



Relationship between daily caregiving hours and quality of life among caregivers of patients with mental disorders

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Abstract

Background: Caregivers of patients with mental disorders experience significant burdens affecting their physical, psychological, social, and environmental well-being. While the relationship between caregiving burden and quality of life (QOL) is well established, the role of daily caregiving hours as a determinant of caregiver well-being remains unclear. This study aimed to examine the relationship between daily caregiving hours and QOL among caregivers of patients with mental disorders.

Methods: This cross-sectional comparative study was conducted at Bangabandhu Sheikh Mujib Medical University, Dhaka, among 50 caregivers of patients with mental disorders. Caregivers were categorized based on their daily caregiving hours, and QOL was assessed using the World Health Organization QOL Scale, Brief Version. Statistical analyses, including independent *t*-tests, one-way analysis of variance, and Pearson's correlation coefficient, were performed to determine the relationship between caregiving hours and QOL scores across four domains: Physical, Psychological, Social Relationships, and Environmental.

Results: The majority of caregivers were middle-aged, married women (62% housewives) providing long-term care for young adults with schizophrenia or bipolar disorder. 42% of caregivers provided full-time (18–24 h) care, leading to lower physical health and environmental QOL scores. However, no statistically significant differences were found in QOL scores across caregiving durations ($P > 0.05$ in all domains), indicating that factors beyond caregiving hours, such as financial stress, social support, and emotional burden, may have a greater impact on caregiver well-being.

Conclusion: Caregiving hours alone do not significantly impact caregiver QOL, emphasizing the need for comprehensive support systems addressing financial, emotional, and social burdens. Psychological distress and social isolation remain persistent challenges, regardless of caregiving duration. Holistic interventions, including mental health services, financial assistance, and structured caregiving networks, are necessary to improve caregiver well-being.

Keywords: Caregiver burden, caregiver well-being, caregiving hours, mental disorders, psychological distress, quality of life, social support, World Health Organization quality of life- Brief Version.

Introduction

Mental disorders are a major public health concern worldwide, contributing significantly to the global disease burden. According to the World Health Organization (WHO), one in eight people worldwide is affected by a mental disorder, with depression and anxiety disorders being among the leading contributors to disability-adjusted life years (DALYs).^[1] The burden of mental disorders has been steadily increasing, particularly in low- and middle-income countries, where mental healthcare infrastructure remains inadequate.^[2] South Asia, including Bangladesh, faces an alarming mental health crisis, with studies indicating that one in seven individuals in India and Bangladesh suffers from some form of mental illness, a figure that has nearly doubled since 1990.^[3] This escalating prevalence underscores the essential role of caregivers, both formal and informal, in supporting individuals with mental disorders. However, caregiving, particularly when informal and unpaid, is often accompanied by significant psychological, physical, social, and economic burdens.^[4] Caregivers play an indispensable role in the management of mental disorders, bridging the gap between professional healthcare services and patients' day-to-day needs. The role of caregivers extends beyond providing physical assistance to include emotional and psychological support, medication adherence, and crisis intervention, often without formal training.^[5] Caregivers can be classified into two broad categories: Formal caregivers, who are trained professionals providing paid assistance, and informal caregivers, who are typically family members or close acquaintances offering unpaid care.^[6] In Bangladesh, where mental healthcare facilities remain underdeveloped and psychiatric resources are scarce, the responsibility of caregiving disproportionately falls on family members, many of whom lack adequate support.^[7] Consequently, informal caregivers in Bangladesh often experience heightened distress due to the absence of structured support systems, economic instability, and cultural expectations that caregiving is a familial duty rather than a societal responsibility.^[8] The burden of caregiving

is a multidimensional challenge that significantly affects caregivers' physical, emotional, social, and financial well-being. The term caregiver burden refers to the cumulative strain associated with prolonged caregiving, which often results in burnout, depression, anxiety, and social isolation.^[9] Studies have demonstrated that nearly 59.1% of caregivers experience severe burden, with negative consequences for their mental and physical health.^[10] A growing body of evidence suggests that caregivers of individuals with chronic mental disorders face higher levels of psychological distress compared to caregivers of physically ill patients due to the unpredictability and long-term nature of mental illnesses.^[11] The WHO Quality of Life Scale, Brief Version (WHO QOL-BREF) scale has been widely used to assess caregivers' well-being, highlighting strong negative correlations between high caregiving burden and QOL in all measured domains, including physical health, psychological well-being, social relationships, and environmental factors.^[12] Despite the increasing global focus on caregiver burden and QOL, research exploring the specific relationship between daily caregiving hours and QOL in Bangladesh remains scarce. While studies have examined the psychological distress and burden among caregivers in South Asia, most have not quantitatively analyzed how daily caregiving hours impact different QOL domains.^[13] A study in India found that caregivers from low-income backgrounds who provided prolonged care had significantly lower QOL due to financial hardship, emotional stress, and lack of social support.^[14] Another study found that caregivers providing more than 12 h of care daily were at heightened risk of burnout and depression, highlighting the urgent need to assess caregiving hours as a critical factor affecting QOL.^[15] However, these studies are not specific to mental health caregiving, and there remains a critical research gap regarding the direct impact of daily caregiving hours on caregiver QOL in Bangladesh's mental healthcare landscape.^[16] The rationale for this study is reinforced by changing family structures, increasing life expectancy, and the rising prevalence of mental health disorders in Bangladesh. Conventionally,

extended family networks played a crucial role in caregiving, but due to urbanization and migration, caregiving responsibilities are now concentrated on fewer individuals, often with limited resources and support.^[17] Studies indicate that intensive caregiving responsibilities significantly reduce social participation, increase emotional distress, and exacerbate financial strain.^[18] Given Bangladesh's lack of structured caregiver assistance programs, respite care, and financial incentives for family caregivers, it is critical to evaluate how caregiving hours influence QOL to inform policy interventions and support mechanisms.^[19] The significance of this study extends beyond academic inquiry, offering practical implications for policymakers, healthcare providers, and caregivers themselves. Previous studies indicate that providing structured caregiver support, such as financial aid, mental health counseling, and respite care, significantly reduces caregiver burden and enhances QOL.^[20] By quantifying the relationship between caregiving hours and QOL, this research can provide evidence-based recommendations for healthcare reforms, mental health policies, and social welfare programs in Bangladesh.^[10] Furthermore, understanding how caregiving intensity impacts caregivers' well-being can lead to the development of culturally appropriate interventions that acknowledge the socioeconomic realities of caregiving in Bangladesh.^[21] Thus, this study aims to examine the relationship between daily caregiving hours and QOL among caregivers of patients with mental disorders in Bangladesh. By addressing a significant research gap and contributing to the growing body of evidence on caregiver well-being, this study can inform policy-driven solutions that improve mental healthcare systems while reducing caregiver distress. Given the rising burden of mental illness and shifting caregiving dynamics in Bangladesh, this research is both timely and essential for enhancing caregiver support mechanisms, mental health policies, and overall healthcare infrastructure in the country.

Methods

This cross-sectional comparative study was conducted at the outpatient and inpatient

departments of Psychiatry at Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka, from October 2019 to September 2021. The study included 50 caregivers of patients with mental disorders and a control group composed of hospital staff, including resident physicians, nurses, and medical personnel, who had no personal or familial history of mental illness. Caregivers were selected based on the DSM-5 criteria for their family member's mental illness, and if multiple caregivers were available, the most actively involved caregiver was chosen. Participants were 18–65 years old, resided in a household with only one mentally ill family member, and had been providing continuous care for at least 6 months. Caregivers needed to be involved in daily supervision, emotional and financial support, medical management, and personal care. Those with physical illness or cognitive impairment preventing participation were excluded. Data collection was conducted through face-to-face interviews using a structured sociodemographic questionnaire that included age, sex, education, occupation, marital status, residence, family type, and income. The WHOQOL-BREF was used to assess QOL.^[22] This validated tool, derived from the WHOQOL-100, measures four domains: Physical Health, Psychological Health, Social Relationships, and Environment. The WHOQOL-BREF has been validated for use in Bangladesh and was translated into Bengali using a standardized process to ensure linguistic and conceptual accuracy. Ethical approval was obtained from the Institutional Review Board of BSMMU, and all participants provided written informed consent before participation. Data were analyzed using IBM Statistical Package for the Social Sciences version 25. Descriptive statistics, including frequency, percentages, mean, and standard deviation, were used to summarize demographic and clinical characteristics. To compare WHOQOL-BREF domain scores between caregivers and controls, independent sample *t*-tests were conducted, with additional subgroup analyses assessing differences by sex, residence, and family structure. One-way analysis of variance was used to examine categorical variables, including marital status, occupation, and education, while

Pearson's correlation coefficient was used to assess relationships between WHOQOL-BREF scores and age, income, illness duration, hospitalization frequency, and caregiving hours. A $P < 0.05$ was considered statistically significant.

Results

The baseline characteristics of the 50 caregivers in the study revealed that the mean age was 43.50 ± 13.63 years, with the majority (30%) falling within the 46–55 age group, followed by 26% in the 36–45 age group. A significant proportion of the caregivers were female (74%), while 26% were male. More than half of the caregivers (56%) resided in urban areas, whereas 44% were from rural backgrounds. Regarding educational status, the highest proportion had completed secondary education (28%), followed by HSC (22%) and primary education (20%), while only 2% were postgraduates and 2% were illiterate. The majority of caregivers were married (78%), while 10% were unmarried and 12% fell into other categories (widowed, divorced, or separated). In terms of occupation, the most common category was housewives (62%), followed by service holders (12%) and students (8%), while farmers, businessmen, and retired individuals each accounted for a smaller percentage of the sample. No participants were unemployed [Table 1].

The characteristics of the 50 patients receiving care showed that the mean age was 30.44 ± 12.85 years, with the majority (40%) aged 18–25 years, followed by 30% aged 26–35 years. A larger proportion of the patients were male (58%), while 42% were female. Among the diagnostic distribution, schizophrenia (30%) and Bipolar I Disorder (28%) were the most prevalent conditions, followed by Major Depressive Disorder (12%), while other diagnoses such as Obsessive-Compulsive Disorder (6%), Generalized Anxiety Disorder (4%), and Borderline Personality Disorder (6%) were less common. A dual diagnosis was present in 8% of patients, indicating comorbid psychiatric

conditions. Regarding illness duration, 52% of the patients had been ill for 1–5 years, while 20% had been diagnosed for 6–10 years, and only 4% had an illness duration exceeding 20 years. In terms of hospital admissions, the majority (64%) had been hospitalized 1–3 times, while 18% had never been admitted. The primary caregivers were predominantly parents (64%), followed by spouses (18%), children (10%), and siblings (8%). Social support for caregivers was notably low, with 80% reporting no external support, further emphasizing the burden on families [Table 2].

The distribution of daily caregiving hours among the participants revealed significant variations. The largest proportion of caregivers (42%) provided 18–24 h of daily care, indicating full-time caregiving responsibilities. This was followed by 36% of caregivers who spent <6 h/day providing care, likely suggesting shared caregiving responsibilities or less intensive care needs. 18% of caregivers reported 6–11 h of daily caregiving, while only 4% provided 12–17 h of care per day, making it the least common caregiving duration [Figure 1].

The mean scores of WHOQOL-BREF domains among caregivers revealed notable insights into their overall QOL, physical health, psychological well-being, social relationships, and environmental factors. The overall QoL score was 2.44 ± 0.84 , indicating a moderately low perception of life quality, while the overall health score of 2.80 ± 0.99 suggested a somewhat better but still compromised health status. In the physical health domain, caregivers reported moderate levels of pain and discomfort (2.98 ± 1.04), dependence on medicinal substances (2.98 ± 1.04), and energy levels (2.88 ± 1.00). Mobility (2.82 ± 0.59) and work capacity (2.72 ± 0.86) were also moderately rated, but sleep and rest scored the lowest (2.36 ± 0.94), indicating potential sleep disturbances and fatigue due to caregiving responsibilities. In the psychological domain, positive feelings (2.60 ± 0.78) and self-esteem (2.84 ± 0.93)

remained moderate, while negative feelings scored the highest at 3.72 ± 0.95 , suggesting high emotional distress and mental burden. Caregivers reported moderate cognitive abilities (thinking, learning, memory, concentration: 2.72 ± 0.78) and spiritual beliefs (2.56 ± 0.79), but their overall psychological well-being was strained. The social relationships domain showed moderate personal relationships (3.12 ± 0.80) and sexual activity (2.72 ± 1.05), but extremely low social support (1.92 ± 1.03), highlighting isolation and lack of external assistance for caregivers. The environmental domain reflected moderate satisfaction with physical safety (2.92 ± 0.78), home environment (2.88 ± 0.85), and accessibility to healthcare (2.90 ± 0.86). However, caregivers faced notable financial constraints (2.02 ± 0.98) and limited opportunities for acquiring new skills (2.42 ± 0.91) and recreation (2.00 ± 0.76) [Table 3].

The overall mean scores of WHOQOL-BREF domains among caregivers indicated a moderate to low QOL across all dimensions. The physical health domain had the highest mean score (11.21 ± 2.58), suggesting that while caregivers experienced some degree of physical strain, their health was relatively better compared to other domains. The psychological domain scored 10.57 ± 2.38 , reflecting emotional distress, negative feelings, and potential mental health challenges associated with caregiving responsibilities. The social relationships domain had the lowest mean score (10.35 ± 3.00), indicating limited social interactions, lack of support, and possibly strained personal relationships due to caregiving demands. The environmental domain scored 10.46 ± 2.04 , showing moderate challenges related to financial constraints, limited recreational opportunities, and accessibility to healthcare and social services [Table 4].

The mean WHOQOL-BREF scores across different daily caregiving hour groups revealed variations in physical health, psychological well-being, social relationships, and environmental factors, though none of the differences reached statistical

significance ($P > 0.05$ for all domains). Caregivers providing 6–11 h of care per day reported the highest physical health scores (12.06 ± 3.17), while those with 18–24 h of caregiving had the lowest (10.94 ± 2.63), suggesting that longer caregiving hours may contribute to greater physical strain and fatigue. The psychological domain scores remained relatively stable across groups, ranging from 10.41 ± 2.55 (<6 h) to 11.33 ± 0.94 (12–17 h), indicating that caregivers experience similar emotional and mental burdens, regardless of caregiving duration ($P = 0.931$). In the social relationships domain, caregivers providing 18–24 h of care reported the highest score (10.67 ± 3.24), while those in the 6–11 and 12–17 h groups had the lowest scores (9.33 ± 3.71 and 9.33 ± 3.77 , respectively). This suggests that moderate caregiving durations may be associated with greater social isolation, possibly due to time constraints and stress. However, the differences were not statistically significant ($P = 0.67$). For the environmental domain, caregivers with 6–11 h of caregiving had the highest scores (10.89 ± 2.59), while those providing 18–24 h of care reported the lowest (10.21 ± 2.09), suggesting that higher caregiving hours may be linked to poorer environmental QOL, potentially due to financial constraints and limited opportunities for recreation ($P = 0.848$) [Table 5].

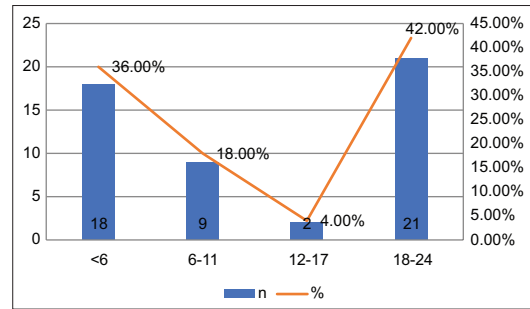
Discussion

The present study examined the relationship between daily caregiving hours and the QOL of caregivers for patients with mental disorders. Findings revealed that caregiving hours alone did not significantly impact QOL across WHOQOL-BREF domains, suggesting that other factors, such as social support, financial stability, and external stressors, may play a more prominent role. This aligns with previous research, which found that caregiving burden and social factors, rather than hours spent caregiving, were stronger predictors of caregiver QOL.^[23,24] Despite variations in physical, psychological, social, and environmental QOL scores among caregivers with different caregiving durations, none of these

Table 1: Baseline characteristics distribution of the caregivers ($n=50$)

Variable	Caregiver ($n=50$)	
	<i>n</i>	%
Age (in years)		
18–25	8	16.00
26–35	6	12.00
36–45	13	26.00
46–55	15	30.00
56–65	8	16.00
Mean±SD	43.50±13.63	
Sex		
Male	13	26.00
Female	37	74.00
Habitat		
Urban	28	56.00
Rural	22	44.00
Education		
Illiterate	1	2.00
Primary	10	20.00
Secondary	14	28.00
SSC	8	16.00
HSC	11	22.00
Graduate	5	10.00
Postgraduate	1	2.00
Marital status		
Married	39	78.00
Unmarried	5	10.00
Others	6	12.00
Occupation		
Student	4	8.00
Businessman	3	6.00
Housewife	31	62.00
Service holder	6	12.00
Retired	3	6.00
Unemployed	0	0.00
Farmer	1	2.00
Others	2	4.00

differences reached statistical significance ($P > 0.05$), reinforcing the argument that caregiving burden is multifaceted and cannot be solely

**Figure 1:** Distribution of daily caregiving hours among the participants

attributed to the time spent providing care. The physical health domain of caregivers in this study was found to be lowest among those providing full-time care (18–24 h/day), yet the difference across caregiving durations was not statistically significant ($P = 0.725$). This is consistent with findings from Quesada *et al.*, who reported that caregivers providing extensive daily care did experience lower physical health scores, but caregiving hours alone were not predictive of physical health deterioration.^[25] Similarly, other studies noted that while caregivers reported fatigue and somatic complaints, external stressors such as financial strain and access to healthcare had a more substantial impact on physical health than caregiving hours.^[26] The lack of a statistically significant difference suggests that caregivers experience chronic strain regardless of their caregiving duration and that targeted interventions beyond reducing caregiving hours are needed to improve their physical well-being. Psychological well-being remained relatively unchanged across caregiving durations in this study ($P = 0.931$), indicating that emotional distress is a universal burden among caregivers. This aligns with previous studies showing that caregiving stress is more dependent on external factors, such as financial burden and social support, rather than hours of care provided.^[27] Ribé *et al.* similarly found that depression and anxiety in caregivers were not directly related to caregiving duration but rather to caregiving burden and lack of professional support.^[23] Given the high level of negative feelings reported in the current study (3.72 ± 0.95), it is

Table 2: Distribution of characteristics of the patients receiving care ($n=50$)

Characteristics of patients receiving care	<i>n</i>	Percentage
Age of the patient (in years)		
<18	4	8.00
18–25	20	40.00
26–35	15	30.00
36–45	3	6.00
46–55	4	8.00
56–65	4	8.00
Mean±SD	30.44±12.85	
Sex of the patient		
Male	29	58.00
Female	21	42.00
Diagnosis of the patient*		
Intellectual disability	1	2.00
Schizophreniform disorder	1	2.00
Schizophrenia	15	30.00
Bipolar I disorder	14	28.00
Substance-induced bipolar and related disorder	1	2.00
Major depressive disorder	6	12.00
Panic disorder	1	2.00
Agoraphobia	1	2.00
Generalized anxiety disorder	2	4.00
Obsessive-compulsive disorder	3	6.00
Conversion disorder	3	6.00
Somatic symptom disorder	1	2.00
Conduct disorder	2	4.00
Borderline personality disorder	3	6.00
Dual diagnosis	4	8.00
Total duration of illness (in years)		
<1	4	8.00
1–5	26	52.00
6–10	10	20.00
11–15	4	8.00
16–20	4	8.00
>20	2	4.00
Number of hospital admission		
1–3	32	64.00
4–6	8	16.00

(Contd...)

Table 2: (Continued)

Characteristics of patients receiving care	<i>n</i>	Percentage
7–10	1	2.00
No hospitalization	9	18.00
Relationship with the patient		
Parents	32	64.00
Child	5	10.00
Siblings	4	8.00
Spouse	9	18.00
Support from society		
Yes	10	20.00
No	40	80.00

SD: Standard deviation

evident that mental health interventions, emotional support services, and stress management strategies are crucial for caregivers, regardless of caregiving duration. One of the most striking findings in this study was the low social support available to caregivers, with 80% reporting no external assistance. Social relationship scores were lowest among caregivers providing 6–11 h of care, while those providing 18–24 h had slightly higher scores, though this difference was not statistically significant ($P = 0.67$). This is consistent with Amorim *et al.*, who found that caregivers providing moderate hours of care (6–12 h/day) were at the highest risk of social isolation.^[28] In contrast, caregivers providing extreme caregiving hours (either minimal or full-time care) were more likely to have some level of social engagement, possibly due to increased involvement from extended family or healthcare providers. In addition, Anjos *et al.* emphasized that social support, rather than caregiving hours, was the most critical predictor of QOL in caregivers, further reinforcing the need for structured community and institutional support systems.^[29] The environmental QOL domain was also negatively affected among caregivers providing full-time care, yet, similar to other domains, this difference did not reach statistical significance ($P = 0.848$). Caregivers with heavier caregiving responsibilities reported greater financial strain and reduced access to leisure activities, findings that are in line with

Table 3: Mean±SD of item scores of WHOQOL-BREF domains by respondents

Characteristics	Caregivers (n=50)
	Mean±SD
Overall QOL	2.44±0.84
Overall health	2.80±0.99
Domain 1: Physical health	
Pain and discomfort	2.98±1.04
Dependence on medicinal substances and medical aids	2.98±1.04
Energy and fatigue	2.88±1.00
Mobility	2.82±0.59
Sleep and rest	2.36±0.94
Activities of daily living	2.88±0.82
Work capacity	2.72±0.86
Domain 2: Psychological	
Positive feelings	2.60±0.78
Spirituality/Religion/Personal beliefs	2.56±0.79
Thinking, learning, memory, and concentration	2.72±0.78
Bodily image and appearance	2.86±0.97
Self-esteem	2.84±0.93
Negative feelings	3.72±0.95
Domain 3: Social relationship	
Personal relationships	3.12±0.80
Sexual activity	2.72±1.05
Social support	1.92±1.03
Domain 4: Environment	
Freedom, physical safety, and security	2.92±0.78
Physical environment (pollution/noise/traffic/climate)	3.02±0.65
Financial resources	2.02±0.98
Opportunities for acquiring new information and skills	2.42±0.91
Opportunities for recreation/leisure activities	2.00±0.76
Home environment	2.88±0.85
Health and social care: accessibility and quality	2.90±0.86
Transport	2.76±0.80

SD: Standard deviation, QOL: Quality of life, WHOQOL-BREF: World Health Organization quality of life scale, brief version

Table 4: Overall mean±SD scores of WHOQOL-BREF domains by respondents

Domains	Caregivers (n=50)
	Mean±SD
Physical health	11.21±2.58
Psychological	10.57±2.38
Social relationship	10.35±3.00
Environment	10.46±2.04

SD: Standard deviation, WHOQOL-BREF: World Health Organization quality of life scale, brief version

Araújo *et al.*, who highlighted the financial burden as a primary determinant of caregiver distress.^[30] This suggests that caregiving hours alone do not dictate environmental well-being; rather, economic hardship and employment restrictions may contribute more significantly to caregivers' reduced QOL. In addition, Magalhães *et al.* reported that caregivers with lower financial stability had the most difficulty balancing their caregiving roles with their personal and occupational responsibilities.^[31] Given that the majority of caregivers in this study were housewives (62%) with limited independent income, this financial burden may be a major factor impacting their overall well-being. The lack of statistical significance in all caregiving hour comparisons suggests that the QOL of caregivers is shaped by a combination of psychological, social, and financial stressors rather than caregiving duration alone. Studies have repeatedly emphasized that social support, economic resources, and coping mechanisms play a more prominent role in caregiver well-being than the number of hours spent providing care.^[23-25] Given the findings of the present study, policy interventions should prioritize financial aid, mental health support, and structured caregiving networks over simply reducing caregiving hours. In conclusion, this study highlights that caregiving burden is a complex phenomenon that extends beyond caregiving duration. While full-time caregivers experienced slightly lower QOL scores across most domains, the differences were not statistically significant, suggesting that other external factors play a crucial role. The lack of social support, financial difficulties, and emotional distress remain key areas

Table 5: Mean±SD scores of WHOQOL-BREF scale domains in the caregivers by daily caregiving hours

Daily caregiving hours	Physical health	Psychological	Social relationship	Environment
<6	11.05±2.38	10.41±2.55	10.59±2.35	10.47±1.85
6–11	12.06±3.17	10.89±2.38	9.33±3.71	10.89±2.59
12–17	11.71±0.40	11.33±0.94	9.33±3.77	11.00±0.71
18–24	10.94±2.63	10.51±2.43	10.67±3.24	10.21±2.09
P-value	0.725	0.931	0.67	0.848

WHOQOL-BREF: World Health Organization quality of life scale, brief version

that need intervention, irrespective of caregiving hours. Future research should explore longitudinal effects of caregiving burden, interventions for reducing emotional stress, and strategies for improving caregivers' financial and social well-being. A holistic approach addressing both caregiving-related and external socioeconomic challenges is essential for improving caregiver QOL and preventing long-term health deterioration.

Limitations of the study

The study was conducted in a single hospital with a small sample size. Hence, the results may not represent the whole community.

Conclusion

The findings of this study emphasize that caregiving burden extends beyond the duration of daily caregiving hours and is influenced by multiple psychosocial, financial, and emotional factors. Despite variations in physical, psychological, social, and environmental QOL scores among caregivers with different caregiving durations, none of these differences reached statistical significance ($P > 0.05$). This suggests that factors such as lack of social support, financial constraints, and emotional distress play a more substantial role in determining caregiver well-being than caregiving hours alone. The low social support reported by caregivers (80%), along with the high prevalence of negative feelings and poor financial resources, highlights the urgent need for structured interventions, including mental health support, financial aid, and social assistance programs. Full-time caregivers, who accounted for 42% of

the study population, experienced lower physical health and environmental QOL scores, reinforcing the need for holistic caregiver support systems. Given that psychological well-being remained low across all caregivers, regardless of caregiving hours, targeted mental health interventions and community-based support programs should be prioritized.

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Conflicts of Interest

None declared.

Ethical Approval

The study was approved by the Institutional Ethics Committee.

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