

FAMILY CAREGIVERS OF ELDERLY WITH DEPRESSIVE SYMPTOMS
FAMILIARES CUIDADORES DE IDOSOS COM SINTOMAS DEPRESSIVOS
FAMILIARES CUIDADORES DE ANCIANOS CON SÍNTOMAS DEPRESIVOS

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ABSTRACT

Objective: to get acquainted the care relationships of family members of the elderly with depressive symptoms and their perceptions about the weariness of the caregiver. **Method:** qualitative study, with data collection between August and September of 2018, through semi-structured interviews, submitted to analysis of thematic content and organized into three categories. **Results:** three family caregivers participated. The care provided to the elderly with depressive symptoms by family members is recognized as gratifying for providing means to contribute to the family member, which can guarantee establishment of bonds, however this care has the potential to generate overload on these caregivers. **Conclusion:** understanding the implications that guide the care activity performed by family members can guide the creation/reorientation of public policies, which offer a network of support and support to these caregivers, contributing to their quality of life.

Descriptors: Aged; Depression; Family; Caregivers.

RESUMO

Objetivo: conhecer as relações de cuidado dos familiares de idosos com sintomas depressivos e a suas percepções acerca do desgaste do cuidador. **Método:** estudo qualitativo, com coleta de dados entre agosto e setembro de 2018, por meio de entrevista semiestruturada, submetidos à análise de conteúdo temática e organizados em três categorias. **Resultados:** participaram três cuidadores familiares. O cuidado empreendido ao idoso com sintomatologia depressiva por familiares é reconhecido como gratificante por poder contribuir com familiar, garantindo o estabelecimento de vínculos, porém este cuidado pode gerar sobrecargas nestes cuidadores. **Conclusão:** compreender as implicações que norteiam a atividade de cuidado realizada por familiares pode nortear a criação/reorientação de políticas públicas, as quais ofereçam uma rede de suporte e amparo a esses cuidadores, contribuindo para sua qualidade de vida.

Descritores: Idoso; Depressão; Família; Cuidadores.

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RESUMEN

Objetivo: conocer las relaciones de cuidado de los familiares de ancianos con síntomas depresivos y sus percepciones sobre el uso del cuidador. **Método:** estudio cualitativo, con recolección de datos entre agosto y septiembre de 2018, a través de entrevistas semiestructuradas, sometidas a análisis de contenido temático y organizadas en tres categorías.

Resultados: participaron tres cuidadores familiares. La atención brindada a los ancianos con síntomas depresivos por parte de los familiares se reconoce como gratificante por poder contribuir con los familiares, asegurando el establecimiento de vínculos, pero esta atención puede causar sobrecargas en estos cuidadores. **Conclusión:** comprender las implicaciones que guían la actividad asistencial realizada por los miembros de la familia puede guiar la creación / reorientación de políticas públicas, que proporcionan una red de apoyo y apoyo para estos cuidadores, contribuyendo a su calidad de vida.

Descriptor: Anciano; Depresión; Familia; Cuidadores.

INTRODUCTION

The aging of the Brazilian population has been accompanied by an increase in the prevalence of non-communicable chronic illnesses, with important repercussions on both social and health policies and also elderly people with functional limitations in constant need of care from other people.¹

In the Brazilian socio-cultural context, in situations where the elderly need care due to health problems and functional disabilities, it is up to the family to care for them. These individuals are often unprepared for such a situation, and are often experiencing situations of adaptation and coping with this new situation.¹

Among the health situations that affect the elderly and can affect their functionality as well, which, in turn, causes them to need support in care, depression is a very frequent problem.² Around 300 million people worldwide have depressive

symptoms, with the middle-aged elderly populations being greatly affected.³

One of the factors that may be associated with the onset of depression is the provision of care to family members. Studies point to a high correlation between home care and depression when care was provided to a relative.^{1,2,4}

The continuous exercise of the task of caring interferes in the lives of family caregivers, increases their overload and causes physical, psychological and social problems. Thus, uninterrupted dedication may cause weariness and exhaustion of caregivers, as well as the characteristic symptoms of those who suffer overload, which leads the caregiver to neglect their own needs⁴, so it is common for caregivers to complain frequently from depression, stress, anxiety and overload.²

There are two types of overload: the objective, related to changes in the routine, the performance of tasks, a decrease in social and professional life of caregivers,

which in turn, can cause a subjective overload, which refers to negative feelings, concerns and discomfort derived of the tasks performed. Therefore, professional caregivers are prone to experiencing more objective overload, while informal caregivers feel greater subjective overload.³

When considering aspects related to the overload and emotional discomfort of the family caregiver, understanding how these symptoms relate to the task of caring for the elderly with depressive symptoms can allow a better understanding of the phenomenon and facilitate the care planning process. It is extremely important to adopt measures that minimize discomfort resulting from the task of family care for the dependent elderly, minimizing intensity and diversity of feelings that may arise in this task. Also, there are few studies carried out with secondary caregivers and mainly related to strategies promoting mental health to informal caregivers of the elderly.

In this perspective, this study aimed to get acquainted with care relationships of family members of the elderly with depressive symptoms and their perceptions about the weariness of the caregiver.

METHOD

This is an exploratory and cross-sectional research, with a clinical-qualitative approach. Family caregivers of the elderly who attended two Basic Health

Units in the city of Uberaba, in the state of Minas Gerais, were invited to participate.

The inclusion criteria for participation in the study was to be the primary family caregiver of elderly people who suffered from depressive symptoms. Family caregivers who showed some cognitive impairment did not participate in the study. Cognitive deficit was assessed by the Mini Mental State Examination, originally developed by Folstein and collaborators⁵ and validated for the Brazilian population by Almeida.⁶

The choice of Basic Health Units was made because they are matrix health units in the municipality, in which each one has three family health teams each, which enabled a more heterogeneous and representative sample, given the high prevalence of elderly people with depressive symptoms identified in a previous study.⁷

Sampling criteria was given for convenience⁷, with the participation of three family caregivers of elderly people with depressive symptoms, respectively mild, moderate and severe, verified by the Geriatric Depression Scale (GDS-15) validated for the Brazilian population.⁸

After the coordination of these units provided their authorization, the recruitment of elderly people with depressive symptoms was carried out in the waiting room. Twenty-three elderly people

were approached, in which the cognitive impairing and depression indicative screening instruments were applied. Eight elderly people had scores equal to or above five points on the geriatric depression scale, being classified as indicative of pressure, four with mild symptoms, two with moderate symptoms and two with severe symptoms.

After the recruitment process of the elderly with depressive symptoms, a home visit was arranged with the elderly person, so the stage of interviews with the caregiver was carried out.

Of the eight elderly people initially recruited, five were excluded due to failure to meet inclusion criteria of the study: they lived alone (one elderly person), had no family members as primary caregiver (two elderly people), were not at home (one elderly person) and did not agree to participate in the study (one elderly person).

Family caregivers were invited to participate in the study, conducting open individual interviews with the following guiding question: *Tell me what it is like to care for the elderly person you live with?*

The interviews were carried out from August to September of 2018, at the participants' own home, in a quiet room that protects ethical confidentiality. Participants were named by fictitious names to ensure anonymity.

The meetings were audios recorded and transcribed, and the data was analyzed in depth using the technique of thematic content analysis, through three stages: pre-analysis, exploration of material and treatment of results (inference and interpretation).⁹

The present study was approved by the Research Ethics Committee of the Universidade Federal do Triângulo Mineiro, opinion number 2,769,433.

RESULTS

Three caregivers of elderly people with depressive symptoms were interviewed. The first was a woman named Betina (43 years old), daughter of an elderly woman classified with mild depressive symptoms (05 points-GDS15). The second was Salvador (51 years old), son of an elderly woman with moderate depressive symptoms (08 points-GDS15), and the third was Antônia (78 years old), sister of an elderly woman with severe depressive symptoms (10 points-GDS15).

Through thematic content analysis, three categories emerged from the interviews, namely: (1) Good enough caregiver and the possibility of an enabling environment for the elderly with depressive symptoms; (2) The family caregiver and the strengthening of autonomy during aging and (3) Subjective overload and the need to

implement public policies for informal caregivers.

The categories were listed through common elements according to the relevance criteria, and grouped by semantically similar contents that respond to the objective of the study.

Category 1 – Good enough caregiver and the possibility of an enabling environment for the elderly with depressive symptoms

In this category, it was possible to identify how affective relationships take place between caregivers and elderly people with depressive symptoms. Participants reported:

Put on a cute new outfit just because we're going out, do her nails just to stay home, cut her hair, her hair was red, now she changed her look, it's good to take care of the elderly, I have a lot of patience, right, mom?! ... it doesn't matter, there are three things you must have to care for elderly people: time, love and dedication, there are no other things. (Betina)

I wish she cared for herself, like all the elderly women, go dance forró, do water aerobics, befriend other people, not be alone in this world, I wanted her to get friends, take care of her, of her hair, I wish she didn't worry. That's what I think. I want to see my mother well. (Salvador)

When she is here it is good, it is good, she is happy, she improves, right? Here, she hardly complains, I think it's because she is there alone, she has been here since her husband died, anything happens, she comes here, if she's scared, if she's sick, she comes here. Now that our sister died, she became sadder,

but she has been here for many years, 5 years ago. (Antônia)

Category 2 – The family caregiver and the strengthening of autonomy during aging

This category emphasizes the importance of the caregiver to strengthen the elderly's autonomy, while still offering the necessary care. Caregivers noted:

Sunday she got ready to go dancing, I said 'I'll drop you off there. You can take a motorcycle taxi to leave, because I won't be able to, because I also can't drive', she said like this, 'in a few days, the neighbors will start talking', I replied, 'you are the one who pays your bills', I don't care much about what the neighbor talks about either. (Betina)

I want my mom to be happy, understand? I wanted her to quit these soup things, I wanted her to participate, at least once a month or twice, I want her to go elsewhere. (Salvador)

Also living in other people's homes is very bad, you know, I don't dismiss her reasons for it, I just wanted her to have a constant companion; maybe her depression will improve. But you're right, our home is different, I have nothing against it! But for me, she would go, she would live in my room, but she doesn't accept it. (Antônia)

Category 3 - Subjective overload and the need to implement public policies for informal caregivers

Care generates an emotional dependence that affects the family's health,

causing subjective overload. The family caregivers said:

I had just returned from the hospital, the doctor said I was supposed to rest, keep using eye drops, I couldn't see anything, my mother arrived in about an hour and I had to get her lunch. Nobody does anything, and no, I don't have anyone who does anything for me. I think it's important to focus on the elderly, who knows, to arrive at the health centers, make a group of elderly people, not measure blood pressure, no! I'm talking about recreation for the elderly in the neighborhoods. (Betina)

I had a relapse recently and my mother, she is sorry because she was once an alcoholic, what happens when we relapse, when you relapse is complicated and I think it affects her a lot, so I think about myself, but I think about her too, I want her to live well, not that I want to change for me to have my life, I want to change to have my corner that I didn't even have. (Salvador)

She doesn't have a very good temper, but she doesn't get tired at all: I feel tired now that I'm in hemodialysis, I'm more quiet, I'll go every other day, but cook, I do all of that, I just don't do heavy work. (Antônia)

DISCUSSION

When the elderly get older, some family caregiver will provide this care, in turn, the caregiver is called to do a psychic work similar to that of the mother/continent, to welcome and make sense of feelings, without reacting to them, with the newborns the mother (or the substitute) is the one who promotes the initial care.¹⁰

The first experience of bonding creates a condition of psychic structuring and in the relationship with the other, the human is constituted as a subject. This situation experienced by the baby is different from the situation of dependency of the elderly, because they already have the basis of their formed personality and are more likely to signify their situation of dependence and care. However, primitive experiences of fear, confidence, pleasure, hatred and love, lived in the first care relationship, remain as a matrix for later experiences.¹⁰

All participants with depressive symptoms in this study have some primary family caregiver who is willing to offer the necessary care, however, each one offers such care according to their emotional maturity. Caregivers within their limitations sought to offer a facilitating environment for the elderly, however, environmental conditions do not always meet the needs of these elderly people with depressive symptoms.

The family caregivers of this research demonstrated to promote a facilitating environment, but it can be noted that the first interlocutor has a greater maturity and manages to promote a *good enough environment*, while the second, although very aware of his emotional condition and encourages his mother taking more care of herself, suffers with chemical

dependency that puts him in a position of vulnerability and inability to offer care. The third, on the other hand, is also weakened by being similar to the age of the elderly woman she cares for (sister) and with health problems, and it is not possible to be the necessary continent. The second and third family caregivers can be correlated to a role of caregiver not consciously integrated and personalized, as can be seen in sick mothers.¹⁰

A facilitating environment is necessary for the construction of the individual self of a human being, but it is possible that this potential facilitating environment may not be effective, the family needs to be seen as something that recognizes the needs of the individual in order to provide conditions for their satisfaction, a family with a good health potential, is not exempt from conflicts, but is able to facilitate the emotional growth of its members, finding ways to solve their problems.¹⁰

Winnicott was the founder of the terms *not good enough environment*, which distorts the baby's development, as well as *good enough environment*, which makes it possible to achieve, at each stage, the innate and pertinent satisfactions, anxieties, and conflicts of each stage of maturation. For this psychoanalyst and pediatrician, the provision of a *good enough environment* in the most primitive phase enables the baby

to begin to exist, have experiences, master instincts, face all the difficulties inherent in life, and to constitute a personal ego.¹¹

Development is a function of the inheritance of a maturation process, and the accumulation of life experience, but this can only occur in an enabling environment, it is the surrounding environment that makes growth possible, without minimum environmental reliability, growth cannot unfold, or unfolds with distortions.¹¹

The same happens in the aging phase. If the family caregiver adapts to the needs as in the case of the first caregiver. The tendencies towards a good development and with less incision of depressive symptoms are evident, even though the elderly woman has gone through traumatic events. This first caregiver recalls the sense of maternal love that makes the baby develop healthily, and fits perfectly with the *good enough caregiver*, so that while the family caregiver gratifies her mother, she frustrates in the same proportion.

However, when the facilitating environment is more confusing and tumultuous, as in the case of the second family caregiver, where the intensity of his anxieties and addiction to legal drugs prevent him from offering the necessary care to his mother, the caregiver resembles the mother who is incapable to be the continent for the baby.

As for the third caregiver, the environment is fickle, now she is living with her sisters, now she is alone and lonely at home, this lack of constancy further increases her depressive symptoms, even though her sister tries to provide the necessary provisions. As can be seen, a parallel was transposed between the theory of emotional development focused on mother-baby relationships, but in the last phase of human development, old age, where the elderly are also influenced by the environment and relationships.

In this sense, the development of the human being only stops with death. The individual develops and becomes mature, and adult maturity cannot be considered separate from previous development. This development is extremely complex, and occurs from birth, or even earlier, through adulthood, to old age. The existence of a continuous process of emotional development continues throughout life, until natural death.¹²

In the three family caregivers, it is possible to notice an effort to offer sufficiently good care to the elderly, the first caregiver encourages leisure, fun and body care; the second suggests better habits, therapy and entertainment, and the third encourages the caregiver to live with her, but the first caregiver is the one that offers a holding company with greater efficiency,

with greater emotional ability to meet the mother's needs.

When adulthood is reached, there is relative autonomy and independence in the care of the other, however, with aging, the situation of dependence, helplessness and care needs returns and will be determined by the quality of previous care experience.¹³ Thus, the first caregiver, usually is the mother, and for the elderly there are substitutes such as family members, professionals or even some institution.¹⁴

The elderly because of the senescence process tend to be treated as a helpless child, however it is important that the caregiver helps them to achieve independence. Dealing with anguish and the dark aspects of aging, along with the loss of body functionality, cognitive and physical dependence causes caregivers to use self-defense mechanisms in order to protect their mental health in the face of a rude routine, and one of the mechanisms used is the infantilization of the elderly, which allows the caregiver to protect himself from the fact that that elderly person is an adult, and helps him and face this reality.¹²

In the second category of this study, in which autonomy presupposes the creation of a welcoming environment where the elderly can manifest their will without having been subjected to coercion, influence, induction or intimidation by caregivers, family members or health

professionals, that is, the presence of the caregiver or health professional who inspires confidence and considers the uniqueness of aging and the identification of their needs, which can contribute greatly to the quality of life of the elderly.¹⁰

Many elderly people feel discomfort in relation to the experiences of fragility and dependence, aging is not a disease, therefore, the elderly must ask themselves, what to do to make life meaningful, and the answer should be to feel alive, with the internal feeling of fulfillment and not of emptiness, having a purpose in your existence, and not waiting for the arrival of death.¹³

For these reasons, the care given by family members could follow as a principle the instrumentalization of those involved to perform tasks aimed at independence and humanization, as these principles favor the recognition of the autonomy of those who age, therefore, taking care towards autonomy is a complex task that requires preparation by professionals and family members, since it alters the concept of care.¹⁴

Many have a fear of disrupting the lives of their caregivers, roles are often mixed and the identities of the elderly versus caregivers are affected and, over time, they feel distressed. In turn, from the moment that the caregiver loses his personal references, eliminates his desires and needs,

thinks that he is fulfilling his role, but the task of caring becomes more painful.¹⁵

The view centered on the figure of the elderly person as a fragile and incapable person, should gradually be replaced by a perspective of positive aging, offering a reinterpretation of this phase of the life cycle. It is important to enhance interventions based on the positive aspects of the elderly, their bonding skills, their resources and the rereading of those who are cared for.¹⁵

The three family caregivers in this study contribute to maintaining the autonomy of the elderly. The first family member is the one who offers the most care to his mother, it is perceived a more intensified care that if careless can become dependent and suffocating, and although (caregiver and caregiver) apparently have a symbiotic relationship, it also allows the caregiver some freedom which increases the relational capacity and autonomy of the elderly woman.

The second caregiver wishes that his mother does not go to make soup as often, unconsciously he does not allow the caregiver to fulfill his desires and breaks with the elderly woman's autonomy, but on the other hand, in his speech, he encourages the mother to look for ways to fulfill herself. The third caregiver respects her sister's longing to live in her own home and have her corner and shows empathy in accepting

her sister's desire, in contrast she does not leave her helpless, bringing her close to her and offering care.

Entering the third category, it is common that the primary care of a family member of elderly people with mental disorders is particularly difficult, demanding and has adverse health consequences. Caregivers must adopt a complex range of coping strategies to reinforce their own resilience¹⁶. Caregivers often fall ill more than the person being cared for, the excess of chores and constant dedication, the caregiver falls ill, which puts his life in second place plan.¹⁵ The caring attitude causes concern, restlessness and a sense of responsibility for the other's life, caring is very demanding and can lead the caregiver to stress, especially when care is not a sporadic act, but a permanent attitude.¹⁵

Thus, as caregivers are limited beings, subject to fatigue, failures and disappointments, they often feel alone, and for this reason, they also need care, otherwise the will to care weakens, and the good energy that radiates of care fails to corroborate in the cure.¹⁵ The elderly often project their feelings on family members or the health team, transferring, reliving and transforming affections into conflicts.¹³ These unconscious transfers about the caregiver overload them, when the elderly have depressive symptoms like the

interlocutors of this research, the projection of ambivalent, confused, angry and pessimistic feelings is even more accentuated.

The three caregivers in these studies showed aspects that caring is a demanding task, but they are not yet exhausted. One of the possible alternatives to minimize the overload is to establish a relay routine among family members, allowing the primary caregiver to alternate care with other members, so that they can reestablish their needs for rest and rest, however this strategy is not yet part of everyday life of most accompanied families.¹⁷

A study that assessed the overload of informal caregivers of elderly people with cognitive impairment in Ribeirão Preto, in the state of São Paulo, identified the cognitive decline as a predictor for the overload and emotional discomfort of their family caregivers.¹⁸

When assessing the overload of family caregivers in a canton of Chordeleg (Ecuador) evidenced a high prevalence of overload on caregivers, with association to having more than five years as caregiver and moderate to severe disability of the elderly.¹⁹ Longitudinal study on Korean aging identified greater chances of impairment of depressive symptoms among family caregivers who need care for daily activities.²

When evaluating the positive and negative situations experienced by family caregivers of the elderly cared for in a Home Care Service, they point out that the negative situations related to the care undertaken relate previous inexperience and ignorance of technologies used for care; to be alone for the care and psychophysiological changes of the caregiver. Positive situations synthesize the comfort of being at home, support from the Home Care Service and reduction in expenses with commuting to the health service.²⁰ Although detachment to care at home for an elderly person is a challenging situation, it can often generate comfort aspects for the caregiver to keep the elderly at home and guarantee even better quality of life.

For this reason, the importance of carrying out studies that investigate the profile of family caregivers, and the implications that guide the activity performed by these subjects occurs to the extent that they can enable the creation of public policies, which offer a support and support network to these caregivers, contributing to their quality of life. It is necessary to offer support to family members, aiming to reduce the overload of caregivers who stay full time and care actions with a view to providing formal support to caregivers.¹⁶

For the elderly and their families, humanized assistance should be offered to identify and assess their needs with the intention of providing better health conditions and planning care actions, especially in relation to depressive symptoms in the elderly and the overload of their family caregivers.¹⁷

CONCLUSION

The study made it possible to get acquainted with the relationships of family caregivers of elderly people with depressive symptoms. It is noticed that the three family caregivers showed a lack of social support by other family members. The primary caregivers tend to become more overloaded, while the secondary caregivers have little time with the elderly, constituting distant and uncompromising affective relationships. The study reveals little relay among family members.

The main limitation of this study refers to the specific characteristics of this sample and a small number of family caregivers. The results do not allow generalizations, it is suggested to expand the data in future research. The need to create public policies for family members of the elderly and implementation of care actions is emphasized.

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