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Mental Illness of Female Nurses at Federal Public Hospitals in Brazil

Teresa Cristina O. Carreteiro*, Danielle Vargas S. Baltazar

Fluminese Federal University, Rio de Janeiro, Brazil

Abstract This article uses a psycho-sociological approach. It presents the results of a study into nurses working at federally-run public hospitals in Rio de Janeiro, Brazil, who have suffered from mental illness and been granted medical leave of absencefor anxiety and/or depression. It describes the Brazilian hospital service with the aim of providing a background context for the research findings. The qualitative methodology employed constituted the content analysis of narratives of working lives. In-depth interviews were conducted with ten nurses aged 35 to 50. The main finding of the investigation link the nurses' suffering and mental illness to the socio-analytical category of "hierarchization of health care practices," which was broken down into four sub-categories: 1) formation of professional territories organized around medical knowledge; 2) power management in hospitals; 3) overvaluing of medical knowledge and undervaluing of nursing knowledge, and 4) highly competitive relationships in federal tertiary hospitals. The concluding statement is that the rigid hierarchization of the medical profession has an impact on hospital productivity.

Keywords Nursing, Federal public hospitals, Mental illness, Hierarchy

1. Introduction

This article addresses the suffering and mental illness of nurses working at federally-run hospitals in the municipality of Rio de Janeiro, Brazil, and analyzes, from a psycho-sociological perspective [1-5], within the field of social psychology, the working life narratives [6-10] of these professionals who had taken or were taking leave of absence from work because of symptoms of anxiety and depression, according to ICD-10 and DSM-IV-TR [11, 12].

The study is guided by the hypothesis that psychic suffering and mental illness emerge when a person is impeded from carrying out their work [13-15], implying that the way hospital labor is organized prevents professionals from being minimally realized. This in turn affects the pleasure they glean from their work, the quality of the patient care they provide, and the productivity of the hospital.

WORK PROCESSES IN HEALTH CARE IN BRAZIL

The conceptions of health and illness, work processes in health care, and healthcare practices have changed over time [16]. Hospitals used to be essentially religious, and the care provided was primarily of a spiritual nature; only occasionally did clinical physiciansattend the patients. It was only after liberalism[17]that hospitals started to be spaces for treating patients and training doctors and other health workers [18, 19].

Thus far, the fields of hospitals and medicine had been independent, insofar as caring for the sick inside hospital institutions was based on treating injuries, making teas and food – care provided by laypersons. Only in the late eighteenth century did medical knowledge penetrate the hospital environment, introducing disciplinary mechanisms for controlling diseases and iatrogenesis. Later, as of the nineteenth century, when hospitals started to centralize healthcare, the related work processes became a collective task subordinated to the physician's knowledge, which had a strong influence on the production of hierarchical practices [19, 20].

After the creation of medical-surgical academies, the practice of medicine was consolidated as an institutionalized profession in the field of health in Brazil. It became the legal repository for health-related scientific knowledge, it laid down the rules for education and practices in health, and started to regulate the practice of other professions, such as midwifery, pharmacy, nursing and dentistry.

The professions that were introduced to the hospital environment at a later date, such as nursing, social work and psychology, were regarded as subordinate to medical power. As such, the strengthening of the hospital as a field of medical practice also prompted the hierarchization of practices in health, molding the relationships between the professions in this institutional context.

Patient care and the administration of the hospital care environment were considered to be the work of nurses, but

* Corresponding author:
carreteiro.teresa@gmail.com.com (Teresa Cristina O. Carreteiro)
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were only professionalized after 1860, when in England Florence Nightingalecreated a model for the practice of nursing and training of nurses.

Today, hospitals are classified according to their technological apparatus, which enables improved diagnoses and disease treatment, transforming them definitively from crafts into technological work processes [21-23].

As knowledge and practices in the field of health progressed, the population grew, and interventions became increasingly complex, hospitals had to be expanded. They have become large institutions divided into units, sectors and services that work around the clock to meet the needs of the population at all hours. The number of health professionals working in hospitals has grown correspondingly.

As hospitals are divided into different services and specializations, they can be characterized organizationally according to the logic of the sharing of tasks and medical management. They have a hierarchical structure that is based on the principle of the division of labor between the university educated and those with technical qualifications [24].

The hierarchization of hospital practices is an everyday reality for health workers, reflecting the separation between the work of physicians and the work of all other health professionals. It is not so much that these latter professionals' knowledge is undervalued, but that they are dependent; it is the doctors, with their extensive education, who ultimately control the health care process. Even though the other health workers have specific legislation for the organization of their work in the health service and their professional activities as a whole, the rules for the division of labor and organization of the work process depend on correlated forces and powers, ultimately hierarchizing their practices [25-27].

We would stress from our research that the hierarchical organization of hospital labor can have a serious effect on the mental health of nursing professionals. Although the number of nursing professionals is large and they are almost exclusively responsible for patient care, they have far less autonomy in their daily activities than the other university-educated health professionals. Their conduct and procedures remain almost entirely dictated by the physicians' appraisals of the patients' health status. The knowledge that informs the patient care provided by nursing teams at hospitals is perceived as being subordinate to medical knowledge [28, 29].

For nurses, the hierarchy and power relations in hospitals follow a vertical line of command from the professional with a degree in nursing to the auxiliary nurse. The nurses' relationships with doctors constitute another line of power and hierarchy structured around medical knowledge. This has been pointed out as an area wrought with dilemmas and interprofessional conflicts. Given the power dynamics in these relationships, they are also seen as potentially causing suffering and illness amongst nurses working in hospitals [30].

Finally, we would add that hospitals have a key role in the provision of public healthcare in Brazil, while hospital management is characterized as the management of power relations between the different health professionals. The issues relating to the division of laborare the ones that have proved to be most implicated in the mental illness of nurses in Brazil's federal hospitals.

2. Method

This research was approved by the Brazilian Research Ethics Committee (protocol # 1 /2012) after its inclusion in and appraisal by the Brazilian platform for research on human beings. An informed consent form was read and signed by all the participants. A qualitative methodology of an exploratory nature was used, based on content analysis [31, 32]. Qualitative approaches enable the more in-depth study of the issue in question and more detailed interviews.

From the theoretical perspective of psycho-sociology, the use of qualitative methodologies is based on the understanding that individuals and collectivities are indivisible, thereby enabling the construction of articulations between the social and the psychic. In this research, this perspective is associated with content analysis in order to draw links between suffering and mental illness, the labor collective, and the hospital institution. We analyzed suffering and illness not only as an experience, but also as an expression of the hospital setting. These articulations will be discussed in the analysis of the research data.

2.1. Data Gathering Technique and Sample

Snowball sampling was used to form the sample of nurses. According to Biernacki and Waldorf [33], this technique enables samples to be formed by referral, with the number of subjects being defined by the criteria of accessibility, experience, and knowledge about subject under study.

According to this technique, after the first interview has been conducted and transcribed, a preliminary analysis should be done, from which the researcher will make some tentative theoretical formulations. This interviewee will then refer another subject, and so forth. The idea is that the subjects' involvement with the research topic will make them qualified to make such referrals. This process proceeds until no new data for the analysis of the topic under investigation is added in the interviews.

The sample was made up of ten female nurses with a degree in nursing aged 35 to 50. They all graduated at least ten years before the interview and had been working in direct patient care in federal hospitals in Rio de Janeiro for at least seven years. They had all taken or were taking medical/psychiatric leave for anxiety and/or depression.

The fact that all the nurses sampled were women can be attributed to the fact that nursing in Brazil is still a predominantly female domain. The choice of professionals with at least seven years' experience at federally run public hospitals was because we judged this to be the minimum time necessary for them to familiarize themselves with the federal hospital culture.

The investigation of their working life history was conducted using in-depth, semi-structured interviews covering three major areas:

i) choice of profession and early career;
ii) work at the federal health service, including details of the services they had worked for and the positions they had held; and
iii) the process leading to their leave of absence for anxiety and/or depression.

The data were collected in semi-structured interviews, because according to Taylor and Bogdan [34], this is the most appropriate method when the aim is to understand the interviewees' viewpoints on their experiences and circumstances.

The sample size was determined as the research progressed until the point of saturation or redundancy was reached [35-38]. The sample was considered closed when no new information was obtained on the subject under investigation or when redundant data started to be gathered in the interviews.

The data on the professionals in the sample are set forth in Table 1.

2.2. Data Analysis

The data from the interviews was treated using content analysis. Systematic comparisons were made of the points highlighted by the interviewees, repeated words, ideas and reflections about mental illness, organized under semantic groups. This analysis gave us access to the experiences and meanings the nurses attributed to their work, and the processes that led to their being granted leave on medical grounds.

All the interviews were transcribed, then content analysis was used to organize an analytical category with four sub-categories, as shown in Table 2.

3. Results and Discussion

In their narratives, the nurses talked about the difficulties, limitations and conflicts they encountered in their professional practice, stressing how these related with doctors and hospital management. The socio-analytical category "**hierarchization of health care practices"** is, in the interviewees' view, associated with a process of suffering and mental illness. Below, we set forth our analysis of the results and narratives in four sub-categories.

3.1. Formation of Professional Territories Organized around Medical Knowledge

This sub-category involved the semantic groups of "power", "control" and "feuds", all relating to medical knowledge. At the hospital, the professionals organize their activities around the diagnosis made by the doctor, following his/her recommendations and prescriptions, which leaves them little room for autonomy in their professional activities.

Table 1. Data on the nurses interviewed

INTERVIEWEE	AGE	DIAGNOSIS –IDC 10	LENGTH OF PSYCHIATRIC LEAVE	SECTOR OF WORK
E-01	50	**F32** – mood disorder; mild depressive episode	3 months	Pediatrics and Pediatric Intensive Care
		F 32.2 – severe depressive episode without psychotic symptoms	10 months	
E-02	50	**F 32.2** – severe depressive episode without psychotic symptoms	1 year	General Practice
E-03	42	**F32** – mood disorder – mild depressive episode	60 days	Urology
		F 32.2 – severe depressive episode without psychotic symptoms	6 months	
E-04	37	**F 32.2** – severe depressive episode without psychotic symptoms	1 year	Pediatrics
E-05	38	**F41.2** – mixed anxiety and depressive disorder	10 days	Pediatrics
		F 32.2 – severe depressive episode without psychotic symptoms	6 months	
E-06	38	**F 32.2** – severe depressive episode without psychotic symptoms; and **F43** – reaction to severe stress and adjustment disorders (burn-out)	1 year	Patient Safety Group
E-07	35	**F 32.2** – severe depressive episode without psychotic symptoms	6 months	Cardiopediatrics
E-08	46	**F 32.2** – severe depressive episode without psychotic symptoms	1 year	Cardiopediatrics
E-09	50	**F 32.2** – severe depressive episode without psychotic symptoms / **F43** – reaction to severe stress and adjustment disorders (burn-out)	1 year	Maternity
E-10	35	**F 32.2** – severe depressive episode without psychotic symptoms	9 months	Outpatients

Table 2. Analytical Category with sub-categories

ANALYTICAL CATEGORY	ANALYTICAL SUB-CATEGORIES
HIERARCHIZATION OF HEALTH CARE PRACTICES	Formation of professional territories organized around medical knowledge
	Power management in hospitals
	Overvaluing of medical knowledge and undervaluing of nursing knowledge
	Highly competitive relationships in federal tertiary hospitals

This method of organizing work in the hospital results in a hierarchy of practices and specific forms of relationship between the different professional groups, which the interviewees highlighted as being a source of tension, conflict and suffering. This is reflected in the relationships between the professionals in the context of the work processes, as the interviewees describe.

"At the hospitals there were lots of feuds. Each member of the medical staff was in charge of a few beds. Each staff member controlled a bit of the hospital, and I didn't have any say in my work. I couldn't go to work any more, and working became a burden for me. We see situations at work where a doctor's doing something wrong, but ethically your hands are tied when it comes to saying anything, because doctors always know more than nurses" ***(sic, E-04).***

"What made me ill was not working with the patients. No, that's not right! That's what I trained for, that didn't scare me ... quite the contrary! What made me ill was the health care model and the relationship with the doctors" ***(sic, E-02).***

What these narratives show is that in hospitals there is more than one physical division of space in the organization of healthcare. There is also the organization of territories of power and knowledge that sustain the practices, and can become a source of suffering and illness.

3.2. Power Management in Hospitals

This sub-category concentrates on the semantic group of "power management." The managerial model adopted in Brazil's public hospitals has undergone some major changes both in the realm of healthcare management and in terms of human resources. As medical knowledge has been paramount in guiding these changes, nurses feel that in this process there is little room for the participation of other professionals. They experience the changes as if they were imposed, and complain that the knowledge and experience they acquire over years providing patient care in the hospital setting is disregarded. The narratives highlight a sense of humiliation and at the same time a contradiction between the organizational rule book and the reality of what is done [39] in hospital management, resulting in dissatisfaction and suffering.

"It's humiliating, having people from the hospital administration and all the sectors telling us what to do. I think my leave was a consequence of not being able to take action in my own work" ***(sic, E-03).***

"The relationships inside the hospital are very intense. So it's really hard to make this life flow inside this field of power relations in nursing. You're always working with a focus on decentralizing management, but you know that what actually happens is always the other way round. That inevitably leads to suffering"* ***(sic, E-01).***

"My history of illness is far more related to the question of the management model and power relations within the hospital structure. That's the main source of suffering in my experience. There came a time when the hospital became unbearable and the only way I could survive was to take time off" ***(sic, E-09).***

The narratives in this sub-category lead us to state that analyzing the professionals' suffering and illness results in questions being asked about the prevailing managerial model and the power relations on which it is structured. By this means, psychiatric leave can also be seen as a response to the hierarchical labor organization model.

3.3. Overvaluing of Medical Knowledge and Undervaluing of Nursing Knowledge

This sub-category involves the semantic groups of "superiority and inferiority" and "appreciation and lack of appreciation of experience." A hospital is a field of practices revolving around medical knowledge. What we see from the interviews is that nurses' knowledge has become peripheral, and that this is something that cantrigger mental illness.

"Not having a voice, not having anyone willing to listen to a person with more experience. The common practice of nurses always being told what to do by doctors has never ended, because that's what we experience at work all the time" ***(sic, E-08).***

"We end up seeing a lot of things we won't be able to fix. I think that's what made me ill" ***(sic, E-05).***

The knowledge-power dialectic emerges in the nurses' narratives as the basis for practices that are particularly related to the physicians. In this context, nursing receives less prestige, less recognition, than the work of a doctor, making it a source of suffering, dissatisfaction and illness.

3.4. Highly Competitive Relationships in Federal Tertiary Hospitals

This sub-category involves the semantic group of "competition." Federal hospitals provide very complex healthcare and demand highly qualified professionals, involving state-of-the-art technologies and procedures. This combination of requirements shapes the way the teams interact, based on very high levels of competition. At the hospitals, these teams are seen as constituting hubs of knowledge and differentiated practices, making use of novel procedures and contributing to the development of medical specializations. In this context, nursing professionals are also required to maintain a high level of educational quality and training to maintain the level of excellence expected of the hospital. These ideals of qualification and performance are felt as a source of suffering, and are expressed in the

interviewees' narratives as contributing to their illness.

"The federal hospital is specialized, so that heightens the level of vanity and competition between the different professions. When I was completely worn out, I'd try to get a new lease of life, and carried on until I couldn't manage anymore because I felt I had to give the best I could and I couldn't do that anymore"*(sic, E-07).*

"For the nurses at the federal hospital to have a voice, they have to be super-nurses. Not many people will pay attention to a normal nurse" ***(sic, E-03).***

"The suffering comes from realizing that that healthcare model, that institutional model, the institutional model as a whole, wasn't capable of changing the cycle of illness. That was what made me suffer the most" ***(sic, E-07).***

Being extremely well qualified did not protect these professionals from illness, because what was at stake in the hierarchic relations in the hospital was the supremacy of medical power, which still supersedes that of a nurse, however well qualified he/she is.

Working at a Brazilian federal hospital is important for the career development of health professionals. However, for the sample studied, the higher relative value of the physicians over the nurses, allied with high expectations in terms of qualification, resulted in intense competition. It also triggered suffering and mental illness, caused by the need to adapt to and overcome the difficulties presented by the organization of labor in the hospital.

4. Conclusions

The findings of this study indicate that public hospitals are privileged loci for healthcare, and also political force fields, where what is at stake is not only the provision of care for the ill, but also the hierarchical relations between the different professions.

Hospitals are extremely hierarchical spaces organized under the aegis of medical power and knowledge. This means of structuring work processes in the hospital setting shapes the relationships between the different health professionals, determining how autonomous their activities are, and giving some greater recognition than others. The different hierarchies between the professions were found to be a source of intense dissatisfaction when we analyzed the narratives of the nurses who took medical leave.

Mental illness was expressed in the professionals' narratives as a process that began with some dissatisfaction with the way work at the hospital was organized, and gradually transmuted into mental illness. When the mental disorder was recognized, it opened the way for leave to be granted on health grounds. There is a passage from "being a worker" to "being ill." It is at this point that the diagnosis of anxiety and/or depression intervenes as an institutional mechanism that links the professional, during the period of leave, to the world of the psychiatric patient.

The findings of this research indicate that the hierarchical organization of hospital practices and the illness of nurses merit analysis beyond the issues of individual suffering, not least because of the impact this has on hospital productivity. We suggest that future research could also investigate the same issues in the private hospital setting.

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REFERENCES

[1] Levy, A., & Gaulejac, V. (2000). *Récit de vieethistoiresociale*. Paris: Eska.

[2] GAULEJAC, V. (2005) *La sociétémalade de lagestion: Idéologiegestionnaire, pouvoirmanagérial et harcèlement social*. Paris: Éditions du Seuil.

[3] Enriquez, E. (2012). Psychosociologiedesorganisations. In A. Bevort, A. Jobert, M. Lallement& A. Mias (orgs.), *Dictionnaire du travail* (pp. 255-593). Paris: Quadrige/PUF.

[4] Enriquez, E. (2002). El relato de vida: interfaz entre intimidad y vida coletiva. *Revista Perfiles Latinoamericanos*, 21, 35-48.

[5] Carreteiro, T. C. (2001). Psicossociologia em exame. In M. N. da M. Machado, E.M. Castro, J. N. G. de Araújo & S. Roedel, (orgs.). *Psicossociologia: análise social e intervenção*. (pp. 107-108). Belo Horizonte: Autêntica.

[6] Bertaux, D. (1997). *LesRécits de vie*. Paris: Nathan.

[7] Bertaux, D. (1980). L'Approchebiographique, savaliditéméth odologique, sespotentialités. In Histoires de Vieet Vie Sociale. *CahiersInternationaux de Sociologie*. (pp. 197-226). Paris: PUF.

[8] Bertaux, D. (1971). *L'Approche Biographique. Histoires de Vie ou Récit de pratique?*Paris: Cordes.

[9] Carreteiro, T. C. (2012). Vidas fazendo história e construindo histórias de vida. In T. C. Viana, G. S. Diniz, L. C. Fortunato & V. Zanello, (orgs.). *Psicologia Clínica e Cultura Contemporânea.* (pp. 33-50). Brasília: UNB.

[10] Carreteiro, T. C. (2002). Historia de una vida, historia de uma sociedad de exclusion .*Perfiles Latinoamericanos. Revista de la Sede Académica de México de la Faculdad Latinoamericana de Ciencias Sociales*. 21, 11-33.

[11] American Psychiatric Association (APA). (2002). *Manual diagnóstico e estatístico de transtornos mentais – DSM-IV-TR*. Porto Alegre: Artmed.

[12] Organização Mundial de Saúde. (1993). *Classificação de Transtornos Mentais e de Comportamento da CID-10: Descrições Clínicas e Diretrizes Diagnósticas.* Porto Alegre: Artmed.

[13] Clot, Y. (2011). Clínica do trabalho e da atividade. In P. F. Bendassolli & L. A. Soboll, (ed.).*Clínicas do trabalho*. (pp. 71-83). São Paulo: Atlas.

[14] Clot, Y. (2006). *A função psicológica do trabalho*. Petrópolis: Vozes.

[15] Clot Y. (1998). *Le travail sans l'homme? Pour une psychologiedesmilieux de travailet de vie*. Paris: La Découverte.

[16] Neto, A. F. P. (2009). *Ser médico no Brasil. O presente no passado.* Rio de Janeiro: Fiocruz.

[17] Hirata, H. (1989). A divisão capitalista do trabalho**.** *Tempo Social. Revista Sociologia USP*, 2(1), 73-103.

[18] Pires, D. (2008). *Reestruturação Produtiva e trabalho em saúde no Brasil.* São Paulo: Annablume.

[19] Peduzzi, M. (2002) Mudanças tecnológicas e seu impacto no processo de trabalho em saúde*. Revista Trabalho, Educação e Saúde*, 1(1), 75-91.

[20] Schraiber, L. B. (1996). *O médico e seu trabalho: limites da liberdade*. São Paulo: Hucitec.

[21] Pitta, A. (1999). *Hospital dor e morte como ofício*. São Paulo: Hucitec.

[22] Silva, G. B. (1986). *Enfermagem Profissional. Análise Crítica*. São Paulo: Cortez.

[23] Pires, D. (2000). Reestruturação produtiva e consequências para o trabalho em saúde. *Revista Brasileira de Enfermagem*, 53, 251-63.

[24] Merhy. E. & Onocko, R. T. (1997). *Agir em saúde um desafio para o público*. São Paulo: Hucitec.

[25] Cecílio, L.C.O. (1999) Autonomia versus controle dos trabalhadores: a gestão do poder no hospital. *Ciência e Saúde Coletiva*, 4(2), 315-329.

[26] Capitão, G. C. & Nicoletti, I.G. (2013). Correlation between depression and Burnout in nursing professional. *Internacional Journal of Applied Psychology*, 3(5), 133-138.

[27] Baba, V., Galaperin, B. L., Lituchy, T. R. (1999). Occupational mental health: a study of work-related depression among nurses in the Caribbean. *International Journal of Nursing Studies*, 36, 163-169.

[28] Manetti, M. L. Marzialli, M. H.P. (2007). Fatores associados à depressão relacionada ao trabalho de enfermagem. *Estudos de Psicologia*, 12(1), 79-85.

[29] Santos-Filho, S. & Barros, M.E.B. (2007). *Trabalhador da saúde. Muito prazer! Protagonismo dos trabalhadores na gestão do trabalho em saúde.* Ijuí: Unijuí.

[30] Pires, D. (1989). *Hegemonia médica na saúde e enfermagem.* São Paulo: Cortez.

[31] Patton, M. (2002). *Qualitative research and evaluation methods*. London: Sage.

[32] Bardin, L. (1995). Análise de conteúdo. Lisbon: Edições 70.

[33] Biernacki, P. & Waldorf, D. (1981). Snowball sampling: problems and techniques of chain referral sampling. Sociological Methods & Research. Thousand Oaks, CA, 10(2).

[34] Taylor, S. & Bogdan, R. (1984) *Introduction to qualitative research methods: the search for meanings*. New York: John Wileyand Sons.

[35] Turato, E.R. (2003). Tratado da metodologia da pesquisa clínico-qualitativa. Construção teórico-epsitemológica, discussão comparada e aplicação nas áreas da saúde e humanas. Petrópolis: Vozes.

[36] Alves-Mazzotti, A. J. & Gewandsznajder, F. (1999) O método nas Ciências Naturais e Sociais. São Paulo: Pioneira.

[37] Biernacki, P. & Waldorf, D. (1981) Snowball Sampling: Problems and techniques of Chain Referral Sampling. Sociological Methods & Research, 02, 141-163.

[38] Denzin, N. K. & Lincoln, Y.S. (1994). Handbook of qualitative research. Londres: Sage Publications.

[39] Dejours, C, Abdoucheli, E. & Jayet, C. (1994). *Psicodinâmica do Trabalho. Contribuições da Escola Dejouriana à Análise da Relação Prazer, Sofrimento e Trabalho*. São Paulo: Atlas.