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Research Paper

Understanding Caregiver Well-Being: Role of Age, Gender, and Caregiving Duration

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ABSTRACT

The provision of care for individuals diagnosed with alcohol use disorder (AUD) imposes considerable emotional, physical, and psychological burdens on caregivers, consequently impacting their quality of life (QoL). This study aims to investigate the correlation between non-modifiable factors, such as the age and gender of caregivers, as well as the duration of caregiving, and the QoL of caregivers of individuals with AUD. For this purpose, data were gathered from 128 caregivers of AUD patients in two psychiatric hospitals located in the Amritsar district of the Punjab province. A demographic questionnaire was employed to collect the data, and a chi-square analysis was utilized for data analysis. The study findings did not show any significant connection between the age and gender of caregivers and the duration of caregiving with their QoL. The results have been discussed within the framework of existing research.

Keywords: *Alcohol use disorder, Quality of life, Caregiving, Non-modifiable factors, Duration of caregiving*

Caregiving has been defined as "the process of helping another person who is unable to do for themselves in a holistic (physically, mentally, emotionally and socially) manner" (Hermanns & Mastel-Smith, 2012). According to Family Caregiver Alliance (2015), "a caregiver is anyone who provides assistance to someone else who is, in some degree, incapacitated and needs help". Providing care for individuals with persistent mental health conditions, exemplified during the deinstitutionalization era for schizophrenia (Leff et al., 1990), bears similarities to caring for those with alcohol use disorder.

Globally, research on caregivers has mainly focused on those caring for the elderly with dementia or chronic physical illnesses. More recently, there has been some attention given to caregivers of individuals with schizophrenia (Allen et al., 2019; Rao et al., 2020). However, there is a noticeable lack of studies involving caregivers of individuals with alcohol use disorder (AUD) and other psychiatric conditions (Caqueo-Urízar et al., 2014). AUD is "a medical condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences" (NIAAA, 2020). The enduring

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changes in the brain due to alcohol misuse contribute to the persistence of AUD and make individuals prone to relapse.

Additionally, caregivers often report depressive symptoms, poor sleep quality, and a decrease in overall wellbeing (Feeley et al., 2014) and an association has been found with higher financial costs and burden among caregivers (Brinda et al., 2014). The prevalence of caregiver burden is notably high, with study by Kadam et al. (2020) revealing a 95% prevalence rate among caregivers of AUD patients. Vaishnavi et al. (2017) identified a positive correlation between the severity of alcohol dependence and the substantial burden experienced by caregivers. Their conclusion emphasizes the necessity of alleviating caregiver burden during the treatment of individuals with AUD to enhance treatment effectiveness. Swaroopachary et al. (2018) concluded that alcohol problems in a partner pose various health risks for women that extend beyond the well-documented association with domestic violence. In a meta-analytic study, Marshal (2003) found that alcohol abuse is linked to marital discord, communication breakdowns, and elevated levels of marital violence.

Kiran and Senthil (2016) have found that caregivers of individuals with AUD often experience high levels of stress and reduced well-being. Symptoms of depression, poor sleep quality, and an overall decline in well-being are also commonly reported (Feeley et al., 2014). Additionally, caregivers also face increased financial burdens (Brinda et al., 2014). Research by Kadam et al. (2020) revealed a high prevalence rate of 95% for caregiver burden among those caring for individuals with AUD. Vaishnavi et al. (2017) identified a positive correlation between the severity of alcohol dependence and the significant burden experienced by caregivers. It is crucial to address caregiver burden in the treatment of individuals with AUD to improve the effectiveness of the treatment. Swaroopachary et al. (2018) concluded that alcohol problems in a partner pose various health risks for women, extending beyond the well-documented association with domestic violence. Marshal (2003) found that alcohol abuse is associated with marital discord, breakdowns in communication, and higher levels of marital violence in a meta-analytic study.

Quality of Life (QoL) is a multidimensional concept that relates to a person’s overall well-being (Davis et al., 2010). According to the World Health Organization, QoL is defined as “individuals' perceptions of their position in life within their culture and value systems, in relation to their goals, expectations, standards, and concerns” (World Health Organization, 2012). This broad term encompasses a person's physical and mental well-being, psychological and social well-being, achievement of personal objectives and goals, financial security, and the ability to carry out everyday activities regularly. While historically focused on patients, QoL studies are now also considering caregivers, recognizing their crucial role in comprehensive treatment plans and highlighting their QoL as an important variable of interest (Caqueo-Urízar et al., 2009).

Zendjidjian et al. (2012) discovered that caregivers of individuals with psychological illnesses undergo a notable impairment in their QoL, primarily attributed to changes in psychological well-being and social life. Aggarwal et al. (2011) noted that increased objective burden, coupled with disturbances in family leisure and interaction due to mental health conditions, led to significantly diminished quality of life across all domains for caregivers. According to Casswell et al. (2011) QoL of caregivers is often lower than QoL of the general population and in certain instances may even be lower than QoL of the patients they are caring for.

In a study by Zendjidjian et al. (2012), it was found that caregivers of individuals with psychological illnesses experience a significant decline in their QoL. This decline is mainly due to changes in psychological well-being and social life. Another study by Aggarwal et al. (2011) observed that the increased objective burden, along with disruptions in family leisure and interaction because of mental health conditions, resulted in a notable decrease in the quality of life across all aspects for caregivers. According to Casswell et al. (2011), the QoL of caregivers is often lower than that of the general population and, in some cases, it may even be lower than the QoL of the patients they are caring for.

The existing body of caregiving research has predominantly directed attention towards modifiable determinants such as social support, family functioning, appraisal of caregiving, and coping strategies. However, certain non-modifiable individual-level elements also hold significance in influencing the overall wellbeing of caregivers. Among these, age and gender have been the subject of extensive scrutiny. According to studies conducted by Keir et al. (2009) and Yamamoto-Mitani et al. (2003), older caregivers typically manifest a more favorable perception of caregiving and exhibit superior levels of wellbeing. Although an investigation by DiBartolo and Soeken (2003) did not reveal an independent impact of caregivers' age, amalgamated demographic factors, inclusive of age, have been identified as determinants of caregivers' wellbeing (Wang et al., 2020).

The existing literature does not present a unanimous consensus regarding the impact of gender on the well-being of caregivers. Research conducted by DiBartolo & Soeken (2003) and Keir et al. (2009) has revealed positive correlations between male gender and well-being in caregiving scenarios. Conversely, studies by Imaiso (2015) and Liu & Huang (2018) have reported negative associations between male gender and well-being in similar contexts. Furthermore, Harwood et al. (2000) have identified a negative correlation between female gender and negative well-being. Thus, it is evident that gender, encompassing socially constructed roles, may influence caregivers' attitudes and behaviors (Wang et al., 2020).

There are varying findings regarding the relationship between the duration of caregiving and caregivers' wellbeing. Two studies (Lee et al., 2010; Yamamoto-Mitani et al., 2003) have shown that longer caregiving durations are associated with better caregiver wellbeing. On the other hand, DiBartolo and Soeken (2003) found that while factors like caregiving duration, demographic, and antecedent variables collectively predicted caregiver wellbeing, there was no significant independent relationship between caregiving duration and caregivers’ wellbeing.

In summary, it is not completely clear how non-modifiable factors such as caregivers' age, gender, and the duration of caregiving correlate with their appraisal of caregiving. Some studies show that older caregivers and male caregivers tend to have more positive caregiving appraisals and better wellbeing, while others suggest the opposite or find no significant relationship. Moreover, the impact of caregiving duration on wellbeing seems to differ across cultural contexts. Therefore, further research is necessary to gain a better understanding of these relationships and their implications for caregiving.

Objective of the study

To understand the relationship of QoL with the age and gender of the caregivers and the duration of caregiving.

Hypotheses

- The age of the caregivers will not have a significant relationship with the QoL of caregivers of AUD patients.
- The gender of the caregivers will not have a significant relationship with the QoL of caregivers of AUD patients.
- The duration of caregiving will not have a significant relationship with the QoL of caregivers of AUD patients.

METHODOLOGY

Sample

The cross-sectional study was conducted in two psychiatric hospitals in Amritsar city, located in the Punjab province in North India. Informed written consent was obtained from participants recruited from both inpatient and outpatient services between August 2022 and January 2023. The sample consisted of 128 caregivers, including 18 males and 110 females, with an average age of 43.05 years. Purposive sampling technique was used to collect the data, and consenting caregivers underwent initial assessments based on pre-established inclusion and exclusion criteria.

Inclusion and Exclusion Criteria

The study included caregivers who were 18 years or older and had been caring for a male patient diagnosed with AUD according to ICD-11 for at least one year. Caregivers who were caring for patients diagnosed with multiple substance dependence other than nicotine or any other comorbid psychiatric conditions or chronic physical ailments were not included. Additionally, caregivers who themselves had psychiatric conditions or chronic physical ailments, or were caring for another family member diagnosed with psychiatric conditions or chronic physical ailments, were not included in the study.

Instrument

Demographic modifiers: Demographic characteristics of the respondents were evaluated using categorical variables such as age, gender, and duration of caregiving. Age was grouped into three categories: 18-35 years (Early Adulthood), 36-55 years (Middle Adulthood), and 56-80 years (Late Adulthood) based on Erikson's stages of psychosocial development (Gross, 2020). The duration of caregiving was classified into three groups: 1-2 years, 2-5 years, and more than 5 years.

Procedure

First, efforts were made to build a good relationship with the participants by fully informing them about the study's purpose, procedures, and their roles in the data collection process. Written consent was obtained from participants who met the inclusion and exclusion criteria, and they were assured of confidentiality. Participants were also informed that they were free to leave the study at any time without facing any consequences. Following this, data was collected from the participants using a demographic questionnaire. The collected data was then analyzed using chi-square analysis with SPSS 21.

RESULTS

The association between caregivers' reported QoL and their age, gender, and duration for which they were providing the caregiving was examined using chi-square analysis. Table 1 summarizes the distribution of high and low levels of QoL among three different age groups of caregivers within a total sample size of 128.

The analysis shows that caregivers with high QoL were distributed as follows: 18 in the early adulthood group, 39 in the middle adulthood group, and 8 in the late adulthood group. Similarly, caregivers with low QoL were distributed as follows: 18 in the early adulthood group, 30 in the middle adulthood group, and 15 in the late adulthood group.

The results of the chi-square test indicated that the connection between QoL and age groups among caregivers was not statistically significant ($\chi^2 = 3.274$, df = 2, p = 0.195). This suggests that there is no notable difference in the distribution of QoL levels across various age groups of caregivers. Rodríguez-Sánchez et al. (2011) similarly had reported a lack of significant correlation between the QoL and the ages of caregivers.

Table 1: Showing results of Chi-Square Analysis of the Relationship Between Quality of Life (QoL) and Age of Caregivers

QoL	**Age (in years)**			**Total**
	18-35 (Early Adulthood)	**36-55 (Middle Adulthood)**	**56-80 (Late Adulthood)**	
High QoL	18	39	8	65
Low QoL	18	30	15	63
Total	36	69	23	128

$\chi^2 = 3.274$, df = 2, p=.195

Moving forward, Table 2 presents a summary of the distribution of high and low levels of QoL among male and female caregivers in a total sample size of 128. In Table 2, it can be observed that among male caregivers, high QoL was reported by 11 participants and low QoL was reported by 7 participants out of a total of 18 male participants. As for female caregivers, 54 out of 110 reported high QoL, and 56 reported low QoL.

Table 2: Showing results of Chi-Square Analysis of the Relationship Between Quality of Life (QoL) and Gender of the Caregiver

QoL	**Gender**		**Total**
	Male	**Female**	
High QoL	11	54	65
Low QoL	7	56	63
Total	18	110	128

$\chi^2 = .894$, df = 1, p=.344

The chi-square test statistic calculated for this analysis was $\chi^2 = 0.894$ (p = 0.344) indicating that there is no statistically significant association between QoL and the gender of the caregivers in this study. The findings of the current study differ from those reported in previous research (Rico-Blázquez et al., 2022; Zwar et al., 2023), which identified lower QoL among female caregivers compared to male caregivers.

Likewise, Table 3 summarizes the distribution of high and low levels of QoL among three different categories of caregivers, classified as low, medium, and high based on the duration of caregiving within a total sample size of 128. Out of 128 caregivers surveyed, 65 reported having high QoL while 63 reported having low quality of life. When categorized by the duration of caregiving, caregivers reported their QoL scores as follows: 25 out of the caregivers with low duration reported high QoL, and 29 reported low QoL. For caregivers with medium duration, 19 reported high QoL and 15 reported low QoL. Among caregivers with high duration, 21 reported high QoL and 19 reported low QoL.

Table 3: Showing results of Chi-Square Analysis of the Relationship Between Quality of Life (QoL) and Duration of Caregiving

QoL	**Duration**			**Total**
	Low	**Medium**	**High**	
High QoL	25	19	21	65
Low QoL	29	15	19	63
Total	54	34	40	128

χ^2 = .836, df = 2, p=.658

The chi-square test statistic was calculated as $\chi^2 = 0.836$ ($p = 0.658$), indicating that there is no statistically significant association between QoL and duration of caregiving in this study. The findings from the current study are consistent with those of DiBartolo & Soeken (2003) and Kate et al. (2013).

DISCUSSION

The purpose of this study was to explore the relationship between the QoL of caregivers of individuals with AUD and their age, gender, and duration of caregiving. The study used chi-square analysis to examine these relationships. The findings from the chi-square analysis indicated that there is no significant relationship between the age and gender of caregivers, as well as the duration of caregiving, and the QoL of the caregivers in this specific sample. Overall, based on the chi-square analysis results presented in Tables 1, 2, and 3, hypotheses 1, 2, and 3 are supported. The results obtained require potential explanatory mechanisms.

For this study, the lack of a significant relationship between the QoL and the age of caregivers may be due to the fact that the stress and demands of caring for individuals with AUD can impact caregivers in similar ways across different age groups. The responsibilities of caregiving, including managing the erratic behaviors of the patient, addressing the stigma associated with AUD, and navigating the recovery process, can be equally challenging regardless of the caregiver's age.

The results of the present study deviated from those of the studies in the literature. This discrepancy in obtained results in the present study may be partly due to the smaller sample size of male caregivers (n=18). Both overly small and excessively large sample sizes have limitations that can impact the validity of study conclusions. A small sample size may limit the generalizability of findings, while an excessively large sample size can potentially magnify statistical differences that lack clinical significance (Faber & Fonseca, 2014). Further research with appropriately sized samples is recommended to comprehensively investigate gender differences in QoL within the context of caregiving for individuals with AUD.

Additionally, the duration of caregiving was found to have an insignificant association with the caregivers' QoL. As time passes and the illness and treatment duration increase, it is possible that the illness stabilizes, and caregivers may develop more effective coping mechanisms to manage the associated stress (Kate et al., 2013). Furthermore, the lack of correlation may also reflect the diverse nature of caregiving experiences and the individual variability in caregivers' responses to the demands and rewards of caregiving. This result suggests that factors other than the length of time spent in caregiving roles may play a more significant role in determining caregiver QoL (Wang et al., 2020).

The results of three chi-square analyses indicate that demographic variables such as the age and gender of caregivers, as well as the duration of caregiving, do not have a significant correlation with the QoL of caregivers in this study. This suggests that other factors may play a more crucial role in determining caregivers' QoL in specific situations of AUD caregiving. The implications of this study on the QoL of caregivers of individuals with AUD are multifaceted and significant. Clinically, the findings suggest that support programs for caregivers should be tailored to individual needs rather than based solely on demographic factors such as age, gender, or duration of caregiving. This approach underscores the importance of holistic care models that integrate caregiver well-being into the treatment plans for AUD patients.

In summary, this study highlights the intricacy of factors influencing the QoL of caregivers of individuals with AUD. While demographic variables such as age, gender, and duration of caregiving did not exhibit a significant correlation with caregivers' QoL in this study, the findings underscore the necessity for more personalized and comprehensive support strategies. The study also underscores the importance of further research to explore additional factors affecting caregivers' QoL, indicating that future studies could investigate psychological, social, and environmental variables, as well as conduct comparative research across different psychiatric conditions.

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