



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

CONTEXT OF A RESEARCH: REFLECTIONS ON OCCUPATIONAL PSYCHIC SUFFERING

CONTEXTOS DE UMA PESQUISA: REFLEXÕES SOBRE O SOFRIMENTO PSÍQUICO DO TRABALHADOR

CONTEXTOS DE UNA INVESTIGACIÓN: REFLEXIONES SOBRE EL SUFRIMIENTO PSÍQUICO DEL TRABAJADOR

Rúbia Mara Maia Feitosa¹, Lia Carneiro Silveira², Arisa Nara Saldanha de Almeida³

ABSTRACT

Objective: to identify the main problems persisting in occupational healthcare policy, specifically its interface with mental suffering. **Methods:** descriptive and exploratory study of qualitative approach, carried out in support services for mental health and occupational health in the municipalities of Mossoró/RN and Fortaleza/CE, with 12 health professionals acting in these services. This study had the project approved by the Research Ethics Committee, Protocol 15768013.1.0000.5296. **Results:** it was observed that, in the research fields, the number of work-related mental health reports is still relatively small compared to the total calls. **Conclusion:** although it is a low number, the presence of workers complaining of psychological distress, without proper diagnosis, is something quite common. **Descriptors:** Mental Health; Work; Research.

RESUMO

Objetivo: identificar os principais problemas que persistem na política de assistência a saúde do trabalhador, especificamente sua interface com o sofrimento psíquico. **Método:** estudo descritivo e exploratório, de abordagem qualitativa, realizado em serviços de assistência em saúde mental e saúde do trabalhador nos municípios de Mossoró/RN e Fortaleza/CE, com 12 profissionais da saúde atuantes nestes serviços. O estudo teve o projeto aprovado pelo Comitê de Ética em Pesquisa, protocolo nº 15768013.1.0000.5296. **Resultados:** observou-se que, nos campos de pesquisa, o número de notificações de saúde mental relacionado ao trabalho ainda é pouco significativo em relação ao total dos atendimentos. **Conclusão:** embora seja um número baixo, a presença de trabalhadores com queixa de sofrimento psíquico, sem o devido diagnóstico, é algo bastante frequente. **Descritores:** Saúde Mental; Trabalho; Pesquisa.

RESUMEN

Objetivo: identificar los principales problemas que persisten en la política de asistencia de salud del trabajador, específicamente su interface con el sufrimiento psíquico. **Método:** estudio descriptivo y exploratorio, de abordaje cualitativo, realizado en servicios de asistencia en salud mental y salud del trabajador en los municipios de Mossoró/RN y Fortaleza/CE, con 12 profesionales de la salud actuantes en entes servicios. El estudio tuvo el proyecto aprobado por el Comité de Ética en Investigación, protocolo nº 15768013.1.0000.5296. **Resultados:** se observó que, en los campos de investigación, el número de notificaciones de salud mental relacionado al trabajo aún es poco significativo en relación al total de los atendimientos. **Conclusión:** sin embargo sea un número bajo, la presencia de trabajadores con quejas de sufrimiento psíquico, sin el debido diagnóstico, es algo bastante frecuente. **Descriptores:** Salud Mental; Trabajo; Investigación.

¹Nurse, Master Student, Graduate Program in Clinical Care in Nursing and Health, State University of Ceara/UECE. Fortaleza (CE), Brazil. E-mail: rubinhafeitosa@hotmail.com; ²Nurse, PhD Professor, Graduate Program in Clinical Care in Nursing and Health, State University of Ceara/UECE. Fortaleza (CE), Brazil. E-mail: silveiralia@gmail.com; ³Nurse, Master Professor, Faculdade Metropolitana da Grande Fortaleza/FAMETRO. Fortaleza (CE), Brazil. E-mail: arisanara@gmail.com

INTRODUCTION

In Brazil, according to the Statistical Yearbook of Occupational Accidents (OA), released by Social Welfare in 2011, shows that work-related Mental and Behavior Disorders ranks third place in number of illness and accident aids, presenting an increase of 2% compared to 2010, reaching the mark of 12,337 cases.¹ However, we observed that still few cases of workers with complaint of psychological distress related to work and who seek the CEREST (Occupational Health Reference Center) are reported.²

This service is a reference in the diagnosis of work-related diseases, having multi-professional team for guidance to workers, organizing information and subsidizing surveillance, in order to structure the network of care to workers' health in each State. But due to the few reported cases of workers in psychological distress seeking CEREST, some questions started to intrigue us: Why does this happen? Why do health professionals mention that there are workers with psychological distress complaint, but there are no workers with diagnosis of work-related mental and behavioral disorder?

This can be observed during the preparation and development of pilot research "An Approach on the Clinical Nursing Care to Workers in Psychic Suffering", whose primary objective is to identify the configuration of the complaint of psychological distress related to work in view of the uniqueness of the worker. However, to start it, two prepositions called our attention: the first was how to find these workers with complaint of psychological distress and the second, which the most suitable place to find them was. These points have guided us to the formulation of the methodological aspects of the research and by confronting them with the reality of the services we started to reflect over this article about what they presented to us.

OBJECTIVE

- To identify the main problems that persist in occupational healthcare policy, specifically in its interface with the psychological distress.

METHOD

This was a descriptive and exploratory study with a quantitative approach, performed with 12 health professionals working in care services in mental and occupational health in the municipalities of Mossoro/RN and Fortaleza/CE.

This research is the result of the survey of information learned during the development of pilot research "An Approach to the Clinical Nursing Care to Workers in the Psychic Suffering" of the Graduate Program in Clinical Care in Nursing and Health, State University of Ceara (UECE).

It was conducted from March to May 2013, period in which approaches with the various support services in mental and occupational health in two municipalities, Mossoro/RN and Fortaleza/CE were made, so as to identify workers with the diagnosis of Work-Related Mental and Behavioral Disorder.

To achieve this step, we carried out exploratory visits to the Regional Occupational Health Reference Centre (CEREST); Psychosocial Care Center (CAPS) and Integrated Mental Health Unit (UISAM); Occupational Health Center of a Regional Hospital. These services are located in the city of Mossoro. In Fortaleza we visited the State CEREST and the Regional CEREST.

Didactically, we emphasize that the State of Rio Grande do Norte has State CEREST seat in Natal and two regional CERESTs, in Mossley and Caico, respectively. In turn, the State of Ceara counts on a State Cerest and seven Regional CERESTs. In Fortaleza it is located the State CEREST and a regional CEREST.

The state CERESTs develop and implement the Occupational Health State Policy, follow the regional CEREST action plans, the participation of the pact for the definition of sentinel network and the contribution to the health surveillance activities. In turn, the regional CERESTs are assigned to train the network of health services, support more complex investigations, support the formulation of public policies, support the structuring of assistance of medium and high complexity to meet occupational accidents and harm contained in Work Related Disease List.

The CAPS, another research location, is a public institution inserted into the Unified Health System (SUS), according to the recommendations proposed by the psychiatric reform, that values the displacement of psychiatric practices for intensive, community care practices. Is constituted by a multidisciplinary team, playing the role of regulator from the entryway of mental health care network. In turn, UISAM is a regional reference service in mental health of Mossoro, where users, in most cases, first go to that unit to subsequently be referred to other health services. They also offer outpatient care of psychiatrists, psychoanalysts, psychologists, social workers and nurses.

Feitosa RMM, Silveira LC, Almeida ANS de.

Context of a research: reflections on occupational...

The Occupational Health Center of a Regional Hospital in Natal, implemented in 2006, is an instrument that aims to provide a better quality of life for servers, whether in physical, mental and social aspect. The Center has a multidisciplinary team of nurses, physician, psychologist, physiotherapist, among others.

In this exploratory phase, we talked to different health professionals, for example: nurses, speech therapists, lawyers, physiotherapists, psychologists, doctors. If the initial goal was just to identify workers with a diagnosis of work-related mental and behavioral disorder, we began to gather, from the professionals, information on the difficulties that persist in assistance to workers' health, specifically its interface with mental suffering. For that, we used open interview from the following guiding question: why do you mention that there are workers with psychological distress complaint, but there are no workers with a diagnosis of mental and behavioral disorder related to work?

Thus, the methodological obstacles encountered during exploratory visits to services and the speeches of professionals in these locations are the study material of this text, analyzed from a reflection based on the literature on the area (mental health and work).

For implementing the research, we observed the precepts issued in Resolution No. 196/96 of the National Health Council (CNS), which proposes the principles of autonomy, beneficence, non-maleficence and justice/equity.³ Similarly, we considered the requirements of Resolution No. 311/2007, which deals with the Ethics Code of nursing professionals, highlighting the provisions included in Chapter III, which deals with the scientific production.⁴

This work was submitted to the Research Ethics Committee of the Potiguar University, Campus Natal, Protocol 15768013.1.0000.5296.

RESULTS AND DISCUSSION

The ICD-10 was adopted as a criterion for inclusion of subjects in the study, which seemed something obvious within the context of Manual of Work-Related Diseases, that guides the organization of the service and is developed in the proposal of ICD-10 and, with it, we could bring out more elements to support the discussion of our research, however, we point out that this search criteria for medical diagnosis was only to guide us in meeting these subjects, since it

would be less likely to find them another way. However, it would be discarded after this phase and we would focus on each worker's speech about their suffering.

We initially selected the Occupational Health Reference Center (CEREST) of Mossoró for the research location. Therefore, the choice was justified by the fact that this service is, according to the Occupational Health National Policy, a reference in the establishment of diagnosis of work-related diseases and conducts, among other activities, individual or collective monitoring of the worker who comes to service with a complaint of psychological distress.

This service enabled to know and approach the workers who could fit the inclusion criteria of the study, which is being a carrier of work-related mental disorder diagnostic. And according to professionals, there were, in the service, four workers with that diagnosis. Again, it seemed obvious to us that this would be the right location for the research.

This was our proposition. The past tense was used deliberately, because not always along a research what seems obvious is sustained as such. This finding came from the second contact with the research field aimed at obtaining the first samples for the interview: who the workers were, how often they would go to the consultations, if there was the possibility of conducting the interview at the service, however, it was known at the time, that there had been administrative changes in the regional CEREST of Mossoró and coordination was in charge of another person. It happened that this new coordination decided to no longer allow the research. We tried to talk to the coordination and with other team members to better explain the purpose of the research. The talk followed a single way: the researcher stating the objectives and importance of research, and professionals strongly saying, without clarifying much: "You cannot have access to patients!" With the insistence in knowing the reason for not having access to patients, staff members claimed that the interview could aggravate the clinical picture of patients. Professionals also reported that:

What do you want to know about them? There is no way you can talk to patients. But, if you want, you can give us the questions and we can do it for you. But talking to them, no. Because it can worsen the situation in which they are. (CEREST)

It is believed that at that point we faced with veiled issues that underlie this refuse, without being explicit. After all, the proposal of the interview was to start from an open question "tell me about the reasons that led

Feitosa RMM, Silveira LC, Almeida ANS de.

Context of a research: reflections on occupational...

you to seek care in service" and hear their stories. Why talking about what happened to them could worsen their crisis? In addition, patients would have the opportunity to refuse to participate if they thought they were not in a position to do so. In fact, it was realized that we were touching a kind of glass ball, a symptomatic formation of the institution that, while denouncing a truth, conceals the difficulties inherent in mental health diagnosis in occupational health.

It is from the anxiety caused by this situation (only captured by those who experience the demands inherent in graduate programs) and by the repetition of a meeting with an invisibility of occupational psychological distress in services visited that we began to interest more deeply in this reality. So, we described in detail the reality found in each of the municipalities covered, and then, we analyzed the main points found. We could gradually weave the plot that unfolds in this invisibility.

After new moments with the work advisor, we decided to look for other health services in Mossoro directed to mental healthcare and occupational health, separately. These services were Psychosocial Care Center (CAPS); Mental Health Integrated Unit (UISAM) as well as samples of professionals, there could be workers seeking assistance of the very service where they work, such as Occupational Health Center of a regional hospital.

In these spaces, we started to explain again the research objectives and seek information about the existence of people with the diagnosis of Work-Related Mental Disorder. This time, we had another problem. In the three fields we visited, the response as to conduct the study was favorable. However, none of the three services had in their records any patient diagnosed with work-related mental health.

[...] today, we realize that the oldest employees already have this complaint of suffering: exhaustion, stress, depression. These are people who work night shifts, in which there is a great fatigue, there are situations of psychological illness, indeed [...], but there is no diagnosis, because it is the situation that the physical symptoms draw attention, but if you want to interview these people with the complaint of suffering because of work, you will find. (Health Center)

A professional from another service depicted the same perception by mentioning that "we have a patient who discusses in his speech a complaint of psychological distress and brings some elements of the work. He has even benefit granted by Brazilian Social

Security Institute (INSS), but we need to look in the medical record, because the work-related diagnostic, I think there is not". (UISAM)

Given this reality and due to the research was linked to a University of Ceara, we sought, during the month of April, to address the State and regional CEREST of Fortaleza. The situation was repeated in those places we visited: no workers with this diagnosis, only with the complaint of psychological distress. However, more information was being collected and we now had a significant material to support processes of reflection of work. As shown in the speech of a professional of one of the CERESTs:

I have not answered yet any case that presented to be work-related. It is not easy to identify this relation to work. I even had a case which I thought it might be, but I discarded because it had a very clear personal history.

We had a meeting to discuss the methodological disadvantages of the research discussed and to set new strategies to identify workers in psychological distress, because it was no longer configured in methodological obstacle, impediment to listen to the workers in CEREST of Mossoro but also in the problems that persist to establish the causal relationship between mental health and work.

The first obstacle, the prohibition of at least invite patients and leave them the option to decline, shows for a speech position whose professional takes the place of expert, speaking for the patient, assigning him the position, not of subject, but a mere appendage of care. The second obstacle, the lack of diagnosis of psychological distress related to work in the visited services in causes some concern because when confronting the information provided by scientific articles that discuss the subject, we noticed that, in recent years, these diagnoses are also frequent, sometimes causing disabilities, evolving to work absenteeism and reduced productivity.²

Reflecting on the reality that becomes present in health services is thinking about what kind of clinic supports the actions of occupational health policies and health professionals. In any case, both situations we came across to the accomplishment of the research show an invisibility of suffering. Whether in the clinic, in theory or in policy, work-related suffering was released to invisibility. The best way not to deal with a problem is not recognizing it. But it would be appropriate to take the invisibility of work-related psychological distress as part of the problem. Invisibility needs to be explained

Feitosa RMM, Silveira LC, Almeida ANS de.

Context of a research: reflections on occupational...

because, far from being restricted to the action of not wanting to see, it becomes a constituent part of the problem.⁵

We emphasize that, regardless of the health professional performance space, we know that they must operate a clinical care grounded in listening to the worker's ailments. And break with the practice of care that only cares about identifying what signs and symptoms relate to which "mental illness." This was one of the reasons for the inclusion of other spaces, in addition to CEREST, to be research locations.

In the course of lines of different professionals, we realize that there were other obstacles that potentiate the struggles on occupational health: psychological distress and lack of organic damage.

We do not have workers with this diagnosis. Actually, it is very difficult to detect the symptoms. They are not so visible. Unlike other diseases, you know? (CAPS)

There are cases of workers with a clear complaint of work-related psychological distress ...there are various situations, an example is an employee with depression, another one that was in a delicate situation in the workplace, because she was on duty and the father was hospitalized that day in serious condition, her father died and, at the boundary between personal and professional, she ended up developing situations of suffering, does not want to work, feels bad when she is in hospital. And there is another case of an employee who works at Intensive Care Unit (ICU). But actually they all do not have the diagnosis itself. There has been the complaint because we know they have it, we accompany these workers for a long time. (Health Center)

Employee's complaint is heard, but it will only be recorded if there is a report of physical pain in the body, denouncing changes and abnormalities. When referring to psychic complaints, they are mostly often put in the second place or associated with physical symptoms. Thus, many workers seem to feel more authorized to seek help in occupational care services when feeling physical problems.⁶

The speech of one of the professionals denotes this reality and adds another problem: the separation between the personal and the professional aspects:

These days, a worker came to CEREST and in initial consultations I thought he had clear features of mental disorder related to work, but then this worker started to emphasize more his personal life, saying that his mother and another family member had had depression, and then I started to reject the possibility of work-related diagnosis. But that person did not return to service. So far we do not have anyone with this diagnosis (CEREST).

It is noticed that for the professionals, subject and worker are put in different planes. The worker is dissociated from his subjectivity. This dilemma remains and dichotomy is present when it comes to discussing work-related mental suffering. The professionals' strategy, then, is to try to separate the story of life that individuals construct before (or, rather, out of) work in an attempt to find the exact contribution of work in the constitution of their suffering. On the other hand, which is most common, professionals seek to exorcise, or at least ignore the work in the history of suffering of workers.⁷

Research conducted in Australia showed that it is presumed that occupational mental illness is developed outside the workplace,⁸ therefore, it can be seen that the personal history of the patient and the history related to work are self-exclusive. As if life story and work could really be separated. The subject is structured since childhood, he does not begin to exist when starts working and neither it is possible to leave personal problems in the front door, life history and work history cannot be separated. Only analyzing each case this can be thought from worker's speech and not the decision of the professional.

In an attempt to solve this dilemma, it is observed that the incessant search for a technical recognition of the causal nexus between the disease and work, with a view to justify such a relation, has been guiding the norms in the field of occupational health and actions of professionals. The term causal nexus refers to what may prove the occurrence of cause and effect. Thus, a technical nexus is the confirmation, through medical examination, of the existence or inexistence of risk in the workplace. The speech below shows that for professionals:

It is difficult to establish the epidemiological technical nexus, often we are afraid to make the diagnosis. Look, I even bought the book about the epidemiological technical nexus on social security to better understand it, for I confess I need to study more about it (CEREST).

In order to remember that this determination on the causal nexus is related to a view of occupational health focused on interpretation of the uni or multi-causal theory of phenomena related to health/disease, specific risk factors are taken into account, when acting in the body, which can also cause specific illnesses⁷ and that may characterize as being legally recognized as work-related diseases. However, it is not possible to identify, objectively, the

Feitosa RMM, Silveira LC, Almeida ANS de.

Context of a research: reflections on occupational...

determinants involving occupational mental suffering and the exact moment that the conditions or the organization of work were the "cause" of mental changes. Fact revealed in intense speeches of professionals and it is precisely to act in the psychic sphere that dominates one of the greatest impasses to establish the technical recognition of the causal nexus between mental health and work.

Unlike typical work accidents, mental and behavioral disorders do not clearly show the relationship of cause and effect. Although many professionals understand this characteristic, there is still fear and political resistance to recognize the evidence of other factors and their relationship with work. (CEREST)

What occurs in practice is the difficulty that the worker with psychological distress has to seek treatment and get the recognition of the connection with work, that because the company physicians, responsible for issuing the diagnosis, most of the times, will not establish such link because the biomedical model shows for the relentless pursuit of an organic lesion, the labor union is unprepared to defend them, the professionals from the public system also have difficulty in associating their frame and, when this is recognized and the worker is sent to the INSS, in that place, they will find someone who will tell them that their problem is individual and has nothing to do with the organization and the conditions of their work.⁹

It is noticed that the connection with work is sought only if there is exclusion of elements involving the previous personal life of the patient. As one of the doctors of one of CERESTs claims: "the [suffering] complaints with work are even common, but when we started to investigate the situation, personal issues are stronger. It is a worker who lost his father, the mother is depressed, the brother uses drugs".

From listening to these people, we can visualize the difficulties to establish the technical recognition of the causal nexus between mental illness and work. The Occupational Health Policy itself has realized the difficulty of establishing this cause when it comes to mental health. That is why it have sought grounding in epidemiology, creating, according to Decree No. 6042 of February 12, 2007, the "epidemiological technical nexus" as an attempt to overcome this lack of causality in mental health.⁹

When epidemiological data indicate that, in certain productive branch, there is a high incidence of working disability resulting from the same health problem, the inserted worker

in a company that sector will no longer have the responsibility to prove that their illness, whether physical or mental, was caused by the activity they played. Rather, it will be up to the employer the burden of proving that such a link does not exist.¹⁰

It is the statistical incidence, in the line of work, if it is observed, that underlies the relationship between mental health and work. Regardless of whether high or not, of who proves causal nexus, whether the employer or the employee, it is a reality that in both cases a number will determine the presence of "mental illness". And when a situation occurs, it is the first to be investigated. When such a relationship is not proved, the employee's speech starts to present a strong relationship with weakness, at the risk of being considered pretense, ill-will or laziness. Finally, a multitude of features that undergo the worker to a guilty situation.¹¹

Employers' biggest interest is to maintain productivity, work cannot get sick and the worker is only an appendage of production. In these circumstances, worker's speech about their suffering in the workplace becomes devalued. An Australian research addressed the concern of employers about work-related mental illness and one of them says "I do not need to know if a team member had a diagnosis of mental illness. My job was to identify problems and come up with solutions to make the team more productive".^{12,17}

Professionals of the services visited claimed that there is still, in many cases, a suspicion that the patient is using the psychic claim to benefit financially. According to one of the professionals with whom I spoke, "situations of workers asking for withdrawal were frequent, saying they had no psychological conditions, just to get the financial benefit." Other professional of CEREST tries to exemplify this situation: "There is this worker who has already come twice asking for removal, but we did not find physical and or psychological changes. She just wanted the removal".

Thus, addressing these challenges is especially important in the current context, in which shall read the epidemiological technical nexus on social security⁶, since the psychological distress is not only in an organic dimension. Thus, assistance for workers in psychological distress should be (re)signified, breaking with the purely biological and medical-centered perspective of the health-disease process.

There is the need for accurate listening on workers' complains, for the clinic and epidemiology consider basic criteria for the classification of mental disorders the presence

Feitosa RMM, Silveira LC, Almeida ANS de.

of changes, wear in psychic functioning and duration of these changes. However, this model of understanding excludes situations where there is psychological distress which may not be defined as a disease or mental disorder in the classical sense.

It is important that care is not restricted to hard technologies, but also involves those targeting the reception, the bond and listening to this subject. Professionals need to listen to what they bring and how they speak, making each case singular. We realize, in face of impasses, to recognize the technical causal nexus between mental illness and work, that the aspect that should be at the heart of care is how to demonstrate this relationship so that it values the listening of worker's psychological distress and at the same time, continues to have legal status.

It is believed that professionals must assume an ethical position. This implies in going beyond listening reduced to an act of protocol, to a collection technique of evidence, signals, or, to an interpretive game in order to identify whether the worker's speech is considered pretense or not. Therefore, it is not about the professional standing at the worker's side or the employer's side. But it is about the ethical duty to listen to the worker's suffering, because the employee is the one complaining of psychological distress, not the employer. Thus, the professional must be able to recognize the worker in psychological distress, as a subject of singular existence, considering their subjective position. Thus, the tool for care should be based on listening the worker and not on the performance of the professional as a mediator of the employer's interests.

Professionals may understand that workers do not request the service just to get a diagnosis in order to exclusively acquire a financial benefit. Thinking this way would be a prejudice. In addition, we understand that receiving a diagnosis, no matter its purpose, do not represent the best thing that can be done for the employee, if they do not receive appropriate monitoring. However, in mental health this "cause" often is not a material cause. It is about the subject's relation with what causes it, what affects them, in their desire and their relationship with others.

This is not about ignoring that the objectivity of science helps us to get to a useful understanding of certain phenomena, however, imagining that all aspects of human life, especially those related to the functioning of psycho, can be reduced to

Context of a research: reflections on occupational...

cause-effect type mechanistic principles is incurring in a strong reductionism.¹³⁻⁴

Visiting the research fields gave us a larger dimension on the approach of mental health and work. Each conversation with professionals make us feel that we were asking about something invisible. And gradually we realized that it was not invisible, but veiled. This is a proven fact when one looks at the number of notifications related to mental health and work, still relatively small compared to the total attendances in the health service. Although it is a low number, the presence of workers complaining of psychological distress, without proper diagnosis, is something quite common, according to professionals' speeches. Thus, it is believed that this is an issue that worths reflection.

The negligible number of these diagnoses does not necessarily indicate its low frequency in the working population. On the contrary, it seems to show the persistence of difficulty by all involved - companies, health professionals and INSS experts - to recognize the work as a mental health troublemaker², which consequently reduces the search for help at the reference services, such as CEREST. If this was a conclusion of the authors of those studies in 2005 and, the same reality is set in 2013, then we ask: why do the problems persist? Perhaps the answer lies in the following question: which demands are being attended?

After visiting services and talking to some of these professionals, one can see that their interventions need to extrapolate the instrumental character and the procedure of filling forms for clinical information about the disease, but, instead, they need to seek a care guided by other indicators that can value the worker in psychological distress. Despite the issues raised had appeared initially as an obstacle to the realization of our work, it was considered appropriate to discuss them here even before the final production of the dissertation, since they are not without meaning and show a series of unspoken thoughts within the occupational health assistance policy, which needs to be explored.

FINAL REMARKS

As for the methodological issue, it was decided to leave the bias of diagnosis, because we realized that it did not refute not reduce the wealth of our discussion. Rather, the difficulty that professionals claimed to establish the causal nexus between mental illness and work only strengthened the argument that the peculiar aspect of the

psychological distress is that it is not subject to objectification. Thus, he felt the need for change in the formulation of the research inclusion criteria. Instead of starting with the diagnosis, we decided to interview the workers with complaint of work-related psychological distress. These workers were found from the speech of health professionals to the following question: which workers do you identify as having a complaint of work-related psychological distress?

We highlight that every choice has a price to pay. If the bias of diagnosis confronted us at all times with the risk of falling in the biomedical discourse, we are now aware that these subjects' choice will lie in the perception of professionals about the occupational psychological distress. Therefore, it goes beyond the dimension of the technical nexus and is configured in the speech of the person who complains and in the meanings attributed by those who listen to them.

REFERENCES

1. Brasil. Ministério da Previdência Social. Instituto Nacional do Seguro Social - INSS. Empresa de Tecnologias e Informações da Previdência Social. Anuário Estatístico de Acidentes do Trabalho. Brasília: MPS/DATAPREV; 2011.
2. Sato L, Bernardo MH. Saúde mental e trabalho: os problemas que persistem. Ciênc saúde coletiva [Internet]. 2005 [cited 2013 June 2];10(4): 869-878. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232005000400011&script=sci_arttext
3. Brasil, Ministério da Saúde. Conselho Nacional de Saúde. Resolução n.º 196, de 16 de outubro de 1996. Aprova diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos, 1996.
4. Conselho Federal de Enfermagem. Resolução COFEN n.º 311, de 8 de fevereiro de 2007. Aprova a Reformulação do Código de Ética dos Profissionais de Enfermagem. Rio de Janeiro, 2007.
5. Pereira L. O trabalho em causa na "epidemia depressiva". Tempo soc [Internet]. 2011[cited 2013 June 3]; 23(1):67-95. Available from: <http://www.revistas.usp.br/ts/article/view/12652/14429>
6. Paparelli, R; Sato, L; Oliveira, F. A saúde mental relacionada ao trabalho e os desafios aos profissionais da saúde. Rev. bras. saúde ocup [Internet]. 2011[cited 2013 June 7]; 36(123): 118-127. Available from: http://www.scielo.br/scielo.php?pid=S0303-76572011000100011&script=sci_arttext
7. Borsoi ICF. Da relação entre trabalho e saúde à relação entre trabalho e saúde mental. Psicologia e Socied [Internet]. 2007 [cited 2013 June 7];19(1):103-111. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-71822007000400014
8. Australian Human Rights Commission. 2010 Workers with Mental Illness: a Practical Guide for Managers. Mental health in the workplace. Sydney NSW, 2010, p. 4-6. Available from: <http://www.humanrights.gov.au/publications>
9. Nardi HC, Ramminger T. Políticas públicas em saúde mental e trabalho: desafios políticos e epistemológicos. Psicol. cienc. Prof [Internet]. 2012 [cited 2013 June 12]; 32(2):374-387. Available from: http://www.scielo.br/scielo.php?pid=S1414-98932012000200008&script=sci_arttext
10. Seligmam-Silva E, Bernardo MH, Maeno M, Kato M. Saúde do Trabalhador no início do século XXI. Rev bras saúde ocup [Internet]. 2010 [cited 2013 June 12];35(122): 185-6. Available from: <http://www.fundacentro.gov.br/rbso/BancoAnexos/RBSO%20122%20editorial%20Sa%C3%BAde%20do%20Trabalhador%20sec%20XXI.pdf>
11. Jacques MG. O nexo causal em saúde/doença mental no trabalho: uma demanda para a psicologia. Psicol e Socied [Internet]. 2007 [cited 2013 June 18];19(1):112-9. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-71822007000400015
12. Australian Human Rights Commission. 2010 Workers with Mental Illness: a Practical Guide for Managers. Managing mental illness in the workplace. Sydney NSW, 2010, p.9-20. Available from: <http://www.humanrights.gov.au/publications>
13. Vietta EP, Kodato S, Furlan R. Reflexões sobre a transição paradigmática em saúde mental. Rev Latino-am Enfermagem [Internet]. 2001 [cited 2013 June 25];9(2):97-103. Available from: http://www.scielo.br/scielo.php?pid=S0104-11692001000200014&script=sci_arttext
14. Rodrigues DCS, Gouveia EML, Silva DMS, Josefa A, Arruda CG, Lopes MEL. Mental health and work: psychosomatic effects under the perspective of nurses. J Nurs UFPE on line [Internet]. 2012 [cited 2013 June 28];6(11):2785-9. Available from: <http://www.revista.ufpe.br/revistaenfermage>

m/index.php/revista/article/view/3306/pdf_1672

Submission: 2013/07/13

Accepted: 2014/12/06

Publishing: 2015/01/15

Corresponding Address

Rúbia Mara Maia Feitosa
Programa de Pós-Graduação Cuidados Clínicos
em Enfermagem e Saúde
Universidade Estadual do Ceará (UECE).
Rua Cícero Aires de Lima, 52 / Ap. 05
Bairro Aeroporto
CEP 59607-390 – Mossoró (RN), Brazil