

Family of older adults with mental disorder: perception of mental health professionals

Família do idoso em sofrimento psíquico: percepção dos profissionais de saúde mental
El sufrimiento psíquico en la familia del anciano: una percepción de los profesionales de salud mental

Maria Giovana Borges Saidel¹, Claudinei José Gomes Campos¹

¹Universidade Estadual de Campinas, School of Nursing, Center of Qualitative Research in Health. Campinas, São Paulo, Brazil.

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ABSTRACT

Objective: to understand the perceptions of healthcare professionals of the Psychosocial Care Centers regarding the family of older adults with mental disorders. **Method:** study of a Qualitative Case conducted with 12 healthcare professionals from a Psychosocial Care Center, with a convenient and exhaustive sample. Conducting semi-structured interviews to collect data, which were analyzed with the Content Analysis technique. **Results:** the following categories stood out: "Family exhaustion and deterioration in the perception of the healthcare professional" and "The abandonment of older adults by family members and their distancing in the perception of the healthcare professional." **Final considerations:** culpability of older adults and penalization of the family were verified by healthcare professionals. To bring awareness about the difficulties faced in the attempt to bring the family closer to the healthcare service, it is necessary to analyze the care given to the older adult and to overcome challenges in the effective construction of the bond between family, healthcare user and mental health service.

Descriptors: Professional-Family Relationship; Geriatric Psychiatry; Older Adults; Frail Older Adults; Community Psychiatry.

RESUMO

Objetivo: compreender as percepções dos profissionais do Centro de Atenção Psicossocial acerca da família do idoso em sofrimento psíquico. **Método:** estudo de Caso Qualitativo conduzido com 12 profissionais de um Centro de Atenção Psicossocial com amostra composta por intencionalidade e fechada por exaustão. Realização de entrevistas semiestruturadas para coleta de dados, analisados por meio da técnica de Análise de Conteúdo. **Resultados:** destacaram-se as categorias "O cansaço e o desgaste familiar na percepção do profissional" e "O abandono e o afastamento do idoso pela família na percepção do profissional". **Considerações finais:** verificou-se a culpabilização do idoso e a penalização da família pelos profissionais. Visando à conscientização das dificuldades em aproximar a família, é necessária a criação de espaços reflexivos sobre o cuidado a essa população, bem como a superação dos desafios na construção efetiva do vínculo entre família, usuário e serviço de saúde mental.

Descritores: Relações Profissional-Família; Psiquiatria Geriátrica; Idoso; Idoso Fragilizado; Psiquiatria Comunitária.

RESUMEN

Objetivo: conocer las percepciones de los profesionales del Centro de Atención Psicossocial sobre el sufrimiento psíquico en la familia del anciano. **Método:** estudio de caso cualitativo no aleatorizado con agotamiento de la muestra, del cual participaron doce profesionales del Centro de Atención Psicossocial. Para la recolección de datos se hizo entrevistas semiestructuradas, y después se los evaluaron desde el Análisis de Contenido. **Resultados:** las siguientes categorías fueron las más subrayadas: "El cansancio y el desgaste familiar desde la percepción del profesional" y "El abandono y el alejamiento del anciano por la familia desde la percepción del profesional".

Consideraciones finales: se verificó la culpabilidad al anciano y la penalización de la familia desde la perspectiva de los profesionales. Con el propósito de concientizar las dificultades de acercarlo a la familia, es necesario crear espacios que discutan el cuidado a esta población, así como superar los retos para la efectiva construcción del vínculo entre familia, usuario y servicio de salud mental.

Descritores: Relación Profesional-Familia; Psiquiatría Geriátrica; Anciano; Anciano Frágil; Psiquiatría Comunitaria.

CORRESPONDING AUTHOR **Maria Giovana Borges Saidel** Email: giovana.saidel@gmail.com

INTRODUCTION

Investigations about the consequences of the current demographic and epidemiologic transition in Brazil are relevant. The topic plays an important role in governmental efforts, and instruments are necessary for workers to understand and face these changes in their work environments. Thus, research about ageing may contribute to the planning of continuing and permanent education actions, helping the work of those who are in direct contact with older adults or who occupy managing positions.

The results of these investigations may lead to analyses made by healthcare professionals from these work environments who help older adults in their daily lives. Because of technological advances⁽¹⁾, older people now have a higher life expectancy and use healthcare services for longer periods.

This reality increases the number of people with chronic conditions, described by the World Health Organization as those that are persistent and require permanent care. Long-term psychological distress is described as a chronic condition, and consequently family relationships need to become more intense because of its particularities⁽²⁻⁶⁾.

Older adults with long-term psychological distress witnessed changes in Brazilian psychiatric care in the 1990s, especially the reassessment of the system of psychiatric hospitals, which was dominant until then. Many patients went home after long years of hospitalization, returning to their families. However, during these hospitalizations, they experienced inhumane treatment conditions such as social isolation, vigilance and strict routines with inflexible rules to *re-educate the mentally ill*, according to the terms used at the time. One of the causes of psychological distress back then was the family negligence regarding moral issues and a lacking education, in such a way that it was natural for the family to be excluded during the hospitalization. After the Brazilian Psychiatric Reform (RPB), Psychosocial Care Centers (CAPS – *Centro de Atenção Psicossocial*) became an alternative to treat/supervise people with psychological distress, without assuming the breaking of social relations to treat the patient⁽⁷⁻⁹⁾.

Today, these older adults – who use many psychotropic medications and present physical and mental side-effects of long-term psychological distress and long hospitalizations – are treated in the CAPS. They alternate between moments with their families and with healthcare professionals, since the CAPS breaks the previous paradigm and sees families and users as a key part of a successful treatment. Thus, the new scenario is a challenge for these actors and for healthcare professionals as well⁽¹⁰⁻¹²⁾.

The present study is justified by two main reasons. The first is the higher number of older adults with mental disorders, which increases the time spent with family members and consequently the difficulties in their relationship. The second is that the results of studies such as this may contribute to discussions about mental health services, creating space for analyses and for possible different constructions that can transform care practices.

Since family members are important for the therapeutic process, and since healthcare professionals need to welcome them in the context of psychosocial care treatment, what do healthcare professionals from the CAPS think about the

family of older adults with psychological distress? Based on this question, our study aims to understand the perceptions of healthcare professionals of Psychosocial Care Centers about the family of older people with mental disorders.

METHOD

Ethical aspects

The project was authorized by the City Department of Health and approved by the Research Ethics Committee of the University of Campinas (UNICAMP). Then, the authors contacted the CAPS and the subjects of the research to start the process of acculturation and data collection using Informed Consent Forms. The anonymity of the subjects was guaranteed by alphanumeric codification, and any sentence that indicated their identities was omitted.

Theoretical and methodological references and type of study

Qualitative research was developed with the Qualitative Case Study (QCS) methodology, using the Theory of Social Representations (TSR) as a theoretical and methodological reference. In a qualitative methodology, the QCS shows a critical conception of reality considering processual elements, investigated situations and the possibility of transforming these actions using the analyzed considerations⁽¹³⁻¹⁴⁾.

QCS, in its turn, is linked to the TSR through the construction of the latter using mechanisms of *anchorage* and *objectification* as well as through the construction of meanings using the *consensual* and *reified universe*. Thus, the theoretical foundation shows the constant interrelation between social structure and subject, and among the subjects themselves, with social representations (SR) being constructed in these relationships⁽¹⁵⁾.

The subject that this study focuses on – *the healthcare professional from the CAPS* – attributes meanings to the object of the study – *perception of healthcare professionals about the family of the older adult patient with psychological distress* – in an analytical manner (critical conception of reality), considering their professional experiences with the family of the older adult (processual elements). Therefore, attributed meanings are directly related to daily life activities, i.e., the subject produces a representation of the object according to their direct care practices, and the evidence of these practices can indicate the need to change a behavior or to reflect upon it (possibility of transforming these practices).

With these considerations, the methodology is believed to work together with the method and the theoretical and methodological references towards the aim of the study.

Methodological procedures

Data collection was performed using a semi-structured interview with the following question: *What do you think about the family of the older adult patient with psychological distress?* The collected data was gathered during eight months (from November 2013 to July 2014), since time is considered essential to maximize integrity and precision in this qualitative study. Thus, a long engagement (period of acculturation) enabled a more in-depth understanding of the culture, language and perceptions of

the studied group⁽¹⁶⁾. Thus, the period of acculturation lasted five months, while data collection lasted three months.

Hence, it is a unique and integrated case study⁽¹³⁾ in the context of a CAPS II in the countryside of the state of São Paulo; a peculiar, typical and revealing case. The convenient sample of 12 workers (one doctor; two nurses; two nursing technicians; one social worker; two occupational therapists; one supervisor; one administrative assistant; one general services assistant and one psychologist) was exhaustive, i.e., all the workers at the CAPS – the focus of the current study – were interviewed.

Units of analysis were constructed using the contents obtained from the interviews. Among the indicators of completeness of the QCS, relevant evidences not determined by time or resource constraints were collected⁽¹³⁾. Interviews were performed in different days and times, with at least three days between meetings, which enabled time triangulation. Many healthcare professionals from different categories and with different education levels (personal triangulation) were interviewed.

The aforementioned strategies were used to validate data using multiple perspectives of a same phenomenon⁽¹⁶⁾.

Data collection and analysis were performed simultaneously. Interviews were recorded and integrally transcribed. First, they were analyzed individually by the researchers. With the technique of content analysis, it was possible to conduct an analysis based on the systematic categorization of units of text (words/sentences) that were repeated and on the inference of information/indicators of the conditions of production and reception of the obtained data. This type of analysis is based on the conception of communication as a process, and not something rigid, since it is constructed by staying away from structures and formal elements⁽¹⁷⁾. Here, they are understood with the TSR reference, which enables the collection of possible anchorages and objectifications used by the group.

RESULTS

The final sample was composed of twelve healthcare professionals, nine women and three men aged between 29 and 46 years old. The interviewees had worked in psychosocial care for a period that ranged between three and 31 years, and in the CAPS for three to eight years. After content analysis, two themes were defined and they will be presented in the following section.

Exhaustion, deterioration and the absence of the family according to the worker

Healthcare professionals from the CAPS mentioned that old age together with chronic psychological distress makes family care more complex. Over time, confrontations and “exhaustion” arise in these relationships that end up deteriorating. Chronicity is also mentioned by the professionals as a condition that aggravates this deterioration.

[...] In addition to the mental illness, he is old. There are families who endure a lot, they take care as they can, within their limits, because everything has its limits. The mentally ill tests our limits, can you imagine that during your entire life? How long has the older adult been with his family? And his mental illness? Wow. It must be exhausting. (PNM03)

[...] We see their exhaustion. They have dealt with that their entire lives, and with old age, with their quirks [...] it is tiring. (PNS04)

[...] The family has become exhausted with this whole situation. Here they behave in a certain way, at home they are different, more aggressive, you know? [...] So the patients that benefit from the service, without a history of long hospitalizations, we see the family differently, their integration is easier. (PNS05)

[...] We have been following some cases for a long time in which the family used to be very present, but now they never come. It has been too many years, one of the children ends up taking charge and it becomes too much for them, we need clearer strategies. (PNS01)

There is the understanding that this exhaustion and deterioration may come from a perspective that older adults with psychological distress does not fulfill the social role that common sense attributes to them such as taking care of the grandchildren. As a result, healthcare professionals think that that the behavior of the family is justifiable, since the patient behaves differently at the CAPS and at home.

[...] Some children grew up with a mother with mental disorder, a mother who only mistreated them. All of the sudden, these children need to take care of her. The children have their own children, they have other priorities, and the mother can't even help at home or take care of her grandchildren. Some patients make us exhausted here, can you imagine the family spending 24 hours with them? It is not easy at all. (PNS04)

[...] This older adult doesn't do anything at home, he is a burden to the family [...]. (PNM01)

[...] Some older people don't want to do anything here, imagine at home with their family, where they are used to everything... [...] He can't take care of the children, he can't wash dishes, it is exhausting, isn't it? (PNM02)

[...] The older adult has incorporated that, at a certain moment he doesn't want it anymore, he wants to rest. There is also his participation, many of them want to rely on someone from the family. Then the family can't handle that, so there are both sides. (PNS02)

The social representations (SR) constructed show the perception that the family becomes overwhelmed when taking care of an older adult with psychological distress, which is evident from the fact that they are absent in important moments of the treatment such as the structuring of a singular therapeutic project and family meetings organized by the service.

[...] Families have brought their older adults more often, because they can't handle it, they have their jobs [...]. They need to leave them at the CAPS because they can't handle them at home. If we checked it, it wouldn't even be necessary [for the senior to go to the CAPS]. And they do not

participate in anything, not even from the PTS [Singular Therapeutic Project] or anything. (PNS03)

[...] The families do not come to the CAPS, not even when there is a party or a meeting, they do not come [...]. Each family gives a different excuse, we even organized it on Sundays, but they come very rarely. (PNF02)

[...] There is no family participation here, we already tried it [...]. (PNM02)

However, there is a moment in which professionals see the family getting closer. When the older adult presents more intense symptoms caused by the mental disorder, the family tries to get help from the CAPS and the doctor, in the perception of those who work at the CAPS.

[...] It is still complicated, we guide them, we try to get closer, but the family only comes during the crisis and they want quick solutions, they want medication, they want to talk to the doctor. But they only come here in this case [...]. (PNS01)

[...] The participation of the family has not been good here. I imagine they are tired, because I see how hard it is for us here, with the workers and all the staff. Sometimes they [the older adults] respect the staff a little and when they get home [the behavior] it is different [...] They only come when medication is necessary, then we see the family here. (PNS07)

[...] The family is only here when the doctor is taking care of them, otherwise, nothing... [...]. (PNF01)

The veiled distancing of the family and the older adults' role of provider in the perception of the professionals

In the perception of the healthcare professionals, the family tries, probably unconsciously, to keep older adults away from home for as long as possible. The term "day care center" was used in some of the interviews, which shows a perception of infantilization of older adults in the studied context.

[...] The family mistakes a lot of things and they also don't have time, everyone works, and it is complicated to stay with an older adult that demands full-time care. That's why the family wants to think of the CAPS as a day care center, sometimes leaving the older adult here for an entire day, they don't want to stay with them, you know? Or maybe they really can't stay with them. (PNS04)

[...] They [the family] don't know what the CAPS is, they don't know. They think it's a day care center. It seems they want to leave the older adult here for as long as possible. (PNM02)

[...] It seems that they don't want to stay with them [the older adults] at home, they need to take them somewhere, and this somewhere is this day care center right here. (PNF01)

Professionals state that families want solutions, and that without proper instruments to deal with the older adult, they end up distancing themselves. This distancing would be justified by

a behavior which is considered "inherent" to the older adult patient, according to the subjects of the research. There is still a perception that the family and the healthcare service are in charge of the older adults. Professionals understand that the family sees the CAPS as responsible for its older adult patient.

[...] We have noticed that the hardest thing is that families want magical solutions. We are a generation of transition, we know our parents will last more, and what do people do? They distance themselves saying: "he is stupid and rude." But this is actually a symptom of the older adult, and one of the most complicated things in that moment is the abandonment of the family. Family members keep themselves distant, and who used to help ends up changing. It is a game of pushing and shoving. (PNS01)

[...] My perception of the family goes from an infantilization of the patient to rejecting him, to extreme reactions, from excessive care to the tendency to abandon them, from avoiding taking care of them to not accepting the limitations caused by the illness. [...] Then they look at the pathology from a moral perspective and say "it is up to the patient, he doesn't do it because he doesn't want to, he's being shameless." The participation of the family could be better [and] I think the service should have a different approach for each presented situation. (PNS06)

[...] The family doesn't know how to handle it, and if they can't handle it, it's better for them to distance themselves, even blaming us when something goes wrong [...]. It is easy to do that. (PNM01)

[...] I think the family doesn't see it as their responsibility [taking care of the older adult with mental disorder], they want the healthcare service to do everything. Then they don't participate in the consultations, the treatment, the medication, and the patient does everything alone. So some of them come alone for the consultation. (PNF01)

According to the professionals, in some cases this distancing is veiled, since the older adult patient still provide for the families, i.e., many older people provide for their family members with their retirement incomes.

[...] I realize that the reason for this abandonment is cultural, [and] the older adult is seen like this: he is old, so he is done, someone needs to take on his role. They remove him as a direct actor of the family. I think this is part of Western culture and related to social situations often seen in Brazil, in which the older adults provide for their family. Then the family takes over the household with their money, which is a small retirement income that often provides for the entire family. What is their role? Generating income that they don't manage. It is hard. (PNS02)

[...] Many older people provide for their families; the retirement income covers monthly expenses. And then what? Then they have to endure it. (PNM01)

[...] I think this family issue isn't simple, because the exhaustion after years and years ends up prevailing. But they can't

do much since it is the older adult that provides for the entire household. So they distance themselves as much as possible, but they need the money. (PNM02)

DISCUSSION

Healthcare professionals feel the family is being punished, which is deduced from the fact that they use empathy in their social representations. In other words, they put themselves in the position of the family of the elderly person with mental disorder and try to understand their exhaustion and distancing. When this occurs, the older adult is considered responsible for the situations observed by the subjects of the research, i.e., it is as if older adults are responsible for their own situation. In moments of acculturation, this interpretation is accompanied by the perception that the professionals lack instruments to deal with more complex patients and are often exhausted due to their demanding everyday life. Usually the family is the only social support network of the older adult with mental disorder, and these perceptions lead to an understanding that the bond between both sides becomes deteriorated and needs to be worked on, as the results showed.

The relationships of people in situations of everyday life, in their family or society, represent their social support network. When this network is identified, it is possible to use it as a resource for care, enabling a collaboration between healthcare workers and the family providing care for the subject with psychological distress⁽⁴⁾, an alternative in which the situation is faced outside of hospital walls and together with the patient. In this sense, the perception is that effective bonds should be obtained between healthcare professionals/family/society, aiming at their collaboration and at the expansion of the resources of the support network, considering the relationships of the microsystem and macrosystem of the family⁽¹⁸⁻¹⁹⁾.

After a thorough analysis of the data, the perceptions of the healthcare workers caused some uneasiness, similarly to the representation of the mother who never took care of their children due to her mental disorder and who now needs to be taken care of by the children she "neglected" all her life, according to the perception of the healthcare workers. This statement guides the understanding of the subjects with respect to the pain suffered by some families, i.e., they even offer plausible justifications for the absence of the family in the CAPS, according to the perception of the subjects.

These representations are complex, since they analyze the cases of older adults with psychological distress, with most of them having spent forty or more years living with their families while facing the particularities of mental disorders. Moreover, the singularities of the ageing process are also added to the scenario. Anchored on the sensation of emotional and physical burden associated with the care of these older adults, this representation leads to an analysis of the attitudinal dimensions that stem from these perceptions, as well as of what this perception generates in the everyday life of care relationships, both with the families and the older people who are seen in a stigmatized way.

Family overload was the topic most studied by articles, according to a recent integrative review on the family care of

people with severe mental disorders⁽²⁰⁾. Although the study does not consider the duration of the care, it relates family overload to the care of people with mental disorders.

After the Brazilian Psychiatric Reform, the patients that used to be isolated during long hospitalizations started to spend their everyday lives with their family. People with mental disorders started to look for ways to resume their life courses, differently from what happened in the dominant hospital-centric paradigm. They reintegrated themselves to the everyday lives of their families, becoming present and actively participating in many processes.

However, due to these changes that took place in many sectors, home care became hard since the family should search for dialogue and opportunities to express different forms of thinking and of positioning oneself when facing a certain situation. This process should take place in respect to some of the difficulties experienced by the person with psychological distress, imposed by the mental disorder and long hospitalizations. Moreover, their singularity should be acknowledged and their distress should be evaluated with everyday contact⁽²¹⁻²³⁾.

The moment in which the family gets closer, as reported by the healthcare workers, is anchored on the biomedical and medicalizing model, in which the doctor and the medication are the center of the treatment. The representation of the healthcare workers indicates the need to analyze the moment family members arrive and the way they are received. Therefore, it is an opportunity for healthcare workers to try a more effective (re)approximation, creating partnerships and (re)creating connections that are necessary to bring the family closer to the healthcare service.

Confirming these findings, a study about the family of people with psychological distress shows that it is necessary for the family to be guided about situations related to mental disorders and to have the support of mental health services, which integrates the project of the Brazilian Psychiatric Reform. However, this care has not been satisfactorily provided, thus the families do not meet the expectations of enabling social reintegration⁽²¹⁾.

These representations come from the consensual universe of healthcare workers, i.e., from their everyday experience with healthcare users and often from contact with the family. Their experiences and all the information constructed perceptions anchored in negative images, which will possibly influence their work routines.

The findings of studies performed with families of older adults with psychological distress reinforce these representations, indicating that the family has difficulties in taking care of them. Hostility and some adverse behaviors, which in some cases are side effects of the mental disorder, make the older adult a burden for family caregivers. When living with the illness, family members deal with phases such as crises of aggressiveness, making them overwhelmed and physically and emotionally exhausted⁽⁵⁾. Family interaction with the diseased becomes complicated, and some family members cannot establish healthy processes in relationships, harming the family bond^(19,24).

The complexity in the care presupposes that the caregiver and the person that will receive the care have mixed feelings that range from fear, guilt, affliction and even stress, aggressiveness and sadness. These feelings need to be analyzed and understood

since they are part of the care relationship. It is important for the caregiver to notice the reactions and feelings that arise in certain situations in order that the care and the bond between them are improved as much as possible⁽⁴⁻⁵⁾. Informal healthcare network is still centered around the family, for it is in everyday life that it is possible to recognize illnesses, seek healthcare professionals, stimulate self-care and provide emotional support to the older adult, which is equally important^(19,23-24).

It is possible to infer that, according to these professionals, the family uses the healthcare service in moments of crisis to solve an isolated problem, usually anchored in the biomedical and medicalizing model as previously described.

In addition to the construction that the older adult is "difficult," in which the entire ageing process with psychological distress is objectified in the representation of a "person who creates difficulties," anchored in negative feelings that the family tries to avoid, there is also the fact that the older adult often helps substantially with family finances. According to the subjects, the family transfers their care responsibility to CAPS professionals, which may be interpreted as an attempt to divide their suffering after so many years of care due to the lack of instruments to help in the process, with interpretations from both sides (professional-family) being hindered.

In a study about the contribution of the family to the quality of life of people with severe mental disorders, patients presented a higher level of satisfaction with family affection and motivation as well as with closeness and mutual support. These collaborations with the family, with healthcare services providing orientation to them, indicate that the efforts should be equal in both processes: in the care given to the person with psychological distress and in the support/collaboration provided to the families⁽¹⁹⁾.

The representation of the healthcare professionals points out difficulties in establishing these relationships. Thus, there is the perception of family abandonment over time, from which it is possible to observe that there is also a negative perception of older adults, with behaviors attributed to them as if they were inherent to the older person, which indicates a process of excessive care and even leads to a behavior of rejection by some families. As a result, it is possible to deduce that the family holds older adults accountable for their own behavior and their lack of participation in therapeutic processes, which suggests that the CAPS should act in each experienced situation.

The representational elements of the object of the study are anchored in issues of the consensual universe of the interviewees. Thus, the distancing of the family is seen as a normal process of Western culture. It is worth highlighting that the professionals consider this abandonment to be veiled since the older adults stay in touch with their family, often living in the same physical space.

The collective construction of the professionals leads to a significant version about the family care of older adults with psychological distress, and at the same time it contradicts itself in its contents and analyzed topics. On the one hand, there is the representation about the loss of the social role of the older adult inside the family due to the process of senility, aggravated by

clinical issues that are added to the long-term psychic distress (such as, for instance, not being able to take care of their grandchildren). On the other hand, there is the financial support that the retirement income of these older people provides.

Thus, the perception that the healthcare service – and not the family – is responsible for the care of the older adult is reinforced due to family abandonment or to the notion that the healthcare service provides specialized care. However, it is not possible to define which because of the limitation of the present study, as it analyzed only the perception of healthcare professionals.

Thus, according to the perception of healthcare professionals, the representation is that the older adult is "complicated", which may be related to the reified universe of care and treatment for these patients, as well as to the perceptions which result from their own experiences with them. Therefore, it is possible to interpret that they feel bad for the family, and that they also feel empathy, understanding the abandonment issues and trying to explain them in solidarity with the family members.

Thus, there is the representation of the understanding of the family abandonment, and at the same time there is the inference of a possible blaming of the older adult for the situation, which may influence behaviors related to this object (the "abandonment" of older people by the family) in the work routine.

In this context, action strategies, the commitment to deal with the mental disorder and the collaboration with the family provide potential exchanges between service/user/social network and/or family member⁽²³⁻²⁴⁾. The family is an important support network in all phases of life, being particularly relevant during transitional periods or permanent periods with less physical and/or psychological ability, which provides older adults with satisfactory and participative life conditions^(19,23-24).

Study limitations

The study enabled the understanding and interpretation of the perceptions of healthcare professionals about the family of older adult patients with psychological distress. It is worth highlighting the limitations of the present study. Even though the perceptions came from professionals, they cannot be considered similar or equal to the perceptions of families in other studies, moments and contexts. For methodological reasons, the results and the discussion should not be generalized. In any case, a naturalistic generalization may be possible, i.e., for professionals who face similar situations in their everyday life, but the reader is responsible for this generalization.

Contributions for nursing, health or public policies

Studies about the older adult population with mental disorders are becoming more relevant, since we are experiencing a demographic and epidemiologic transition. Moreover, we are also experiencing the precepts of the Psychiatric Reform, thus it is increasingly important for family members to spend time with these older people. Analyses are necessary to point out the difficulties faced by healthcare professionals when providing care to this population, allowing for mental health services to be assessed and its professionals to be seen in a more humanized way.

FINAL CONSIDERATIONS

The results obtained indicate that healthcare professionals have a clear representation of the family, which is seen as deteriorated/exhausted/absent. The professionals understand this posture and justify that it is hard to take care of an older adult who has had a mental disorder for years. However, it is necessary to ask if this perception comes only from the consensual universe of the healthcare service or if the families themselves would justify their absent behavior in the care of the older adult. Moreover, it is also important to analyze the responsibility of mental health services in the context of this reality.

There is suffering related to the care of older adults with psychological distress and to family relationships. However, this relationship with the family is not viable due to the perception that they do not want contact with healthcare services, except in moments of crisis, according to the professionals.

Thus, we believe that the obtained results may increase interest in the topic and affect mental health services in their search for strategies to bring families closer to them, consolidating this collaboration of mutual help to benefit the healthcare user. Additionally, the results also show that it is necessary to create space to plan and analyze this attention paid to the family. For instance, the formalization of care protocols or offering trainings to healthcare professionals and family members would enable a better coordination between healthcare professionals/older adults/family and healthcare services.

In the moment healthcare professionals are taken out of their comfort zones, in which we presume the existence of a mechanized practice constructed after years of routine and frustrations, the challenge of analyzing their own professional practice arises. Thus, with each question, healthcare professionals constructed their perceptions with concepts/comparisons/expressions that were – in a certain way – in the level of their subconscious thoughts.

This effort enabled the construction of the social representation originated by ideas that need to be anchored and objectified, transforming the moment of the interview in an analysis of their own actions, which became evident when we found sentences such as “I think that,” “moments of reflection” and “in staff meetings” in the data obtained.

In the TSR and the CQS, representations and ideas of the group need to be known, noticed and interpreted since they guide work practices and conducts regarding the studied object. Thus, the representation this group produces for the family of the senior directly influences their attitudes when treating the healthcare user (attitude dimension).

In the context of the relationship between family/user/staff/service, we recognize that this contact had better moments inside the CAPS. Moreover, it is revealing that in some moments the professionals attribute to themselves part of the responsibility and the desire to think and propose new strategies.

About the exhaustion of the family after long and continuous care of the older adult with mental disorder, we verified the representation of empathy towards the family due to the complexity of this type of care, and a certain blame was attributed to the older adult regarding the behavior that would be more complicated with the family than with the healthcare service.

The QCS method completed the TRS, and both come from Humanities and Social Sciences. They offer assistance to the discussions and are compatible with the analysis of a context/group (case), a proposal that attributes the results and the social representations to the group and not to individual subjects.

The results of this study are expected to provide an indication of *some* realities experienced by healthcare professionals from the CAPS. However, this does not deprive them of their important role in the process of analyzing the scenario and the necessary changes that need to be planned and implemented in this healthcare service with respect to the reception of families of seniors with mental disorders.

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