionals, such as physical exercises, religious practices, and psychotherapy, indicate an active attempt to manage anxiety. The use of physical exercise is particularly relevant, as it is associated with proven benefits in reducing anxiety. Narciso and Guimarães Neto (2023) reinforce this by stating that regular physical exercise benefits physiological mechanisms, promotes well-being, improves sleep quality, and reduces anxiety and tension. Religious practices can offer spiritual and emotional comfort, while psychotherapy provides professional support for coping with anxiety. The significant correlation between higher anxiety scores and habits such as going out and listening to music suggests that these activities provide temporary relief but do not address the underlying causes of anxiety, indicating the need for more robust and institutionally supported coping strategies.

For Santos and Cardoso (2010), the emotional costs for mental health professionals negatively impact the development of care, the quality of the services provided and the health of workers. Understanding the health status of mental health professionals is crucial, since physical and psychological problems can lead to a variety of somatic problems, elevated levels of anxiety, depression, insomnia, and substance abuse. In the present study, it was elucidated that the lack of adequate support from teams and coordinations,

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reported by 67% of the participants, is a critical factor that contributes to high levels of anxiety. The absence of organizational support can exacerbate anxiety symptoms and reduce the effectiveness of individual coping strategies, underlining the urgent need for organizational interventions to provide psychological support and adequate resources to health professionals. Workplace mental health programs and specific training to manage stress could be beneficial.

The statistical analysis revealed a significant difference in the anxiety score between professionals who perceive work as causing anxiety and those who do not. This finding highlights the importance of targeted interventions in the workplace to reduce anxiety. Improving organizational support is one of the crucial first steps. This can involve everything from implementing psychological support policies to creating an environment where professionals feel valued and heard. Additionally, offering effective coping strategies, such as training in stress management techniques and access to mental health resources, can empower workers to better cope with daily challenges. One of the current strategies is postulated in the literature review by Townsley et al. (2023) where it brings positive psychosocial interventions (PPI) for health professionals aimed at mindfulness and gratitude-based interventions. The study showed efficacy comparable to medications in the treatment of anxiety disorders. In addition, healthcare professionals reported improvements in coping with stress and overall well-being, including physiological effects such as regulating the stress response and reducing inflammatory activity.

Another complementary systematic review study on non-pharmacological interventions, published in the Cochrane Database of Systematic Reviews, inferred that interventions aimed at individuals, such as cognitive-behavioral approaches, relaxation techniques, music therapy, and massage therapy, showed some efficacy in reducing stress, burnout, and anxiety among health professionals. In addition, interventions aimed at the work environment, which included changes in communication, support from colleagues, and work reorganization, also showed positive results in reducing symptoms of stress and depersonalization (Tamminga et al., 2023).

The results of this study emphasize the need for a multidimensional approach to address anxiety among health professionals. Structured and ongoing interventions are essential to promote a healthier work environment. Implementing mental wellness programs and encouraging the use of effective coping strategies can help reduce anxiety levels and improve the quality of life for healthcare workers, benefiting both workers and patients. For

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Guimarães, Jorge and Assis (2011), working in mental health care requires motivation from professionals, as the work activity must provide moments of satisfaction and fulfillment, even if they are exposed to different situations with different levels of satisfaction, considering that this is the environment in which people spend most of their time. Finally, Leka et al. (2003) suggest that improving organizational support and offering specific training to manage stress can reduce anxiety and improve the well-being of health professionals.

In short, in addition to the challenges raised by the study, it presented limitations linked to its small number of targets and a single municipality where the research was applied, which may limit the generalization of the results, in addition to the difficulty in obtaining similar studies. We can also stick to the cross-sectional and longitudinal character of the study, which restricts the ability to infer causal relationships or understand how anxiety levels can vary over time and not capture changes in response to interventions or changes in the work environment. Another aspect is social desirability bias, where participants may not accurately report their anxiety levels for fear of stigmatization.

CONCLUSION

The present study aimed to evaluate the prevalence of anxiety and factors related to the work environment among professionals in the Psychosocial Care Network of Patos, Paraíba. The survey revealed that a significant portion of the professionals, especially those who work at the UBS and CAPS, reported symptoms of anxiety, such as agitation, irritability, insomnia and palpitations. In addition, it was identified that most participants associate the work environment with the development of anxiety and that the lack of support from the team or coordination contributes to the worsening of this condition.

The survey of the social profile of the RAPS teams revealed significant differences between the professionals who work at the UBS and at the CAPS, which contributed to a deeper understanding of the variables that can influence the levels of anxiety among the members of these teams. The information obtained allowed us to identify that, in fact, there are marked differences between the profiles of the teams, which directly impacts the emotional experience of these professionals.

Regarding the identification of the profile most affected by anxiety levels, the research showed that CAPS professionals are the most vulnerable, due to the complex and challenging nature of the work they perform. Constant exposure to crisis situations and the

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management of severe mental health cases was pointed out as a crucial factor that increases anxiety levels among these professionals.

In the analysis of protective and triggering factors, the study identified that, while team cohesion and social support function as elements of protection against anxiety, work overload, lack of adequate resources and direct contact with the patients' psychological suffering act as triggering factors. These findings reinforce the need for continuous attention to the working conditions of mental health professionals, particularly at the CAPS.

Finally, when evaluating strategies to combat mental health problems, the research suggested the implementation of specific measures, such as psychological support programs and the promotion of spaces for dialogue and continuous training of professionals. These strategies have been found to be effective in mitigating anxiety levels and improving quality of life in the workplace.

Therefore, it can be concluded that the objectives of the research were fully achieved. The investigation not only fulfilled its goal of identifying and analyzing anxiety levels among RAPS professionals in Patos-PB, but also offered valuable insights into how these levels are influenced by the work environment, proposing viable solutions to improve the mental health of workers in the area and bringing new insights and inspirations to scientific production in the field of mental health in public health services.

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