

Social constructions of love and their crossing in family caregivers

Construções sociais do amor e seus atravessamentos em cuidadores familiares

Construcciones sociales del amor y sus atravesamientos en los cuidadores de la familia

Received: 03/08/2020

Approved: 22/11/2020

Published: 09/01/2021

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This is a qualitative and field study conducted in 2018 in a city in the interior of Minas Gerais state. Its aim was identifying social and historical constructions about love as an affective experience and how these understandings go through the care aimed at a family member with a neurological or psychiatric condition. 12 caregivers of neurological and psychiatric patients were interviewed. Data were collected at a university hospital using a semi-structured interview script as well as the presentation of two works by Frida Kahlo. The analysis of the data resulted in the elaboration of four thematic axes: *Those who love care; Taking care of another is fulfilling a duty; It is natural to take care of those I love; and Care is a feminine task.* The social constructions about love cross relationships of love, as they not only mold them, but also define what means to take care of someone.

Descriptors: Caregivers; Chronic disease; Emotions.

Este é um estudo qualitativo e de campo realizado em 2018 numa cidade do interior de Minas Gerais, com o objetivo de identificar construções sociais e históricas acerca do amor enquanto vivência afetiva, e como essas compreensões atravessam o cuidado voltado a um familiar com adoecimento neurológico ou psiquiátrico. Foram entrevistados 12 cuidadores de pacientes neurológicos e psiquiátricos. Os dados foram coletados em um hospital universitário, utilizando-se como instrumento um roteiro de entrevista semiestruturada, além da apresentação de duas obras de Frida Kahlo. A análise dos dados resultou na elaboração de quatro eixos temáticos: *Quem ama cuida; Cuidar do outro é cumprir um dever; É natural cuidar de quem eu amo e O cuidado é feminino.* As construções sociais acerca do amor demonstraram atravessar as relações de cuidado não apenas as moldando, mas definindo o que é exercer o cuidado.

Descritores: Cuidadores; Doença crônica; Emoções.

Este es un estudio cualitativo y de campo realizado en 2018 en una ciudad del interior de Minas Gerais con el objetivo de identificar construcciones sociales e históricas sobre el amor como experiencia afectiva y cómo estas comprensiones pasan por el cuidado de un familiar con una enfermedad neurológica o psiquiátrica. Se entrevistó a doce cuidadores de pacientes neurológicos y psiquiátricos. Los datos se recogieron en un hospital universitario utilizando como herramienta un guion de entrevista semiestruturada, además de la presentación de dos obras de Frida Kahlo. El análisis de los datos dio como resultado la elaboración de cuatro ejes temáticos: *Quien ama cuida; Cuidar al otro es cumplir con un deber; Es natural cuidar a quien amo; y El cuidado es femenino.* Las construcciones sociales sobre el amor han demostrado pasar por las relaciones de cuidado no sólo dándoles forma, sino definiendo lo que es ejercer el cuidado.

Descriptores: Cuidadores; Enfermedad crónica; Emociones.

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INTRODUCTION

Chronic neurological and psychiatric diseases are related to multiple causes and are characterized by a gradual onset, with a generally uncertain prognosis, with a long or indefinite duration, which may have a clinical course with possible periods of exacerbation. They require lifestyle changes and interventions with the use of soft, soft/hard and hard technologies present in a continuous care process that does not always lead to a cure¹. Therefore, when the disease is irreversible, the focus should not only be curative, but it must be recognized that there is still much to be done. For all these reasons, the chronic patient may need the help of a caregiver.

The formal caregiver is the one who has knowledge acquired in targeted training, referring to the health professions, and, in general, receives remuneration in exchange for their services. The informal caregiver comes from the laymen segment, usually represented by a family member.

Specifically about taking the role of informal caregiver, it requires a redefinition of a previous role, as part of the family environment, be it spouse, parents, or child, and the integration of a new role: that of caregiver. This restructuring often causes certain feelings, such as the tension generated by the need to develop new skills and the conflicts that are associated with this reorganization^{1,2}. Thus, caregivers can experience negative feelings and attitudes towards the exercise of caring for others, such as frustration, stress and impotence, and it is essential to build spaces where caregivers can also be cared for³.

A frequent characteristic of family caregivers is the fact that they are mostly women and close family members, such as wives or daughters^{4,5,6}. This fact seems to be related to the historical and culturally constructed place for the female figure, often associated with care that supports life, such as the roles of taking care of the household and serving the (male) head of the family with their sex, which, historically, justified the existence of the wife and are the result of the social division of labor^{4,7,8}.

On the other hand, love, as a social construction of affective experience, affects the way people relate and, consequently, how they care for each other⁷. Throughout history, much was asked about whether to love with a sense of duty or affection. In a Catholic view, good love could be rewarded with eternal life; passions, on the other hand, with hell⁷. Therefore, questioning the loves that nowadays and in the past make and made love justifies how relationships are maintained⁷. The understanding of this affective experience, as a social construction, obliges the human being to leave the place of authority and holder of a normative knowledge, and adopt a posture of not knowing, being open to encounter according to what social constructionism proposes⁹.

Thus, it is essential to investigate how the construction of love, as an intimate and affective experience of family relationships, translated by the institutions as belonging to a traditional and conservative family, that is, defining social and gender roles, unquestionable between men and women, crossed and shaped care relationships within families^{7,10}. Over time, the religious conception excluded the possibility of love providing pleasure. Thus, Christian love should cause some suffering, since pleasure was a sinful concept. Thus, conjugal love should be hard work to be supported⁷. Reified from time to time, the feeling of love became, therefore, a way of subjective expression of family relationships.

For all these reasons, it is relevant to understand how the family caregiver of a neurological and psychiatric chronic patient understands the affective and intimate experience of love, since this understanding has shaped family and social relationships over the years⁷. So, discursive practices that allow the construction of meanings around the act of caring for a family member can be understood according to the history they carry^{3,9}. Thus, the present study aims to identify the social and historical constructions about love as an affective experience and how these understandings cross the care aimed at a family member with neurological or psychiatric illness.

METHOD

This is a qualitative-descriptive and cross-sectional research. It is an excerpt from a larger study, which sought to understand the support offered by psychologists for caregivers of patients with chronic diseases. It was carried out between June and July of 2018 in an outpatient service for neurological and psychiatric diseases at a university hospital in Minas Gerais state. The study included men and women, primary caregivers and family members of patients with neurological and psychiatric illness.

The theoretical basis was the understanding of love as an affective experience, that is, much more than a feeling, but rather a construction that crossed the feeling and shaped the intimate relationships of families in Brazil since the beginning of the discovery⁷. In addition, the discussions are anchored on the assumptions of social constructionism⁹.

Social constructionism can be considered a polysemic movement, which seeks to understand the phenomena from its historical-social and cultural context and criticizes the assumptions of traditional science, proposing a new intelligibility of science⁹. Thus, it can be said that the meanings given to feelings can become beliefs that guide the conduct of human beings¹¹. Thus, in this perspective, it is necessary to understand the history of a given phenomenon, recognizing it as a product of social and historical forces¹¹.

For data collection, a semi-structured interview and the presentation of two works by the artist Frida Kahlo, entitled "*Abrazo amoroso*"¹², produced in 1949, and "*Dos desnudos en un bosque (La tierra misma)*", 1939 were used, both printed on paper and selected with the Google search tool, which refer to situations of care.

These pictures were chosen in order to broaden the understanding of the spontaneous and affective dimension of the caregivers about the care they exercised, thus making it possible to capture un verbalized understandings of this function during the interview.

The instruments used sought to investigate the process of becoming a caregiver and the feelings aroused by assuming such a function, as well as identifying the social and historical constructions of caregivers about love as an affective experience. The images were presented to the caregivers right after the interview, asking them about what the contents of the works represented for them.

The option to carry out the study in the neurology and psychiatry outpatient clinics was due to the fact that these specialties were the ones that most had the presence of family caregivers during consultations. The services in these clinics took place four days a week, in the morning and afternoon shifts, and the appointments were made on a first-come, first-served basis.

The outpatient service of the hospital, where the collection was performed, maintains 38 outpatient clinics, with consultations scheduled by the Fila Eletrônica System, with 60% of the beds destined to the Unified Health System (SUS). Eight visits were made to the neurology and psychiatry outpatients of that hospital, during which time they attended the outpatient clinics at the time when the appointments were made, alternating between morning periods, from 8:00 to 11:00 am, and afternoon periods, from 1:00 pm to 5:00 pm. During these visits, invitations were made to the patients' caregivers, who were awaiting medical consultation at the outpatient service reception. The interviews took place after the patients went through the evaluation of the medical students of the institution.

The interviews were conducted in a quiet place in the outpatient service itself, with only the presence of the researcher and the participant. The questions were about: the process of becoming a caregiver, feelings and thoughts associated with caring, and the daily caregiver routine. At the end of the interviews, participants were presented with selected images of Frida Kahlo, allowing them to express themselves freely about the representations awakened by the screens. This process lasted an average of 20 minutes, and all the demonstrations were recorded. It should be noted that the research was approved by an Ethics Committee, with protocol number 2,546,799.

RESULTS

Twelve informal family caregivers participated in the research, this being the total number of invited participants who fit the inclusion criteria: main family caregivers.

A greater number of caregivers of neurological patients was found than caregivers of psychiatric patients. As can be seen in Table 1, most of the caregivers interviewed were composed of women who performed activities at home and were closely related to the subject being cared for. The average age of the participants was 51.3 years, with a predominance elementary educational level, either complete or incomplete.

Among the patients receiving care, there were adolescents, adults and elderly people, with more adults and elderly. In neurological patients, Alzheimer's and dementia diagnoses predominated. While in psychiatric patients, major depression, bipolarity and dementia were found.

Table 1. Sociodemographic data of respondents. Uberaba, Minas Gerais, 2018.

Interviewee	Gender	Age	Educational level	Occupation	Relationship with the patient
Interviewee 1	Female	52	Elementary school (incomplete)	Housewife	Mother
Interviewee 2	Female	40	High school	Makeup artist	Daughter
Interviewee 3	Female	48	Elementary school	Unemployed	Girlfriend
Interviewee 4	Male	52	Post-graduate degree	Bank clerk	Son
Interviewee 5	Female	57	High school (incomplete)	Housewife	Wife
Interviewee 6	Male	47	Elementary school (incomplete)	Unemployed	Husband
Interviewee 7	Female	65	Elementary school	Seamstress	Ex-wife
Interviewee 8	Female	46	Elementary school (incomplete)	Housewife	Mother
Interviewee 9	Female	49	Elementary school (incomplete)	Housekeeper	Mother
Interviewee 10	Female	54	High school	Secretary	Mother
Interviewee 11	Female	65	Elementary school (incomplete)	Housekeeper	Sister-in-law
Interviewee 12	Female	41	Elementary school (incomplete)	Manicurist	Daughter

The analysis of the collected data consisted of the full transcription of the interviews, followed by an exhaustive reading of the transcribed material, in order to focus on the way in which people produce meanings and position themselves in social relationships¹¹. Subsequently, the constructions of meaning about love were separated into major themes. Thus, the exhaustive reading of the interviews provided that the feelings of the interviewed caregivers emerged and could be analyzed.

The exhaustive reading of the collected material showed that one of the most present representations in the caregivers' speeches was the expression of love as an affective experience, which demonstrated crossing care relationships. Thus, it was considered extremely important to analyze how what they understood about love affected the care provided.

The themes that sought to identify the main social and historical constructions about love as an affective experience, present in care relationships, are: *Those who love care; Taking care of another is fulfilling a duty; It is natural to take care of those I love; and Care is a feminine task.*

“Those who love care”

One of the main constructions of meaning about what love is is that it is intrinsically linked to care, corroborating the belief that those who love take care. Such finding was observed in the following statements:

(...) *I take care of him because I love him too much, he is, wow, I don't even like to think about losing him (...)* (Interviewee 3)

Can I tell the truth? I feel good taking care of him, I like him, I love him a lot, I feel good... for me, it's not that difficult, no. (Interviewee 8)

Taking care of another person in the name of an idealized love conception can also generate negative feelings, such as feelings of helplessness, loneliness and concern, as can be seen in the statements presented below:

Taking care of her, I feel, like, ah, it's very bad, we worry, like, she only has this problem at night, at the time she goes to bed, and it is that damned anguish. (Interviewee 1)

Ah, I am, ah, apprehensive, right, because the problem he has hurts him too much. (Interviewee 3)

I accompany her, because it is dangerous, right, she is on the street alone, and also, I am also not working, so I come with her. (Interviewee 6)

There are times when it gets a little difficult, you know, because we have to keep going, we have to help him walk, get up, and there are times when he forgets, he doesn't, there are times when he leaves everything for us, so if we don't stand our ground, we fall together. (Interviewee 8)

Oh, for me it's very difficult, see. There are days when, like this, if he were able to go to his father, I am, like this, in a phase of my life of tiredness. Very tired, exhausted. There are days when I wish her would travel for a bit, so I can have a break from problems. (Interviewee 10)

“Taking care of another is fulfilling a duty”

Another characteristic observed is that there is a feeling of obligation in care, be it social, as a moral duty, or religious, as a duty with God or waiting for a divine reward:

Look, for me, it is interesting to take care of her, because when I was a child, we lived in a place, you know, and I remember her effort, that she took it, she didn't have a car (...) and she had a very special attention for the three of us over there, you know. So, for me, it is a pleasure to be able to give back to her in some way (...) this opportunity to have that time, right, because life is very short, and we can do something in this sense, it helps us psychologically, huh (...). (Interviewee 4)

Ah, I feel good, I feel good to accompany her, because I feel like this, it is a way to help her, being with her, I give support, which is necessary, because depression needs a lot of support, affection, huh? So, we, we do what we can, (...) I feel, as I am her husband, I feel under my obligation to take care of her. So, doing what I can for her, I feel good, I feel good helping her. (Interviewee 6)

Ah, a feeling of being doing my duty (...) with God, right? (Interviewee 7)

No, we feel very sorry, because I think it is very sad to see such a person in this situation, right? I think that the person themselves does not notice, right? I think she doesn't see that she's like that, right? But it's good, we seem to feel that it's still useful for something, right? There, it is like that. I feel good, I don't feel bad, no. (Interviewee 11)

“It is natural to take care of those I love”

The naturalization of the process of becoming a caregiver, as if care were inherent in the family environment, could be observed in the interviewees' statements so that many did not know how to express it when they started to assume this role although he marks the responsibility in the exercise of care:

No, I lost my mother, and it was just me and him, we are six children, and I was single, I ended up staying at home. Then, I got married and took him to live with me. (Interviewee 2)

Ah, it was when we started dating, you know, dating and such, I started to participate in his life. So, I started to accompany him. (Interviewee 3)

Look, it happened naturally, right? The other brothers have more activities, right? (Interviewee 4)

No, she was not very caring. It was because I was married to her husband and she always came and went. And one day she came and she had nowhere else to go. And she stayed at home and is still there. (Interviewee 11)

“Care is a feminine task”

When using the works of Frida Kahlo, to try to account for the relationships and actions that are not expressed verbally, it was found that the female figure, within the family, is a social representation of care. The following are the interviewees' works and perceptions about the images of the Mexican painter.

Figure 1. *Abrazo amoroso*

Source: <https://www.meupapeldeparedegratis.net/artistic/pages/frida-kahlo-abrazo-amoroso.asp>¹²

Ah, as if it was a mother, a sister, taking care of another person, that's what I imagine here, in someone else's lap. (Interviewee 2)

Ah, a mother's love, right, protection, zeal, right? Wanting the child not to grow up so fast, right? (Interviewee 3)

That's a mother looking after a child, I think. (Interviewee 5)

It must be a mother taking care of a child, right? Oh, I don't know, because it seems that, by the way she looks, she seems to have, she has a love. (Interviewee 7)

A mother with. There are three mothers. Two mothers holding an adult on their lap. It is a protection, they are grandmother, mother and child. Because a mother always carries a child. Ever. And grandma becomes a mother twice. (Interviewee 9)

Ah, I understand that, let's suppose, a mother taking care of a sick person, a sick person, right? Giving your support, your affection, right? (Interviewee 11)

Figure 2. *Dos desnudos en el bosque (La tierra misma)*

Source: <https://es.slideshare.net/fairyqueen421/pinturas-de-frida-kahlo>¹³

Here, it's more man and woman, right? A couple, affection, protection too, but more couple, a different love. (Interviewee 3)

A mother supporting a child? (Interviewee 7)

This is a daughter taking care of a mother. (Interviewee 8)

This one is already the person in your lap, right? With affection for each other, right? A kind of evolution of the human being, right? This one may even be the species after the end of an affective relationship, the two of them at rest. (Interviewee 10)

DISCUSSION

The lower presence of caregivers of psychiatric patients interviewed may reveal that, since the Psychiatric Reform, there has been the challenge of making the insertion of family members into the care provided to psychiatric patients effective. On the other hand, there is also an effort to achieve the autonomy of the psychiatric patient after the Reformation.

As a reference to the history of love, it is a feeling seen as something essential in care relationships^{4,6}. However, when talking about the construction of meanings around love, there is a great distance between what is expected from love and the reality of lovers' lives⁷.

Throughout the history of love, what can be seen is that this feeling is not ideal, carrying with it dependence, servitude, loneliness, rejection, sacrifice and transfiguration⁷. Thus, the conception that love would be intrinsically present in care relationships, added to a belief in ideal love, can make it difficult for caregivers to recognize and express the negative feelings that this function can cause.

In this sense, it is essential to understand that the relationship between love and care is not simply established in a linear way, but is the result of a conflicting relationship, in which several negative feelings, such as tiredness and exhaustion, are present. The desire to interdict the other in care relationships is natural, as such an encounter explodes as a revelation of groupings, when subjects are placed in front of other groups with the will and action to stop the other, even in their thinking¹⁴.

For this reason, the other is seen as a foreigner, with their own marks of their history, making it necessary to exercise their support in their existence, which does not always imply loving them at all costs or at all times. The subject being cared for is also a being in the interaction, and as such resists and tries to manipulate the actions of their caregiver in an attempt to rescue their autonomy and make their wishes valid³.

In this way, care becomes a representation, which generates a contradiction between the vision of unconditional love, but which on the other hand implies suffering⁴, which makes it even more difficult for the caregiver to recognize their feelings and seek help, since to say of the overloads that this function can cause seems to say of a love that is not ideal, corroborating the results presented in this study. When they take on the role of caregiver, family caregivers feel oppressed with the tasks they must perform, especially because they feel the need not to lose the essence of the person they care for, thus assuming the largest possible number of functions⁵. In addition, the feeling of being overloaded is frequent in primary informal caregivers^{1,2,5,15,16}.

In turn, when the belief that caring is fulfilling a duty is built, there is an obligation to take charge of this function, agreeing with the conception of love built throughout history: loving requires sacrifices^{5,7}, as it was possible to identify in the statements presented. Caregivers, too, experience feelings that fulfill a moral function⁴ and place themselves in a position of seeking recognition, as a figure who sacrifices themselves for the sake of the one they love^{4,6}. Caregivers also tend to feel compassion, duty of reciprocity, feeling of guilt, reparation, return of love and affection to some family member⁴⁻⁶.

Thus, the care exercised to the other can be accompanied by an expectation of retribution, which also makes it difficult to understand that it is an arduous task. In this multiplicity of feelings, it can be understood that, for the interviewees, care is a relationship of several territories and subjects, in events and happenings, of several things at the same time and that are not excluded¹⁴.

In view of the variability of feelings and sensations aroused in care relationships, it must be remembered that, although this act is performed in different ways, it has been part of human existence since the beginning of life^{4,6}. Therefore, care aimed at the one you love is naturalized, being seen as an extension of the family function^{1,4}, which builds the sense that caring for others is a natural process.

Thus, assuming the role of family caregiver is seen as something inherent in life, no questions are asked about this role, as it seems that family life imposes responsibility for the

care of their family members, whether for emotional, cultural or kinship reasons⁴. However, although there is a social construction that caring is a natural act, as it implies the relationship between human beings, it must not be forgotten that this does not dispense with training or prior care in relation to the person who offers this care³.

This preparation prior to the exercise of care aimed at the other was not verified in any participant, which invites another question: *Would there also be a difficulty for the health system itself in not recognizing the family caregiver beyond the naturalization of this process?* In this aspect, health professionals, too, can be crossed by constructions about love in family care, which would generate a difficulty in identifying the caregiver's suffering.

Although care has become naturalized, as something that is the duty of the one who loves and is the result of family relationships, care for a family member can awaken a feeling of unpreparedness and suffering. Many families report difficulties in maintaining self-control due to the awakening of intense feelings in the care relationship, which ends up generating anger, impatience, loneliness, shame, frustration and fear⁶. Despite this, the family caregiver still feels obliged to fulfill a social and moral function in an attempt to avoid the feeling of guilt and maintain an empathetic and affective relationship⁴.

The attribution of family care to women is related to the representations historically constructed about motherhood, seen as the ability to care and educate, inherent to the female figure^{4,7}. Historically, women have been placed in this caregiver position. This is mainly due to the patriarchal view of the Catholic Church, present in the colonial period, justifying relationships of domination and power exercised by men, which constituted the affective relationships, placing the woman in a position of submission. This may even explain the greater number of female caregivers than male caregivers found in the outpatient service in question.

In addition, the woman, too, became responsible for maintaining marriage as a business for life, thus being in charge of ensuring that love was something lasting⁷. In this way, care implies the inseparability of the gender issue, which, throughout history, until the present day, has been delegated to women, which leads to psychological suffering and overload^{4,7}. This factor could be identified in the verbal expression of the participants in relation to the paintings of Frida Kahlo^{12,13}, which were related to maternal care, female family care and even the care exercised in an affective relationship between man and woman, constructions that relate love, care and gender.

It is fundamental to problematize that the woman, when considered as provider of care and source of love, constitutes herself as someone who must abdicate herself in favor of the other, not being able to deny this responsibility, since the woman's time starts to be timed with taking care of the other and renouncing oneself⁸. Given this, social constructionism shows the importance of reflective posture, which is to recognize that what is taken as an inevitable part of the world can be different and promote changes¹¹.

So, the act of caring, for family caregivers, is also marked by gender inequality and inequality in the distribution of tasks⁴. In this sense, it is paramount that health services focus on women caregivers, since they tend to experience isolated living in their daily lives, in which, imbued with the care of their loved one, they renounce themselves⁸. Notwithstanding this, it is important to understand that love does not necessarily bring an ideal life experience - security, absolute fidelity and sacrifices in favor of the other - and that women should detach themselves from the role of to be in charge of love⁷.

Thus, in view of the multiplicity of feelings that this care relationship awakens and the senses that support the way of relating to the other one that is loved, it is essential to open spaces so that the issue of care can be questioned in an unequal society⁴. One of the ways to make this possible is through what suggests social constructionism by questioning the varnish of reality or what people take as truths, anchored in social and historical processes¹¹, as proposed in the present study.

The present study showed that care is a relational process; therefore, it is historical and social, and its understanding should start from this dimension. As a historical and social dimension, care does not happen in the same way, being influenced by the culture of each context.

This study starts from a specific region, which is included in a macro context, a social and political reality marked by social, gender, class and race inequalities. These intersections directly affect how love is felt and, consequently, how care is exercised, but should not be generalized to other cultures and forms of relationship. Therefore, it was possible to identify a specific social construction, which determines a dependency relationship between care, love and gender.

Enabling the critical listening of family caregivers of chronic patients, taking care as relational, is to contribute to the deconstruction of the belief that there is an ideal way to care for and love someone. In addition, fighting social impositions is also fighting for free expression and social inequalities that characterize relationships, since each subject is unique in their culture, with no correct way of feeling or being a caregiver. For health professionals, it becomes essential to adopt this critical listening, collaborating for new constructions of meanings, as well as questioning their own constructions, in a constant exercise of deconstruction. For this, at first, the active search of caregivers in health care units is essential, since, while they do not recognize and assume their own suffering, they will have difficulties in seeking help spontaneously.

There was a significant gender gap in the role of caregiver. Thus, listening to this audience, too, must be guided by the differences in gender roles and their crossings in the mental health of women caregivers. The difficulties found in this study go through the constructions about care, since many caregivers sought justifications for what they felt.

CONCLUSION

The social and historical constructions about love have shown crossing care relationships not only molding them, but, many times, defining what it is to exercise care for the other. In this way, the main crossings of the conceptions of love in this relationship were highlighted in the titles of the themes, seeking to enable reflection on these thoughts, which have become determinant beliefs in conduct.

The understandings identified in the present study, that love is intrinsic to care, it is a duty, it is natural and it is feminine, become a hindrance for reflection on the feelings that this function can arouse, especially those related to the burden of family caregivers. When a social construction is not questioned, it becomes an imposition, and impositions generate suffering.

Finally, it is essential to emphasize that studies with a critical bias on care must be carried out, as long as some practices are not questioned and denaturalized, there will always be a distance between professional, caregiver and subject cared for. The research that gave rise to this study is limited in its focus on only two specialties. Thus, the importance of further studies focusing on other areas, as well as on formal or unfamiliar caregivers, is emphasized.

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CONTRIBUTIONS

Natanna Késsia Nunes contributed to the conception, collection and analysis of data. **Cintia Bragheto Ferreira** participated in data analysis, writing and review.

How to cite this article (Vancouver)

Nunes NK, Ferreira CB. Social constructions of love and their crossing in family caregivers. REFACS [Internet]. 2021 [cited in *insert day, month and year of access*]; 9(1):99-109. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)

NUNES, N. K.; FERREIRA, C. B. Social constructions of love and their crossing in family caregivers. REFACS, Uberaba, MG, v. 9, n. 1, p. 99-109, 2021. DOI: *insert DOI link*. Available from: *insert access link*. Access in: *insert day, month and year of access*.

How to cite this article (APA)

Nunes, N.K., & Ferreira, C.B. (2021). Social constructions of love and their crossing in family caregivers. REFACS, 9(1), 99-109. Retrieved in *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.