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Overlapping of duties and technical autonomy among nurses of the Family Health Strategy

ABSTRACT

OBJECTIVE: To understand how *Estratégia Saúde da Família* (Family Health Strategy) nurses experience the overlapping of duties and building of technical autonomy.

METHODOLOGICAL PROCEDURES: This was a qualitative study performed with 22 nurses, in the city of Recife, Northeastern Brazil, between August 2005 and November 2006. Based on management evaluation (geographic access; conflicts in the team, between team and district and between team and community; and public violence in the area), four teams were selected in each of the six health districts. Semi-structured interviews were conducted. The main themes in the interview guide were about work expectations and relevance, its organization and process, and feelings towards these practices. The results were interpreted under the perspective of burnout.

ANALYSIS OF RESULTS: The nurses' opinion on the excessive number of families, insufficient organizational support and pressures from user demands that had not been met was recurrent. Overlapping of health care and management caused work overload, creating anxiety, impotence, frustration and the feeling of being treated unfairly when tasks were divided among team members. The clinical dimension of practice led to a feeling of insecurity of a technical and ethical nature, in addition to the satisfaction for the power and prestige achieved by the professional category. Specialized medical training represented an obstacle to autonomy and responsibility becoming interdependent. Stress, dissatisfaction, becoming physically and mentally ill, recognition of the relevance of work and importance of one's performance, and low work involvement were reported.

CONCLUSIONS: In view of the lack of expectation of changes in the short term, the overlapping of low professional satisfaction and work overload causes negative attitudes, indicating the importance of health promotion to increase the possibility of influencing and changing work conditions.

DESCRIPTORS: Nurses. Family Health Program. Community Health Nursing. Burnout, Professional. Stress, Psychological. Job Satisfaction. Qualitative Research.

INTRODUCTION

Redesign of the role of nurses in the *Estratégia Saúde da Família* (ESF – Family Health Strategy) meets the expectations of a more fair technical and social work division. The challenge of building technical autonomy is set and, as a result,

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so is the responsibility for choice and decision among the possibilities.¹⁵ According to Ricoeur¹⁷ (1991), autonomy can only be fully conceived as collective work, the fruit of a relationship where others are always present as alterity. In the ESF, the relational nature of decision is emphasized by the search for reciprocity and complementarity in the work of agents with different qualifications.²

This challenge shows the central role of professional competence and the overcoming of inequality of value attributed to distinct jobs in the health team.^{2,7} However, many aspects of the micro-policy of work process and organizational and macro-structural dimensions hinder the performance expected of the nurse in the ESF, emphasizing the dissatisfaction with work experiences. The pressures coming from the change in work rationality, especially when organizational support is deficient, can lead to low professional satisfaction and fatigue burnout.^{19,23} These aspects are essential for the appearance of negative feelings and attitudes defining the burnout syndrome.^{6,24,25}

Since the 1970s, the term burnout has been used metaphorically to describe professionals' lack of interest and negativity, who had been motivated and committed, but who subsequently underwent frustrating and straining work conditions. First, it was associated with individual characteristics such as sex, age, type of personality and length of professional service.²⁵ Next, burnout began to be explained by the organizational conditioning factors of work: overload, interpersonal conflicts, expectations in the implementation of technologies, performance of roles, lack of reciprocity, and limitations to autonomy, among other things.^{3,19} Currently, its understanding is associated with interrelations among people's singularity, work situation and life context.⁶

According to Tamayo & Tróccoli²⁴ (2002), burnout maintains a strict relationship with perceived organizational support, which includes the following: management style of directors; regulating work practices and policies; productivity defined by workers; availability, adequacy and sufficiency of material and financial resources; social support and interpersonal relationship with directors, supervisors and coworkers; and rewards (moving up the corporate hierarchy, salary, care for well-being). Perception of insufficient organizational support is a significant predictor of fatigue and it constitutes a key factor of burnout.^{14,24}

The reference concept for research and diagnosis is still the one defined by Maslach & Jackson:²⁵ burnout is the sequential process involving exhaustion (emotional resources being worn off or lost), depersonalization (negative attitudes and feelings in the workplace) and low personal satisfaction (feelings of inadequacy and failure). This definition led to the Maslach Burnout Inventory (MBI), the instrument most frequently used

to assess this syndrome, regardless of the sample's place of birth and occupation.²⁵ Although differences in the sequence of appearance and meaning among authors, the three aspects previously described are essential in burnout.^{6,10,19}

Studies showed the significant world distribution of burnout in primary care professionals, with nurses showing a high frequency of stress and low professional satisfaction, especially due to the changes in the work process.^{1,19} In Brazil, research on this syndrome in health professionals, performed mostly in hospitals, found its presence among doctors, nurses and nursing assistants.^{14,24}

The objective of the present study was to understand how ESF nurses experience the overlapping of duties and building of technical autonomy.

METHODOLOGICAL PROCEDURES

This was a qualitative study performed with 22 female nursing professionals in the city of Recife, Northeastern Brazil, between August 2005 and November 2006. Professionals who comprised the 24 family health teams selected were invited to participate in the research. There was a refusal by one professional, while another was on a sick leave.

To select teams, managers of six health districts and their technical group made an assessment based on estimate questions that indicated the decreasing level of intensity for each item. In the items associated with the existence of conflicts in the team, between the team and health district, between the team and community, and public violence in the area, the response categories were as follows: always, sometimes, rarely and never. For the question about the level of difficulty in geographic access, the responses were: much, little, none.

Based on the sum of values corresponding to the items mentioned, each team was categorized into the following situations: good, fair, poor and very poor. When two or more teams totaled the same number of points, the one with more internal conflicts was prioritized. When the same number of points corresponded to equal scores in the items assessed, a random selection was made, using a random number table. A total of 24 teams with one or more years of experience were selected (four were good in terms of work situations, seven were fair, seven were poor, and six were very poor). In two of the districts, no team was categorized as good, with one more representative of the predominant class being included.

All teams selected were submitted to a visit to be familiarized with the unit to establish contact with the work environment. Interviews were performed by two researchers, out of the services, to guarantee secrecy

and promote reflection, brought about by the guide, which included the following: professional trajectory, work organization and process, team relationships, relationships between the team and the district and community, feelings towards the practices, reported morbidity for work and quality of life.

Interviews were recorded and transcribed in full. A minimum of two sessions were performed to explore the interview guide. The number assigned to the team follows the identification of professional category in the illustrative quotations shown in the results to guarantee interviewees' anonymity.

The hermeneutic-dialectic approach was used in this study.^{8,12} The analysis involved the following: (a) initial reading to understand each report in full; (b) thorough exploration to know the interests and meanings in speech; and (c) identification of ideas and feelings through which work experiences are built. Throughout the process, the interrelation between subjective and contextual dimensions was considered. The participation of three researchers broadened nurses' rationality view, whose main thematic areas, developed from empirical material, were as follows: (1) overlapping of tasks and responsibilities; (2) building of technical autonomy; (3) discrepancy between institutional values and individual desires; and (4) inequality in the institutional treatment. The study analyzed the two first themes under the perspective of burnout, valuing similarities and variations among reports.

This study was performed according to the Declaration of Helsinki and approved by the Research Ethics Committee of the *Instituto de Medicina Integral Professor Fernando Figueira* (IMIP – Professor Fernando Figueira Institute of Comprehensive Medicine).

ANALYSIS OF RESULTS AND DISCUSSION

The majority of nurses had between seven and 14 years of experience (amplitude between 6.5 and 26 years). A total of 15 continued to work in the service, of which 11 were nurses on duty. Length of experience in the ESF was from three to seven years (distribution between three and 11 years), 12 of which worked in this health care model in other cities and 12 were supervisors of the *Programa Nacional de Agentes Comunitários de Saúde* (Brazilian Program of Community Health Agents).

Inclusion in the ESF resulted from the expectation of performing educational work, especially through collective activities that, being considered key to promote health, would establish the difference between traditional care and the current model. Better pay, the desire to work in public health, the perception of greater value given to health nurses and the possibility

of nursing consultations being performed were also motivated nurses. During the period when interviews were performed, 18 nurses had temporary employment agreements.

Overlapping of tasks and responsibilities

Obstacles to perform group educational practices resulted in great frustration and a feeling of loss, due to the divergence with what is perceived as the ESF mission. These obstacles mostly involve time spent in consultations and managerial functions; lack of space in the units; and lack of interest of the community, community health agents and doctors. The majority had between one and five years of experience in the current family health team (distribution from a year and three months to ten years) and they frequently expressed their dissatisfaction with work.

In a typical week, as reported, between six and seven shifts were spent on consultations: prenatal care, child care, family planning and prevention of uterine-cervical cancer. In the remaining time, they performed group educational activities, home visits, team meetings, care for patients with tuberculosis and leprosy, supervision of community health agents and nursing assistants, consolidation of reports from the *Sistema de Informação da Atenção Básica* (Primary Care Information System) and coordination of vaccination campaigns and commemorative weeks (breastfeeding and dengue fever, among other things). As managers, they were responsible for the maintenance of the unit, supplies, setting up consultations and specialized tests.

Nurses reported that the excessive number of families and insufficient organizational support (physical area, medications, diagnostic support, specialized care and professional qualification) had led to the ESF norms not being met. Great emotional pressure resulting from unmet demands of users is a systematic reason for anguish, stress and strain.^{19,25} These professionals represent a reference point when seeking to overcome difficulties: users, districts and teams usually search for them, regardless of who is managing the unit.

"(...) when you arrive, there are three or four people waiting for you – someone who got there late, someone else who needs an ointment or who doesn't have an appointment... So, you get stressed in the service, this becomes something that upsets you. I rarely drink water so as not to go to the toilet, because going there means to pass by reception and this is torture. As I pass, I got to solve countless problems. So, it's stressful." (Nurse 4)

Work overload emphasizes the criticisms about division of tasks, especially the little involvement of doctors with management and the information system. Participants reported that the districts were responsible

for the inequality found in the division of tasks, stating that district and local teams reproduce conceptions rooted in the nurses' managerial dimension of work, which is not in accordance with the ESF. The perception of lack of equity, which originates the feeling of being treated unfairly, is frequent.^{19,25}

"This is polemic, isn't it? Because everything is centered on the nurse, there's help obviously, but help doesn't mean the responsibility of doing... (...) It's the health district's fault, because it only seeks nurses. Whatever the program, survey or activity, it comes down to the nurse. I think this is completely wrong." (Nurse 1)

In the hospital, excellence in the work process is a managerial function. In contrast, in the ESF, the simultaneity of priority given to health care and management activities emphasizes work overload. This is the reason for the demand to include management in the field of medical competence. This dissatisfaction also reveals an experience to be overcome: distancing oneself from direct care led to the loss of autonomy in the hospital team. In the ESF, to perform the role one is assigned, autonomy must be achieved again. In addition, there is the lack of definition about the nurses' object of work.^{11,13} According to Peduzzi & Hausmann^a (2005), organizations providing qualification tend to deny that management is part of the nursing work and to value health care as if both were not complementary.

In a context of great need for professional self-assertion, nurses felt too much was required of them in the workplace, raising the debate about what they described as the polemic of multi-tasking, which causes nurses to do a little of everything.²⁰ According to Sorrato & Pinto²³ (2000), the combination of many different tasks represents a greater requirement in the preparation and performance of work, leading to stress, strain and exhaustion. Reports reveal the consequences of chronic stress in the nurses' health and quality of work (absenteeism and change of teams by nine interviewees).

"Nurses work a lot, it's such an overload of work, we often think we won't manage, because in addition to all bureaucracy, in addition to offering care in our area, there are also those who we need to listen to. The PSF nurse ends up being a social worker, psychologist, nutritionist, and even team doctor. (...) it's been about two or three weeks since I got really sick. The doctor's said it's because of stress, because we're overloaded with work." (Nurse 7)

In the present study, multi-tasking increases the conflict between what must be done and the pressure

of time, leading to the perception that problems were greater than the resources available to solve them⁶ and causing anxiety, feelings of impotence and frustration. Incompatibility between work and family requirements increases the perceived overload, which, in the absence of perspective of changes in the short term, results in low professional satisfaction, burnout and little involvement with work.^{22,23} This occurs especially when the intensity of conflicts does not enable them to rely on support from their coworkers.

"(...) I feel overloaded, sometimes I get to the unit and don't feel as committed as I used to, sometimes I ask myself, 'What's happening to me?' In the past, my work was much more pleasant, I got involved with the actions. Now, I can't get so involved and others don't get involved either; we go, do the job and then leave." (Nurse 22).

Building of technical autonomy

According to Moreira¹³ (1999), reflections on technical autonomy should change the attention from the great diversity found in the field of knowledge to the heterogeneity of nursing practices. Gomes & Oliveira¹¹ (2005) stated that technical autonomy transcends the medical hegemony-nursing relationship, being associated with the operating knowledge that defines the specific field and the common field of knowledge and practices, aimed at resolvability of care. Thus, autonomy is associated with better outlining of the nurses' object of work.

In Recife, Cartaxo^b identified controversies in the academic qualification of nurses as regards their practice. Professors and students were divided into two groups: one associated consultation and drug prescription with the emancipating process of the nurses' practice, whereas the other questioned the legitimacy of such attributions, considering them polemic. In the present study, nurses repeat the divergences of possibilities of the professional exercise of nursing in the ESF, in terms of the definition of what is essential and what is useful to the profession.

"(...) my greatest difficulty involves the doctor; she doesn't have experience with care for pregnant women. When I have a patient who's at risk, she goes, 'Refer her, refer her!'. But can I refer her? I know how to pick up a form and refer patients, but she's my point of reference, I don't have to refer patients, unless she's on vacation: I always note this down as a footnote – team doctor is currently on vacation – I know this is a doctor's job, I know how far I can go." (Nurse 20)

^a Peduzzi M, Hausmann M. A enfermagem como prática heterogênea que busca ressignificar as interfaces entre seus diferentes agentes e objetos de trabalho. In: Anais do Congresso Brasileiro de Enfermagem; 2004 Out 24-29; Gramado, BR: Associação Brasileira de Enfermagem; 2004 [citado 2007 dez 10]. Disponível em: <http://www.bstorm.com.br/enfermagem/palestrantes/Marina%20Peduzzi.php>

^b Cartaxo CMB. A formação profissional da enfermagem como prática social: um estudo no campo das representações sociais. [tese de doutorado]. São Paulo: Programa de Estudos Pós-Graduados em Psicologia da Educação da PUC; 2003.

“(...) the users we refer to the policlinic or some other place have difficulties, like, professionals even say that a nurse is not capable of making referrals and that they won't see to this, because it was a nurse who referred the patient.” (Nurse 3)

Particularly among professionals with more experience, the nursing consultation causes a feeling of professional vulnerability, due to both the understanding that nurses are not adequately qualified to perform in a clinic and the perception that the boundaries of their competence in this domain have not been clearly defined yet. As children were almost always ill upon arrival, child care involves many uncertainties that cause insecurity of a technical or ethical nature. This requires greater technical support and a more consistent delimitation of what pertains to the profession.

“I think child care is really hard, because mothers are not used to always bringing a healthy child. The AIDPI (Atenção Integral às Doenças Prevalentes na Infância – Comprehensive Care for Diseases Prevalent in Childhood) helps a lot, but it's a huge responsibility. (...) The nurse wasn't qualified to perform clinical tests and prescribe drugs, even in the program. (...) You run a great risk because there's nothing defined, like, where you can go, where you can't go.” (Nurse 1)

For over 20 years, professional regulation has been comprised of a set of clinical activities exclusive of nurses and aimed at primary health care. Since then, the insufficient qualification to perform such activities has been known.²¹ With professional paths mostly developed in the hospital network, it was after the inclusion of ESF that the majority of interviewees began to be qualified for the healthcare model. In view of the challenges, some nurses question the adequacy of the nursing curriculum for the qualified exercise of the multiple aspects of the clinical dimension found in this practice.

“The university needs a change, we spend a lot of time learning how to fold diapers, leaving the pharmacological question aside at times (...) doctors have more credits in pharmacology, while we only have two periods. (...) there are the Ministry's standardizations, which I try to follow not to have technical and professional problems.” (Nurse 19)

According to what was reported by nurses, in the work division in the team, doctors are not always qualified to provide resolute care, compromising the necessary interdependence of autonomy and responsibility they are in charge of. The impossibility of maintaining care in the team or clarifying questions about one's conduct causes conflicts and increases the technical insecurity of this professional towards clinical decisions,¹⁵ especially in prenatal care. The urgency of technical support care should be emphasized here.

“(...) there are professionals who aren't properly qualified to work... it should be like this, doctors should work in prenatal care. But these are usually pediatricians and they don't have experience with prenatal care, so the nurse is left with this job. But, suddenly, this nurse has a question and she can't solve this question because the doctor doesn't know that either. (...) I feel a bit lost, without anybody to turn to. So, you got to resort to a book or refer the patient to high-risk prenatal care, if it's something that you think needs to be referred”. (Nurse 5)

Organizational support below what is necessary requires great affective and cognitive investment to reduce the distance between prescribed and performed work.⁶ Work overload, lack of definition and restrictions in the performance of roles and interpersonal conflicts promote burnout.²² In ambiguous and unstable experiences, the following are present: stress; a feeling of lack of qualification due to inequality of pay, when compared to doctors; low professional satisfaction; physical and mental illnesses; and recognition of the relevance of work and one's own performance. Among less experienced nurses, there were reports of satisfaction with the nurse's power and prestige in the ESF.

“(...) it's tiring, it's more tiring to deal with the community, going from door to door. It's exhausting, but it's the place that offers the highest pay for nurses. (...) that's the place for a nurse, I think, because you have no freedom whatsoever in a hospital, all you do there has to involve a medical prescription, somebody has to sign, to ask for and to request, but not in the PSF.” (Nurse 15)

The search for personal solutions for tensions caused by work is worrisome, and so is the occupational strain with palliative methods (religious practices, self-massage, yoga, florals, Reiki, medications). The development of stress-relief strategies to reduce the consequences of chronic work-related stress and to continue to work promotes the appearance of burnout. Individual aspects cannot be discarded, although organizational processes to better support team work and the health of its members should be emphasized. Health promotion in the workplace implies room for constant interaction among planning, execution, management and assessment.^{10,24}

FINAL CONSIDERATIONS

Dissatisfaction of professionals is significant in the ambiguity of work experiences, frequently considered as one of the feelings involved with burnout. Soratto & Pinto²³ (2000) warned that, even among professionals who perceive that much is required of them and that they are being pushed to the limit of their capacity, dissatisfaction could be incipient and all unsatisfied professionals show certain manifestations associated with burnout. There is an inverse relationship between burnout and work satisfaction, in addition to a direct

relationship between positive affectivity and work satisfaction. A study performed in a Brazilian hospital organization pointed to satisfaction as being a protective factor against this syndrome.¹⁸

The autonomy nurses aim for is described as knowing something and being able to do something, which is connected to the praxis in which, according to Gadamer⁹ (2006), a constant process of learning and self-correction is experienced, whether with success or failure. In the ESF, an essential part of this learning is the professional's recognition of the need of someone else's work and the division of tasks, discussing central aspects of work organization and process, such as technical autonomy, integration of actions, communicative interaction, institutional support and relationships with the community.¹⁶

Castoriadis⁵ (1982) stated that, in the praxis, there is an internal relationship between what is aimed at

(development of autonomy) and the reason why it is aimed at (exercise of this autonomy), something conditioned by the contexts of interaction. In this sense, participation in the identification of needs, selection of priorities, implementation of decisions, and assessment and execution of initiatives associated with comprehensive health care increase the possibility of influencing and changing work conditions,¹⁵ strengthening positive feelings that are related to them.

Considering the tension between these changes sought by the ESF and personal interests of team members, dialogue is essential to meet the needs of the community (ESF mission) and to achieve one's work satisfaction. Dialogue enables the development of creative strategies to cope with burnout, which, paraphrasing Campos⁴ (2000: 129), allow one "to discover unique balancing between meeting social needs and the interest of agents developing health actions".

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