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Prevalence of depressive and anxious symptoms on primary health care professionals in a city in the metropolitan region of Recife, Pernambuco

Prevalência de sintomas depressivos e ansiosos em profissionais da Atenção Primária à Saúde em um município da região metropolitana do Recife, Pernambuco

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Abstract

Objective: To verify the prevalence of depressive and anxious symptoms in primary health care (PHC) professionals in Olinda, a city in the metropolitan region of Recife, Pernambuco, Brazil. **Methods:** This cross-sectional study included 243 PHC professionals distributed in 50 basic health units in Olinda, Pernambuco, Brazil. Data were collected between February and May 2023 using the sociodemographic characterization questionnaire, the Beck Anxiety Inventory, and the Beck Depression Inventory – II. **Results:** The study identified a prevalence of 58% of anxious symptoms, mostly classified above the mild level. The prevalence of depressive symptoms was 43.2%, with 27.6% on the light level, 13.2% on moderate, and 2.4% on severe. A significant association was observed between depressive and anxious symptoms and dissatisfaction with the structure of the basic health unit (prevalence ratio [PR] = 1.31; 95% confidence interval [95% CI] = 1.05 - 1.63), psychological abuse during working hours (PR = 1.55; 95% CI = 1.26 - 1.92), seek for psychological or psychiatric care (PR = 1.72; 95% CI = 1.21 - 2.45), and use of alcohol (PR = 2.33; 95%CI = 1.31 - 4.12) and psychotropics (PR = 2.15; CI 95% = 1.54 - 3.00) to relieve symptoms. **Conclusion:** Strategies aiming for the comprehensive care of

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PHC professionals are needed to improve their quality of life and the assistance to the population.

Key-words: Anxiety; Depression; Mental health; Occupational health; Primary health care.

Resumo

Objetivo: Verificar a prevalência de sintomas depressivos e ansiosos em profissionais da atenção primária à saúde em um município da Região Metropolitana do Recife, Pernambuco. **Métodos:** Estudo transversal, envolvendo 243 profissionais da Atenção Primária à Saúde distribuídos em 50 Unidades Básicas de Saúde de um município da Região Metropolitana do Recife. A coleta de dados ocorreu entre fevereiro e maio de 2023 e foram aplicados 3 instrumentos: questionário de caracterização sociodemográficas, Inventário de Ansiedade de Beck e Inventário de Depressão de Beck II. **Resultados:** O estudo identificou uma prevalência de 43,2% de sintomas depressivos e 58% de sintomas ansiosos entre os entrevistados. Referente aos sintomas ansiosos, a maioria foi classificada acima do nível leve. Quanto aos sintomas depressivos, houve prevalência de 27,6% para o nível leve, 13,2% para o nível moderado e 2,4% para o nível severo. Houve associação significativa dos sintomas depressivos e ansiosos entre os trabalhadores que relataram estar insatisfeitos com a estrutura da unidade (RP= 1,31; IC 95% 1,05–1,63), que já sofreram abuso psicológico durante o expediente (RP= 1,55; IC95% 1,26–1,92), que buscaram atendimento psicológico ou psiquiátrico (RP= 1,72; IC 95% 1,21–2,45) e que fizeram uso de álcool (RP= 2,33; IC 95% 1,31–4,12) e psicofármacos (RP= 2,15; IC 95% 1,54–3,00) para aliviar sintomas. **Conclusão:** Observou-se a necessidade de estratégias direcionadas ao cuidado dos profissionais para o enfrentamento do problema que ofereçam qualidade de vida ao trabalhador e garantam a prestação de serviço e o cuidado à saúde integral da população adscrita.

Palavras-chave: Ansiedade; Atenção Primária à Saúde; Depressão**;** Saúde mental; Saúde ocupacional.

INTRODUCTION

The national basic care policy of Brazil (Ordinance No. 2,436 of 2017) considers basic care and primary health care (PHC) similar, corresponding to the main access to the Unified Health System and the communication center of the health care network. The family health strategy includes the PHC team, which comprises nurses, physicians, community health agents, nursing technicians, and dental health technicians; they are responsible for the regional population of the basic health unit (BHU). These professionals perform integrated actions in individual, family, or collective care, aiming at the promotion, prevention, and protection of health, qualified listening of patients, diagnostic and treatment of clinical conditions, actions on damage reduction, palliative care, and health surveillance.[1,2]

The PHC team executes territorialization and area mapping, including information in the system and integral care of the population, comprising admission, follow-up, and activities performed at the BHU, in the community, and at home.[1]

Occupational health is a concern due to the exposure of healthcare professionals to occupational risks. Many responsibilities and tasks, insufficient material and human resources, extended working hours, populational claims, precarious structures of health services, salary dissatisfaction, and work overload may trigger mental and physical suffering. These conditions enable the occurrence of health problems, such as anxiety and depression with different patterns, and also affect the quality of healthcare provided to the population.[3]

Anxiety is a state of mental, emotional, behavioural, social, and physical perturbation, defined as a long-term anticipation of negative episodes that may occur during uncertainty, existential threats, or possible and real hazards. Meanwhile, depression is a humour alteration that conducts actions and modifies the notion of self, causing the perception of difficulties and uncertainties as tragedies.[4] This context contributes to the disease process of PHC professionals, increasing mental health issues and exposure to stress, insomnia, difficulty concentrating, and factors that impair functionality and quality of life.[5]

Actions of occupational health in the Unified Health System promote and protect the PHC professionals through the surveillance of risks in the environment and work conditions, health problems, and organization and assistance to workers. Occupational health encompasses integrative diagnosis, treatment, and rehabilitation, as well as studying and intervening in the relations between work and health to promote quality of life.[6]

Knowing the psycho-emotional conditions that influence daily lives of healthcare professionals allows changes in the working context, respecting the national policies of occupational health. Thus, fostering the need to understand risk factors for mental diseases targets the strengthening of the health care of workers.[6] Therefore, this study aimed to verify the prevalence of depressive and anxious symptoms in PHC professionals in a city in the metropolitan region of Recife, Pernambuco, Brazil.

METHODS

This cross-sectional study included PHC professionals from Olinda, a city in the metropolitan region of Recife, Pernambuco, Brazil.

The sample calculation used the formula of the finite population for epidemiological studies (level of confidence of 95% and error power of 5%), resulting in 243 PHC professionals collected between February and May of 2023.

Interviews occurred during visits to 50 BHU, with a previous presentation of the study aims and an invitation to participate when available. PHC professionals were guided on data confidentiality and signed the informed consent form, followed by data collection in a private room.

PHC professionals included physicians, nurses, dentists, pharmacy technicians, dental health assistants, nursing technicians, and community health agents (CHA) who answered ques-

tionnaires. Exclusion criteria were PHC professionals aged under 18 years, on vacation or leave during data collection, or who did not answer questionnaires.

Previously validated instruments were used, such as a questionnaire on sociodemographic characteristics and lifestyle of professionals developed by the researchers, the Beck Anxiety Inventory (BAI), and the Beck Depression Inventory-II (BDI-II).[7,8]

The BAI (21 questions) assesses emotions from the last week and measures the intensity of anxiety symptoms with excellent internal consistency and test-retest reliability[7,8]. Answers are classified into four levels: no, light, moderate, or severe. The BDI-II measures the intensity of depression (21 questions) using scores from zero to three, assessing depressive (lack of hope, cognitive deficits, irritability, culpability, and punishment emotions) and physical symptoms (weakness, weight loss, and libido decrease). The BDI-II was validated in Brazil and assessed depressive symptoms of the Brazilian population.[7,8]

Data were organized in a spreadsheet (Excel software) and validated by the Epi-Info program (version 3.5.4). Statistical analysis was performed using the program STATA - Statistical Package for Social Sciences (IBM Corp., CA, EUA), version 13.0, with descriptive statistics (absolute and relative frequencies, and percentages) and correlation tests (Pearson Qui-square). The association between sociodemographic characteristics and lifestyle with anxious and depressive symptoms was estimated using the prevalence ratio (PR). A significance level ≤ 5% (0.05) for a 95% confidence interval (CI) was considered.

RESULTS

A total of 243 PHC professionals participated in the study, including 22 (9.0%) physicians, 25 (10.3%) nurses, 10 (4.1%) dentists, 3 (1.2%) pharmacy technicians, 12 (4.9%) dental health assistants, 21 (8.6%) nursing technicians, and 150 (61.7%) CHA.

The sociodemographic characteristics showed more PHC professionals aged ≥ 50 years (54.3%). Most were female (84.8%), catholic (39.1%), with brown skin (63.0%), and with a monthly income of ≤ R$ 3033.00 (65.8%). Most PHC professionals had high school (76.5%), worked more than five years in a BHU (82.3%), and were unsatisfied with its structure (56.8%). In the last six months, 63.0% suffered psychological abuse during working hours; 24.7% sought psychological or psychiatric care; 14.0% used alcohol, and 33.3% used psychotropics to relieve depressive and anxious symptoms. PHC professionals practiced self-care (72.0%), 67.5% spent less than 40 minutes on the work route, 69.5% did not use public transport to get to work, and 87.6% did not live alone.

The prevalence of anxiety and depression symptoms was 58.0% and 43.2%, respectively. Regarding anxiety symptoms, 102 (42.0%) PHC professionals presented the minimum level, and most (58.0%) had light (25.9%), moderate (16.9%), and severe (15.2%) levels. Depression levels

presented a prevalence of light (27.6%), moderate (13.2%), and severe (2.4%), and according to BDI-II, 56.8% of PHC professionals were not depressed (Table 1).

Table 1. Anxiety and depression levels of PHC professionals. Olinda, Pernambuco, Brazil, 2023

Classification	N = 243	(%)
BAI		
Minimum level	102	42.0
Light anxiety	63	25.9
Moderate anxiety	41	16.9
Severe anxiety	37	15.2
BDI-II		
Not depressed	138	56.8
Light depression	67	27.6
Moderate to severe depression	32	13.2
Severe depression	6	2.4

BAI: Back Anxiety Depression; BDI-II: Back Depression Inventory-II.

The association between sociodemographic variables and anxiety and depression levels is shown in Tables 2 and 3, respectively. The BAI score was grouped into “light to severe anxiety” and “minimum anxiety”, and BDI-II was divided into “light to severe depression” and “not depressed”.

Table 2. Association between sociodemographic variables and lifestyle with anxiety levels. Olinda, Pernambuco, Brazil, 2023

		BAI			
Variables	**N = 243 n (%)**	**Light to severe anxiety**	**Minimum anxiety**	**PR (95% CI)**	**p-value***
Age (years)					
25 – 49	111 (45.68)	66 (46.80)	41 (44.10)	1.06 (0.78 - 1.43)	0.678
≥ 50	132 (54.32)	75 (53.20)	57 (55.90)	1.00	
Gender					
Female	206 (84.77)	121 (85.80)	85 (83.30)	1.10 (0.74 - 1.64)	0.613
Male	35 (14.40)	19 (13.50)	16 (15.70)	1.00	
Transgender male	2 (0.82)	1 (0.70)	1 (0.80)	1.21 (0.29 - 4.90)	
Religion					
No	23 (9.50)	12 (8.50)	11 (10.80)	0.86 (0.54 - 1.36)	0.550
Yes	220 (90.50)	129 (91.50)	91 (89.20)	1.00	

Skin color[a]					
Not white	201 (82.70)	117 (83.00)	84 (82.30)	1.00 (0.67 - 1.51)	0.239
White	38 (15.60)	22 (16.60)	16 (15.70)	1.00	
Educational level					
High school	186 (76.50)	118 (83.70)	68 (66.70)	1.63 (1.22 - 2.17)	0.002
Higher education	57 (23.50)	23 (16.30)	34 (33.30)	1.00	
Monthly income (R$)					
≤ 3033.00	160 (65.80)	100 (70.90)	60 (58.80)	1.340 (1.02 - 1.80)	0.045
> 3033.00	83 (34.20)	41 (29.10)	42 (41.20)	1.00	
Work years in BHU					
≥ 5	200 (82.30)	115 (81.60)	85 (83.30)	1.01	
< 5	43 (17.70)	26 (18.40)	17 (16.70)	0.93 (0.62 - 1.39)	0.721
Satisfaction with the structure of the BHU					
Unsatisfied	138 (56.80)	89 (63.10)	49 (48.00)	1.42 (1.05 - 1.90)	0.019
Satisfied	105 (43.20)	52 (36.90)	53 (52.00)	1.00	
Suffered psychological abuse during working hours					
Yes	153 (63.00)	103 (73.00)	50 (49.00)	1.76 (1.32 - 2.35)	< 0.001
No	90 (37.00)	38 (27.00)	52 (51.00)	1.00	
Sought psychological or psychiatric care in the last six months					
Yes	60 (24.70)	47 (33.30)	13 (12.80)	2.24 (1.35 - 3.71)	< 0.001
No	183 (75.30)	94 (66.70)	89 (87.20)	1.00	
Used alcohol to relieve depressive and anxious symptoms					
Yes	34 (14.00)	25 (23.80)	9 (6.50)	2.33 (1.31 - 4.12)	< 0.001
No	209 (86.00)	80 (76.20)	129 (93.50)	1.00	
Used psychotropics to relieve depressive and anxious symptoms					
Yes	81 (33.30)	55 (52.40)	26 (18.80)	2.150 (1.54 - 3.00)	< 0.001
No	162 (66.70)	50 (47.60)	112 (81.20)	1.00	
Practice of self-care					
Yes	175 (72.00)	73 (69.50)	102 (73.90)	1.00	
No	68 (28.00)	32 (30.50)	36 (26.10)	1.10 (0.85 - 1.42)	0.450
Mean travel time to work (minutes)					
≥ 40	79 (32.50)	39 (37.10)	40 (29.00)	1.18 (0.91 - 1.51)	0.179
< 40	164 (67.50)	66 (62.90)	98 (71.00)	1.00	
Use of public transport to get to work					
Yes	74 (30.50)	44 (31.20)	30 (29.40)	1.050 (0.75 - 1.45)	0.764
No	164 (69.50)	97 (68.80)	72 (70.60)	1.0	
Did not live alone					
Yes	213 (87.60)	92 (87.60)	121 (87.70)		
No	30 (12.40)	13 (12.40)	17 (12.30)	1.00 (0.71 - 1.40)	0.988

a: Four lost values (two refused to answer and two did not know)
BAI: Back Anxiety Inventory; CI: confidence interval; PR: prevalence ratio; BHU: basic health unit.
* Fisher's correlation coefficient

A significative association ($p < 0.05$, $PR > 1$) was observed for light to severe anxious symptoms in PHC professionals with high school (83.7%), monthly income ≤ R$ 3033.00 (70.9%), dissatisfaction with the BHU structure (63.1%), psychological abuse during working hours (73%), seek for psychological or psychiatric care (33.3%), and use of alcohol (23.8%) and psychotropics (52.4%) to relieve depressive and anxious symptoms. In addition, the use of alcohol and psychotropics (52.4%) to relieve depressive and anxious symptoms showed a prevalence of 2.33- and 2.15-fold to develop anxious symptoms, respectively.

Table 3. Association between sociodemographic variables and depression levels. Olinda, Pernambuco, Brazil, 2023

		BDI-II			
Variables	**N = 243 n (%)**	**Light to severe depression**	**Not depressed**	**PR (95% CI)**	**p-value***
Age (years)					
25 – 49	111 (45.68)	47 (44.80)	64 (46.40)	0.97 (0.78 - 1.21	0.802
≥ 50	132 (54.32)	58 (55.20)	74 (53.60)	1.00	
Gender					
Female	206 (84.77)	90 (85.70)	116 (84.00)	1.01 (0.74 - 138.00)	0.462
Male	35 (14.40)	15 (14.30)	20 (14.50)	1.00	
Transgender	2 (0.82)	0 (0.00)	2 (1.45)	1.77 (1.57 - 2.00)	
Religion					
No	23 (9.50)	10 (9.50)	13 (9.40)	1.00 (0.68 - 1.46)	0.978
Yes	220 (90.50)	95 (90.50)	125 (90.60)	1.00	
Skin color[a]					
Not white	201 (82.70)	92 (87.60)	109 (79.00)	1.26 (0.98 - 1.62)	0.242
White	38 (156.00)	12 (11.40)	26 (18.80)	1.01	
Educational level					
High school	186 (76.50)	84 (80.00)	102 (73.90)	1.15 (0.90 - 1.46)	0.267
Higher education	57 (23.50)	21 (20.00)	36 (26.10)	1.00	
Monthly income (R$)					
≤ 3033.00	160 (65.80)	69 (65.70)	91 (65.90)	1.00	
> 3033.00	83 (34.20)	36 (34.30)	47 (34.10)	0.99 (0.78 - 1.25)	0.970
Work years in PHC					
≥ 5	200 (82.30)	82 (78.10)	118 (85.50)	1.00	
< 5	43 (17.70)	23 (21.90)	20 (14.50)	0.78 (0.56 - 1.10)	0.134

Satisfaction with UBS structure					
Unsatisfied	138 (56.80)	69 (65.70)	69 (50.00)	1.31 (1.05 - 1.63)	0.014
Satisfied	105 (43.20)	36 (34.30)	69 (50.00)	1.00	
Suffered psychological abuse during working hours					
Yes	153 (63.00)	81 (77.10)	72 (52.20)	1.55 (1.26 - 1.92)	< 0.001
No	90 (37.00)	24 (22.90)	66 (47.80)	1.00	
Sought psychological or psychiatric care in the last six months					
Yes	60 (24.70)	38 (36.19)	22 (15.90)	1.72 (1.21 - 2.45)	< 0.001
No	183 (75.30)	67 (63.81)	116 (84.10)	1.00	
Used alcohol to relieve depressive and anxious symptoms					
Yes	34 (14.00)	25 (23.80)	9 (6.50)	2.33 (1.31 - 4.12)	< 0.001
No	209 (86.00)	80 (76.20)	129 (93.50)	1.00	
Used psychotropics to relieve depressive and anxious symptoms					
Yes	81 (33.30)	55 (52.40)	26 (18.80)	2.15 (1.54 - 3.00)	< 0.001
No	162 (66.70)	50 (47.60)	112 (81.20)	1.00	
Practice of self-care					
Yes	175 (72.00)	73 (69.50)	102 (73.90)	1.00	
No	68 (28.00)	32 (30.50)	36 (26.10)	1.10 (0.85 - 1.42)	0.450
Average travel time to work (in minutes)					
≥ 40	79 (32.50)	39 (37.10)	40 (29.00)	1.18 (0.91 - 1.51)	0.179
< 40	164 (67.50)	66 (62.90)	98 (71.00)	1.00	
Uses public transport to get to work					
Yes	74 (30.50)	30 (28.60)	44 (31.90)	1.00	
No	164 (69.50)	75 (71.40)	94 (68.10)	0.93 (0.74 - 1.17)	0.578
Does not live alone					
Yes	213 (87.60)	92 (87.60)	121 (87.70)	1.00	
No	30 (12.40)	13 (12.40)	17 (12.32)	1.00 (0.71 - 1.40)	0.988

a: Four lost values (two refused to answer and two did not know)

BDI-II: Back Depression Inventory-II; CI: confidence interval; PR: prevalence ratio; PHC: primary health care.

* Fisher's correlation coefficient

The association was statistically significant between depressive symptoms and dissatisfaction with the BHU structure (PR = 1.31; 95% CI = 1.05 - 1.63), psychological abuse during working hours (PR = 1.55; 95% CI = 1.26 - 1.92), seek for psychological or psychiatric care (PR = 1.72; 95% CI = 1.21 - 2.45), and use of alcohol (PR = 2.33; 95% CI = 1.31 - 4.12) and psychotropics (PR = 2.15; 95% CI = 1.54 - 3.00) to relieve depressive and anxious symptoms.

DISCUSSION

This study observed a prevalence of depressive and anxious symptoms among PHC pro-

fessionals of 58.0% and 43.2%, respectively. Brazilian studies performed on different care strategies showed a significant prevalence of anxiety and depression in health professionals, highlighting the increasing pattern of this health issue in recent years.[3,4,9,10]

Light (25.9%), moderate (16.9%), and severe (15.2%) anxiety levels were demonstrated in PHC professionals, corresponding to the majority (58%) of the sample. In comparison, a study[0] conducted in São Paulo with 173 professionals of a PHC team showed that 45.3% of them had anxiety (25.0% light, 9.9% moderate, and 10.5% severe). During the last decade, the prevalence of anxious symptoms increased among PHC professionals, especially on moderate and severe levels, evidencing concerns about mental diseases in occupational health.

Regarding depressive symptoms, PHC professionals demonstrated 27.6% light, 13.2% moderate, and 2.4% severe levels, summing 43.2% of the sample. However, 56.8% were not classified with depressive symptoms based on the BDI-II score. In a study with a similar sample, depression was identified in 41.0% of the professionals (28.9% light and 12.1% moderate).[10]

The significant association with different sociodemographic variables and symptoms of anxiety and depression indicated that mental suffering is increasing in PHC professionals. Significant associations were observed between light to severe anxiety symptoms and high school educational level with monthly income, psychological abuse, dissatisfaction with the workplace, alcohol and psychotropics use, and seek for psychological or psychiatric care, which evidences anxiety symptoms as not random and more frequent. Pressure in the workplace, biological sex, dysregulated sleep, and civil status showed an association with anxiety. Depression was associated with work department, employment relationship, role, age, and skin color.[10,9]

Regarding the age group and mental diseases, 54.32% were aged > 50 years, of which 84.4% were female, contributing to an increased prevalence of depressive and anxious symptoms. Thus, the PR was not associated compared with other genders. Studies with larger samples identified a higher chance of anxious symptoms in females due to social and cultural factors, gender inequality, caring labour beyond work, and more openness to express emotions compared with males.[11]

In the present study, 14.0% and 33.3% of PHC professionals used psychotropics and alcohol, respectively. Previous studies evidenced the influence of depression, anxiety, stress, and chronic fatigue in the use of these substances for symptom relief. Intrinsic and extrinsic factors to work may be associated with psychotropic use. The same study demonstrated anxious and depressive symptoms in PHC professionals, indicating a correlation already observed.[5]

The association between light to severe anxiety symptoms in PHC professionals with high school was significant, representing 83.7%. The 150 CHA (61.7%) were the majority (> 50%) and the most affected by anxiety and depressive symptoms. Moreover, higher education professionals showed lower impacts, corroborating the literature. A study with 4749 professionals observed

32.0% of CHA and a prevalence of psychiatric conditions of 18.4% compared with 10.0% of professionals with higher education.[3] Besides the lower educational level, the increased work requirement and mechanical, biological, physiological, and mental workload could overload CHA, impacting mental health. This context may explain the difference in emotional levels observed between professional categories. Findings also suggest that professionals with higher education may have greater resilience, which leads to lower emotional exhaustion.[10,11,12]

The income and educational level showed an association with anxiety symptoms. Although they varied according to professional category, PHC professionals with high school (83.7%) and a monthly income of ≤ R$ 3033.00 (70.9%) demonstrated an increased prevalence of anxiety. These findings indicate the negative impact on mental health of PHC professionals and contradict the study that observed increased depression in professionals with lower income and educational level.[13]

Regarding psychological and psychiatric care, only 24.7% of PHC professionals sought assistance in the last six months, a percentage lower than professionals with high education (33.3%). These findings corroborate the psychological abuse during working hours suffered by 63.0,% of which 73.0% had a high school educational level since they were more susceptible to disrespect and oppression in the workplace. Each professional category has a work dynamic with psychological, physical, and emotional demands, validating the need for psychological or psychiatric care for mental diseases.[14]

PHC professionals accept challenges and tasks while performing their assigned activities and unexpected demands. Moreover, a dissatisfaction of 56.8% was demonstrated with the structure of the BHU, suggesting an influence of the lack of resources and materials in the severity of depressive an anxious symptom.

A Canadian study of 2021[15] also indicated that psychosocial abuse and long work hours increased the risk of depressive and anxious symptoms. The present study showed that 83.3% of PHC professionals working in the BHU over five years had a minimum level of anxiety, and 78.1% had light to severe depression, indicating the association of the exposure time to increased physical and emotional exhaustion.

Considering health as an integral physical, mental, and social well-being state and not only the lack of diseases,[16] the comprehension of a culture in formulating and providing professional care is fundamental. Therefore, national campaigns of awareness and support for mental health of PHC professionals and assistance of trained professionals should be considered to reduce depression and anxiety symptoms. In addition, self-care practices may improve quality of life, according to a study[17] with nursing professionals on the effects of meditation at the beginning of the daily routine at work, which strengthened positive mental states to cope with work-related stress.

CONCLUSIONS

The present study identified depressive and anxious symptoms in PHC professionals. Lower income and educational level, dissatisfaction in the workplace, and those who suffered psychological abuse during working hours were demonstrated to increase the prevalence of depressive and anxious symptoms.

Moreover, findings enable the development of strategies to recognize and approach depressive and anxious symptoms in PHC professionals. The promotion of a culture of care and support with mental health services and self-care programs may foster well-being and quality of care, improving the quality of life of PHC professionals and their assistance to the population.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

CONTRIBUTIONS BY AUTHORS

APRC: Formulation of ideas, elaboration of objectives and comprehensive objectives of research, preparation and creation, writing of the initial draft and critical review, comments, and full article review. **ASS**: Formulation of ideas, elaboration of objectives and comprehensive objectives of research, data collection, preparation, and creation, writing initial draft and critical review, comments, and review. **IAMB**: Formulation of ideas, elaboration of objectives and comprehensive objectives of research, data collection, preparation and creation of methods, conclusion, reference review, and adjustments on discussion and abstract. **MCFFS**: Formulation of ideas, elaboration of objectives and comprehensive objectives of research, data collection, preparation and creation of discussion, conclusion, references review, and full article review. **JRCS**: Application of statistical, math, computational techniques, and other formal techniques to analyse or summarize study data, supervision and orientation for planning and executing research activities, and critical review, commentary, and full article review.

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