Isabelle Cordeiro de Nojosa Sombra
(Organizadora)

DISCURSOS, SABERES E PRÁTICAS DA ENFERMAGEM 3

Atena Editora
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APRESENTAÇÃO

A obra "*Discursos, Saberes e Práticas da Enfermagem"* aborda uma série de estudos realizados na área da Enfermagem, sendo suas publicações realizadas pela Atena Editora. Em sua totalidade está composta por 6 volumes, sendo eles classificados de acordo com a área de abrangência e temáticas de estudo. Em seus 25 capítulos, o volume III aborda diferentes aspectos relacionados à Enfermagem, desde assuntos inerentes ao processo de avaliação em saúde, quanto os fatores que envolvem os principais enfrentamentos da profissão.

As pesquisas sobre avaliação em saúde, surgem trazendo publicações sobre iniquidade, infraestrutura, humanização e organização dos serviços de saúde no Brasil. Em se tratando de saúde ocupacional, a vertente é estudada desde a formação profissional até a atuação propriamente dita do profissional nos serviços assistenciais.

Quando se trata da evolução da Enfermagem enquanto ciência, bem como de sua atuação nos mais diversas vertentes, é inquestionável a sua importância e os avanços obtidos até os dias de hoje. No entanto, mesmo diante da necessidade desse profissional para a qualidade na assistência à saúde e demais ramos de sua atuação, observa-se o constante adoecimento do profissional de enfermagem, havendo assim, a necessidade de medidas que visem a saúde ocupacional.

Ademais, esperamos que este livro possa fornecer subsídios para o conhecimento dos mais diversos desafios enfrentados pelos serviços de saúde no Brasil, bem como a identificação de situações que possam comprometer a qualidade de tais serviços e a consequente busca de estratégias que visem qualificá-los. Além disso, objetivamos com o presente volume dessa obra, fortalecer e estimular a prática clínica de enfermagem através de pesquisas relevantes envolvendo os aspectos evolutivos de sua essência enquanto ciência que cuida, bem como estimular a sensibilização para observação das necessidades de saúde ocupacional mediante o reconhecimento do profissional e promoção da saúde do profissional de enfermagem.

Isabelle C. de N. Sombra

SUMÁRIO

CAPÍTULO 20

PERFIL SOCIODEMOGRÁFICO E ACADÊMICO E SÍNDROME DE BURNOUT EM RESIDENTES MULTIPROFISISONAIS

Data de aceite: 25/11/2019

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RESUMO: Avaliou-se o perfil sociodemográfico e acadêmico e a ocorrência de Síndrome de Burnout em Residentes Multiprofissionais de uma universidade pública. Trata-se de um estudo descritivo, transversal, quantitativo. Aplicaram-se um formulário de dados sócio-demográficos e o MBI-HSS em 37 residentes entre Abril e Junho de 2011. Em relação ao perfil sócio- demográfico, observou-se o predomínio do sexo feminino (83,78%), solteiros (81,08%), sem filhos (94,6 %), na faixa etária entre 25 a 29 anos (51,35%) e que residem com a família (51,35%). Verificou-se que a média da população para a sub- escala Incompetência Profissional (após a exclusão dos dois itens) foi de 3,42 (dp = 0,73), para Exaustão Emocional 2,55(dp =0,71) e para Despersonalização 2,72(dp= 0,80). Constatou-se que 37,84% apresentaram Alta Exaustão Emocional, 43,24% Alta Despersonalização e 48,65% Baixa Realização Profissional. Na associação dos domínios, verificou-se que 27% apresentaram indicativo para SB. Os residentes pesquisados estão expostos aos estressores da profissão e da formação, o que pode favorecer a ocorrência

da síndrome nesses profissionais. Destaca-se a necessidade de promover atividades educativas e de orientação sobre estresse, estratégias de enfrentamento e burnout para possibilitar a identificação dos estressores e o estabelecimento de estratégias adequadas para enfrentá-los e com isso prevenir a Síndrome de Burnout.
PALAVRAS-CHAVE: Enfermagem. Síndrome de Burnou. Residência Multiprofissional em Saúde.

SOCIODEMOGRAPHIC AND ACADEMIC PROFILE AND BURNOUT SYNDROME IN MULTIPROFESSIONAL RESIDENTS

ABSTRACT: We assessed the sociodemographic and academic profile and the Burnout Syndrome occurrence in Multidisciplinary Residents from a Federal University. This is a descriptive, cross-sectional and quantitative study. We applied a form of sociodemographic data and the MBI-HSS in 37 residents between April and June 2011. Regarding the sociodemographic profile, we observed a predominance of females (83,78%), single (81,08%), without children (94,6%), aged between 25 and 29 years (51,35%) and living with family members (51,35%). We found that the population average for the sub-scale Professional Incompetence (after excluding two items) was 3,42 (sd = 0,73); for Emotional Exhaustion, it was 2,55 (sd = 0,71), and for Depersonalization, it was 2,72 (sd = 0,80). We noted that 37,84% showed High Emotional Exhaustion, 43,24% High Depersonalization and 48,65% Low Professional Achievement. By associating the domains, we verified that 27% showed indication of BS. The surveyed residents are exposed to stressors of the profession and training, which may favor the occurrence of the syndrome in such professionals. One should highlight the need to promote educational and supportive activities on stress and Burnout, as well as fighting strategies, in order to allow the identification of stressors and the establishment of suitable strategies to face them and therefore prevent the Burnout Syndrome.
KEYWORDS: Nursing; Burnout Syndrome; Multidisciplinary Health Residency

1 I INTRODUCTION

Currently, stress has been highlighted as a causal factor of cardiovascular diseases, psychic disorders and gastrointestinal changes. It is present in the daily lives of people, thereby affecting their quality of life, which is attested by the World Health Organization (WHO) (KAWAKAME AND MIYADAHIRA, 2005).

The concept of stress in the biological sciences was developed by Hans Selye, during the XX century, with emphasis on neuroendocrine manifestations that take place in the individual before internal or external stimuli. Based on the studies of Claude Bernard and Walter Cannon on organic homeostasis, Selye defined stress

as a specific reaction from the body to any stimulus (GUIDO, 2003).

Lazarus and Folkamn (1984) conceptualize stress from the interactionist model, since they consider the interaction between the environment and the person or group as responsible and active in the process. In their words, stress is defined as any stimulus that requires from the external or internal environment and that charges or exceeds the sources of adaptation of an individual or social system, with a determining factor of severity of the stressor.

Overall, most authors agree that the Burnout Syndrome (BS) is a characteristic syndrome of labor environment, seen as a process that takes place in response to the chronicity of the stress, with possible negative consequences, whether in the individual, professional, familial and social level (BENEVIDES-PEREIRA E MORENO-JIMÉNEZ, 2003). For Campos (2005), Burnout is a response from the body to a state of prolonged and chronic stress, installed when conflict situations were not used, failed or were not enough for a situation assessed as stressful by the individual.

In the health area, one should realize the presence of Burnout linked to the working process, as reported by Gil-Monte (2002), when he states that the predominance of nurses in scientific productions may have a close link with the occurrence of the syndrome in this category. Moreover, this author cites that it can be linked to a profession marked by shortage of professionals, which entails labor overload, proximity with the patient and family members in stressful situation, by direct contact with the disease, lack of autonomy and authority in decision-making processes.

Nevertheless, in vocational training activities, both in undergraduate courses and in graduate programs, there are factors that may be assessed as stressful. Seen in these terms, it is worth highlighting that the Multidisciplinary Health Residency Programs (RMS, as per its acronym in Portuguese), regulated as *Lato Sensu* Graduate Program, existing in Brazil, seek to break with the paradigms related to the training of professionals for the Brazilian Unified Health System (SUS) and contribute to qualify the care that the local health services need to offer their communities. They show a variety of methodological designs, but all, in unison, advocate the use of active and participatory methodologies and continuing education as a pedagogical axis (BRASIL, 2006).

In addition, the intrinsic characteristic of interdisciplinarity gives an innovative nature to the programs, which is mainly demonstrated through the inclusion of 14 professional health categories. This way of conducting the training 'inter-categories' aims at providing a collective training inserted into the same 'field' of work while prioritizing and respecting the specific 'nuclei' of knowledge of each profession (ROSA AND LOPES, 2010). In the process of training residents, the population, the

social control, the community and the neighborhood schools are invited to think and produce spaces for health and quality of life (BRASIL, 2006).

In light of this context, where one can observe the philosophy of the health training process with innovative actions, some aspects may be assessed as stressors, mainly because they are not included in the education model in force. Among them, one should highlight: teamwork, active and participatory methodologies, interpersonal relationships established with colleagues from other professions and responsibility to provide a comprehensive and humanized care.

For Nogueira-Martins (1998), stress can be associated to the professionalization and development of the professional role in society (controlling the weight of professional responsibility, dealing with difficult patients and problematic situations, managing the growing amount of knowledge and establishing limits of their personal and professional) identity. In addition, it can result from training characteristics, such as sleep deprivation, fatigue, excessive care load, excess of administrative work, problems regarding the quality of teaching and the educational environment. For this author, the individual characteristics and personal situations, such as gender, personality characteristics and psychological vulnerabilities may also be stressful. Moreover, Nogueira-Martins highlights that depression and sleep deprivation are described in the literature as the most significant problems that affect the residents.

Based on the foregoing, we aimed to know the sociodemographic, professional and academic profile Multidisciplinary Residents of the countryside of Rio Grande do Sul; e and to verify the occurrence of Burnout Syndrome in Multidisciplinary Residents from the Federal University of Santa Maria.

2 I THEORETICAL REFERENCES

2.1 Stress

The term stress is used in books, magazines, television and newspapers, due to its importance in people's lives and is linked to labor activities, vehicle traffic of big cities, competitiveness in the labor market, among other factors. Its occurrence points out the experience of people in stressful situations as a priority for the measurement of quality of life (KAWAKAME AND MIYADAHIRA, 2005).

Since Pre-history, there is the recognition that the human being suffered from exhaustion after work, fear, exposure to heat and cold, hunger, thirst, blood loss or some illness (Bianchi, 2001). The term stress derives from the Latin language and was firstly studied by the Physics and Engineering in reference to how long a metallic structure resists before it is broken or deformed. Subsequently, it was introduced into the field of Psychology. In the beginning of the XVII century, it meant

fatigue, tiredness, but, during the next two centuries, it started to have a relationship with the concept of force, effort and strain (LIPP et al., 1998; PEREIRA, 2002).

In the second half of the XIX century, Claude Bernard highlighted the capacity of living organisms to maintain the constancy of welfare and balance of the body, even with external modifications, which was defined as homeostasis by Walter Cannon, in the XX century. This concept was very important in studies of this period and gave support to the findings of Hans Selye, who started their works as a student of medicine in the year 1925 (BIANCHI, 2001; GUIDO, 2003).

In the 1920s and 1930s, Selye used the term stress for the first time in the health area (MIRANDA, 1998). Considered as the father of stress theory, his concern was with the "syndrome of being sick". Accordingly, he verified that customers who sought the clinic, regardless of etiology, showed common signs and symptoms, such as weight loss, lack of appetite and decreased muscle strength (BIANCHI, 2001).

Currently, Selye is considered as the first researcher to describe the stages of the biological stress and the General Adaptation Syndrome (GAS) or of the Biological Stress, defined as physiological defensive reaction of the body in response to any aversive stimulus. According to his words, such syndrome is divided in three phases: reaction of alarm, of resistance and of exhaustion (GUIDO, 2003). The first takes place immediately after the confrontation with the stressor and may or may not be conscious. It is defined as a chemical mobilization, a common reaction of the body that needs to meet the requirements, considered as a basic mechanism to protect the body, both from challenges and threats to integrity. In a short time, if there is persistence on the part of the stressor, the resistance takes place. This is the phase in which the body works for survival and adaptation. If the stressor persists or the balance does not take place, the exhaustion phase is started, where adaptation does not take place and there may be diseases and even death (BIANCHI, 2001).

The interactionist model defines stress as any stimulus that requires from the external or internal environment and that charges or exceeds the sources of adaptation of an individual or social system, a determining factor of severity of the stressor. Currently, it is the most disseminated model, since it considers the interaction among the environment and the person or group as responsible and active in the process (BIANCHI AND GUERRER, 2008; GUIDO, 2003).

Lazarus and Folkman (1984) understand that the organic changes, linked to stress, have a biological stage and a phase in which some cognitive, emotional and behavioral functions are involved, which can influence in the intensity of these changes. They highlight that, in the interactionist model, a cognitive assessment happens, which is understood as a mental process of locating the event or situation in a series of assessment categories that are related to the meaning of welfare of the subject (GUIDO, 2003).

In this categorization process, primary and secondary assessments are possible, and they are able to produce responses. In the first, the individual identifies the demands of a certain situation and defines the meaning of the event, which may result in an action. Such event may mean a challenge, a threat or be irrelevant to the individual. The result of this first assessment will depend on some factors, such as: nature of the stimulus, its intensity, previous experience of the individual and his response to the experienced emotion (GUIDO, 2003).

If the stressor is defined as a threat or as a challenge, the stress reaction happens and the individual will accomplish a secondary assessment, where the possibilities and strategies of confrontation or adaptation to the stressful event will be verified. The use of these strategies to deal with the situation assessed cognitively as stressful is called Coping. If they are not used by the individual or there is no success in their use and the stressor remains, becoming chronic, the Burnout Syndrome may develop.

2.2 Burnout

The term Burnout was firstly used in 1953 in a publication known as 'Miss Jones' in which it describes the problems of a psychiatric nurse disappointed with her work. In 1960, another publication, called 'A Burnt-Out Case', reported the case of an architect who abandoned his profession due to feelings of disillusionment with the profession. The symptoms and feelings described by these professionals set up what is known as Burnout in the present days (CARLOTTO AND CÂMARA, 2008).

According to Campos (2005), the psychoanalyst and physician Herbert Freudenberger served a community of drug users in the city of New York, who were often called Burnout because they gave importance to drugs and were not interested in other matters, such as family, work or friends. In 1974, he published a paper entitled Staff Burn-out for the Journal of Psychology, without giving focus to local slangs, but with the intention of warning the scientific community about the problems to which the professionals were exposed by virtue of the occupation. During that same year, Herbert described the phenomenon as a feeling of failure and exhaustion caused by an excessive waste of energy resources. He complemented his studies between 1975 and 1977, including behaviors of fatigue, depression, irritability, annoyance, loss of motivation, work overload, rigidity and inflexibility in its definition. Carlotto and Câmara (2008) report that, when examining people with Burnout, realized that there was a combination of bad choices and good intentions. Nonetheless, despite being assigned to Freudenberger, in 1974, the first paper about burn-out, Bradley, in 1969, had already published a paper in which he used the term staff burn-out, by referring to the exhaustion of professionals and proposing coping organizational measures (BENEVIDES-PEREIRA E MORENO-JIMÉNEZ, 2003). Nevertheless,

one should assign to Freudenberger and, later, to Maslach & Jackson (1981), the dissemination and the interest that emerged from their studies.

There is agreement that the first studies were conducted from personal experiences of some authors, case studies, exploratory studies, observations, interviews or narratives based on programs and specific populations. From the year 1976, the studies acquired a scientific nature, and, in this period, theoretical models and instruments were built, which were able to record and comprehend this chronic feeling of discouragement, apathy and depersonalization. Christina Maslach, a social psychologist, researcher from the University of California, was the one who first understood that people with Burnout showed negative attitudes and personal distancing. Together with the psychologist Susan Jackson, in 1981, developed the Maslach Burnout Inventory (MBI) in order to verify personal feelings and attitudes of nurses in their work and in the face of their patients. Christina Maslach, Ayala Pine and Gary Cherniss were the scholars who popularized the concept of Burnout and legitimized it as an important social issue (CAMPOS, 2005; CARLOTTO AND CÂMARA, 2008).

According to Carlotto and Gobbi (1999), the most used and accepted definition of Burnout in the scientific community is grounded on the social-psychological perspective, and it is understood as a process and composed of three dimensions: *Emotional Exhaustion*, characterized by the lack or shortage of energy and a feeling of emotional depletion; *Depersonalization*, defined as the lack of sensitivity and the toughness to respond to the people who are receivers of this service; and the *Low Professional Achievement*, which refers to the decrease of feelings of competence regarding the personal gains obtained in the working environment with people.

For Carlotto and Câmara (2008), the already proposed definitions for the Burnout Syndrome (BS), although with some divergent questions, emphasize, at least, five common elements: the predominance of symptoms related to mental and emotional exhaustion, fatigue and depression; the emphasis on behavioral and mental symptoms, and not on the physical symptoms; the symptoms are related to work; the manifestation in people who did not suffer from psychopatological disorders before the onset of the syndrome; decreased effectiveness and work performance as a result of negative attitudes and behaviors.

BS is considered a relevant social problem and is investigated in several countries, since it is linked to organizational costs. Thus, the interest that Burnout raises in current days has expanded its field of study. The first investigations were focused on professional helpers. Other professional fields were subsequently surveyed, and, more recently, the productions have worked with students (CARLOTTO, NAKAMURA AND CÂMARA, 2006). If Burnout in health professionals is an issue already consolidated in different studies MASLACH, 1982; RODRÍGUEZ-

MARÍN, 1995; MASLACH, SCHAUFELI AND LEITER, 2001), one can think that Burnout in health care students also is shown as a relevant and differentiated issue (CARLOTTO, NAKAMURA AND CÂMARA, 2006). These students work directly with people and occasionally carry with them problems and conflicts found in patients. Specifically for Multidisciplinary Health Residency Programs, considered *Lato Sensu* Graduate Programs, one should highlight the challenge of being inserted into a new training model that emerges to break with the contradictions between the health system and the training model of health professionals in force.

2.3 Multidisciplinary Health Residency Program

Between the 1970s and 1980s, the hegemonic model adopted in Brazil was focused on the hospital scope and on the specialized medicine. However, from the year 1973, social movements were united around the defense of human rights and political freedom. In the health area, the fight was for the organization of a unique and hierarchicalized health system, which would not restrict the care to disease and promotion of health, individual health and collective health (DA ROS et al., 2006). With the Sanitary Reform, which took place in the 1970s, one started to highlight the wider concept of health that considers other dimensions of the human being that go beyond the biological aspect, by considering the interrelationship of the factors involved in the processes of illness (CANGUILHEM, 1995)

However, despite recognizing the efforts of the Sanitary Movement in the fights for defending health, the vocational training was not adapted to this logic because the seizure of knowledge overcomes the expanded concept of health, such as, for example: the technical content targeted to the biomechanical perspective, the biologically centered medical model and the privilege of hard technologies (CAMPOS, 1991; MERHY, 2005; CARVALHO, 2005; CAMPOS, 2006). These aspects are placed as essential skills in the composition of the professional profile and therefore present themselves as axes of learning in most schools of professional training for health workers (ROSA AND LOPES, 2010).

This situation, placed in undergraduate courses, allows the maintenance of the hospital-centered model, with its medical-centered and healing practices, supported by the paradigm of biomedicine, as well as it contributes to the low efficacy characteristic of the health system, predominance of privatizing interests and existence of managerial and financial mechanisms that hamper its rationalization (CARVALHO, 2005). In 1993, with the creation of the Family Health Program, the system started to be structured by means of primary care, and the municipal governments started to require a professional profile targeted to the logic of the SUS, thereby highlighting the contradictions between the health system and the health training. In this context, the Multidisciplinary Health Residency Program

(RMS) was created, which was presented as strategy for reorienting the Primary Care for the implementation/ reorganization of public services grounded on the logic of the SUS, with the objective of producing the necessary conditions for changing the aforementioned model (BRASIL, 2006; ROSA AND LOPES, 2010).

Thus, we have established that the RMS would be as a program of intersectoral cooperation to foster the qualified insertion of young health professionals into the labor market, particularly for the construction of the SUS. Under this perspective, one can also say that it was presented as a strategy of the State that sought a specific training, with a view to instituting an arsenal of professionals able to modify practices in force and to produce a new culture of intervention and understanding of health in the scope of the implementation of the SUS, through in-service training (BRASIL, 2006).

3 I METHOD

This is a cross-sectional, descriptive and quantitative study. This research was performed in a higher education institution in the countryside of the state of Rio Grande do Sul/Brazil. The study population was composed of 55 multidisciplinary residents, according to the selected inclusion and exclusion criteria. Accordingly, this study included Multidisciplinary Residents, with activities in the University Hospital of Santa Maria (HUSM, as per its acronym in Portuguese). The multidisciplinary residents who were on leave period belonging to any nature were excluded from the survey.

Data collection was performed in the months of April and June 2011 by means of self-applicable instruments to individuals invited and who accepted to participate in the study after being clarified about the objectives and characteristics of the survey. The first approach was held through scheduled meetings, according to the schedule of the residency, where the questionnaires were delivered and, throughout the collection period, gathered. There was the need to search the people in an individual manner.

In order to operationalize the data collection, we made the presentation of the Free and Informed Consent Form, as well as the guidelines for filling out the instruments. In order to obtain data, we used the Maslach Burnout Inventory (MBI) and a Form to characterize the Multidisciplinary Residents in social, demographic and professional aspects.

The questionnaire was used for personal and professional characterization of Multidisciplinary Residents. We addressed the following quantitative variables: age, number of children, travelling time to university campus, daily study time dedicated to RMS and time spent for study groups weekly; and the qualitative variables: gender,

marital status, presence of children, housing situation, practice of sports, leisure activity, profession, training year, month and year of the beginning of the residency, satisfaction of residents with the program, interest in withdrawing the RMS and the emphasis of action.

For this study, we have considered the emphases of action as follows: “Management”, “Hospital Care” and “Health Surveillance and Family Health”.

The Maslach Burnout Inventory, version HSS (Human Services Survey), elaborated by Christina Maslach and Susan Jackson (1978), was translated and adapted to the Brazilian reality by Lautert (1995).

The MBI, version HSS (Human Services Survey), is a self-applicable questionnaire with a Likert-type scale, in which the individual chooses one of the alternatives: “never”, “a few times a year”, “a few times a month”, “a few times a week” and “daily” (with values ranging from zero to four) that best depicts its daily experience at work. The instrument is composed of 22 items distributed into three sub-scales: Emotional Exhaustion (EE) formed by items 1, 2, 3, 6, 8, 13, 14, 16 and 20; Depersonalization (DP), made up of items 5, 10, 11, 15 and 22, and Professional Incompetence (PI), composed of items 4, 7, 9, 12, 17, 18, 19 and 21 (LAUTERT, 1997). Nevertheless, due to being more current, the following nomenclature was used for the sub-scales: Emotional Exhaustion (EE), Depersonalization (DP) and Professional Achievement (PA) (CARLOTTO and CÂMARA, 2007).

High scores on emotional exhaustion and depersonalization, coupled with low scores on professional incompetence signalize that the individual is in Burnout (LAUTERT, 1997). It is worth remembering that the score of the sub-scale Professional Incompetence has reverse effects, that is to say, the higher the score in this dimension, the better will be the individual’s perception with regard to its professional efficiency (LAUTERT, 1997).

After collection, data were organized and stored in a spreadsheet in the program EXCEL 2003 (Office XP) so that they subsequently were electronically analyzed with the help of the program Statistical Analysis System (version 8.02). Qualitative variables were presented in absolute (n) and percentage (%) values. Quantitative variables were exposed in descriptive measures: minimum and maximum values, average and standard deviation.

In order to analyze the MBI scores, we held the average of responses of the population by sub-scale. From these measures, the subscales were dichotomized in “high” and “low”. In order to analyze the internal consistency of this instrument, we made use of the Cronbach’s alpha coefficient.

This work is a subproject deriving from the project Stress, Coping, Burnout, Depressive Symptoms and Hardiness in Multidisciplinary and Physician Residents, approved by the Research Ethics Committee (REC) at the Federal University of

Santa Maria (UFSM), under the Protocol number 23081.020160/2010-06, taking into consideration that this research involves residents of the aforementioned institution. Upon presentation of the study and its objectives, the Confidentiality Agreement, which states the commitment of researchers before the use and preservation of material (for a period of five years) with information on investigation subjects, was delivered. In addition, in order to meet the Regulatory Guidelines and Standards for Research Involving Human Beings (CNS Resolution 196/96), a Free and Informed Consent Form was sent, together with instruments, with information relating to the research, which was signed (in two copies, one for the subject and one for the researcher), with a view to authorizing voluntary participation in the research.

4 I RESULTS

Of the 85 multidisciplinary residents, all met the eligibility criteria, but 40 (47,07%) refused to participate in the survey and 8 (9,41%) returned the instruments in blank. Hence, we obtained a total of 37 (43,52%) participants.

In order to ease up the visualization of sociodemographic and academic data, the qualitative variables will be presented in line with the characterization: sociodemographic, professional and academic. The quantitative variables will be presented in a grouping manner.

Concerning the sociodemographic profile of Multidisciplinary Residents, one should observe, in Table 1, the predominance of females (83,78%), single (81,08%), without children (94.6%) and aged between 25 and 29 years (51,35%). Among the respondents, 51,35% live with family, 59,46% do not practice sports and 91,18% perform some leisure activity. About the first, one should highlight that one resident did not respond to the item; and, about the last, three residents did not respond to it. One should emphasize that 41,66% entered the RMS one year after the completion of the undergraduate course, followed by those who entered in the same year of completion of the course and four years or more after the academic training (19,44%). Furthermore, 66, 67% work in hospital emphasis (Table 1). One should verify that 58,82% are satisfied with the residency program and 62,16% thought about quitting the program at some point.

Variable	N	%
Time in years between the completion of the undergraduate course and the admission to the RMS*		
Same year	7	19,44
1 year	15	41,66

2 year	4	11,12
3 year	3	8,34
4 years ou more	7	19,44
Emphasis of action **	4	11,11
Management		
Hospital Care	24	66,67
Health Surveillance and Family Health	8	22,22
Total	37	100,00

Table 1. Distribution of multidisciplinary residents regarding the time between the completion of the undergraduate course and the beginning of the residency program (in years), and emphasis of action, 2012.

* One resident did not respond to the item.

** Three residents did not respond to the item.

Regarding the professional activity, one should highlight that 94,59% of residents do not perform extra-professional activities in addition to the multidisciplinary residency, 59,46% have professional experience in the health area and 89,19% do not have training in other higher education courses. One should observe that 25% are nurses, 16,67% are speech therapists and 13.89% are physiotherapists.

On average, the residents study 111,4 minutes per week. In addition, they take an average of 35,27 minutes to reach the university campus at stake. One should also highlight that 51,35% are not part of the study groups. Those who participate (48,65%) dedicate, on average, 84 minutes per week to this activity. We observed that four residents did not respond to the study time and one to the emphasis of action. Descriptive measures for these variables can be seen in Table 2.

Variable	Minimum	Maximum	Average	S. Deviation
Age	22	33	26,29	2,89
Number of children	0	2	0,10	0,45
Time dedicated to the group weekly	0	60	80,0	102,88

Table 2. Descriptive measures for age, number of children, travelling time, hourly load of study, time dedicated to the group weekly

The sociodemographic profile of the Multidisciplinary Residents shows a predominance of single (81.08%), women (83.78%) without children (94.6 %), between 25 and 29 years old (51.35%), living with their families (51.35%).

The internal consistency analysis of the items composing the MBI-HSS subscales presented a Cronbach's alpha of 0.82 for Emotional Exhaustion and 0.635 for Depersonalization. Since the Cronbach's alpha for the subscale Professional Realization was 0.248, items 9 and 21 were included, which increased the coefficient

to 0.606. According to the authors [16], these values are sufficient to attest to the instrument's satisfactory internal reliability. The subscales' averages are presented in Table3.

Subscales	Mean	SD*	Min.	Max.
Emotional Exhaustion	2,55	0,71	14	39
Depersonalization	2,72	0,80	8	20
Professional Realization	3,42	0,73	14	33

Table 3. Distribution of Multidisciplinary Residents according to the averages obtained on the Maslach Burnout Inventory, Brazil, 2012.

*SD: Standard Deviation

The average obtained for the subscale Professional Realization was 3.42 (±0.76), which shows low professional satisfaction. The distribution of the population according to the classification by MBI subscale is presented in Table 4.

Subscales	**High N**	**%**	**Low N**	**%**	**Total n**
Emotional Exhaustion	14	37.84	23	62.16	37
Depersonalization	16	43.24	21	56.76	37
Professional Realization	19	51.35	18	48.65	37

Table 4. Distribution of Multidisciplinary Residents according to the classification by the subscales of the Maslach Burnout InventoryBrazil, 2012

A total of 27% of the participants presented an indication they were experiencing burnout syndrome after the domains were associated.

5 I DISCUSSION

When analyzing our data, there was predominance of multidisciplinary female residents (83,78%), single (81.08%), without children (94.6%), aged between 25 and 29 years (51,35%), with an average age of 26,29 years. Such results are in line with those observed in a publication with nursing residents, where the majority of the sample was composed of women (81,3%), single (93,8%), without children (87,5%) and with an average age of 25,8 years (FRANCO E BARROS, 2011). A research conducted in São Paulo highlighted the increased female participation in the field of health, mainly among professionals with higher education (from 18% to 35%) [14]. Moreover, such study indicates a renewal in the workforce in health care,

with a special focus on workers with higher education, where professionals aged between 20 and 29 years evolved from 14% to 26% (NOGUEIRA-MARTINS,1991).

One can infer that the fact of being unmarried and childless is related to the young aspect of this population and the participation of women in the labor market. The latter, besides characterizing the aforementioned social profile, has allowed financial independence to women and made them heads of families. According to the Brazilian Institute of Geography and Statistics (IBGE, as per its acronym in Portuguese), over the 1990s, the average schooling level of these women increased from 4,4 to 5,6 years of study annually, and there was a decline in the fertility rate, which started in the mid of 1960s. Nowadays, women have an average of 2,3 children. 40 years ago, the average was 6,3 children. Furthermore, we noted the participation of 25% of Nurses in the study population, and this occupation is historically characterized by the predominance of women. This may be related to the amount of these professionals enrolled in the program and the structure of health care teams, composed of a greater quantitative of nursing technicians and nurses. With regard to nursing, some authors(VALE E GUEDES, 2004) highlight that one of the challenges faced concerns the training of competent professionals, able to articulate theory and practice and with critical view of reality. We understand that the RMS contributes to this, not only because of the fact that the teaching takes place in the reality of health services, as well as the possibility of interaction with other members of the multidisciplinary team, which fosters the exchange and sharing of new skills (LANDIM, BATISTA E SILVA, 2010).

We have found that 59,46% of residents do not practice sports, but perform some leisure activity (91,18%). Nonetheless, in a research with medical residents, they highlighted the lack of time for leisure, family, friends and personal needs (NOGUEIRA-MARTINS,1991). Although 51,35% of multidisciplinary residents live with their families, some authors claim that family conviviality is broken or postponed due to professional request and schedule, frequent shifts and hospital visits on weekends and holidays. This isolation that permeates the undergraduate level, and is intensified in Residency Programs, causes the professionals to run apart from the labor context (NOGUEIRA-MARTINS,1991).

We found that 41,66% entered the RMS one year after the completion of the undergraduate course. In the light of this, surveys describe that newly-trained nurses from universities, young and inexperienced in professional life, seek theoretical and practical qualification in residency programs, which may explain the data found (MATHEUS, IDE E ARNGELO, 2003). Likewise, the residency corresponds to the beginning of a professional career, which is confirmed by a study involving physicians, where 71% of them attended at least one program of medical residency or similar (NOGUEIRA-MARTINS,1991). A study with nursing home residents emphasized

that the Residency provides a mild transition between academic world and practical reality, which enables the acquisition of greater professional safety (CARBOGIM, SANTOS, ALVES E SILVA, 2010).

The residents who participated in the survey were concentrated (66,67%) in hospital emphasis. Among the existing Multidisciplinary Residency Programs in Brazil, one should observe a privilege in relation to hospital experience, although with structures that vary according to the RMS project of each institution. There are studies(LANDIM, BATISTA E SILVA, 2010) that mention that the inclusion of nurses in hospital environments seeks to strengthen the clinical judgment and promote a clinical and reflective experience of health problems. This happens when, related to the epidemiological profile of Primary Health Care, it enables a comprehensive view of the health-disease process. Accordingly, the diversification of learning scenarios is essential in the face of the types of complexity involved in health problems, which require the mobilization of different areas of knowledge(LANDIM, BATISTA E SILVA, 2010; CARBOGIM, SANTOS, ALVES E SILVA, 2010).

We have found that 58,82% are satisfied with the Residency Program and 62,16% thought about quitting at some point. In this regard, some scholars mention that a sequence of emotional phases or stages are experienced by the resident during the first year of Residency, described as a kind of psychological natural history of this pupil (GORDON, GIRARD E HICKAM, 1987). According to them, when starting the Residency Program, there is a predominance of a feeling of early excitement which is followed by a period of uncertainty, with recurrent depression crises. This depressive sense is subsequently replaced by feelings of competence and a certain degree of pride at the end of the first year. Uncertainty takes place when the resident begins to experience frustrations and realize its limitations. Hence, depression is linked to overload of work, sleep deprivation and lack of institutional emotional and/or social support. The second year tends to be less troubled than the first, and, at the end, the resident usually expresses satisfaction with the professional decision and feels competent (NOGUEIRA-MARTINS,1991).

Regarding the professional activity, one should highlight that 94,59% of residents do not perform extra-professional activities in addition to the multidisciplinary residency. We believe that this data is related to the exclusive dedication required by the RMS Program of the institution as a prerequisite for admission. The project of the RMS involved in this study envisages the duration of two years in a full-dedication regime, with an annual hourly load around 2.880 hours and a period of 30 days of holidays (rest) every year. The average hourly load is 60 hours a week (UNIVERSIDADE FEDERAL DE SANTA MARIA, 2010). Such structure produces a new paradigm for residency because learning takes place in the network of services itself, and, especially, allows the relationship between reflective and critical attitudes

with interdisciplinary health practices, which contributes to the onset of alternative training experiences (MINISTÉRIO DA SAÚDE, 2006).

As for the professional experience in health care, 59,46% responded affirmatively. This indicates that residency programs, besides enabling theoretical-practical qualification to the newly-graduated people, provide skills for professionals who already have experience in the labor market in a certain area of knowledge. The RMS allows these professionals to critically reflect on their practices, as well as rethinking their everyday lives and enhancing their knowledge. The modality of graduate teaching (*Lato Sensu*) in the Residency frames is a strategy that trains health professionals to act in their working realities in such a way as to produce effective interventions (CARBOGIM, SANTOS, ALVES E SILVA, 2010).

On average, residents study 111,4 minutes per day, 51,35% did not participate in study groups. Those who are dedicated to this task take an average of 84 minutes per week to it. Concerning this issue, some surveys indicate that the investment of health workers in the pursuit of knowledge encompasses dimensions and objectives that serve the practical and pragmatic use and, consequently, the construction of the everyday history and science of each profession. In addition, the accomplishment of surveys, participation in scientific events and the guidance of term papers of residents are practices that boost and empower the construction of knowledge in the area (LOPES E MOURA, 2004). In this way, Multiprofessional Residency has direct impact on the training of health professionals and teams to the conduction of an articulate and conjoined care. This enables, in an indirect way, the structuring of the Brazilian Unified Health System and the improvement of the quality of care provided by these professionals (CARDOSO, 2011).

Burnout syndrome has been defined as a psychosocial phenomenon that emerges as a chronic response to interpersonal stressors that take place in the work environment (LAUTERT, 1997). In addition to the common stressors observed in practice, the residents also experience situations in Multidisciplinary Residencies that can be seen as stressful, such as writing academic papers and final papers, taking tests and theoretical classes, etc.

In this context, we observe that the average population scores on the Professional Realization subscale were 3.42 (SD = 0.73), 2.72 (SD= 0.80) for Depersonalization, and 2.60 (SD = 0.71) for Emotional Exhaustion. A study conducted with medical residents in a federal university reported an average of 28.6 for Emotional Exhaustion, 10.4 for Depersonalization, and 36.0 for Professional Realization (LIMA E BUUNK, 2005). A study investigating burnout syndrome in 105 psychologists reported the following averages: 18.57 for Emotional Exhaustion, 5.24 for Depersonalization and 38.10 for Professional Realization(BENEVIDES-PEREIRA E MORENO-JIMÉNEZ, 2003). We note that the highest averages are concentrated in the Professional

Realization domain, also called Professional Incompetence or Reduced Professional Realization by some authors (BENEVIDES-PEREIRA E MORENO-JIMÉNEZ, 2003; LIMA E BUUNK, 2005). Hence, we observe that perceptions of low efficiency and productivity at work prevail among the professionals included in the studies. The state that better translates this domain is when the professionals start questioning their choices and doubt their aptitude for their profession. The individual no longer becomes involved with the work and starts feeling personally and professionally inadequate. This behavior affects one's ability to perform well at work and to relate with people, harming productivity (GRAZZIANO E BIANCHI, 2010).

A total of 27% of the Multidisciplinary Residents presented an indication of experiencing burnout syndrome. The incidence of burnout among medical residents was 20.8% (LIMA E BUUNK, 2005). A study investigating burnout syndrome among nursing residents in the four periods of the program reported one resident (6.3%) in the fourth period of the program showed alterations on the three subscales, indicating the presence of burnout syndrome (CARLOTTO E CÂMARA, 2007). It is known that burnout is mainly related to organizational factors and occurs when a professional has to deal with frustrations and work overload and has to expend extra effort to deal with challenges. Hence, one compensates for psychological suffering with extra effort (GISBERT, FAYOS E MONTESINOS, 2008).

Additionally, poor working conditions, low salaries, heavy workload, and an unfavorable workplace favor the emergence of burnout among health workers, interfering in the therapeutic relationship between professionals and patients (NOGUEIRA, 2007). In this context, a study with nursing residents reported that these professionals provide direct care to more than one patient per shift while not being totally familiarized with the job and not having all the tools required to assume a greater patient load; for this reason they feel overwhelmed (CARLOTTO E CÂMARA, 2007). Additionally, there are frequent complaints of nurses concerning lack of autonomy, work overload, and consequent demotivation of the staff. Patients wait increasingly longer to be cared for, there are difficulties due to scarce economic resources, the law does not favor access to all, the limited system of promotion and valorization of personnel in the health field, a tendency to medicalize human experience, and lack of professionals, among other issues (LAUTERT, 1997).

Thus, the presence of burnout among health professionals can negatively affect the quality of care delivery and the lives of workers, leading to depression and difficult family and social relationships, also affecting the organization with absenteeism and presenteeism (NOGUEIRA, 2007)- the act of attending work while sick. For these reasons, burnout syndrome is considered the syndrome of "giving up" because the affected individuals no longer invest in their work and affective relationships and apparently become incapable of becoming emotionally involved with their workplace

(NOGUEIRA, 2007).

We verified that 37.84% present High Emotional Exhaustion, 43.24% High Depersonalization, and 48.65% Low Professional Realization. A total of 17.2% of the nursing residents presented changes in the Emotional Exhaustion and Depersonalization subscales and 18.8% presented alterations in the Professional Realization subscale (CARLOTTO E CÂMARA, 2007). Among medical residents: 65% of which presented High Emotional Exhaustion; 61.7% High Depersonalization, and 30% Low Professional Realization (LIMA, BUUNK, ARAÚJO, CHAVES, CHAVES, MUNIZ E QUEIROZ, 2005).

A comparison among the scores obtained on the MBI by physicians, nursing technicians and nurses revealed that physicians presented greater Emotional Exhaustion (66.7%) and Low Professional Realization (50%), while nurses presented greater Depersonalization (42.9%)(MATHEUS, 2002). A study investigating burnout among psychologists, provided evidence that 22.9% of the sample presented values above the average on Emotional Exhaustion, 23.8% reported high levels of Depersonalization, while 24.8% manifested dissatisfaction and feelings of inefficiency regarding the professional activities they were performing (Low Professional Realization) (BENEVIDES-PEREIRA E MORENO-JIMÉNEZ, 2003). Studies conducted with different populations always show a portion of professionals with high emotional exhaustion, depersonalization and low professional realization.

The residency program is an exhausting professional experience and such a fact is well documented in studies (LIMA, BUUNK, ARAÚJO, CHAVES, CHAVES, MUNIZ E QUEIROZ, 2005; CARLOTTO E CÂMARA, 2007; ROSA E LOPES, 2010). Nursing residents complain about the working conditions during professional training, manifest dissatisfaction in relation to the policy of how employees are replaced during days off, vacations, sick leave, and due to a deviation from their functions, low remuneration, physical, mental and emotional exhaustion, no time for leisure, and a conflictive lack of professional identity in particular (CARLOTTO E CÂMARA, 2007).

The identification of populations with a high percentage of Depersonalization deserves attention due to two main reasons (LAUTERT,1997). The first is that depersonalization is considered a specific element of burnout syndrome when compared to the other two dimensions. The second reason is that depersonalization reflects an attitude of estrangement and negative feelings toward one's job, which affects both the patients and the staff (LAUTERT, 1997). In relation to Professional Realization, a study of nursing residents reported that this newly graduated, young and professionally inexperienced professional sought theoretical and practical tools in the residency program(CARLOTTO E CÂMARA, 2007). For this reason, they may initially present feelings of incompetence and devaluation, but gradually

these give space to personal and professional reconstruction and competence (CARLOTTO E CÂMARA, 2007). In relation to medical residency, we note that a state of anticipatory excitement predominates at the beginning of the program, which is followed by insecurity and recurrent depression. This depressive state is then replaced by feelings of competence at the end of the first year of residency (NOGUEIRA-MARTINS, 1998).

There are, however, nurses who consider that virtually all activities they perform correspond to their qualification and also consider themselves professionals with the autonomy to make decisions, with freedom of action, and are satisfied with their work (LAUTERT, 1997). This is confirmed by nursing residents, who, when discussing professional realization, report that to avoid uncomfortable situations with the nursing staff, assume the care of more severe patients and also manage the unit(LAUTERT, 1997). When they advance in the program and through routine and daily experiences in each unit/specialty they experience, these feelings are minimized and replaced by greater self-confidence and technical ability (CARLOTTO E CÂMARA, 2007).

Therefore, we verify that the factors related to burnout among residents and professionals in the health field seem to be numerous. We also highlight that in addition to sociodemographic, occupational and behavioral characteristics, there is individual variability in the nature of other characteristics and susceptibility to burnout-related factors in the face of certain situations, which frequently influence and determine changes of behavior and attitudes (CARLOTTO E CÂMARA, 2007). Stressors indicated during the educational process coupled with those arising from the profession, expose residents to stress. When appropriate strategies to minimize or eliminate such stressors are not implemented or are not available, these professionals become exposed to burnout syndrome. In this context, individuals may be negatively affected at the personal, family, institutional and social levels.

6 I CONCLUSION

We have observed that the sociodemographic profile of residents is characterized by young women, single, childless and living with their families. Regarding the academic activity, we have found that residents are fully dedicated to the RMS and study, on average, 111,4 minutes per day. Those who participate in study groups take an average of 84 additional minutes per week to this activity. Although they have professional experience in health care, one should highlight that the Residency provides a professional qualification in health services, that is to say, before the actual everyday situations. Moreover, it ensures the title of specialist in the emphasis selected by the student.

Accordingly, the Residency qualifies health workers to act in public systems and services, by inserting them into different levels of complexity, where they may perform practices that integrate teaching-research-extension-care-management services, aligned with the Principles of the Brazilian Unified Health System. Such residency, enrolled in interdisciplinary and inter-institutional frames, pursues the creation and experimentation of new teaching methodologies and integration with public health services, which impact effectively on the restructuring of the care-management-training models, in an interdisciplinary, intersectoral and inter-institutional perspective.

We conclude that the profile found is in line with that required by the labor market, that is to say, professionals with professional qualification, experience in health care services and that have their study habits associated with working activities, with the objective of qualifying the care to be provided. Seen in these terms, the RMS has repercussions in the training of professionals with characteristics that adapt them to the public health model proposed by the SUS.

This study allowed us to measure the dimensions of burnout and relate them to the education of professionals for the Unified Health System (SUS). Hence, we conclude that the studied residents are exposed to stressors arising from their profession and its educational process, which may favor the occurrence of the syndrome among these professionals. Burnout takes place when stress becomes chronic; it is multi-causal, and may begin during the undergraduate program.

It was also possible to determine that young and nursing residents predominate, while some present an indication of burnout syndrome. It is known that people develop and revise strategies to cope with stressors based on their experiences. Thus, young individuals may possess fewer skills to overcome the exhaustion that emerges from personal and professional contexts. It is also important to consider that nursing is considered a stressful profession and is also included in the studied Multidisciplinary Residency Program.

Therefore, we highlight the need to promote educational activities and instruct individuals about stress, coping strategies and burnout syndrome to enable people to acquire knowledge about these constructs. It permits the identification of stressors and the establishment of more effective strategies to cope with them in order to avoid burnout. We also suggest further studies to deepen knowledge about this syndrome and its occurrence during educational processes.

A limitation of this study is the number of participants. Even though the results are reliable, further data could be obtained with a greater number of participants. It was also not possible to analyze the professionals separately or the concentrations that compose multidisciplinary residencies because some professions have only one spot in that specific concentration, which would permit the identification of individual

participants, thus violating confidentiality.

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ÍNDICE REMISSIVO

A

B

C

D

E

F

H

I

M

N

P

R

S

T

U

V