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UNDERSTANDING THE MANAGEMENT STRATEGIES ADOPTED BY CAREGIVERS OF PEOPLE WITH MENTAL HEALTH CONDITIONS

COMPREENDENDO AS ESTRATÉGIAS DE GESTÃO ADOTADAS POR CUIDADORES DE PESSOAS COM PROBLEMAS DE SAÚDE MENTAL

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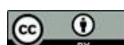
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Abstract
Caregiving is a road that most individuals take at some time in their life. Informal caregivers, for instance, are in charge of looking after their loved ones. However, some caregivers extend these duties for extended periods of time while providing care for loved ones who have been diagnosed with a variety of chronic illnesses. It may be rewarding and difficult to provide informal care to those who are depressed. Caretakers may have financial, emotional, or physical health challenges in addition to losses like lost wages, reduced health coverage, and decreased retirement funds. In some circumstances, caregivers could even be compelled to quit their employment or reduce their hours. This study is essential given the growing number of people with mental health conditions and the increased demand for caregivers. An empirical review of management techniques used by caretakers for individuals with mental health conditions is presented in this article. According to this study, those with uterine fibroids, cancer, heart illness, diabetes, epilepsy, and physical or mental disabilities are considered mental patients. Future caregivers will find it easier and more beneficial to have a wide awareness of the topic.

Keywords: Caregivers. Experiences. Management Strategies. Mental Health Conditions.

Resumo
Cuidar de alguém é um caminho que a maioria das pessoas trilha em algum momento da vida. Cuidadores informais, por exemplo, são responsáveis por cuidar de seus entes queridos. No entanto, alguns cuidadores prolongam essas tarefas por longos períodos, prestando cuidados a entes queridos que foram diagnosticados com diversas doenças crônicas. Pode ser gratificante e difícil prestar cuidados informais a pessoas que sofrem de depressão. Os cuidadores podem enfrentar desafios financeiros, emocionais ou de saúde física, além de perdas como salários perdidos, cobertura de saúde reduzida e diminuição dos fundos de aposentadoria. Em algumas circunstâncias, os cuidadores podem até ser obrigados a deixar o emprego ou reduzir suas horas de trabalho. Este estudo é essencial, dado o número crescente de pessoas com condições de saúde mental e a maior demanda por cuidadores. Uma revisão empírica das técnicas de gestão utilizadas pelos cuidadores para indivíduos com condições de saúde mental é apresentada neste artigo. De acordo com este estudo, aqueles com miomas uterinos, câncer, doenças cardíacas, diabetes, epilepsia e deficiências físicas ou mentais são considerados pacientes mentais. Os futuros cuidadores acharão mais fácil e benéfico ter uma ampla consciência do tema.

Palavras-chave: *Cuidadores. Experiências. Estratégias de Gestão. Condições de Saúde Mental.*

1 INTRODUCTION

Informal caregivers provide support to loved ones who require it due to illness, disability, or frailty (Gerain & Zech, 2019). Caring for a loved one or family member may be both rewarding and difficult (May, 2021). Depression is a mental disease characterized by a lasting sensation of despair and indifference (Woody *et al*., 2017). Mood disorders are common mental health conditions that are frequently misdiagnosed and underreported in Sub-Saharan Africa (SSA), particularly in Nigeria. However, more than 10% of all illnesses in SSA are related to neuropsychiatric issues (Fekadu *et al*., 2017). Depression is a psychiatric condition that frequently leads to suicide. It is believed that 5% of people globally suffer from depression (Woody *et al*., 2017).

According to Evans-Lacko *et al*. (2018), mild, moderate, and severe depression may all be successfully treated, and women experience depression more frequently than men. Depression may affect anybody. People who have suffered from abuse, major losses, or other stressful circumstances are more likely to have depression. An estimated 3.8% of the population, including 5% of adults (4% of males and 6% of women) and 5.7% of individuals over 60, suffer from depression, which affects around 280 million people globally (Institute of Health Metrics and Evaluation, 2024). Depression is almost 50% more common in women than in males. Depression affects more than 10% of pregnant and postpartum women globally (Woody *et al*., 2017).

Suicide is the fourth leading cause of mortality for those between the ages of 15 and 29, accounting for over 700,000 deaths annually. A key component of depression treatment is the availability of family members as caregivers. Gerain and Zech (2019) found that social, cultural, political, and environmental events were associated with depression. Everyone will periodically suffer depression, which is significant because it is a basic and universal ailment (May, 2021). The need for caretakers is only anticipated to increase due to increased personal hygiene standards, environmental sanitization, and advances in technology that have improved life expectancy worldwide (May, 2021). Environmental factors and internal factors both affect human depression (May, 2021).

Depending on changes in their physiology, psyche, and physical status, people might suffer from various forms of depression (May, 2021). Care is provided informally to close family members, friends, adult children, and loved ones. They consistently manage and arrange services, help out, and perform simple home chores. A variety of services are offered by caregivers, such as setting up public assistance, finding a nursing home, getting medical care, keeping an eye on quality, and managing money (May, 2021).

Caregiving is a road that most individuals take at some time in their life. For instance, parents are in charge of taking care of their kids. However, some parents extend these responsibilities for longer periods of time while caring for adult children who live with a disability (May, 2021). According to the National Research Council (2010), people may also take care of their parents, siblings, friends, and even their sick, aged, or sad spouses. Family caregivers offer information, medical attention, and emotional support to their loved ones (May, 2021). Informal family caregivers offer these services in part to

honor their depressed loved ones and maintain the dignity and quality of their lives (Akinloye, 2024a; Parveen *et al*., 2013).

In certain contexts, service delivery units include natural social networks and household units, which are composed of people who share housing and other services and may include friends, spouses, and children in addition to other family members (Morton *et al*., 2015). May (2021) claims that caretakers become weary and lose interest in their profession. They must thus rely on other systems, such community-based respite programs, in order to sustain and strengthen families.

There will soon be a high need for caretakers because to the rising number of depressed individuals and the general life expectancy (Morton *et al*., 2015; Gbadamosi *et al*., 2022; Akinloye, 2024b). Studies of Uche *et al*. (2015); Gbadamosi *et al*. (2022); Adewuya (2018) indicate that the number of people with depression increased from 172 million in 1990 to 258 million in 2017, a 49.86% increase. According to estimates, 3.1% of Nigerians suffer from depression. There has been a notable 124.42% rise in Sub-Saharan Africa (Gbadamosi *et al*., 2022; Akinloye, 2025). Because they require immediate and continuous help from caretakers, many elderly people remain disabled for extended periods of time, increasing the demand for caregiving services.

In addition to an increase in the number of people with disabilities and illnesses like cancer, schizophrenia, and post-traumatic stress disorder (PTSD), among others, Morton *et al*. (2015) report that the number of older adults suffering from various types of depression has significantly increased. Given that they need to recruit more caretakers, these socioeconomic inequalities are significant. Morton *et al*. (2015) state that further demographic variables include marriage, births, smaller households, and modifications to the composition and arrangement of families. As people live longer, caregivers especially adult children spend more years caring for their depressed patients, which makes even their offspring responsible for their care.

The challenges that caregivers have when tending to their depressed patients or loved ones have been addressed with proposed solutions. This means developing health plans that provide excellent caregiving services without jeopardizing the health of the caregiver (Morton *et al*., 2015). Caregivers may face additional pressures due to the patient's sickness, including family conflicts, financial difficulties, demanding work, and recreational activities (Gerain & Zech, 2019). In these situations, caregivers may have

negative consequences related to their emotional, social, and physical health (Gerain & Zech, 2019). Subjective stress is the term used to describe the psychological feelings that caregivers may have when dealing with disruptive behavior, such as depression, embarrassment, frustration, or other emotions (May, 2021).

Since stress and burnout can manifest as emotional outbursts, personality problems, and unhealthy coping methods, early diagnosis of chronic illness puts more load on caregivers (Gerain & Zech, 2019). Caretakers' harsh words, hostility, loneliness, and contempt for patients as emotional expressions all contribute to recurrent symptoms (Gerain & Zech, 2019). Caretakers' coping mechanisms are associated with both mental and physical stress (May, 2021). There is a strong correlation between caregivers' level of burden and the various management techniques they employ. Implementing management techniques via self-defense may be beneficial or harmful.

Calysta Roy's Stress Adaptation Model, one of her adaptive processes, illustrates how inputs affect regulating strategies (May, 2021). Examples of stimuli that caregivers for patients with schizophrenia encounter as a result of their patients' symptoms include environmental signals and attitudes regarding health. A management approach's process is influenced by the human system, much as an individual's established behavior effects the development of control mechanisms. Four modes make up the cognates and regulator subsystems of these management strategies: interdependence, role function, physiological, and self-concept. Emotion-focused and problem-focused treatment are the two primary approaches that caregivers for people with depression, among other illnesses and disabilities, employ.

The caregivers experience stress as a result of the patient's symptoms and their use of coping strategies (May, 2021). Given the foregoing context, this research will investigate the empirical evaluation of management techniques used by those who provide care for individuals with mental health disorders.

1.1 Statement of research problem

Research by Morton *et al*. (2015), Uche *et al*. (2015), and Gbadamosi *et al*. (2022) has shown the psychological and socioeconomic difficulties caregivers have when caring for a partner, parent, or cohabitant who has depression. These difficulties include, among

other things, decreased job productivity, the possibility of being fired or sacked at work, a loss of autonomy, social isolation, financial hardship, and emotional stress.

Additional losses that caregivers frequently face include diminished income, diminished health benefits, diminished retirement funds, and the potential for job downsizing or even termination (Family Caregiver Alliance, 2016). Forty-five percent (35%) of family caregivers think their health is fair to poor, and their health deteriorates over time, according to the Family Caregiver Alliance (2016). One is more likely to experience a greater physical strain on their health if they have been providing care for more than a year, are older (65 years and older), are carrying a heavier load, care for patients who are mentally ill or who are severely depressed, or live with their care recipient.

Additionally, studies reveal that as caregivers, women experience higher levels of stress than men (Family Caregiver Alliance, 2016). The physical health of full-time caregivers is indeed worse than that of their non-caregivers (Family Caregiver Alliance, 2016; Mayo Clinic Staff, 2022). Twenty percent of caregivers are working women, and up to 70% of them have clinically significant symptoms of depression (Sigelman & Rider, 2015; Family Caregiver Alliance, 2016; Mayo Clinic Staff, 2022). People who are under stress as caregivers are susceptible to health changes and health risks (Wehei, 2018).

Families start giving their loved ones physical and mental assistance because of all these problems that caregivers face. This type of caring is known as informal. They provide care services to respect those who are depressed and to preserve their dignity and quality of life (Parveen *et al*., 2013). But with time, they experience waning appeal and wear out (May, 2021). This study examines the experiences and management techniques used by caregivers of individuals with depression, since it appears to be challenging to control the unpleasant interactions of caretakers. This study adopts literature review method as mentioned by Adeniran and Tayo-Ladega (2024a), Adeniran and Tayo-Ladega (2024b), Adeniran *et al.* (2024), to examine the experiences and management techniques used by caregivers of individuals with depression.

2 LITERATURE REVIEW

2.1 Overview of depression

Depression, another name for depressive disorder, is a prevalent mental illness. It entails a persistently low mood, loss of enjoyment, or disinterest in activities. Depression differs from normal mood swings and sentiments about day-to-day living. All facets of life, including those with friends, family, and the community, may be impacted. It may be caused by or contribute to issues at work and school (Gbadamosi, 2022). Over 75% of individuals in low- and middle-income countries do not receive treatment for mental problems, despite the fact that there are proven, efficient therapies for them (Evans-Lacko *et al*., 2018). Lack of funding for mental health services, a shortage of qualified medical professionals, and the stigma attached to mental illnesses are all obstacles to providing effective care (Sweetland *et al*., 2014).

2.2 Symptoms and patterns of depression

A person feels a depressed mood (feeling sad, angry, and empty) during a depressive episode. They can experience a decline in enjoyment or enthusiasm for activities. Regular mood swings are not the same as a depressive episode (Tolentino & Schmidt, 2018). For at least two weeks, they last for the most of the day, almost every day. There are additional symptoms as well, such as difficulty focusing, feelings of overwhelming guilt or low self-worth, despair about the future, suicidal thoughts, disturbed sleep, changes in eating or weight, and extreme fatigue or low energy (Woody *et al*., 2017).

A person suffering from depression may experience challenges at home, at work, at school, and in the community. According to van den Heuvel (2013), a depressive episode can be classified as mild, moderate, or severe based on the severity and quantity of symptoms as well as the effect on the person’s functioning. Recurrent depressive disorder, which is characterized by a history of at least two depressive episodes; single episode depressive disorder, which is a person’s first and only episode; and bipolar disorder, which is characterized by manic symptoms, including increased energy or

activity, euphoria or irritability, as well as other symptoms like increased talkativeness, racing thoughts, increased self-esteem, decreased need for sleep, distractibility, and impulsive reckless behavior (Ventevogel, 2007).

2.3 Contributing factors and prevention of depression

A complex interplay of biological, psychological, and social elements leads to depression. Depression is more common in those who have had negative life events, such as unemployment, loss, or traumatic experiences. In turn, depression can exacerbate the affected person's living circumstances and the depression itself, resulting in increased stress and dysfunction (Woody *et al*., 2017).

Physical health has an impact on depression and is intimately tied to it. A lot of the things that affect depression, like not exercising or drinking too much alcohol, are also established risk factors for conditions including diabetes, cancer, heart disease, and respiratory disorders. In turn, because of the challenges of treating their illness, patients with these conditions may also experience depression.

It has been demonstrated that prevention programs lessen depression. Effective community-based strategies to prevent depression include school-based initiatives to help kids and teenagers develop healthy coping mechanisms. Parental depression feelings may be lessened and children's outcomes may be enhanced by interventions for parents of children with behavioral issues. According to Sweetland *et al*. (2014), exercise programs for senior citizens can also be beneficial in preventing depression.

2.4 Risk factors for depression and mood disorders in Sub-Saharan Africa

The likelihood of acquiring depression and other mood disorders is increased by a number of recognized and unknown risk factors. The majority of risk factors are either genetic or environmental, and others are linked to relationships, socioeconomic status, bad health, and a low quality of life. One of the main causes of depression in the elderly is poor health management brought on by underutilization and patronage of medical services (Padayachey *et al*., 2017). In a comparable population, it was also shown to increase morbidity and death, as well as cause impairment (Padayachey *et al*., 2017). The

elderly are usually treated for illnesses including dementia, Parkinson's disease, and Alzheimer's disease, which have been identified as risk factors for depression (Felicia *et al*., 2013).

Adolescents' healthy living greatly depends on the family's quality of life, which is defined by the warmth of the parents. These include scheduled family activities, maternal support, better communication, and quality time spent with a parent. Major depressive illness, however, might result from their absence. Teenagers who have previously been diagnosed with depression have shown improved depressed symptoms when they spend more time with their parents (Manczak, 2019). However, compared to the younger generation, the older generation has a greater reported prevalence of depression, which is frequently linked to social, economic, political, and functional impairment variables (Akosile, 2017; Pannetier, 2017).

Once more, it has been demonstrated that a person's socioeconomic status and geographic location influence the prevalence of depression. For example, according to a recent analysis, older people in low- and middle-income nations are more likely to suffer from depression than those in high-income countries (Ojagbemi *et al*., 2020). As expected, the Ibadan study of aging, conducted in a low- and middle-income country (Nigeria), found one of the highest rates of major depressive disorder in the literature. The 12-month prevalence was approximately 7% (Gureje *et al*., 2007), while high-income countries reported an average rate of roughly 3% (De La Torre-Luque & Ayuso-Mateos, 2020).

According to other findings, older adults in low-middle-income nations may be more susceptible to depression than their counterparts in high-income nations (Gureje, 2020). People's illness states are another documented element that raises the likelihood of depression. HIV/AIDS is one such illness. Not unexpectedly, research indicates that sadness affects over half of people with HIV (Osok, 2018). People with HIV were shown to have greater incidence of mood disorders than the general population in a South African sample population (Spies *et al*., 2018).

Regardless of whether an HIV test is positive or not, the majority of persons living with HIV exhibit signs and symptoms of sadness when they are checked for the virus (Kagee *et al*., 2017). Notably, depression has a negative impact on HIV patients' treatment outcomes, particularly when it comes to their attitude toward consistent drug

usage (Spies *et al*., 2018). Accordingly, lower virologic response, decreased physical functioning, and drug adherence have all been linked to depression and deteriorating clinical outcomes for those living with HIV.

With other variables including drug misuse, low economic standing, lack of social support, inadequate educational background, and bereavements making both illness states worse, this successfully produces a positive feedback loop (Kaneez, 2016). In addition to HIV, there have been reports of abnormally high levels of mother depression (antenatal depression) in low- and middle-income nations (Huang, 2016). For instance, it was shown that pregnant adolescents in rural Kenya who are HIV positive and who are very young are more likely to have depressive symptoms than pregnant adolescents who are considerably older (Osok, 2018). Depression risk is also known to be elevated by other chronic conditions as hypertension and arthritis (Beurel *et al*., 2020).

The next section of the literature study will examine the functions, traits, and demography of informal caregivers.

2.5 The demographic: caregivers

Most people experience caring in many ways throughout their lives, and one of these ways is via parenting and raising children (Nemati *et al*., 2017). An individual's obligation can be increased, just as it is for caring for children with special needs or those with mobility challenges caused by a disability or accident, a chronic disease, or age (May, 2021). People also care for their elderly or sick parents, spouses, siblings, and even friends (Kivak, 2020).

According to the National Research Council (2010), providing care is a task that impacts everyone. Even though caregiving has always been a crucial component of the study, the topic is relevant today because of the convergence of several factors, such as aging, the longer life expectancy of baby boomers, who make up the largest population in the US, and, lastly, the development of cutting-edge medical technologies that enable people to live longer but with disabilities and chronic illnesses (National Research Council, 2010). There is institutional bias in the public long-term care system, notwithstanding the fact that many caregiving services are still informal (National Research Council, 2010).

The aging of the American population necessitates the development of additional caregiver-supporting services in rural areas. According to the National Research Council (2010), caregivers are usually underpaid and work in an emotionally and physically taxing job. Furthermore, caregivers fulfill the task in addition to other household and family obligations (Nemati *et al*., 2017). Research that describes the duties of caregivers, their prevalence in the nation, their traits, stress and burnout associated with providing care, as well as the requirements and solutions that will support their effort and well-being, is therefore crucial.

2.6 History of care giving

According to the Family Caregiver Alliance (2016), caregiving was first documented in the 19th century, when a caregiver was described as someone who looked after objects, locations, or people that is, someone who was given responsibility for anything. As the primary caregivers for children, families, and the community, women were inherently valued (Davies, 2012; Family Caregiver Alliance, 2016). As society developed, they came to be seen as nurses or caretakers. Nuns and the military provided nursing-like services prior to the advent of contemporary nursing and caregiving (Nemati *et al*., 2017).

Before Queen Victoria authorized the establishment of a hospital to train and provide nursing services, English nurse Florence Nightingale provided caregiving services to injured military personnel during the Crimean War, which is noteworthy in the history of caregiving (Davies, 2012). Beginning in Britain and Germany in the 19th century, modern nursing began to expand around the world in 1900. Nursing evolved into providing household care for extended family members in the middle of the 19th century. Strangers began employing nurses to take care of their loved ones at home after that (Davies, 2012).

Individuals' progress throughout their lives is influenced by historical variables they have encountered (Morton *et al*., 2015). According to the lifetime perspective concept, situational circumstances that are somewhat connected to these elements have an impact on the standards of care for senior citizens. Differences in individual behavior

are cited by gender, color, ethnicity, and other rural/urban residence configurations as the cause of a variety of problems resulting from growth or intervention (Morton *et al*., 2015).

2.7 Informal care giving

2.7.1 Definition of informal care giving

According to Nemati *et al*. (2017), an informal caregiver who is frequently a family member is a person who usually offers unpaid care to those with whom they have a personal bond. According to Nemati *et al*. (2017), informal caregivers are also considered family caregivers since they frequently offer unpaid home care services to their loved ones. Informal caregivers always provide care for an elderly, ill, or disabled parent, spouse, friend, or family at their house (Sigelman & Rider, 2015).

According to Schultz and Tompkins (2010), informal caregiving is a vital part of the American healthcare system and a valuable resource for the person receiving care. Nonetheless, society still needs to recognize the value and function of providing care. Someone with whom they have a personal relationship receives unpaid care from an informal caregiver, usually a family member (Schultz & Tompkins, 2010). Nemati *et al*. (2017) made an attempt to identify informal caregivers, their needs, their place in society, and the requirements and tactics that might help them in their endeavors. Therefore, by identifying caregivers, their roles and duties, and the difficulties they have in coordinating care such as stress and burnout this study aims to assess and characterize the prevalence of informal care providing in a community (Nemati *et al*., 2017).

As the founder of The Carter Center and the wife of former President Jimmy Carter, Eleanor Rosalynn Carter was well-known for her support of mental health and caregiver concerns (National Research Council, 2010). In her 2010 National Research Council report, American writer and activist Rosalynn Carter observed that “there are only four types of people in the world: first, those who have been caregivers; second, those who are caregivers; third, those who will be caregivers; and finally, those who will need caregivers.” Three kinds of informal caregivers can be distinguished based on the age of the people they provide care for (Sigelman & Rider, 2015).

For example, parents tend to children with disabilities and chronic illnesses, middle-aged parents tend to adult children with illnesses like mental health issues, and elderly care recipients are looked after by both their elderly spouses and adult children (National Research Council, 2010). According to Nemati *et al*. (2017), many of these caregivers also have full-time jobs and perform other responsibilities including cleaning, volunteering, and taking care of their family.

2.7.2 Prevalence of informal care givers

Between 2015 and 2020, the number of Americans who get unpaid care (also known as care receivers) increased by 9.5 million, reaching 53 million (May, 2021). This represents around 17% of the adult population in the nation. Eighty-nine percent of caregivers provide the service to family members and other relatives, including spouses. The average informal caregiver in the nation is 50.1 years old, with 75% of caregivers being female and 25% being male.

With 60% of caregivers being married or in a long-term domestic partnership and 23% being single, the marital status of family caregivers of persons over 50 years old changed dramatically. Of the informal caregivers, 34% had a college degree or higher education, 25% had a high school diploma, and 6% had not finished high school. Seventy-one percent of informal caregivers are working or have other employment (May, 2021).

2.7.3 Characteristics of informal care givers

The adoption and execution of laws and enhancements to support networks that might improve the health of a care recipient and a caregiver could be guided by knowledge of the traits of informal caregivers and the difficulties they face. It is difficult to distinguish the requirements of informal caregivers from those associated with providing care for their loved ones, particularly those who are terminally ill (Torelli, 2020). Due to their daily duties and caregiving obligations, informal caregivers' specific needs are typically not monitored or met (Torelli, 2020).

People are expected to act as informal caregivers at some time in their lives (May, 2021). Caregivers might be of any age and from any socioeconomic background (Ramos,

2019). In the United States, a woman in her mid-forties who has completed college, works outside the house, and gives at least 20 hours of care per week is considered a traditional caregiver (May, 2021). 66% of caretakers are women who work full-time or part-time, according to May (2021). According to Armstrong-Carter *et al*. (2021), 24% of middle school students and 16% of high school students routinely care for their families, whereas those who do so are typically older than 50 (80%) and female (66%).

Old age is the primary presenting issue or sickness in 12% of individuals who require care (Armstrong-Carter *et al*., 2021). Ten percent of this population has dementia or Alzheimer's, seven percent has cancer, seven percent has psychological or emotional disorders, and five percent has heart disease. By contrast, stroke affects the remaining 5%. According to Armstrong-Carter *et al*. (2021), 23% of young adult care receivers between the ages of 18 and 49 have mental diseases and depression as their main health issues that necessitate care. According to Shepherd *et al*. (2018), the primary justification for caring for children under the age of 18 is their special needs, which may include physical and mental impairments, rare illnesses, and autism spectrum disorder.

A wide range of everyday life skills are part of the care that caregivers provide. For example, they spend 83% of their time providing care by assisting with transportation (Adeniran & Olorunfemi, 2020; Olorunfemi & Adeniran, 2020), 75% cleaning the house, 75% doing errands at the grocery store, and 65% cooking and serving the care recipient (Bryant, 2016; May, 2021). According to May (2021), caregivers indicate that they have been providing care for an average of 4.6 years. As a result, informal caregivers experience a lot of stress and symptoms, including physical, emotional, and financial pressure. Although describing the traits of informal caregivers is difficult, it is essential to examine them in order to determine the proper support systems needed to maintain their wellbeing while they are taking care of others and losing sight of themselves (Torelli, 2020).

2.7.4 Roles of caregivers

According to Biello *et al*. (2019), informal caregivers contribute significantly to the US healthcare system by providing additional, unpaid assistance. According to May (2021) and Shin and Choi (2020), informal caregivers do this fulfilling role without the

appropriate, affordable resources and assistance. To provide effective home-based health care, caregivers must assume a variety of responsibilities (May, 2021). In order to provide informal care, family members and caregivers must discuss and agree on care decisions. Care receivers and caregivers need to agree on how the care recipient will be accompanied and supported emotionally, as well as how the caregiver will communicate with doctors and other medical professionals about the patient's condition and requirements (Liu *et al*., 2020).

Additional responsibilities of the caregiver, which should also be discussed and negotiated with the family, include transporting the patients to appointments (Olorunfemi & Adeniran, 2024), cleaning, shopping, filling out paperwork, handling money, helping with personal care and hygiene, lifting and guiding the patient, helping with challenging nursing and medical tasks like tube feeding, infusion therapy, and medication monitoring, and helping with any other daily living skills required by the recipient's health and care conditions (Gérain & Zech, 2019). In addition, caregivers must help patients or care receivers get the resources they require, make tough decisions regarding their service requirements, and coordinate assistance from health and human services providers.

It is important to note that the physical, mental, and emotional health of the caregiver is strained by all of the duties associated with providing care (Gérain & Zech, 2019; May, 2021). However, May (2021) points out that elderly people with low incomes who are also caretakers and have chronic illnesses or impairments are quite likely to suffer negative consequences. 10% of family caregivers for children with special care requirements report spending more than 11 hours per week planning, organizing, and delivering care, according to a nationwide poll on the subject (May, 2021). Twenty-four percent of those caregivers resigned or cut back on their job hours, which ultimately caused their families to face financial difficulties (May, 2021).

According to May 2021, some typical support that caregivers offer to children with special needs include keeping an eye on the child's condition and making sure that others, such teachers, are aware of it and know how to meet the child's requirements. Additionally, caregivers represent the kid before government agencies, other care providers, and schools (Flores, 2021; May, 2021). Additionally, caregivers give the kid their medicine and conduct behavioral or emotional therapy (Flores, 2021).

3 EMPIRICAL REVIEW

3.1 Caregiver stress

According to research by Wilkinson and McLeod (2015), caregiver stress is characterized by a noticeable change from a positive and caring attitude to one of indifference and negativity brought on by mental, physical, and emotional tiredness. When caregiver duties change without receiving the support they need and focusing on chores that drain their mental, physical, and financial resources, this eventually results in burnout and stress (Wilkinson & McLeod, 2015).

Furthermore, Sterckx *et al*. (2013) found a link between stress and providing domestic care. For example, evidence showed that once people and family members had to assume a multifaceted caregiving role that involved providing the patient with ADLs and emotional support, their perspectives on their duties and responsibilities changed (Ramos, 2019). The caretakers frequently have to take on additional responsibilities, which makes them feel like they have a full family and home (Sterckx *et al*., 2013).

3.2 Caregiver burden

The pressure or load that a person who provides care for an aged, handicapped, or chronically sick family member bears is known as caregiver burden (Liu *et al*., 2020). The burden of caregiving is a complex personal pressure that frequently causes the carer to disregard their own physical and emotional well-being (Gérain & Zech, 2019; Liu *et al*., 2020). Anxiety, depression, heart disease, and hypertension are just a few of the physical and mental health issues that can arise from the long-term strain on the caregiver (Gérain & Zech, 2019; Liu *et al*., 2020). In order to define the idea of caregiver burden, Liu *et al*. (2020) reviewed 33 papers as part of their concept analysis.

According to the data, a clinically recognized definition that accurately captures the concept of caregiver burden can be difficult to define because of the subjectivity of emotions, including the goals and feelings of the caregivers as well as the psychological attachment to the significance of a given caregiving activity. Furthermore, this self-

perception was found to be a characteristic of caregiver strain that differs throughout caregivers (Liu *et al*., 2020).

When using this word between genders, a research by Northouse *et al*. (2012) shows another dichotomy in the variance. The findings indicated that compared to their male counterparts, female caregivers have a greater caregiver burden. Caregivers frequently experience stress at work, are underappreciated, and have difficulty managing both personal and professional obligations (Czuba *et al*., 2019). Furthermore, it has been shown that perceived load and quality of life (QOL) are inversely correlated, and thus lowering a caregiver's burden can greatly enhance their QOL (Liu *et al*., 2020).

3.3 Effects of caregiver stress and burden

While providing care for their loved ones takes up a lot of time and energy, caregivers frequently overlook or severely compromise their own needs for proper self-care (Broxson & Feliciano, 2020; Lou *et al*., 2022). Although each caregiver job may operate differently, it is important to recognize that stress may have detrimental effects on a sizable segment of the American population (CDC, n.d.). According to Broxson and Feliciano (2020), family caregivers are more likely than noncaregivers to experience physical and mental health problems. Negative alterations that can affect care and lower quality of life as well as physical and mental health are associated with the strain of caregiving (Liu *et al*., 2020).

A research by Roth *et al*. (2015) indicated that more than 55% of the caregivers who participated reported feeling overwhelmed by the care that their elderly or chronically sick family member required. Broxson and Feliciano (2020) point out that family caregivers who are under stress are at risk of dying young. Because of the bodily, emotional, and social effects of the increased load on the caregiver which can also impair their capacity to provide care for their loved ones research further recognizes caregiver burden as a public health concern (Broxson & Feliciano, 2020).

According to a 2017 study by Irfan *et al*., older adults who provide care for others may be more at risk as they may have to put a lot of strain on their immune systems, physical health, and mental health. According to research by Ramos (2019), providing care is taxing and puts the caregiver's physical, mental, and emotional well-being at risk.

Chronic long-term stress brought on by providing care wears down the body and leads to the emergence of behavioral, mental, and physical disorders (Lou *et al*., 2022; Wilkinson & McLeod, 2015).

These caregivers frequently give up their desires, experience a great deal of stress, and feel unappreciated. Research indicates that the quality of the caregiver's life may be predicted by their age, income, education, and work status, which can affect their results (Northouse *et al*., 2012; WilbornLee, 2015). According to Wilborn-Lee (2015), there is a growing demand for baby boomer homecare services that don't require professional training. Furthermore, some research showed that the more stress and anxiety the caregiver felt, the more detrimental changes in their health occurred (Broxson & Feliciano, 2020; Northouse *et al*., 2012; Rumpold *et al*., 2016; Tuncay & Fertelli, 2019).

Furthermore, evidence suggests that providing care demonstrates every symptom of ongoing stress. Long-term caretakers, for instance, are naturally more watchful, which can lead to physical and mental stress over time. This is made worse by high levels of unpredictability and uncontrollability, which can result in secondary stress in a variety of spheres of life, such as relationships with family and coworkers (Schulz & Sherwood, 2008). Given its congruence with the chronic stress model, caregiving may be used as a model to investigate trends, themes, and patterns in the study of the detrimental effects of chronic stress on health.

Relationship, psychological, and demographic aspects, as well as the patient's condition, all influence the caregiver's well-being and personal traits. Studies provide evidence that the requirements of patients who have grown more incapacitated require higher levels of care, which raises the demands of providing care. These caregiving responsibilities include providing emotional support, adjusting the caregiver's function within the family system or structure, providing the necessary physical care, and having a greater need for financial assistance. Increases in a care recipient's needs have a negative impact on a caregiver's schedule, relationships, finances, physical and mental health, and feeling of self-worth.

3.3.1 Physical health impacts

Caregivers are more susceptible to high levels of stress and are at a higher risk of death, coronary heart disease, and stroke, according to Lou *et al*. (2022). According to Irfan *et al*. (2017), stress among caregivers can exacerbate older caregivers' preexisting chronic health conditions, as evidenced by physical symptoms such as aches and pains throughout the body, chest and racing heart pains, difficulty sleeping, fatigue, dizziness, shaking, and elevated blood pressure. According to Irfan *et al*. (2017), additional symptoms include tense muscles, stomach and intestinal issues, and a weakened immune system.

Additionally, compared to those who do not do ADLs, those who perform their own ADLs such as clothing, toileting and personal hygiene, and food preparation reported higher levels of physical health stress (Morton *et al*., 2015). Compared to those who do not provide care, full-time caregivers report having worse physical health (Family Caregiver Alliance, 2016b; Morton *et al*., 2015). Physical health index scores for full-time caregivers are 77.4% for 16% of them, which is far lower than the 83% for noncaregivers (Family Caregiver Alliance, 2016). The physical stress incurred from traumatic events experienced while providing care is another element influencing caregiver stress (Wilkinson & McLeod, 2015).

Physical stresses that may affect informal caregivers include adverse physiological and biochemical reactions such exhaustion, substance addiction, and nutritional stressors (Sterckx *et al*., 2013; Wilkinson & McLeod, 2015). Research supports evidence showing that caregivers' reported physical health is typically worse than the overall population's, and spousal caregivers' perceived health is worse than parent caregivers' (Roman *et al*., 2021). Comorbid conditions such hypercholesterolemia, or elevated cholesterol, hypertension, obesity, and depression have been reported by many caregivers (Roman *et al*., 2021).

Other physical health issues and comorbidities linked to caregiver strain were noted by Northouse *et al*. (2012) and Broxson and Feliciano (2020). These issues included diabetes, high cholesterol, cortisol, arthritis, cardiac conditions, and hyperglycemia. Northouse *et al*. (2012) both note that caregivers are more likely to have mental health issues.

3.3.2 Mental health impacts

Current empirical and longitudinal research continuously emphasizes the detrimental long-term impacts of caregiving, which can be demanding and stressful (Schulz & Sherwood, 2008). More research explains how the stress of being a caregiver may lead to mental and emotional issues such melancholy, anxiety, impatience, and panic attacks (Rumpold *et al*., 2016). hardship from providing care is linked to sadness, economic hardship, and mental stress, all of which have an effect on self-esteem (Kim, 2017). Northouse *et al*. (2012) analyzed peer-reviewed literature on the psychological health and emotional distress of family caregivers of cancer patients. They discovered that the biggest impact on a caregiver's psychological health is the stress of providing care (Northouse *et al*., 2012).

Studies routinely find other types of psychological stress, such as panic, worry, and a sense of helplessness, when examining data from conventional perspectives (Wilkinson & McLeod, 2015). Further supporting the need for more future research to fully comprehend these causative and correlative factors are studies that have shown findings for anxiety and depression in informal caregivers in addition to findings for depression, PTSD, and substance abuse (Rumpold *et al*., 2016).

In a similar vein, Northouse *et al*. (2012) discovered that when care receivers had more discomfort due to symptoms or poor physical functioning, caregivers' anxiety and depression levels rose. According to the findings of a research by Rumpold *et al*. (2016) that looked at the prevalence of mental illnesses that could exist in informal caregivers, 11.3% of participants had a positive screening for alcohol misuse and 18.7% of participants had a positive screening for PTSD.

Other data also show secondary factors that are important to caregivers' mental health, such money troubles, time constraints, sleep disorders, and other health conditions that made them feel more stressed (Nemati *et al*., 2017). Furthermore, caregivers showed signs of melancholy, anxiety, and poor mental health (Wilkinson & McLeod, 2015). Rumpold *et al*. (2016) concur that informal caregivers have worse well-being and greater levels of anxiety, depression, and perceived stress than noncaregivers of the same age. Furthermore, 42.6% of subjects had a positive or borderline screening for depression, and 34.1% had a positive anxiety score. Up to 70% of caregivers experience clinically severe

depressive symptoms, with 20% of them being working women (Family Caregiver Alliance, 2016).

3.3.3 Emotional health impacts

Accurately classifying emotional traits brought on by psychological stress is another crucial element in assessing caregiver stress. In addition to identifying the emotional aspects of stress, some studies have also emphasized the exterior behaviors of dread, resentment, sorrow, frustration, rage, attachment, and resistance (Santos-García *et al*., 2022; Sterckx *et al*., 2013; Wilkinson & McLeod, 2015). Furthermore, whether voluntarily or inadvertently, these feelings frequently surface when someone assumes the role of caregiver (Santos-García *et al*., 2022).

According to studies, these emotional overload symptoms can also appear suddenly, but it’s vital to remember that some symptoms could be more progressive and take longer to show up over time (Santos-García *et al*., 2022). Ambivalence, which is characterized by contradictory sentiments of compassion (the desire and readiness to fulfill the job of caretaker) and anger and dread (feeling burdened and furious), is another symptom brought on by caregiver stress (Biello *et al*., 2019).

This predicament causes a lot of emotional distress, as caregivers report feeling alone and abandoned during those chaotic times, but they also report feeling happy and refreshed when they see their position as a gift to the person they are caring for (Biello *et al*., 2019). Anger is a second characteristic that arises from the dissatisfaction of being in the care recipient’s presence (Santos-García *et al*., 2022). Anxiety, boredom, fear, sorrow, remorse, grief, wrath, loneliness, and shame are additional signs of emotional excess. Anticipatory sadness is another emotional consequence that informal caregivers may encounter (Clukey, 2008). Erich Lindemann used the phrase “anticipatory grief” in 1944 to describe the grieving processes he saw in non-bereaved individuals (Rogalla, 2018).

Using nine individuals who had all cared for a family member who was near death, Clukey (2008) conducted a qualitative research on anticipatory grieving. He discovered that anticipatory sorrow included a range of dynamic emotions, including sadness, rage, disbelief, numbness, relief, and guilt. Death anticipation, emotional distress, intrapsychic and interpersonal protection, hope, exclusive focus on patient care, personal losses,

relational losses, ambivalence, end-of-life relational tasks, and transition are some of the themes surrounding the family experience of anticipatory grief, according to a literature review of texts from 1990 to 2015 (Coelho & Barbosa, 2017).

Anticipatory sorrow differs from traditional grieving in that it is characterized by the expectation of death (Coelho & Barbosa, 2017). According to Shore *et al*. (2016), anticipatory grief sufferers frequently struggle to emotionally connect with others and doubt the existence of God. Regretfully, the loss that a person feels following the actual death of a loved one is rarely or never lessened by anticipatory sadness. In order to assess and diagnose difficulties, give the required support, and cultivate effective intervention techniques to help patients cope, palliative care physicians must identify patients and families who are suffering anticipatory grieving (Shore *et al*., 2016).

3.3.4 Social and relationship strain

Social isolation is closely linked to the strain of unpaid caregiving duties (Sterckx *et al*., 2013). When informal caregivers have issues in their connections and relationships as a result of their caregiving position, they frequently suffer from psychosocial stress (Wilkinson & McLeod, 2015). This covers marital and interpersonal issues such conflicts with partners, siblings, employers, and coworkers. Psychosocial stress manifests as loneliness, loss of loved ones, and a lack of social support (Wilkinson & McLeod, 2015). Relationship difficulties, which are marked by heightened sentiments of anger, lack of desire, and loss of interest in personal needs, are another adverse consequence of informal caregivers' social and relationship experiences (Shore *et al*., 2016).

When a caregiver becomes disinterested in the person they are caring for, this happens (Shore *et al*., 2016). One prevalent characteristic in caregiving that exemplifies the caregiver load is increased sentiments of animosity and hostility towards a care recipient or family (Shore *et al*., 2013). Depending on the level of support, social networks have different effects (Ghasemi *et al*., 2020). Using analytical techniques to comprehend hypotheses that analyze the relationship after the variables have been adjusted is the main focus of the present literature. This study's drawback is that it primarily estimates the independent effects of diseases or disabilities on the dependent variable, which is a caregiver's health (Ghasemi *et al*., 2020; Shore *et al*., 2016).

3.3.5 Financial impacts

Financial difficulty is another factor contributing to caregiver stress. According to research, patients who were the main financial administrators of their lives and are now faced with giving up that duty show internal conflict and resistance towards caretakers (Sterckx *et al*., 2013). Despite the emotional, physical, and cognitive demands of caregiving, those who do these tasks are frequently unemployed, leaving them at risk of negative financial outcomes (Wilkinson and McLeod, 2015). According to research by the National Research Council (2010), taking care of others lowers one's productivity at work and raises the likelihood that one may quit. Informal caregiving frequently results in caregivers taking time off work, which puts a strain on their finances (Sterckx *et al*., 2013).

Informal caregivers' duties fall on a spectrum, and their fluctuating hours may have an effect on their income or lack thereof (Flores, 2021). Those who work outside the house perform roughly 20 hours of caregiving duties each week, compared to 29 hours for caregivers who do not have outside employment (Walker, 2022). While some caregivers find that working outside the house and being fully engaged in their position helps reduce stress (Wilborn-Lee, 2015), informal caregivers may also experience stress due to juggling their time or variable income.

3.3.6 Poor overall quality of life

In line with other studies, caregivers frequently bear a severe load that prevents them from going about their everyday activities, which increases their sense of isolation (Cavers *et al*., 2012). According to a review of the literature by Wilkinson and McLeod (2015), informal caregivers' quality of life (QOL) was lower than that of the general population because, in addition to their incapacity to maintain daily life, they also had a heavy burden of responsibility. Poor quality of life is a concern for informal caregivers even if it is not a clinical diagnosis.

According to Martin *et al*. (2021), quality of life (QOL) is the degree to which providing care has adversely affected a caregiver's emotional, economical, social, spiritual, and physical well-being. One of the most used definitions and metrics for quality

of life is this one. However, the definition and measurement of quality of life (QOL) have evolved to incorporate some factors, such as the care recipient's illness type and positive evaluations like the perceived advantages of providing care (Martin *et al*., 2021). Researchers look at stress and a caregiver's experience as well as other stresses and responsibilities to determine the quality of life (QOL) (Martin *et al*., 2021).

In a research including hospice family caregivers, the quality of life (QOL) of caregivers was poorer than that of their peers who did not provide care (Parveen *et al*., 2013). The quality of life was lower for caregivers of patients who were more disabled, particularly when it came to their physical health. The findings that caregivers of patients receiving palliative care had the lowest QOL score are corroborated by data from Weitzner *et al*. (1999). The physical demands of providing care, the stage of a care recipient's sickness, and the role and obligations a caregiver performs, such as taking care of the family's household, all have a significant impact on the QOL score (Weitzner *et al*., 1999).

After a loved one passes away, caregivers undergo role pressure and role adjustment (Duke, 1998). They go from providing care to being in need of it. They are now alone after being with their spouse. They are currently at a stage of remembering, when previously they were making memories (Duke, 1998). While some people find it difficult to change, parents and other caregivers adjust to difficult roles. The mental and physical results of informal caregivers are influenced by contextual variables such as socioeconomic position, child aspects, behavior, the degree of a handicap, intrapsychic difficulties, coping mechanisms, and social supports (Raina *et al*., 2004).

In order to provide good health-related home care, caregivers must fulfill a variety of responsibilities, according to Wilkinson and McLeod (2015). To differing degrees, they must interact with medical professionals like nurses and doctors about the patient's condition and needs, as well as communicate and bargain with other family members about care decisions, companionship, and the provision of emotional support (Wilkinson & McLeod, 2015). People who care for their parents, spouses, or cohabitants have difficulties with their financial circumstances as well as their mental and physical well-being (May, 2021). The prevalence and stress on those taking on the position of caregiver will rise as caregiving shifts from institutional to home-based care (Armstrong-Carter *et al*., 2021), increasing the demand for resources and efficient coping strategies.

3.4 Caregivers and coping management approaches

Coping strategies are specific behavioral and psychological attempts to control or reduce stressful situations, according to Monteiro *et al*. (2018). Coping strategies may have positive, negative, or unresolved outcomes (Biggs *et al*., 2017). According to Biggs *et al*. (2017), successful resolution of stressors elicits positive sentiments, whereas unfavorable or upsetting resolutions lead the person to seek out additional coping techniques in an attempt to properly manage the stressor. Numerous pharmacological and behavioral therapies have demonstrated some efficacy in reducing stress among caregivers (Adelman *et al*., 2014).

Biggs *et al*. (2017) and Adelman *et al*. (2014) note that caregivers should get assistance for their well-being in the same way that care users do. Although coping methods differ, they are all made up of the behavioral, emotional, and cognitive reactions that a person experiences when faced with a difficult circumstance (Panicker & Ramesh, 2018). When directing treatments, it is crucial to use models that are consistent with theory (Douglas, 2017). According to Bravo-Benítez *et al*. (2021), intervention programs are crucial for addressing caregivers' emotions in order to track sorrow.

Because caregiver load has such a profound impact on caregiving, it is important to develop strategies to reduce the burden and evaluate their effectiveness. Effective therapies should be available to as many caregivers as feasible. An intervention is considered helpful if its efficacy and utilization increase. As a result, it is essential to create interventions and figure out how to increase and reinforce their usage and awareness.

3.5 Methods of coping for caregivers

According to Folkman (2013), coping is the ongoing modification of one's thoughts and behavior in response to demands, both internal and external, that are deemed to be greater than one's capacity. Coping is a dynamic process that involves reciprocal reactions in addition to a number of intentional cognitive and behavioral efforts. It makes it possible for people and their surroundings to interact and have an influence. Managing stressful events may entail minimizing, avoiding, tolerating, and accepting stressful

situations in addition to regulating the environment. Coping strategies might theoretically be a substantial and changeable component of psychological disorder.

As a result, they include all of the behavioral, emotional, and intellectual responses that an individual has to stresses that are either internal or external, but that are often too much for them to manage (Folkman, 2013). Three categories of coping methods are described by Monteiro *et al*. (2018): dysfunctional (disengaging from the demanding situation or feelings), problem-focused (making practical attempts to remove or reduce the demands), and emotion-focused (regulating one's emotional reaction to stress). The findings of many research about the most effective coping strategies for caregivers have generated disagreements.

Certain coping mechanisms aid in the management of circumstances, symptoms, and expectations (Papastavrou *et al*., 2011). Understanding the situation's overall context and creating positive comparisons are beneficial (Papastavrou *et al*., 2011). Individual resources (both internal and external, such as a seemingly high self-efficacy and a social environment with rich resources) and environmental factors (such as illness or earthquakes) are seen as interconnected elements that are connected by a coping method (Monteiro *et al*., 2018).

3.5.1 Environmental supports

Although relocating or changing careers aren't always the ideal options, one may alter the surroundings they live in (Sabata *et al*., 2005). The home environment has a significant influence on caregivers' capacity to provide assistance, while occasionally being overlooked in conversations on caregiver support (Sabata *et al*., 2005). Services are usually rendered in the home, whether it is the caregiver's or the care recipient's (Nemati *et al*., 2017; Sabata *et al*., 2005; Sigelman & Rider, 2015). According to Chari *et al*. (2015) and Sabata *et al*. (2005), care users often need caregivers to do physically demanding tasks including lifting, turning, and helping someone use the restroom.

Family caregivers need enough space and comfort in their homes to aid in providing care, particularly when caring for care receivers (Sabata *et al*., 2005). Research indicates that carers are better equipped to handle functional demands and are less upset by the care recipient's behaviors when the home environment is modified to be more

helpful. Home changes and assistive technologies or equipment reduce the physical strain on caregivers. For example, in the dark, night lights can help guide someone along a corridor to a restroom. Families who lack the means or expertise to provide safety and allay the worries of caregivers and family members face difficulties in the area of environmental coping (Sabata *et al*., 2005).

3.5.2 Social supports

Resilience and social support lessen the physical and psychological consequences on caregiver burden, according to research by Ong *et al*. (2018), who examined perceived social support as a potential cause of burden among caregivers. In addition to public education on caregiver tasks and burden, agencies could provide greater assistance for caregivers and provide more training in caregiving (Bialon & Coke, 2011). Promoting and identifying supporting networks of friends and family that may help alleviate the caregiver load is crucial for health care professionals, particularly those who offer services to help caregivers (Ong *et al*., 2018).

In the public health system, community interventions are important, particularly if they encourage coping strategies and social support (Mendoza *et al*., 2020). It is also critical to implement programs that educate and support caregivers in order to lessen their caregiving responsibilities. This enhances their quality of life and family functioning (Ghasemi *et al*., 2020).

3.5.3 Religion and spirituality

Nearly 20% of Americans claim they do not practice any religion, compared to over 80% who claim to be religious (Pargament, 2013). People who are struggling with the most challenging problems and have few means frequently turn to religion and spirituality as a coping strategy. Religious coping comes in a variety of forms, some of which work better than others. People can engage in a wide variety of religious and spiritual activities, and these activities have been linked to improved crisis coping (Pargament, 2013). Some examples of these beneficial religious coping strategies include reinterpreting a turbulent experience, spiritual forgiveness, support from a religious

organization, and the belief that God or a higher power may ease life transitions (Ahmadi *et al*., 2018).

According to Ahmadi *et al*. (2018), one of the most fascinating results of a study on coping was that a number of participants claimed to rely on God. In addition to causing emotional, social, and physical problems, stressful life experiences, like providing informal care, may also rock and break individuals spiritually (Pargament, 2013). This happens when a caregiver's expectations are not met, even when they think their faith might serve as a coping tool. When they are unable to overcome their pressures, caregivers who think that their faith in God or their religion may help them recover or adjust to their current situation frequently abandon or doubt their beliefs.

Spiritual concerns may arise for caregivers in regard to their understanding of God, personal problems, or interpersonal and societal interactions. These spiritual tensions have been linked in an increasing number of caregiving studies to worse physical health, increased psychological suffering, and even an increased risk of death (Ahmadi *et al*., 2018).

3.5.4 External resources and online support

Organizations and resources are available to assist people with coping management techniques in every demographic region. The services of outside caregivers are frequently funded by a large number of economically powerful elites. They get this sum on a regular basis, either directly or through their agents. Websites with connections to resources for family caregivers are also available.

3.6 Research on the caregiver demographic

More formal study on caregiving is required, as are studies that restrict the creation of solutions to meet the expanding and unmet needs of informal caregivers. Interest exists in identifying and setting goals for research on informal caregiving that needs expert assistance (Sterckx *et al*., 2013). The lack of agreement on a comprehensive definition of caregiving that takes into account its breadth and depth, its dynamic changes, the

availability of social and financial resources for caregivers, and the cultural and ethnic variations in caregiving roles is one of the research gaps.

Second, because it is uncertain how many people provide informal care, research has to explicitly state the costs of caregiving to both society and caregivers (Sterckx *et al*., 2013). Because of this, it is challenging for academics to comprehend how informal caregiving impacts communities and how demographic shifts impact informal caregiving. According to Wilkinson and McLeod (2015), a cross-national research using international data sampling and harmonization efforts is necessary to determine the ways in which various demographics, geographic locations, economic situations, and composition affect the cost of providing care. According to Wilkinson and McLeod (2015), prior research has also failed to find predictors of high-risk caregivers.

The majority of caregivers are women, who constantly face growing and evolving obstacles. However, since some people flourish while providing care, while others experience stress and burnout, it is unknown how providing care impacts their health and well-being (Smith, 2023). Therefore, if research finds important indicators of high-risk caregiving, intervention methods may be developed to provide treatments that support the community's and informal caregivers' health and well-being. Last but not least, the care requirements of patients with aggressive diseases are always evolving, which causes uncertainty for caregivers and can result in negative consequences including excessive financial strain (Wilkinson & McLeod, 2015).

Evidence-based, community-based solutions that would lessen the strain of providing care have not been produced or disseminated via research (Smith, 2023). According to theoretical frameworks reviewed in the literature, all caregivers offer the receiver a same amount of advantages in terms of their physical and mental health (Ghasemi *et al*., 2020). Informal caregivers and important characteristics related to caregiving interactions, such as familiarity, availability, preference, and motivation, are categorized by the theories (Ghasemi *et al*., 2020; Schulz & Eden, 2016). The parallel that social network theories do not define whether they may be extended to psychological and physical assistance was bolstered by Ghasemi *et al*. (2020).

According to Schulz and Eden (2016), there are a number of reasons why the present study might be more comprehensive. First, according to the authors, a lot of research papers use self-reported data regarding informal caregivers, which is probably

impacted by social desirability and recall bias. Additionally, Schulz and Eden (2016) pointed out that the majority of individuals who are thought of as informal caregivers may not consider themselves to be such, but rather view their involvement in providing care for family members as a personal obligation to their loved ones, which leads to an underestimation of the number of informal caregivers. Lastly, just one individual per home is interviewed by the Behavioral and Risk Factor Surveillance System and other researchers, including Schulz and Eden (2016). As a result, family caregivers who choose not to participate in these research are underrepresented and their opinions are ignored.

3.7 Caregiver stress and burden

Taking care of a loved one is often a lifelong struggle (Smith, 2023). Having to care for someone for years or even decades can lead to a downward spiral of physical, mental, and emotional attrition, according to current evidence examining the long-term problems of caregivers throughout the lifetime. It's common for caregivers to feel overwhelmed. Caregivers eventually feel overburdened and psychologically worn out as a result of the psychological stress these people endure, which causes them to feel as though they are caught in an emotional whirlpool. According to data, this kind of bio-psycho-emotional malaise is more prevalent when a family member's medical condition is declining or there is little prospect that they will recover (Smith, 2023).

Additionally, statistics highlight the wide range of services offered by caregivers employed by human services and health organizations (Wilkinson & McLeod, 2015). According to Wilkinson and McLeod (2015), primary caregivers provide the following coordinated essential services: coordinating services from human services and health agencies, making critical decisions regarding the recipient's needs, and assessing the effectiveness of the way services are applied, implemented, and evaluated. Caretakers also perform other tasks that are required by the care recipient's health, such as shopping, making and transporting appointments, handling money, filling out paperwork, and helping with ADLs like feeding, medication monitoring, and personal and hygiene assistance (Wilkinson & McLeod, 2015).

Furthermore, research on caregivers suggests the fallacy that individuals often view caregiver stress as a temporary or singular occurrence. Although the aforementioned

list of informal caregiver responsibilities proposed by Wilkinson & McLeod (2015) makes sense, Pearlin *et al*. (1990) found that caregiver stress is a combination of situations, experiences, and responses that significantly vary among caregivers, impacting their physical and mental health.

According to their main methods of explaining the stress experience, the explanations of informal caregiver stress can be divided into four categories: stress as an external stimulus, stress response, stress as an individual or environmental interaction, or stress as an individual or environmental transaction (Biggs *et al*., 2017). As a result, it is supposedly clear from these research that caregiver stress is not characterized by a single, landmark incident but rather by a collection of ongoing, current situations in the life of individuals who are caring for a family member. In order to promote the proper ancillary support and self-care services for caregivers who frequently internalize the physical and psycho-social-emotional stressors over lengthy periods of time, it is also crucial that research recognizes these false and misleading interpretations.

4 CONCLUSION

The management strategies adopted by caregivers of people mental health conditions was examined in this study. Gaining understanding from the experiences of informal caregivers might help identify methods to support and lessen the strain on future caregivers. It is crucial to recognize that families and workers will continue to face difficulties in providing care for their loved ones in their communities due to a lack of informal caregivers to support Nigeria's high rate of depressed and ill people (Morton *et al*., 2015).

Therefore, it's crucial to see management strategies as actions that raise desired results while lowering undesirable ones. The coping taxonomy has significantly impacted the larger coping literature and challenges the theoretical division between issue focus and emotion focus. Nonetheless, the taxonomy of dual coping has been questioned due to methodological and theoretical issues (Biggs *et al*., 2017).

According to Lazarus and Folkman's transactional model of stress and coping, one might choose to choose an emotion-focused or problem-focused coping technique. Additional stress management strategies include denying, evading responsibility or

blaming, admitting responsibility, controlling one's thoughts and behavior in relation to the circumstance, and practicing positive reappraisal. If coping mechanisms aid in the long-term management of stress, they are categorized as adaptive coping mechanisms. In terms of stress management, for instance, changing the topic or highlighting the advantages of a situation (Lazarus & Folkman, 1984). Maladaptive coping strategies, on the other hand, shorten the duration of our stressors but are ineffective or worsen the situation over time (Biggs *et al*., 2017).

Giving long-term care is a chronic stressor that has a negative impact on caregivers' mental, emotional, and physical health (Gérain & Zech, 2019; Liu *et al*., 2020; National Research Council, 2010). Therefore, research aims to capture the complexity of caregiving (Biggs *et al*., 2017; Gérain & Zech, 2019). The qualities of the caregiver and the care receiver are constantly linked to the results and dynamics of providing care (Family Caregiver Alliance, 2016b; Gérain & Zech, 2019).

Gender, age, kinship, and other roles and obligations of the caregiver, including family, employment, financial constraints, the care recipient's health, physical and cognitive functioning, and supportive treatments, are also proven to influence caregiver outcomes (Gérain & Zech, 2019). This study's literature review section evaluated informal caregiving, caregiver role stress, informal caregiver characteristics, caregiving, quality of life, and coping mechanisms.

The degree to which various caregiver attributes may influence or contribute to the link between caregiving demands and caregiver stress is investigated by looking at a variety of caregiver variables (Liu *et al*., 2020). Additionally, coping mechanisms and interventions to lessen caregiver stress have been studied. The goal of research has been to evaluate caregiving experiences through qualitative analysis, show how caregivers differ from one another, and provide light on how caregiver responsibilities affect motivation, stress, and burnout (Morton *et al*., 2015). It is essential to locate an informal network and support system (Sun *et al*., 2012).

Additional strategies have been proven to lessen caregiver stress, including mindfulness, online interventions including websites, email support with coaches, chat room groups, and psycho-education combined with technology. Cognitive-behavioral therapy and counseling can lessen the symptoms of depression. Providers need to understand cultural factors, such as coping mechanisms that are religious or spiritual.

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Authors' Contribution

All authors contributed equally to the development of this article.

Data availability

All datasets relevant to this study's findings are fully available within the article.

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