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Anxiety and Depression in the Caregiver of the Family Member with Mental Disorder[1]

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ABSTRACT*: The objective with this study was to analyze the relation between symptoms of anxiety and depression in the family member caregiver in psychiatric treatment. This is a quantitative and descriptive research, performed with 40 caregivers of both genders. For data collection, we used the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory (BDI). The results showed that most of the studied population presented minor to moderated symptoms of anxiety and depression, and 47.5% was already in some type of treatment. It was verified a significant correlation between BDI and BAI results and that anxiety indexes were positively related to the time that the caregiver was responsible for the patient. Therefore, it is concluded that the presence of anxiety and depression symptoms among caregivers highlights the importance of using strategies for psychosocial support from the mental health team to this group.*

KEYWORDS: *Family caregiver. Anxiety. Depression. Mental health*

I. INTRODUCTION

Changes in the field of mental health did not only modify the service model to its users but also provided a reflection on the role played by the family caregiver in this model. Through the implementation of the community psychiatric care, it was increased the participation of family members in the treatment of patients in psychological distress (Bonfada, Guimarães, Miranda & Brito, 2013) [1].

These paradigm changes had as their founding mark the Psychiatric Reform, which had in its core the deinstitutionalization of the person in psychological distress. The reformist movement substituted the hospital-centric model, based on hospitalizations and in the segregation of the family member in psychiatric treatment, by a more humanized model, within a context of psychosocial care, with the objective of reinserting these people in their homes and in the social environment (Batista, 2016 [2], Borba, Schwartz & Kantorski, 2008) [3].

In the deinstitutionalization model, the person in psychiatric treatment acquires the right of living in society, and the family takes the role of care and maintenance, as well as on the treatment process. In this role, the family has a context of care that involves the responsibility on the life of the family member in

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psychological distress, acting as mediator on the activities performed by him/her (Bonfada, Guimarães, Miranda & Brito, 2013) [1].

However, it is noteworthy that, although the deinstitutionalization has a focus on the family as a protagonist on the psychosocial rehabilitation process of the person in psychological distress, the delegation of this function within the family is not always done harmoniously or democratically and/or willingly. Thus, the figure of the main caregiver emerges in the family, this person who assumes, generally alone or with little assistance from others, the direct responsibility by the caring of the mentally ill. Thereby, the family chooses who is more capable or, when there is no alternative, who is available, and in this sense this injunction may cause a high level of stress, since the act of caring was not instinctive (Olegário, Beuter, Girardon-Perlini, Brondani, Budó, & Santos, 2012) [4]. It is up to the main caregiver the primary care, such as feeding, clothing, hygiene, medicine and finances administration, falling on the him/her a physical and emotional burden, thus compromising the mental health (Borba, Schwartz & Kantorski, 2008) [3].

The responsibility transference of the psychiatric patients caring to the caregiver represented a series of difficulties, since, given the complexity of the new activity, due to the serious nature of mental illness, the caregiver undergoes several stressful events, such as changes in household routine, restrictions on social and professional activities, financial burden, as well as emotional reactions, like feeling uncomfortable in performing tasks of daily assistance, and concerns with the patient in the course of the diseases (Cardoso, Galera, & Vieira, 2012) [5], situation that almost always affects family relationships.

Thus, the caregiver daily routine is shifted in detriment of the exercise of care. Many times, the caregiver needs to abdicate his/hers personal and social activities and focus almost exclusively the attention to the family member in mental distress. In other cases, it is necessary to extend the productive journey to meet the new financial needs, such as the high cost of medication, treatment, food, among others (Pegoraro & Caldana, 2008) [6]. And, if there is no orientation and preparation of the caregiver by mental health professionals, psychic suffering may be even greater (Bessa & Waidman, 2013) [7].

Therefore, the lack of support and backing from a mental health team, plus the family lack of prepare when assuming the caregiver role has, gradually, led the caregivers to mental illness as well. Among the presented symptoms, anxiety and depression stand out, often due to the time devoted to care (Barroso, Bandeira & Nascimento, 2007, Borba, Schwartz, & Kantorski, 2008, Draženka, Domagoj, Ana, Petrana, & Vlado, 2014) [8, 3, 9].

1.1. Anxiety

Anxiety, one of the basic human emotions, is a reaction that is part of the emotional and physiological state of the human being, it is responsible for alerting, through the organism, when there is imminent danger, propelling and motivating it to defend himself. That is, anxiety is a sensation or feeling arising from excessive excitation of the Central Nervous System (CNS), which is connected to an empty and unpleasant emotion of fear and restlessness, defined by several manifestations of tension and discomfort, mostly from anticipation of peril or of something unknown or strange that might occur (Castillo, Recondo, Asbahr & Manfro., 2000) [10].

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V, 2014) [11], anxiety disorder is characterized by excessive fear and anxiety, which cause agitation in behavior, where fear is the emotional response to the real or perceived imminent threat, while anxiety is the anticipation of future threats. Still on the manual, these two states overlap, but also differ, being fear more frequently associated to periods of increased autonomic excitability, leading the person to fight-or-flight, and anxiety most often associated with muscle tension or incubation for future threats that may appear.

The person with anxiety, besides the unwanted feelings associated with the disorder, does as possible to avoid situations that cause this emotional response. Consequently, they may have difficulty in performing tasks, enjoy leisure time or participating in social or family activities. When the anxiety takes control, that is, when the symptoms are part of most days, the person becomes distressed, tense, worried, nervous or irritated (Dalgalarrondo, 2008) [12].

However, according to International Classification of Diseases – 10, anxiety may be accompanied by depressive or obsessive symptoms, as wells as certain manifestations that translate into a phobic anxiety, provided that such manifestations are, however, clearly secondary or minor (CID-10, 2012) [13]. In this sense, Beltrami, Souza and Dias (2013) [14], state that anxiety, as any other disorder, is established in several aspects and in varying levels of development, as in many cases anxiety converges to depression, since it is subjected to mood shifts, accompanied by a huge sadness. The mixed anxiety and depression syndrome is characterized by the presence of symptoms of both syndromes, but none is severe enough to constitute a diagnosis by itself (Dalgalarrondo, 2008, CID – 10, 2012) [12, 13].

1.2. Depression

The concept of depression is broad and can be used both to characterize a symptom, a syndrome or disease. The development of the concept came from dogmatic and mystic overcoming, that explained mental disorders until late medieval age. Used initially to designate a state of discouragement or loss of interest, depressive disorder has as characteristic the presence of a sad, empty or irritable mood, accompanied by somatic and cognitive changes that significantly affects the functioning or capacity of the individual, with loss of interest or pleasure in activities, difficulty to think and concentrate and with recurrent thoughts about death (DSM - V, 2014) [11].

According to the CID – 10 (2012) [13], in typical episodes of each of the three degrees of depression (mild, moderate or severe), the patient presents lowering of mood, reduction of energy and decreased activity. It also changes the ability to experience pleasure, loss of interest and concentration decrease, generally associated to marked fatigue, even after a minor effort. As for its subtypes, depression is classified as major depressive disorder, melancholy, dysthymia, depression as part of the bipolar disorder of types I and II, depression as part of the cyclothymia, depressive episode or phase and recurrent depressive disorder, atypical depression, psychotic depression, depressive stupor, agitated or anxious depression, secondary or organic depression (Dalgalarrondo, 2008) [12].

However, it is noteworthy that the term depression can be associated to different meanings. It can refer to a symptom or complaint equivalent to sadness or sad mood and, in this case, it is worth remembering that sadness may be present in pathological situations, but it is, first of all, a normal human feeling manifested to express a natural emotional state. In this sense, when speaking of depressive syndrome, it can be classified as primary and secondary. “Primary depression (genuine, idiopathic or essential) is characterized by the unfamiliarity with its case. Secondary depression, in turn, is associated with well-defined causal factors, such as exogenous substances”, among them among them is the antihypertensive medicine (Cheniaux, 2013) [15].

As for its prevalence, depression is one of the most common disorders found by mental health professionals. Nowadays, it is considered one of the most evident pathologies, being reckoned as a priority public health problem. Current estimates suggest that depression is one of the most expansive diseases in the world, because it affects about 121 million people, being considered the second cause of incapacitation in people ranging from 15 to 44 years old (Dalgalarrondo, 2008) [12].

The drug treatment for depressive patients, according to Romano-Silva et al. (2013) [16], occurs in three phases: acute, continuation and maintenance. The acute phase is the beginning of treatment, with duration of 6 to 12 weeks; the continuation phase comes right after, lasting from 4 to 9 months, with the objective of preventing prevent relapses; the maintenance serves as to avoid the occurrence of depressive episodes, maintaining the antidepressant at the same dose in which was achieved patient improvement, so that the treatment remains effective and the patient can lead a normal life like any other person.

1.2. Prevalence of anxiety and depression symptoms in the family caregiver

Several studies have shown the prevalence of some kind of mental disorder, especially of depressive and anxious syndromes in family caregivers (Pawlowski, Gonçalves, Hilgert, Hugo, Bozzetti, & Bandeira, 2010, Barroso, Bandeira & Nascimento, 2007, Gomes, Silva & Batista, 2018; Garbelini, 2014, Kuo et al., 2013, Silva, Batista & Cerqueira, 2017) [17, 8, 18, 19, 20, 21]. These studies have concluded that the exercise of caring a person who is in psychological distress over time can be associated to the caregiver sickening.

Although researches have divergences in your results, studies focusing on caregivers have found, in depression cases, correlations between age and severity of symptoms. Pawlowski et al. (2010) [17], when conducting a study with 101 caregivers and 84 non-caregivers of patients in mental distress, found symptoms of depression in family caregivers. In the mentioned research, we used the Beck Depression Inventory – BDI and, through its results, identified that caregivers aged between 56 and 64 years were the ones that showed the highest rate of depression.

The caregiver overburden has been also associated to their psychic sickening. According to a research performed by Barroso, Bandeira and Nascimento (2007) [8] with a sample of 150 family members, it was concluded that most participants that took care of family patients suffered from some kind of psychological disorder. A stated by the authors, 75.3% assessed that the burden of caring their relatives in mental distress caused a permanent impact in their lives. It was also revealed that 84% of caregivers resided with the patient and that helping their family members with daily activities caused a high objective burden and, regarding to the subjective burden, what most prevailed was the discomfort of supervising the patient’s problematic behaviors and the permanent changes in their social and professional lives.

Studies have shown that the symptoms presented by patients with psychiatric disorders, such as delirium, anxiety, depression and aggressive behavior, generate an e overburden increase on family caregivers, interfering in their mental health and life quality. This shows that the patient’s depression is commonly associated to the caregiver’s depression (Kuo et al., 2013) [20].

Fava, Silva and Silva (2014) [22] in a study with 37 family caregivers, found that 78% of them had moderate to severe overburden, demonstrating that the act of caring a family member with mental disorder causes serious physical and mental disorders in the caregiver’s lives. A research performed by Garbelini (2014) [19] with 101 family caregivers, pointed out that most are women, and 49.5% presented anxiety symptoms and 45.5% presented depression symptoms. In the mentioned research, it was found that depression symptoms showed no direct association with family functionality, however, this variable was higher when associated to the burden arising from the caregiver function; as for anxiety, the association occurred with the family functionality.

Studies with family caregivers of patients with other pathologies have also pointed to the presence of depression and anxiety symptoms. Ferrara, Langiano, Brango, Cioccio, Bauco and De Vito (2008) [23], in a research with 200 caregivers, found an increase on anxiety and depression in the caregiver proportional to the severity of the patient's disease. In a study made with 30 caregivers of bedridden elderly patients, conducted by Silva, Batista and Cerqueira (2017) [21] shown that 63.3% of participants made use of anxiolytic and or antidepressant drugs.

In this sense, when considering that the mental health assistance in some regions of Brazil, especially the most isolated ones in the Amazon region such as the place of this research, still happens unevenly, as pointed out by Batista (2016) [2], this study is justified by a need of investigating the prevalence of anxiety and depression symptoms in the family caregiver living in the Forest Zone of the State of Rondonia, in the Western Amazon, considering their socioeconomic vulnerability and of access to health care.

Thus, the objective of this research was to answer the following questions: how is the prevalence of depression and anxiety symptoms in the family caregiver of a family member in psychiatric treatment in the Forest Zone of the State of Rondonia? What are the relations between sociodemographic variables and the level of depression and anxiety in these caregivers? To answer these questions, we analyzed the levels of depression and anxiety and their relation with other variables regarding the caregiver of a family member in psychiatric treatment. Therefore, with this research we collaborate with other researchers who seek, through various biases, to investigate the impact of caring in the mental health of caregivers.

II. Method

This is an exploratory, descriptive and of quantitative approach study. The sample, by convenience, was composed by 40 family caregivers of patients in psychiatric treatment, treated at the Psychosocial Care Center (CAPS) in the Forest Zone of the State of Rondonia. The region is composed by 8 municipalities and has a population of over 151.000 inhabitants; the research's region has only one reference unit for mental health care that provides psychiatric treatment.

It is defined as caregiver the person who assumes a role of assisting family members that need help when performing daily activities, such as feeding, locomotion, bath, among others. It was included caregivers with ages equal or over 18 and that identified themselves as main caregivers. We excluded underage caregivers and those that had a depression and anxiety history prior to the family member's diagnosis.

For data collection, we used three research instruments: a sociodemographic questionnaire, containing information about personal and family characteristics and the dynamics regarding the care of the family member in psychiatric treatment; the Beck Anxiety Inventory – BAI, instrument constituted by 21 items with descriptive affirmations of anxiety symptoms, for the own subject to assess, in a 4-point scale, which, according to the Manual, reflects the increasing severity levels of each symptom: 1) "Not at all"; 2) "Mildly: it didn't bother me much"; 3) "Moderately: It was unpleasant, but I could stand it"; 4) "Severely: I could hardly stand it"; and the Beck Depression Inventory – BDI, a self-report scale of 21 items, each one with four alternatives, implying increasing degrees of severity of depression, with scores from 0 to 3.

The initial contact was performed with the director of the Institution, with the objective of providing information about the study, combining operational procedures and obtaining permission. Then, participants were approached on the psychiatric care days of their relatives at the CAPS. In this moment, we made all the all clarifications regarding the study and requested a signature for the Informed Consent Form (ICF). Instruments were applied individually in an institution's room for approximately 30 minutes. Exceptionally, due to personal problems, three participants answered the instruments in their homes. Data was submitted to statistical analysis, through descriptive tests for an exploratory analysis, from which frequency and percentage studies were performed, as well as the Spearman´s rho correlation test and Friedman and Mann-Whitney tests in the program SPSS 15.0.

This study was assessed and approved by the Human Research Ethics Committee of the Rolim de Moura College (FAROL), under Opinion No. 1.201.684 and CAAE No. 47439015.2.0000.5605.

III. Results

In the collected sample, 50% (n=20) had ages between 41 to 60; 25% (n=10) had more than 60 years; 17.5% (n=7) between 26 to 40; and 7.5% (n=3) between 18 to 25 years. Regarding the gender of caregivers, 72.5% (n=29) were women and 27.5% (n=11) were men. As for marital state, 65% (n=26) declared to be married or in a consensual marriage, 15% (n=6) divorced, 12.5% (n=5) single and 7.5% widowers.

Regarding the subjects' schooling, 17.5% (n=7) informed that had incomplete elementary school, 10% (n=4) complete high school; 27.5% (n=11) were illiterate; 17.5% (n=7) had higher education; and 27.5% (n=11) complete elementary school. From the participants of the research, 60% (n=24) identified themselves as main providers for the Family and 40% (n=16) reported that were not financially responsible. As for the duration of care, 12.5% (n=5) of the subjects reported that were in the condition of main caregiver for at least two years; 25% (n=10), between two to four years and eleven months; 27.5% (n=11), between five to nine years and eleven months; and 35% (n=14) took care for more than ten years, as shows table 1.

Table 1 – Characterization of caregivers (2016)

VARIABLE	DESCRIPTION	Nº	%
Gender	Female	29	72.5
	Male	11	27.5
	Total	40	100
Age	18-25	3	7.5
	26-40	7	17.5
	41-60	20	50
	+ 60	10	25
	Total	40	100
Marital status	Single	5	12.5
	Married/consensual marriage	26	65
	Divorced	6	15
	Widower	3	7.5
	Total	40	100
Family income	Less than one salary	11	27.5
	One salary	9	22.5
	Two salaries	14	35
	More than two salaries	6	15
	Total	40	100
Main provider for the family	Yes	24	60
	No	16	40
	Total	40	100
Schooling	Illiterate	11	27.5
	Incomplete elementary	07	17.5
	Complete elementary	11	27.5
	High school	4	10
	Higher education	7	17.5
	Total	40	100
Caregiver under treatment	Yes	19	47.5
	No	21	52.5
	Total	40	100
Duration of care	Less than 2 years	5	12.5
	Between 2 and 4 years	10	25
	Between 5 and 9 years	11	27.5
	More than 10 years	14	35
	Total	40	100

Source: the authors.

As for the mental health of the caregiver, 52.5% (n=21) of them were in some kind of treatment, among the mentioned pathologies are: anxiety, depression, stress, heart problems, diabetes, Chagas disease, high blood pressure, menopausal problems and orthopedic and neurological disorders.

Regarding the diagnosis of the family member in treatment, caregivers reported that 35% (n=14) were diagnosed with schizophrenia, 32.5% (n=13) with depression, 12.5% (n=5) stated that the diagnosis was a psychotic disorder, 7.5% (n=3), other disorders and 12.5% (n=5) did not know the patient diagnosis, as shows table 2.

Table 2 – Diagnosis presented by the family member caregiver (2016).

Patient diagnosis	**Nº**	**%**
Schizophrenia	14	35
Depression	13	32.5
Psychotic disorder	5	12.5
Bipolar disorder	1	2.5
OCD	1	2.5
Dementia	1	2.5
Did not know	5	12.5
Total	40	100

Source: the authors.

The results referring anxiety, identified through the BAI, indicate that the minimum stage was of 40% (n=16), mild presented 22.5% (n=9), moderate pointed had 20% (n=8) and severe 17.5% (n=7), as shows table 3.

Table 3 – Classification of anxiety symptoms (2016).

Anxiety symptoms	**Nº**	**%**
Minimum	16	40.0
Mild	9	22.5
Moderate	8	20.0
Severe	7	17.5
Total	40	100.0

Source: elaborated by the authors based on the Beck Scale - BAI (Cunha, 2001) [24].

From the seven participants that were in the severe stage, six were women and there was only one man, showing the feminine prevalence. As for age group, caregivers are distributed as follows: three aging between 41 to 60, two between 18 and 25 and two have more than 60 years.

In the application of the Beck Depression Inventory, 42.5% (n=17) showed a prevalence of minimum symptoms, while 27.5% (n=11) presented mild symptoms, 20% (n=8) moderate and 10% (n=4), severe symptoms of depression, as shows table 4.

Table 4 – Classification of depression symptoms (2016).

Depressions Symptoms	**Nº**	**%**
Minimum	17	42.5
Mild	11	27.5
Moderate	8	20.0
Severe	4	10.0
Total	40	100

Source: elaborated by the authors based on the Beck Scale - BDI (Cunha, 2001) [24].

Caregivers that were in the severe stage of depression were all women, distributed among all age ranges. As for time of care, 50% (n=20) were caregivers for at least two years, 25% (n=10) from five to nine years, 25% (n=10) for more than 10 years. These data are very similar to the ones found by Fava, Silva and Silva (2014) [22], that investigated the presence of overburden indicators in 37 informal caregivers of people with mental disorders. In the mentioned study, the authors found that 22% of caregivers exercised the function for more than 25 years, and 59% were full-time caregivers.

It was performed the Spearman´s rho correlation analysis between the anxiety and depression indexes and age of caregiver, their schooling and time of caring of the patient. The analysis results of the correlations show that anxiety indexes were related to high levels of depression, in such way that higher anxiety rates were associated with higher depression rates.

Anxiety indexes were positively related to the time in which the caregiver was the main responsible for the patient, in such way that the longer the caregiver was primarily responsible for the patient, higher were the anxiety indexes. Furthermore, schooling was positively related to age, with older participants presenting higher levels of education. It was observed that all other variables investigated were not significantly related to the anxiety and depression indexes, as shows table 5.

Table 5 – Relation between anxiety and depression symptoms and the caregiver age, his/her schooling, duration time of the caring, caregiver gender and the patient gender (2016).

	1	2	3	4	5	6
1) Anxiety						
2) Depression	0.68*^{a}					
3) Age	- 0.18 ^{a}	- 0.19 ^{a}				
4) Schooling	0.21 ^{a}	0.11 ^{a}	- 0.49* ^{a}			
5) Duration	0.41* ^{a}	0.24 ^{a}	- 0.02^{a}	- 0.05 ^{a}		
6) Caregiver gender	0.29 ^{b}	0.15 ^{b}	0.09 ^{a}	0.23 ^{b}	- 0.18 ^{b}	
7) Patient gender	0.10 ^{b}	0.35 ^{b}	- 0.23. ^{a}	- 0.07 ^{b}	- 0.02 ^{b}	- 0.14 ^{b}

Source: the authors.
Note: * - $p \leq 0.001$; a - Spearman´s rho correlations; b - Biserial Point Correlations.

In addition to these analyzes, we investigated the relations between the mentioned variables and the caregiver and patient's gender through Biserial Point correlations. We used the Biserial Point correlations because the caregiver and patient's gender is characterized as a categorical variable.

In order to analyze if the anxiety and depression presented differences according to the patients and caregivers characteristics, it was used the Friedman and Mann-Whitney tests. The tests analysis was used to assess if there were differences between the anxiety and depression indexes between the groups: caregiver age, patient disorder, family relationship with the patient, if the caregiver works or has any other source of income, time that the caregiver is the main responsible for the patient, caregiver education and his/her socioeconomic level.

The analysis results of the Friedman and Mann-Whitney tests showed that no differences were observed between the anxiety and depression indexes in the groups. As for the analysis to investigate the differences in anxiety and depression indexes according to the caregiver and patient's gender, it was performed the Mann-Whitney test. The results also showed no difference in the levels of anxiety and depression considering the caregiver and patient's gender.

IV. Discussion

The results of this research made possible to identify similarities and differences between both men and women, when caregiving patients that present mental disorders, as for the relation of overburden level that they present when exercising the function. Some of these results match data from other researches, which helps consolidating knowledge about the overburden of family members, as follows.

Data found shows that most participants ages range from 41 to 60 years. As for gender, there were predominance of women, with 72.5% of the examined sample. These data are not uncommon, since it was seen before in other studies (Pegoraro, Caldana, 2008, Cardoso, Galera & Vieira, 2012, Barroso, Bandeira & Nascimento, 2007, Rosa, 2011; García-Alberca, Cruz, Lara, & Garrido, 2012) [6, 5, 8, 25, 26].

Another factor that stands out in this group (women caregivers) is the degree of relatedness with the family member in mental distress, mostly represented by mothers, with 47.5% (n=19), followed by daughters with 25% (n=10). It is important to remember that care is historically associated to "naturalized" functions in the sphere of social reproduction, which has a gender component that considers caring a feminine activity and, frequently, this function refers to the mother; and in her absence or impossibility to perform such activity, the person that takes place generally is the daughter or older sister (Rosa, 2011) [25]. In addition, Zanello (2014) [27] states that the attribution of caring to women is linked to gender values, precisely to relational character traits which involve the aspects of object and intensity expressed by women through hyperinvestment in relationships and caring of othersespecially the children and the husband.

What is observed is that the practice of caring people in metal distress still continues to show, directly or indirectly, association to the women as main caregiver, even though the prevalence of female caregivers that live with the patient is given regardless of family or spouse conditions (Pegoraro & Caldana, 2008) [6], although the exclusive exercise of this activity could result in sickening. García-Alberca, Cruz, Lara, & Garrido(2012) [26]observed in their studies that after a time of caring, female caregivers presented depression and anxiety symptoms, due to failed attempts to cope with the situation.

Another relevant factor to be observed in this study is the diagnosis of the family member in mental distress, with prominence of schizophrenia 35% (n=14), and depression 32,5% (n=13). When analyzing this result, it was observed that all caregivers that were in a severe stage of anxiety and/or depression took care of patients with these diagnoses, suggesting that caring depressive or schizophrenic family members provokes a greater psycho-emotional stress in the caregiver. The greater presence of hypothesis diagnoses of schizophrenia and depression can be understood as explanation of predominance of the group with longer care time (over 10 years) in this research. That is because both schizophrenia and severe depression fall into the category of long-term treatment disorders that require, in most cases, uninterrupted family accompaniment.

BAI results presented mostly symptoms of minimal and mild levels of anxiety, which can be interpreted as consequence of the constant alertness and fear state of possible conducts that the sick relative may have, occurring at the same time physical and psychological changes in the caregiver (Bessa & Waidman, 2013) [7]. Furthermore, it is possible that other comorbidities are associated with the origin of the presented anxiety, such as spinal problems, hypertension, heart diseases, stress, tension and anxiety in the family. As for the moderated and severe symptoms, they can be understood as result of an overburden that turns into emotional and physical illness, resulting from the agitation of family dynamics, by the advance of demands from this new condition and by the lack of resources to cope with the condition (Borba, Schwartz, & Kantorski, 2008) [3].

The anxiety indexes related positively to the time as main caregiver can be explained by the fact that the care of family members in mental distress is surrounded by feelings of despair, concern and suffering. This result corroborates with other studies, which have identified the overburden negative effects in the mental health of family members, which may cause psychological disorders such as anxiety and depression (Barroso & Bandeira, & Nascimento, 2007, Borba, Schwartz, & Kantorski, 2008, Draženka, Domagoj, Ana, Petrana, & Vlado, 2014) [8, 3, 9]. Other studies have shown positive correlations between care time and sickening of the caregiver (Camargo, 2010, Fava, Silva & Silva, 2014) [28, 22].

As for the symptoms presented in the BDI (depression), despite most being of minimum and mild intensity, they show that caregivers are vulnerable to psychic sickening during caregiving. And it can be associated to the time dedicated to the patients, as result of having no time to optimize their own interests and social life. These results agree with national and international studies regarding family caregivers of elderly people with Alzheimer's disease and dementia (Pawlowski et al., 2010, Ostojić, et al., 2014, Garcia-Alberca, Lara, & Berthier, 2011, García-Alberca, Cruz, Lara, & Garrido, 2012). [17, 9, 29, 26]

The positive correlation (0.68*) between the scores of the *BAI* (anxiety) and *BDI* (depression) scales confirms the coexistence of depressive and anxious symptoms. This coexistence can be understood as comorbidity or a mutual convergence between the disorders (Beltrami, Souza, & Dias, 2013) [14] or, still, the existence of a mixed anxiety and depression syndrome (Dalgalarrondo, 2008) [12].

V. Conclusion

In this study, we had as objective to investigate the prevalence of anxiety and depression symptoms in caregivers of family members in mental distress. The results found through the anxiety (BAI) and depression (BDI) scales showed that most participants were at minimum and mild anxiety and depressive symptom levels. These data are possible indicatorsthat these caregivers are on alertness state. As for the symptoms of moderate and severe levels presented in both scales can be explained by the number of caregivers that are already in the treatment phase.

The analysis showed positive correlation between the scores of the BAI and BDI scales. It was not found significant relations between care time and depressive symptoms, but there was positive association with anxiety symptoms, suggesting that the caregiving function in long term can be stressing for these individuals. We did not find significant relation between sociodemographic variables and levels of depressive and anxiety symptoms in the BAI and BDI results. However, the socioeconomic inequalities that these caregivers are in can be understood as mediating factors of this relation.

In this case, it is possible to relate the fact of being exposed to a situation of social and economic vulnerability, as well as lack of access to public health, can contribute to the worsening of the depressive and anxious conditions of these caregivers. Moreover, the long waits for care in the public mental health service, the absence of family support by a psychosocial team, added to the frustration of an incapability feeling of reaction, can also provoke in these caregivers mixed feelings of sadness and distress.

Therefore, as recommendation for future researches, it is suggested that more studies are performed to assess the causal relation between social determinants of mental health and the appearing of symptoms of mental disorders, especially the anxiety and depression. The acknowledgement of this possible relation can contribute for the establishment of strategies and relevant practices, both at prevention and intervention levels, for the assistance of the family caregiver. Conducting researches with qualitative methodologies and longitudinal studies can assist in the comprehension of other subjective aspects, such as the perception of caregivers about their own sickening, not covered in this research.

This study presented some limitations that must be overcome by further research and, therefore, its results cannot be generalized. The studied sample was relatively small and the choice of participants was not constituted by probabilistic sampling, which suggests biases in the selection of participants. Despite these limitations, it is understood that this study is relevant for the understanding of factors that influence the caregiver sickening. The referred data allows the instrumentalising of mental health professionals in the planning, implementation and assessment of possible interventions, aiming an effective and qualified assistance, having as objective the support of the family caregiver.

References

[1.] Bonfada, D., Guimarães, J., de Miranda, FAN e de Brito, AAC (2013). Reforma psiquiátrica brasileira: conhecimentos dos profissionais de saúde do serviço de atendimento móvel de urgência. *Escola Anna Nery Revista de Enfermagem*, 17 (2), 227-233. http://www.scielo.br/pdf/ean/v17n2 /v 17n2 a04. pdf.

[2.] Batista, E. C. (2016). A saúde mental no Brasil e o atual cenário dos Centros de Atenção Psicossocial (CAPS). *Revista Eletrônica Interdisciplinar,* 2(16). http://revista.univar.edu.br/index.php/interdisciplinar/article/view/534

[3.] Borba, L. O, Schwartz, E., & Kantorski, L. P. (2008). A sobrecarga da família que convive com a realidade do transtorno mental. *Acta Paulista de Enfermagem,* 21(4), 588-594. http://www.scielo.br/pdf/ape/v21n4/a09v21n4

[4.] Olegário, B. B., Beuter, M., Girardon-Perlini, N. M. O., Brondani, C. M., Budó, M. D. L. D., & dos Santos, N. O. (2012). A sobrecarga do familiar cuidador no âmbito domiciliar: uma revisão integrativa da literatura. *Revista Gaúcha de Enfermagem,* 33(1), 147-156. http://www.scielo.br/pdf/cadsc/v21n4/v21n4a02.pdf.

[5.] Cardoso, L., Galera, S. A. F., & Vieira, M. V. (2012). O cuidador e a sobrecarga do cuidado à saúde de pacientes egressos de internação psiquiátrica. *Acta Paulista de Enfermagem,* 25(4), 517-523. http://www2.unifesp.br/acta/pdf/v25/n4/v25n4a6.pdf.

[6.] Pegoraro, R. F., & Caldana, R. H. L. (2008). Mulheres, loucura e cuidado: a condição da mulher na provisão e demanda por cuidados em saúde mental. *Saúde e Sociedade,* 17, 82-94. http://www.revistas.usp.br/sausoc/article/view/7579.

[7.] Bessa, J. B., & Waidman, M. A. P. (2013). Família da pessoa com transtorno mental e suas necessidades na assistência psiquiátrica.

Texto & Contexto Enfermagem, 22(1), 61-70. http://www.scielo.br/pdf/tce/v22n1/pt_08.pdf

[8.] Barroso, S. M., Bandeira, M., & do Nascimento, E. (2007). Sobrecarga de familiares de pacientes psiquiátricos atendidos na rede pública. *Archives of Clinical Psychiatry,* 34(6), 270-277. http://www.scielo.br/pdf/rpc/v34n6/v34n6a03

[9.] Draženka, O., Domagoj, V., Ana, B., Petrana, B., & Vlado, J. (2014). Prevalence of anxiety and depression in caregivers of alzeheimers dementia patients. *Acta Clinica Croatica,* 53(1.), 17-20. https://pdfs.semanticscholar.org/66f6/8a1037e1fe112a714185b829c36dde53390d.pd.

[10.] Castillo, A. R. G., Recondo, R., Asbahr, F. R., & Manfro, G. G. (2000). Transtornos de ansiedade. *Brazilian Journal of Psychiatry*, 22, 20-23. http://www.scielo.br/pdf/rbp/v22s2/3791.pdf.

[11.] American Psychiatric Association. (2014) *Manual Diagnóstico e Estatístico de Transtornos Mentais:*DSM-5. Porto Alegre: Artmed.

[12.] Dalgalarrondo, P. (2008). *Psicopatologia e semiologia dos transtornos mentais.* Porto Alegre: Artmed.

[13.] Classificação Internacional de Doença.(2012).*CID-10.* São Paulo: Ed. Universidade de São Paulo

[14.] Beltrami, L., de Souza, A. P. R., & Dias, L. O. (2013). Ansiedade e depressão em mães de crianças com distúrbios de linguagem: a importância do trabalho interdisciplinar. *Fractal: Revista de Psicologia*, 25(3), 515-530. <http://www.scielo.br/pdf/fractal/v25n3/a07v25n3.pdf

[15.] Cheniaux, E. (2013). Psicopatologia e diagnóstico da depressão. In: J. Quevedo, A. G. Silva (Eds.). *Depressão:* teoria e clínica.(pp. 39-48). Porto alegre: Artmed.

[16.] Romano-Silva, M. A. et al. (2013). Tratamento farmacológico da depressão. In J. Quevedo, & A. G. Silva, (Eds.). Depressão teoria e clínica. (pp. 67-81). Porto alegre: Artmed.

[17.] Pawlowski, J., Gonçalves, T. R., Hilgert, J. B., Hugo, F. N., Bozzetti, M. C., & Bandeira, D. R. (2010). Depressão e relação com idade em cuidadores de familiares portadores de síndrome demencial. *Estudos de psicologia* (Natal). Natal. Vol. 15, n. 2, p. 173-180. http://www.scielo.br/pdf/epsic/v15n2/06.pdf.

[18.] Gomes, M. L. P., Silva, J. C. B. D., & Batista, E. C. (2018). Escutando quem cuida: quando o cuidado afeta a saúde do cuidador em saúde mental. *Revista Psicologia e Saúde,* 10(1), 03-07. http://pepsic.bvsalud.org/pdf/rpsaude/v10n1/v10n1a01.pdf.

[19.] Garbelini, A. S. (2014). *Funcionamento familiar como mediador da sobrecarga percebida, qualidade de vida, ansiedade e depressão de cuidadores familiares*.2014.Dissertação (Mestrado em Ciências – Programa de Enfermagem Psiquiatra)–Universidade de São Paulo, São Paulo.

[20.] Kuo, L. M., Huang, H. L., Huang, H. L., Liang, J., Chiu, Y. C., Chen, S. T., ... & Shyu, Y. I. L. (2013). A home-based training program improves Taiwanese family caregivers' quality of life and decreases their risk for depression: a randomized controlled trial. *International journal of geriatric psychiatry*, 28(5), 504-513. http://onlinelibrary.wiley. com/doi/10.1002/gps. 3853/full.

[21.] Silva, F. M., Batista, E. C., & Cerqueira, G. R. (2017). The Drug Use Anxiolytics and Antidepressants the Elderly Caregiver of Bedridden. Saúde em Foco, 3(2), 62-76. http://www4.fsanet.com.br/revista/index.php/saudeemfoco/article/view/119 1/1206.

[22.] Fava, M. C., Silva, N. R., & Silva, M. L. (2014). Avaliação da sobrecarga em cuidadores familiares de pacientes de um centro de atenção psicossocial. *Barbarói,* 2(41), 41-55. http://online.unisc.br/seer/index.php/barbaroi/article/ view/ 4690/3872.

[23.] Ferrara, M., Langiano, E., Di Brango, T., Di Cioccio, L., Bauco, C., & De Vito, E. (2008). Prevalence of stress, anxiety and depression in with Alzheimer caregivers. *Health and Quality of life Outcomes,* 6(1), 93. https://hqlo.biomedcentral.com/articles/10.1186/1477-7525-6-93.

[24.] Cunha, J. A. (2001). *Manual da versão em português das Escalas Beck.* São Paulo: Casa do Psicólogo.

[25.] Rosa, L. (2011). *Transtorno mental e o cuidado na família.* São Paulo: Cortez.

[26.] García-Alberca, J. M., Cruz, B., Lara, J. P., Garrido, V., Lara, A., & Gris, E. (2012). Anxiety and depression are associated with coping strategies in caregivers of Alzheimer's disease patients: results from the MÁLAGA-AD study. *International Psychogeriatrics,* 24(8), 1325-1334. http://www.ianec.es/ xinha_files/pdfs_publicaciones/2012_2.pdf.

[27.] Zanello, V. (2014). A saúde mental sob o viés do gênero: uma releitura gendrada da epidemiologia, da semiologia e da interpretação diagnóstica. In V. Zanello, & A. P. M. Andrade (Eds.). *Saúde mental e gênero:* diálogo, práticas e interdisciplinaridade. (pp. 41-58). Curitiba: Appris.

[28.] Camargo, R. C. V. F. D. (2010). Implicações na saúde mental de cuidadores de idosos: uma necessidade urgente de apoio formal. *SMAD. Revista eletrônica saúde mental álcool e drogas*, 6(2), 231-254. http://pepsic.bvsalud.org/pdf/smad/v6n2/2.pdf.

[29.] García-Alberca, JM, Lara, JP e Berthier, ML (2011). Ansiedade e depressão em cuidadores estão associadas às características do paciente e do cuidador na doença de Alzheimer. *The International Journal of Psychiatry in Medicine*, 41(1), 57-69. http://journals.sagepub.com/doi/abs/10.2190/PM.41.1.f.