WORK LEAVE AMONG NURSING PROFESSIONALS DUE TO PSYCHOLOGICAL ETIOLOGIES

Afastamento do trabalho em profissionais de enfermagem por etiologias psicológicas

Baja laboral de profesionales de enfermería por etiologías psicológicas

Original Article

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ABSTRACT

Objective: To analyze the incidence and the length of periods off work specifically linked to psychological causes among nursing professionals. Furthermore, the study tried to identify risk factors for the work leaves and suggest actions that can mitigate the problems encountered. **Methods:** This was a retrospective, ecological study, in the largest public hospital of Curitiba-PR, with data from 3,692 nurses (2,294 auxiliary nurses, 590 nursing technicians and 808 nurses) from January 2007 to September 2010. An exploratory review was performed to form the theoretical basis of this study. The annual incidences for each type of work leave due to psychological causes were identified, among the nursing professionals. **Results:** It was found that the main cause of absenteeism were depressive episodes (F32), with 784 leaves. As for the length of time, the cause for longer periods off among nurses (40.62 days on average) was the bipolar affective disorder (F31). Nursing assistants and technicians were away from work due to recurrent depressive disorder (F33) on average for 40.47 days and 54.33 days, respectively. **Conclusion:** There was a high incidence of depressive episodes and the mean duration of absenteeism due to psychological causes was over 30 days, pointing to the need of investments in prevention and in healthcare for nursing professionals.

Descriptors: Mental Health; Occupational Diseases; Absenteeism.

RESUMO

Objetivo: *O objetivo deste estudo foi analisar a incidência e o tempo dos afastamentos ligados especificamente às causas psicológicas entre profissionais de enfermagem. Além disso, procurou identificar fatores de risco para os afastamentos e sugerir ações que possam mitigar os problemas encontrados.* **Métodos:** *Foi feito um estudo ecológico, retrospectivo, no maior hospital público de Curitiba- PR, com dados de 3.692 profissionais de enfermagem (2.294 auxiliares de enfermagem, 590 técnicos de enfermagem e 808 enfermeiros), de janeiro de 2007 a setembro de 2010. Realizou-se uma pesquisa exploratória de revisão para formar o arcabouço teórico deste estudo. Foram identificadas as incidências anuais de cada tipo de afastamento por causas psicológicas, entre os profissionais de enfermagem.* **Resultados:** *Verificou-se que a principal causa de afastamentos foram os episódios depressivos (F32), com 784 afastamentos. Quanto ao tempo de afastamento, a causa que por mais tempo afastou os enfermeiros (média de 40,62 dias) foi o transtorno afetivo bipolar (F31). Os auxiliares e os técnicos em enfermagem se afastaram devido ao transtorno depressivo recorrente (F33), em média, por 40,47 e 54,33 dias, respectivamente.* **Conclusão:** *Houve uma alta incidência dos episódios depressivos e o tempo médio de afastamento devido a causas psicológicas foi superior a 30 dias, o que aponta a necessidade de investimentos na prevenção e no cuidado à saúde dos profissionais de enfermagem.*

Descritores: *Saúde Mental; Doenças do Trabalho; Absenteísmo.*

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RESUMEN

Objetivo: *El objetivo del estudio fue analizar la incidencia y el tiempo de baja laboral de los profesionales de enfermería relacionados específicamente a causas psicológicas. Además de eso, se buscó identificar factores de riesgo para las bajas y sugerir acciones que puedan suavizar los problemas encontrados.*
Métodos: *Fue realizado un estudio ecológico y retrospectivo en el hospital público más grande de Curitiba- PR, con datos de 3.692 profesionales de enfermería (2.294 auxiliares de enfermería, 590 técnicos de enfermería y 808 enfermeros), de enero de 2007 a septiembre de 2010. Se realizó una investigación exploratoria de revisión para formar el modelo teórico de este estudio. Las incidencias anuales de cada tipo de baja por causas psicológicas fueron identificadas entre los profesionales de enfermería.*
Resultados: *Se verificó que la principal causa de bajas fueron los episodios de depresión (F32) con 784 bajas. Respecto al tiempo de baja, la causa que más afectó a los enfermeros (media de 40,62 días) fue el trastorno afectivo bipolar (F31). Los auxiliares y los técnicos de enfermería tuvieron el alta por trastorno depresivo recurrente (F33), en media de 40,47 y 54,33 días, respectivamente.*
Conclusión: *Hubo una incidencia elevada de episodios depresivos y el tiempo medio de baja por causas psicológicas fue de más de 30 días, lo que sugiere la necesidad de inversiones para la prevención y el cuidado de la salud de profesionales de enfermería.*

Descriptores: *Salud Mental; Enfermedades Profesionales; Absentismo.*

INTRODUCTION

The health care work environment has been considered unhealthy, especially in hospitals, due to the fact that it comprises several factors that contribute to the development of diseases by the professional who work in it. Some of these factors are the complexity of diseases, the imminent care and demand, procedures and techniques, and the stressful environment[1].

Another important factor is the effects of productive reorganization that has also become present in services, including health services, by establishing goals, productivity demands, and resolvability. New demands in nursing services are displayed in the overtime compensation, reduction in personnel, goals demanded by supervisors, etc. These are some of the situations that can lead to the so called work illnesses and leaves[2]. Besides, other factors can be added to this scenario such as task fragmentation, strict hierarchy and the completion of routine tasks[3].

Since the 1930's, the International Labor Organization (ILO), together with the World Health Organization (WHO), have been studying the nursing professional working process. In 1976, during the 61st session of ILO Conference, an important document was presented, which addressed life, work, and employment conditions of these professionals, identifying work precariousness[4].

The hospital environment aims at fulfilling tasks which end up exposing workers to several occupational risks and some situations that present greater risk such as: groups of patients with several diseases; worst working conditions, with fragmentation and normatization in the execution of techniques; alternate shifts; demands for updated scientific and technical knowledge; increasing bureaucratic activities, among other required tasks[5].

Thus, this work reality ends up having an impact over the psychological conditions of workers, which can result in the Burnout Syndrome, a situation that stopped being functional due to tiredness and that can be expressed by feelings of failure and exhaustion caused by excessive energy and resources expenditure, afflicting, mainly, professionals that have a direct contact with people[6].

However, in Brazil, an idealized conception of the profession sees nursing professionals as workers undergoing occupational risks, work accidents, and getting sick, not blaming those problems on unhealthy conditions and risks from their work[1].

In the last decade, several studies have focused on the relationship between mental illnesses and work due to their high prevalence. WHO estimates that the so called minor mental disorders afflict around 30% of active workers, and major mental disorders afflict from 5% to 10%. In Brazil, data from the *Instituto Nacional de Seguridade Social – INSS* (The National Social Security Institute) regarding formally registered workers show that mental disorders rank 3rd among the causes for social security grants such as sickness allowance, work leave for more than 15 days, and permanent disability retirement[7,8].

Given that, the purpose of this study was to analyze the incidence and the length of work leaves due to psychological causes among nursing professionals. Additionally, it sought to identify risk factors for leaves and suggest actions that might mitigate the problems found.

METHODS

An ecological, retrospective research was performed by analyzing quantitative data related to work leaves from 3,692 nursing professionals (2,294 nursing assistants, 590 nursing technicians, and 808 nurses) caused according to the International Classification of Diseases (ICD) between F30 and F45.

To do so, a self-explanatory invitation letter was sent to subjects inviting them to participate in the study. The letter was forwarded to the Director in charge of the Human Resources Department (HRD) and the Services of Safety Engineering and Occupational Medicine (SSEOM) of the selected hospital, meeting all the guidelines for ethical aspects.

All professionals working from January 2007 to September 2010 were included in the study. Data on work leaves of the nursing team refer to: number of leaves due to psychological diseases, cause and duration of work leave (minimum, maximum, and mean time). Data on work leaves that were not caused by psychological problems were excluded (ICD F30 to F45).

For data treatment, the descriptive statistics was primarily used with position (number of leaves, calculation of percentages and mean values) and dispersion (variability regarding the duration of work leave) measures[9]. At last, the chi-squared test was used in order to check for statistical significance between the parameters indicated in the descriptive analysis and the data[10].

The study has followed the ethical guidelines recommended by Resolution No. 196/96 about research involving human beings, as well as the ethical principles contained in the Declaration of Helsinki (1964, reformulated in 1975, 1983, 1989, 1996, and 2000). The research project was approved through Protocol No. 380/10 of the Research Ethics Committee of the *Centro Universitário Campos de Andrade* (Campos de Andrade University Center), Curitiba, Paraná.

RESULTS

By checking the causes for the leaves, one can conclude (according to Table I) that the three main causes of leaves were: depression episodes (F32), with 784 leaves; bipolar affective disorder (F31), with 331 leaves; and recurrent brief depression (F33), responsible for 175 leaves. As it can be seen in Table 2, there are no significant statistical differences among the main causes of these work leaves when comparing the different nursing professionals (nurse and nursing technicians. - p=0.934; nurse and nursing assistants - p=0.298; nursing assistants and technicians - p=0.568).

The bipolar affective disorder (F31) was the etiology that drove nurses away from their jobs for the longest period (40.62 days), while the recurrent brief depression (F33) was the condition that kept nursing assistants and technicians away for the longest time (40.47 days and 54.33 days, respectively) (Table II). By comparing the time of removal of the nurses with nursing assistants and technicians significant differences were observed ($p < 0.001$, $p = 0.039$, respectively).

As for the severity of leaves, bipolar affective disorder (F31) had a maximum of 365 days of leave; in depressive episodes (F32), leaves have lasted for 244 days; the recurrent brief depression (F33), 208 days; and the reactions to acute stress and adjustment disorder (F43) accounted for leaves of up to 100 days (Table III).

Table I - Causes for work leaves of nursing professionals due to psychological disorders in a general hospital in the city of Curitiba, between January 2007 and September 2010.

ICD	Description	Professional	2007	2008	2009	2010	Total
F30	Event Maniac	Assistant	2	-	-	-	2 (0.09%)
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F31	Bipolar Affective Disorder	Assistant	54	41	56	33	184 (8.02%)
		Technician	4	18	12	26	60 (10.17%)
		Nurse	44	19	17	7	87 (10.77%)
F32	Depression events	Assistant	258	145	102	83	588 (25.63%)
		Technician	27	38	19	6	90 (15.25%)
		Nurse	50	30	10	16	106 (13.12%)
	Recurrent depressive disorder	Assistant	28	35	38	22	123 (5.36%)
		Technician	2	4	12	2	20 (3.39%)
		Nurse	20	5	6	1	32 (3.96%)
F34	Mood disorder persistent [affective]	Assistant	10	8	3	1	22 (0.96%)
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F38	Bipolar Affective Disorder	Assistant	-	-	-	-	-
		Technician	-	-	-	-	-
		Nurse	2	-	-	1	3 (0.37%)
F39	Depression events	Assistant	1	3	-	-	4 (0.17%)
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F40	Phobic-anxiety Disorders	Assistant	1	1	-	-	2 (0.09%)
		Technician	-	-	-	-	-
		Nurse	2	-	-	-	2 (0.25%)
F41	Other anxiety disorders	Assistant	-	23	15	30	68 (2.96%)
		Technician	-	4	6	1	11 (1.86%)
		Nurse	-	5	6	-	11 (1.36%)
F42	Obsessive-Compulsive disorder	Assistant	-	2	-	1	3 (0.13%)
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F43	Reactions to acute “stress” and adjustment disorders	Assistant	-	45	22	37	104 (4.53%)
		Technician	-	6	4	4	14 (2.37%)
		Nurse	-	9	1	1	11 (1.36%)
F45	Somatoform Disorders	Assistant	-	5	45	3	53 (2.31%)
		Technician	-	1	-	2	3 (0.51%)
		Nurse	-	-	-	-	-

Table II - Average period of work leaves of nursing professionals due to psychological disorders in a general hospital in the city of Curitiba, between January 2007 and September 2010.

ICD	Description	Professional	2007	2008	2009	2010	Total
F30	Event Maniac	Assistant	5.00	-	-	-	5.00
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F31	Bipolar Affective Disorder	Assistant	28.62	49.65	42.37	34.24	38.72
		Technician	60.50	56.72	61.75	33.03	53.0
		Nurse	42.72	43.21	30.70	45.85	40.62
F32	Depression events	Assistant	29.59	31.17	33.20	29.85	30.95
		Technician	35.29	33.00	29.52	20.33	29.54
		Nurse	49.96	30.93	19.60	24.0	31.12
F33	Recurrent depressive disorder	Assistant	44.21	37.74	39.42	40.5	40.47
		Technician	18.50	62.50	46.83	89.5	54.33
		Nurse	19.80	33.00	10.16	1.00	15.99
F34	Phobic-anxiety disorder persistent [affective]	Assistant	29.10	29.12	16.33	30.0	26.14
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F38	Bipolar Affective Disorder	Assistant	-	-	-	-	-
		Technician	-	-	-	-	-
		Nurse	14.00	-	-	1.00	7.50
F39	Depression events	Assistant	30.00	30.00	-	-	30.00
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F40	Phobic-anxiety disorders	Assistant	1.00	1.00	-	-	1.00
		Technician	-	-	-	-	-
		Nurse	8.00	-	-	-	8.00
F41	Other anxiety disorders	Assistant	-	17.34	23.80	22.53	21.22
		Technician	-	26.00	18.00	3.00	15.66
		Nurse	-	6.80	2.16	-	4.48
F42	Obsessive-Compulsive disorder	Assistant	-	18.00	-	30.00	24.00
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F43	Reactions to acute “stress” and adjustment disorders	Assistant	-	19.06	24.13	24.94	22.71
		Technician	-	22.50	17.75	6.25	15.50
		Nurse	-	35.88	20.00	6.00	20.63
F45	Somatoform Disorders	Assistant	-	31.20	20.40	3.33	18.31
		Technician	-	45.00	-	2.50	15.83
		Nurse	-	-	-	-	-

Table III – Minimum and maximum period of work leaves of nursing professionals due to psychological disorders in a general hospital in the city of Curitiba, between January 2007 and September 2010.

ICD	Description	Professional	2007	2008	2009	2010	Total
F30	Event Maniac	Assistant	0 and 5	-	-	-	0 and 5
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F31	Bipolar Affective Disorder	Assistant	1 and 120	1 and 365	1 and 365	1 and 90	1 and 365
		Technician	30 and 90	1 and 90	1 and 320	1 and 90	1 and 320
		Nurse	6 and 90	1 and 90	1 and 128	4 and 95	1 and 128
F32	Depression events	Assistant	1 and 90	1 and 244	1 and 120	1 and 90	1 and 244
		Technician	3 and 90	1 and 112	1 and 90	10 and 37	1 and 112
		Nurse	6 and 90	1 and 104	4 and 38	1 and 60	1 and 104
F33	Recurrent depressive disorder	Assistant	2 and 90	1 and 208	2 and 120	1 and 60	1 and 208
		Technician	7 and 30	30 and 100	1 and 185	60 and 119	1 and 185
		Nurse	2 and 60	15 and 60	2 and 15	0 and 1	0 and 60
F34	Phobic-anxiety disorder persistent [affective]	Assistant	10 and 60	1 and 60	1 and 43	0 and 30	1 and 60
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F38	Bipolar Affective Disorder	Assistant	-	-	-	-	-
		Technician	-	-	-	-	-
		Nurse	0 and 14	-	-	0 and 1	0 and 14
F39	Depression events	Assistant	0 and 30	0 and 60	-	-	0 and 60
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F40	Phobic-anxiety disorders	Assistant	0 and 1	0 and 2	-	-	1 and 2
		Technician	-	-	-	-	-
		Nurse	0 and 8	-	-	-	0 and 8
F41	Other anxiety disorders	Assistant	-	1 and 62	5 and 90	1 and 60	1 and 90
		Technician	-	4 and 60	1 and 40	0 to 3	0 to 60
		Nurse	-	1 and 14	1 and 5	-	1 and 14
F42	Obsessive-Compulsive disorder	Assistant	-	6 and 30	-	0 and 30	0 and 30
		Technician	-	-	-	-	-
		Nurse	-	-	-	-	-
F43	Reactions to acute “stress” and adjustment disorders	Assistant	-	1 and 90	1 and 90	1 and 100	1 and 100
		Technician	-	1 and 60	1 and 30	1 and 21	1 and 60
		Nurse	-	1 and 90	0 and 20	0 and 6	1 and 90
F45	Somatoform Disorders	Assistant	-	6 and 60	1 and 60	1 and 5	1 and 60
		Technician	-	0 and 45	-	2 and 5	0 2 45
		Nurse	-	-	-	-	-

DISCUSSION

The survey herein assessed the mental health of nursing professionals with incidence of cases of work leaves. Although each nursing professional has his/her own characteristics, several common causes can be perceived in order to justify leaves as professionals seek to understand

and accomplish their working trajectory, being subjected to small disorders – from sadness to depression, among other pathologies[11].

In the present research, the three main causes for leaves were due to depressive episodes (F32), bipolar affective disorder (F31), and recurrent brief depression (F33).

The bipolar affective disorder is a mood disorder, until recently known as manic-depressive disorder, a name that is not used anymore because the psychotic symptoms are not that frequent; however, manic episodes are persistent, and mania is the most noticed trait[12].

The first epidemiological study, performed in the 1980's, is called epidemiological catchment area study (ECA) and was conducted with 18 thousand individuals in five North-American cities. The lifetime prevalences of bipolar and depressive disorders were 1.3% and 4.9%, respectively[13].

Another study called national comorbidity survey (NCS), conducted in the 1990's, has shown a lifetime prevalence of major depression of 17.7% and a momentary prevalence (30 days) of 4.9%. Such discrepancy in relation to the previous study is due to the greater sensibility in the diagnostic interview used in the NCS, the composite international diagnostic interview[14].

In Brazil, an epidemiological survey conducted in the city of São Paulo found lifetime prevalences of 1.0% for bipolar disorder, and 16.8% for depressive disorder[15].

Major depressive disorder is a common condition; it affects 10% of patients in primary care, and 15% of inpatients[16]. In the present study, depressive episodes among assistants, technicians and nurses have presented expressive figures – higher than the prevalence in the general population.

Bipolar disorder is less common than major depressive disorder, with a lifetime prevalence of circa 1% - similar to the schizophrenia rates[16]. The cumulative incidence of bipolar affective disorder according to the present study was of 8.02%, 10.17%, and 10.77%, for assistant, technician, and nurse, respectively. Such figures also represent really high prevalences when compared to the general population.

There are several causes that can contribute to an increase in work leaves, such as the amount of patients to be assisted, hostile and/or claiming patients, patients who pass away, patients with behavior changes, hard talks (when there is a need to communicate severe situations or death), ethical dilemmas, and the fear of acquiring infections[1,17]. Besides, poorly established timetables, pushing the psychological and physical aspects of the professional, low payment rates, the tension related to supervisors, colleagues' isolation and external situations like mugging, assaults, family quarrels and traffic-related stress[17].

Several stress sources can cause leaves: fear of making mistakes, fatigue and tiredness, lack of orientation to perform the job, being under constant pressure, night shifts, lack of time for leisure, family, friends, and personal needs[17]. There are also factors that contribute to worsening the situations reported, such as having more than one job, having mental and physical problems, family problems and external pressure (bills to pay, exams, illnesses, family). All these situations end up contributing to the stress overload of the nursing professional[1,17].

The research has also shown that nursing assistants were the ones who were mostly affected by depressive episodes and recurrent brief depression.

Also, most adverse reactions from psychological demands, such as fatigue, anxiety, depression, and physical disease occur when the work demand is high and the worker's degree of control over the job is low[18].

The bipolar affective disorder (F31) was the cause that kept nurses off work for the longest period (mean of 40.62 days), and the second cause for longer work leaves of nursing assistants (mean of 38.72 days)and technicians (mean of 53 days).

Studies indicate a different prevalence of bipolar disorder and major depression according to gender. Women present a higher risk to develop depressive episodes than men[19]. An almost universal observation, regardless of country or culture, is the prevalence twice as high of depressive disorder in women rather than in men. The hypothesis raised was that the reasons for that to occur involve hormonal differences, the effect of giving birth to children, different gender-related stressing factors, neglect behavioral models, learning processes. In contrast to the depressive disorder, bipolar disorder has the same prevalence among men and women. It is worth remembering that 90% of nursing workers are women[20].

The high socioeconomic level can increase the risk of bipolar disorder a little. On the other hand, low socioeconomic level is associated with higher risk of developing major depression[21].

Another data refers to the marital status. Divorced and separated professionals have a higher risk of developing affective disorders. Even among married professionals, the absence of a confidant is also associated with greater risks. There are not enough studies showing the rate of nursing professionals who are married, separated, divorced, and widowers among nurses, assistants, and technicians.

Recurrent brief depression (F33) was the cause that drove nursing assistants and technicians away from their jobs for longer (mean of 40.47 days and 54.33 days, respectively). However, it ranks fourth when it comes to nurses (mean of 15.99 days of leave) who present as the third greater cause for work leaves the ICD F43 - reactions

to acute stress and adjustment disorders (mean of 20.3 days).

Chronic stress is also related to a greater risk of developing affective disorders, especially depressive episodes. Stressing factors at work, increased demands, long working hours, few sleeping and resting hours are very common situations among nursing professionals who develop "night shift pathology". About 80% of depressed patients complain about sleeping difficulties, especially early wake up in the morning and multiple waking up periods all night long. In such cases, it is also common to use "tranquilizers", benzodiazepine medications, and sleep inducers in an abusive form[22].

Epidemiological data suggests that the incidence of major depressive disease may be increasing among people with less than 20 years old, which can be related to an increase in alcohol and drugs abuse within that group[23]. Additionally, it is known that nursing professionals have easy access to drugs and other substances in the hospital environment. It is also worth remembering that nursing assistants are usually younger than nurses.

Another fact is that inhabitants of urban areas have a greater risk for developing depressive, bipolar, and anxiety disorders than the inhabitants of rural areas[23]. Nursing professionals included in this study live in Curitiba or in urban centers next to the hospital where the research took place.

As for the severity of leaves, bipolar affective disorder (F31) had a maximum of 365 days of leave; leaves due to depressive episodes (F32) have lasted for up to 244 days; leaves due to brief depression (F33), 208 days; and the reactions to acute stress and adjustment disorders (F43) have accounted for leaves of up to 100 days.

There is an ancient and enduring clinical observation that stressing events in life frequently precede the first episode of mood disorder rather than the subsequent ones. That association has been reported both among patients with major depressive disorder and bipolar disorder. A theory proposed to explain such observation is that the stress that follows up the first episode leads to enduring changes in brain biology. Such changes can modify the functional states of several neurotransmitters, changes that can even include the loss of neurons and the excessive reduction in synaptic contacts. As a result, the individual gets a higher risk of developing mood disorder episodes, even without an external stress factor. That might justify the high number of leave days for these professionals. For instance, a manic or depressive episode can take from three to six months until symptoms are in remission[13].

If diagnosed and treated early, depression can be solved more quickly and cause less personal, professional, and social injuries just like other diseases[24].

Other disorders that have emerged in the study, such as recurrent brief depression, persistent mood affective disorder, other anxiety disorders, phobic-anxiety disorders, obsessive-compulsive disorders, acute stress reaction, adjustment disorders, and somatoform disorders do not present any significant difference in prevalence in relation to the general population. However, it is worth pointing out that the general duration of leave was significant for recurrent brief depression, anxiety, and adjustment disorders.

Such significant period – not only for nurses, but also for other populations – is due to the lack of enough qualified professionals to deal with psychiatric disorders. It is estimated that only 25% of the patients that look for treatment for major depressive disorder receive anti-depressant medications, and only part of them receive correct dosages and have appropriate treatment duration[16].

The researched institution should perform educational works with professionals on leave, group discussion and occupational medicine actions aimed at mental health care in order to identify the main factors that cause these problems and intercept them, improving the health conditions of the professionals working in health care services.

CONCLUSION

It was verified that the three main causes for leaves were the depressive episodes (F32), bipolar affective disorder (F31), and recurrent brief depression (F33). However, when considering the average leave period, bipolar affective disorder (F31) was the etiology that has kept nurses away from their work for the longest period while the recurrent brief depression (F33) was the condition that has kept assistants and technicians off work for longer.

REFERENCES

1. Nishide VM, Benatti MCC, Alexandre NMC. Ocorrência de acidente do trabalho em uma unidade de terapia intensiva. Rev Latinoam Enferm. 2004;12(2):204-11.

2. Nowak NL, Campos GA, Borba EO, Ulbricht L, Neves EB. Fatores de risco para acidentes com materiais perfurocortantes. Mundo Saúde. 2013;37(4):419-26.

3. Bezerra MLS, Neves EB. Perfil da produção científica em saúde do trabalhador. Saúde Soc. 2010;19(2):384-94.

4. Raffone AM, Hennington EA. Avaliação da capacidade funcional dos trabalhadores de enfermagem. Rev Saúde Pública. 2005;39(4):669-76.

5. Grazziano ES. Estratégia para redução do estresse e Burnout entre enfermeiros hospitalares. [tese]. São Paulo: Universidade de São Paulo; 2008.

6. Murofuse NT, Abranches SS, Napoleao AA. Reflexões sobre estresse e Burnout e a relação com a enfermagem. Rev Latinoam Enferm. 2005;13(2):255-61.

7. Veríssimo OM, Gomes J, Menezes SA, Gonçalves R, Andrade M. Estresse ocupacional: manifestações de sintomas físicos, psicológicos e sociais dos profissionais de enfermagem de uma maternidade pública no Brasil, Fortaleza-Ceará. Cienc Trab. 2012;14(45):254-9.

8. Jacques MGC. Abordagens teórico-metodológicas em saúde/doença mental & trabalho. Psicol Soc. 2005;15(1):97-116.

9. Marquieviz J, Alves IS, Neves EB, Ulbricht L. A Estratégia de Saúde da Família no controle da tuberculose em Curitiba (PR). Ciênc Saúde Coletiva. 2013;18(1):265-71.

10. Neves EB, Souza MN, Almeida RMVR. Military parachuting injuries in Brazil. Injury. 2009;40(8):897-900.

11. Brant LC, Gomez CM. Da tristeza à depressão: a transformação de um mal-estar em adoecimento no trabalho. Interface Comun Saúde Educ. 2008;12(26):667-76.

12. Jaerger GPSD, Mota Neto JIS. O Papel da lamotrigina no tratamento da depressão bipolar: uma revisão da literatura. In: Anais do XII ENPOS; 2010; Pelotas (RS), Brasil. Pelotas: Universidade Federal de Pelotas; 2010.

13. Angst J, Sellaro R. Historical perspectives and natural history of bipolar disorders. Biol Psychiatry. 2000;48(6):445-57.

14. Kessler RC, Mcgonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. Arch Gen Psychiatry. 1994;51(1):8-19.

15. Andrade LH, Lólio CA, Gentil V, Laurenti R. Epidemiologia dos transtornos mentais em uma área definida de captação da cidade de São Paulo, Brasil. Soc Psychiatry Psychiatr Epidemiol. 2002;37(5):316-25.

16. Kaplan HI, Sadock BJ, Grebb JÁ. Compêndio de Psiquiatria: ciências do comportamento e psiquiatria clínica. 7ª ed. Porto Alegre: Artes Médicas; 2007.

17. Dal Pai D, Lautert L, Krug JS. Psicodinâmica e saúde mental do trabalhador de enfermagem: ritmo acelerado e intensificação do fazer. Enferm foco (Brasília). 2011;2(1):38-43.

18. Araújo TM, Aquino E, Menezes G, Santos CO, Aguiar L. Aspectos psicossociais do trabalho e distúrbios psíquicos entre trabalhadoras de enfermagem. Rev Saúde Pública. 2003;37(4):424-33.

19. Cavalcante FG, Minayo MCdS, Mangas RMN. Different aspects of depression in suicide among the elderly. Ciênc Saúde Coletiva. 2013;18(10):2985-94.

20. Rombaldi AJ, Silva MCd, Gazalle FK, Azevedo MR, Hallal PC. Prevalence of depressive symptons and associated factors among southern Brazilian adults: cross-sectional population-based study. Rev Bras Epidemiol. 2010;13(4):620-9.

21. Mussi SV, Soares MRZ, Grossi R. Transtorno bipolar: avaliação de um programa de psicoeducação sob o enfoque da análise do comportamento. Rev Bras Ter Comport Cogn. 2013;15(2):45-63.

22. Quarantini LC, Rodrigues Netto L, Andrade-Nascimento M, Almeida A, Galvão AS, Miranda-Scippa A. Transtornos de humor e de ansiedade comórbidos em vítimas de violência com transtorno do estresse pós-traumático. Rev Bras Psiquiatr. 2011; 31(Suppl.2):S66-S76.

23. Ores LC, Quevedo LA, Jansen K, Carvalho AB, Cardoso TA, Souza LDM, et al. Suicide risk and health risk behavior among youth between the ages of 18 and 24 years: a descriptive study. Cad Saúde Pública. 2012;28(2):305-12.

24. Candido MCFS, Furegato ARF. Atenção da Enfermagem ao portador de transtorno depressivo: Uma reflexão. SMAD Rev Eletrônica Saúde Mental Alcool Drog. 2005;1(02):02-13.

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