

Caregiver burden and quality of life of family caregivers of older adults: a cross-sectional correlational study

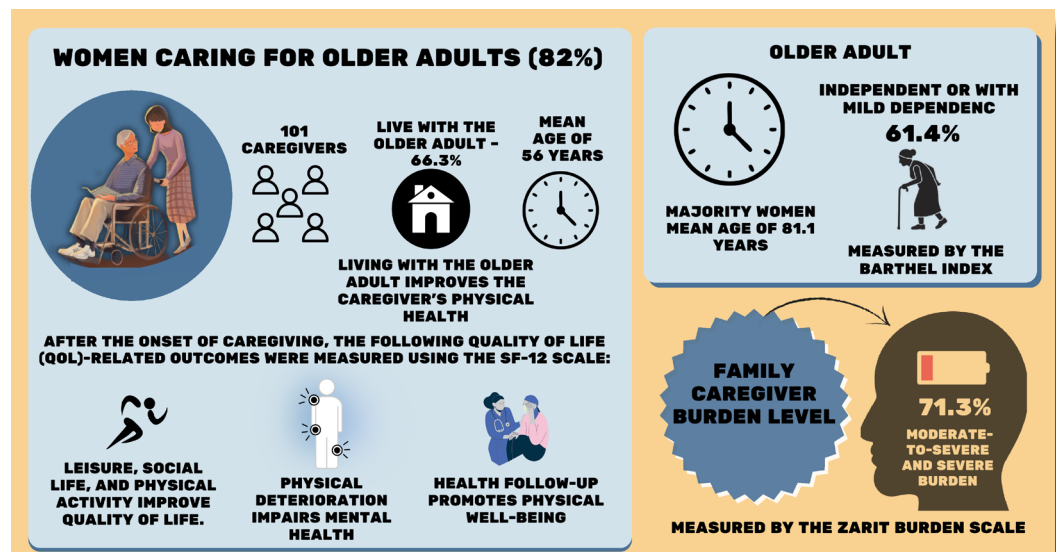
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Graphical Abstract

Highlights

- Predominance of feminization in family caregiving and in the aging of older adults;
- Deterioration in the health of family caregivers, even when caring for functionally independent older adults;
- Low quality of life scores point toward a future of dependency.



Abstract

In a world in which the population is aging, the need for caregivers of older adults arises due to physical and cognitive limitations in performing activities of daily living. In this context, the aims of this study were to describe the degree of independence and functional mobility of older adults, as well as the burden and quality of life of their family caregivers. This was a cross-sectional, descriptive study, conducted from March to December 2024, at a Health Promotion Center, in compliance with the ethical requirements for research involving human subjects (Ethics Opinion No. 6,641,999). Questionnaires were administered to collect sociodemographic characteristics; the Barthel Index was used to assess the degree of functional independence of the older adults; caregiver burden and quality of life were measured using the Zarit Burden Interview and the 12-Item Short-Form Health Survey (SF-12), respectively. A total of 101 family caregivers participated, with a mean age of 56 years; 82.2% were women and 43.5% were daughters. A total of 81.2% reported deterioration in their health status after assuming caregiving responsibilities; 86.1% ceased performing physical, social, and leisure activities; 52.5% presented moderate-to-severe burden and 18.8% presented severe burden. Regarding the older adults, 71.3% were women, with a mean age of 81.1 years; 61.4% were independent or had mild dependency. Women predominantly assume the care of older adults, and when this role is combined with other activities, it results in burden, reduced leisure time, and neglect of personal health. Despite the older adults presenting independence or mild dependency, their caregivers perceived a worsening of their health status after assuming the caregiving role, experienced burden, and showed low quality of life scores – factors that contribute to their becoming dependent older adults in the future. There is an urgent need for the development of health education actions focusing on quality of life and healthy aging of caregivers of older adults.

Keywords: Caregiver Burden. Aged. Quality of Life. Caregivers. Functional Status.

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INTRODUCTION

Aging is a progressive, individual, and heterogeneous process. Individuals aged 65 years or older are considered elderly in developed countries, and those aged 60 years or older in developing countries¹. An increasing number of people are reaching advanced ages; however, with unhealthy lifestyle habits such as physical inactivity, low consumption of fruits and vegetables, smoking, and alcohol use, which become risk factors for the development of chronic diseases and their complications – the leading causes of morbimortality and dependency in functional capacity².

Functional capacity is defined as the ability of the older adult to perform their instrumental and basic activities of daily living – that is, to maintain daily tasks, care for oneself, and preserve autonomy and independence within their living environment³. Dependency arises when this capacity declines, preventing the older adult from carrying out daily tasks without assistance. Frail older adults present a greater number of chronic diseases and a higher risk of dependency in maintaining functional capacity and, as such, may require a caregiver⁴.

Care and caregiving acquire special significance in a progressively aging world. The caregiver of older adults emerges in response to the existence of dependency due to physical and/or cognitive limitations, in order to assist with daily activities, ensure a better quality of life, and maintain social integration. The caregiver may or may not be a family member, and may or may not receive remuneration^{5,6}.

In most cases, it is a family member who voluntarily assumes the care of the older adult, or does so in the absence of another option. Family caregivers are generally close relatives, such as spouses and children – particularly wives and daughters^{5,7}. This scenario of being cared for by a family caregiver can be beneficial to the older adult, since the relationship is more humanized, affectionate, and trust-based, and occurs primarily within the older adult's own home, which favors the preservation of cultural and religious habits and values⁸.

On the other hand, being a caregiver requires time, energy, work, money, patience, effort, affection, and goodwill. The behavioral and emotional changes and cognitive decline that gradually emerge in the older adult demand a great capacity for adaptation in terms of caregiving and cohabitation. Care becomes a daily, solitary, exhausting, and unceasing task – often of long duration – overburdening the caregiver's daily activities^{9,10}.

Burden is defined as the set of consequences arising from the continuous care of an ill individual – in

this case, a dependent older adult – and consists of the family caregiver's personal perception of the consequences of caregiving. It is associated with a deterioration in the caregiver's quality of life and with increased morbidity^{11,12}.

Many caregivers end up experiencing affective and social isolation, worsening of their own health problems, and/or physical, psychological, and/or emotional problems that compromise their quality of life^{9,10}.

The expression health-related quality of life is defined as the value attributed to life, weighted by functional impairments, perceptions, and social conditions induced by disease, health conditions, treatments, and by the political and economic organization of the health care system. There are two main approaches to conceptualizing quality of life, reflected in the assessment instruments used to measure this phenomenon: the first treats it as a generic concept, as seen in the World Health Organization's assessment instrument; the second conceptualization is directly associated with specific groups with health problems¹³.

According to the World Health Organization¹, quality of life began to be incorporated as an important parameter for the assessment of health status from the 1960s onward. It is defined as subjective quality of life – that is, quality of life as perceived by individuals – and what characterizes the concept of quality of life are its dimensions of subjectivity and multidimensionality. Subjectivity refers to the individual's own assessment of their health status, based on self-evaluation. Multidimensionality refers to the fact that this assessment encompasses multiple domains of human nature: physical, psychological, emotional, social, economic, spiritual, and others¹⁴.

The burden related to caring for dependent older adults requires that the family caregiver also receive health care. It is therefore imperative to care for those who care, valuing and dignifying the role of family caregivers¹⁵. It is essential that the multidisciplinary health care team include the caregiver in their care, with the aim of assisting them in coping with the challenges of caregiving, identifying better care strategies, and also attending to the caregiver's own well-being and health – thereby minimizing burden and, consequently, improving quality of life.

In this context, the present study aimed to describe the burden and quality of life of family caregivers of older adults attending a Health Promotion Center, highlighting correlations with the caregivers' own characteristics and those of the older adults they care for.

METHODOLOGY

This was a cross-sectional study with descriptive and correlational analysis examining the burden and quality of life of family caregivers of older adults, as well as identifying associations with their characteristics and those of the older adults. The STROBE checklist was used to report the methodological data¹⁶.

Data collection took place between March and December 2024 at the Centro de Promoção e Reabilitação em Saúde e Integração Social – PROMOVE SÃO CAMILO, located in the southern area of the city of São Paulo, following approval of the research by the Research Ethics Committee under Opinion No. 6,641,999.

All caregivers of older adults seen at the study institution were eligible for inclusion, and caregivers without a family relationship were excluded. Participants were approached in the waiting room prior to or following their appointment time and invited to participate in the research. Those who expressed interest were taken to a private room, where they received information about the study, assurances regarding integrity, data protection, and continuity of care, with no harm in cases of refusal and/or discontinuation of participation. Upon acceptance, participants signed and received a copy of the Informed Consent Form. The convenience sample totaled 101 family caregivers of older adults.

Data were collected using a form developed by the authors for interviews and to obtain independent variables related to the caregiver and the older adult. The functional independence and mobility of the older adult were assessed using the Barthel Index – a globally used instrument to assess the level of functional independence and mobility, administered as an interview. Each task is scored according to the older adult's performance in carrying out activities independently, with some assistance, or in a dependent manner. Scores range from 0 to 100 in five-point intervals, with higher scores indicating greater independence¹⁷. The Zarit Caregiver Burden Scale was used for the family caregiver. The instrument covers questions on health status, psychological well-being, finances, and social life. It contains 22 items, with scores ranging from 0 to 88 points: below 21 points indicates no burden; 21 to 40, mild to

moderate burden; 41 to 60, moderate to severe burden; and 61 to 88, severe burden¹¹. Regarding caregiver quality of life, the 12-Item Short-Form Health Survey (SF-12), translated and validated into Portuguese, was administered¹⁸. The scores of the physical, mental, and total domains of the instrument served as parameters for the analysis of associations between health-related quality of life and the independent variables of this study.

Questionnaire administration was assisted by the researchers, who read the instruments aloud and at a measured pace to the family caregivers of the older adults, who followed along continuously and indicated their chosen response option.

In the correlation analyses between variables, caregiver burden and quality of life – measured by the Zarit Scale and the SF-12 Short-Form, respectively – were considered dependent variables. The independent variables were the caregiver's sociodemographic characteristics: age, sex, relationship to the older adult, educational attainment, occupational status, and family income; health conditions, including presence of illness before and after initiating caregiving, and perceived health status after assuming caregiving responsibilities; and variables related to social, leisure, and physical activities. The independent variables related to the older adult receiving care were: age, sex, religion, and degree of independence as measured by the Barthel Index.

Upon completion of data collection, data were stored in an electronic spreadsheet on a password-protected flash drive for five years. Descriptive statistics were performed for all variables to characterize the overall study sample. Pearson's correlation coefficient and Kendall's tau correlation coefficient were used to analyze the correlations between Zarit Scale scores and the mean scores of the physical, mental, and total SF-12 domains with numerical variables. Wilcoxon-Mann-Whitney, Kruskal-Wallis, and Student's t-tests were used for the association analyses of Zarit Scale scores with categorical variables, with a significance level of 5%.

This study was conducted in compliance with the Guidelines and Regulatory Standards for Research Involving Human Beings set forth in National Health Council Resolution No. 466 of 2012¹⁹.

RESULTS

A total of 101 family caregivers of older adults participated in the study. The mean age of caregivers was 56.0 ± 11.1 years, with a predominance of female

participants (82.2%). The majority lived with the older adult (66.3%) and had a filial relationship (43.6%), as presented in Table 1.



Table 1 - Sociodemographic characterization of family caregivers and older adults participating in the study. São Paulo, 2025.

Variable	Category	n	%
Caregiver age (years)	Mean ± SD	56.0 ± 11.1	—
Caregiver sex	Female	83	82.2
	Male	18	17.8
Lives with older adult	No	34	33.7
	Yes	67	66.3
Relationship to older adult	Spouse	15	14.9
	Son/Daughter	44	43.6
	Other	42	41.6
Caregiver's religion	No	12	11.9
	Yes	89	88.1
Educational attainment	Incomplete primary education (grades 1–5)	3	3.0
	Complete lower secondary education	7	6.9
	Incomplete upper secondary education	12	11.9
	Complete upper secondary education	40	39.6
	Incomplete undergraduate education	2	2.0
	Complete undergraduate education	35	34.7
Occupational status	Postgraduate education	2	2.0
	Active (employed/self-employed)	55	31.7
Family income	Inactive (retired/other)	29	28.7
	1–2 minimum wages	22	21.8
	3–4 minimum wages	30	29.7
	5–6 minimum wages	5	5.0
	7–8 minimum wages	1	1.0
Older adult age (years)	Did not know/did not answer	43	42.6
	Mean ± SD	81.1 ± 9.4	—
Sex of older adults	Female	72	71.3
	Male	29	28.7
Religion of older adults	Yes	89	88.1
	No	12	11.9
Barthel Index	Independent/mild dependency	62	61.4
	Moderate to total dependency	39	38.6

The older adults had a mean age of 81.1 years, with a predominance of female participants (71.3%). According to the Barthel Index, 61.4% presented independence or mild dependency (Table 1).

It was observed that the majority of caregivers did not present illness prior to assuming caregiving responsibilities (69.3%); 80.2% reported deterioration in their health status after assuming care, and a reduction in the maintenance of social and leisure activities. Regarding burden, the moderate-to-severe level predominated (52.5%) (Table 2).

As shown in Table 3, in the correlation analysis between caregiver burden — measured by the Zarit Scale — and numerical variables, a negative correlation

was observed with the Barthel Index ($r = -0.247$; $p = 0.013$) and with family income ($r = -0.240$; $p = 0.024$), indicating lower burden among caregivers of older adults with greater functional independence and among families with higher income. In the comparison of burden scores according to categorical variables, a difference was found between caregivers who developed illness after assuming care (53.38 ± 12.18) and those who did not (44.42 ± 14.65), with greater burden in the former group ($p = 0.001$). Similarly, caregivers who reported deterioration in health status after initiating caregiving presented higher burden scores (50.36 ± 13.49) compared to those who did not perceive any deterioration (41.89 ± 15.84), with a statistically significant difference ($p = 0.022$).

Table 2 - Characterization of health conditions, participation in social activities, and burden level (Zarit Scale) of family caregivers of older adults. São Paulo, 2025.

Variable	Category	n	%
Presence of illness prior to assuming caregiving	No	70	69.3
	Yes	29	28.7
	Did not know	2	2.0
Undergoes health follow-up	No	9	8.9
	Yes	31	30.7
	Did not answer	61	60.4
Developed illness after assuming caregiving	No	53	52.5
	Yes	48	47.5
Perceived deterioration in health after assuming caregiving	No	18	17.8
	Yes	81	80.2
	Did not know	2	2.0
Performed social/leisure activities before caregiving	No	20	19.8
	Yes	81	80.2
Maintains social/leisure activities after assuming caregiving	No	86	85.1
	Yes	15	14.9
Burden level (Zarit Scale)	Absent	2	2.0
	Mild to moderate	27	26.7
	Moderate to severe	53	52.5
	Severe	19	18.8

Table 3 - Correlation of caregiver burden measured by the Zarit Scale according to numerical and categorical variables. São Paulo, 2025.

Variable	r	n	Zarit Mean ± SD	95% CI	p
Caregiver age	r = 0.195	101	—	-0.001 to 0.376	0.051*
Time in caregiving role	r = 0.093	101	—	-0.104 to 0.283	0.354*
Persons financially dependent on income	r = -0.136	63	—	-0.372 to 0.115	0.287*
Older adult age	r = 0.056	101	—	-0.141 to 0.249	0.579*
Barthel Index	r = -0.247	101	—	-0.422 to -0.054	0.013*
Educational attainment	r = -0.040	101	—	-0.170 to 0.091	0.599**
Family income	r = -0.240	58	—	-0.398 to -0.069	0.024**
Caregiver sex	Female	83	49.54 ± 14.46	11-73	0.106***
	Male	18	44.67 ± 12.50	16-64	
Lives with older adult	No	34	49.35 ± 13.66	—	0.846***
	Yes	67	48.33 ± 14.55	—	
Relationship	Spouse	15	48.00 ± 13.13	21-65	0.914****
	Son/Daughter	44	48.32 ± 13.76	16-70	
	Other	42	49.29 ± 15.28	11-73	
Had illness prior to assuming caregiving	No	72	46.78 ± 14.01	—	0.041*
	Yes	29	52.31 ± 13.88	—	
Undergoes own health follow-up	No	39	50.97 ± 13.77	—	0.118*
	Yes	62	47.29 ± 14.29	—	
Occupational status	Active (employed/self-employed)	55	47.11 ± 14.02	—	0.284****
	Inactive (retired/other)	46	50.29 ± 14.31	—	
Developed illness after assuming caregiving	No	53	44.42 ± 14.65	—	0.001***
	Yes	48	53.38 ± 12.18	—	
Perceived health deterioration after assuming caregiving	No	18	41.89 ± 15.84	—	0.022***
	Yes	81	50.36 ± 13.49	—	
Sex of older adult	Female	72	47.33 ± 14.26	—	0.079***
	Male	29	52.00 ± 13.71	—	
Religion of older adult	No	12	49.83 ± 15.57	—	0.512***
	Yes	89	48.52 ± 14.09	—	

*Pearson's correlation; **Kendall's tau coefficient; ***Student's t-test / Wilcoxon-Mann-Whitney; ****Kruskal-Wallis test; SD: standard deviation; CI: confidence interval.

The mean quality of life scores were 42.88 for the physical component, 40.07 for the mental component, and 82.95 for the total SF-12 score.

In the correlation analysis, a negative association was observed between caregiver age and the physical domain of quality of life ($r = -0.328$; $p < 0.001$), indicating worse physical perception with advancing age. A positive

correlation was found between educational attainment and the physical domain ($r = 0.240$; $p = 0.002$), as well as between the Barthel Index and the physical domain ($r = 0.225$; $p = 0.024$), demonstrating that higher educational attainment and greater functional independence of the older adult were associated with better physical quality of life among caregivers (Table 4).

Table 4 - Correlation between mean scores of the physical (PCS) and mental (MCS) quality of life domains of the caregiver and numerical variables. São Paulo, 2025.

Variable	n	PCS	p	MCS	p	SF-12 Total	p
Overall Mean SF-12	101	42.88	—	40.07		82.95	—
		PCS (r)	p	MCS (r)	p	SF-12 Total	p
Caregiver age	101	-0.328	<0.001*	0.193	0.053*	-0.065	0.521*
Educational attainment	101	0.240	0.002**	-0.073	0.335**	0.080	0.288**
Family income	58	0.016	0.881**	-0.034	0.747**	-0.027	0.799**
Time in caregiving role	101	-0.028	0.784*	-0.032	0.747*	-0.042	0.674*
Persons financially dependent on income	63	-0.096	0.452*	-0.233	0.066*	-0.229	0.072*
Older adult age	101	-0.073	0.467*	0.112	0.264*	0.038	0.708*
Barthel Index	101	0.225	0.024*	0.053	0.602*	0.183	0.067*

*Pearson's correlation; **Kendall's rank correlation tau.

In the analysis of categorical variables, caregivers who resided with the older adult presented higher mean scores in the physical domain ($p = 0.016$) and in the total SF-12 score ($p = 0.005$). Furthermore, maintaining regular personal health follow-up was associated with better scores in the physical domain ($p = 0.002$) and in the total score ($p = 0.002$). Caregivers

who reported health deterioration after assuming caregiving responsibilities presented worse mean scores in the mental domain ($p = 0.010$). On the other hand, the maintenance of social, physical, and leisure activities after assuming caregiving was associated with better scores in the mental domain ($p = 0.011$) and in the total score ($p = 0.005$) (Table 5).

Table 5 - Comparison of mean scores of the physical (PCS) and mental (MCS) domains and SF-12 mean with categorical variables of the caregiver and older adult. São Paulo, 2025.

Variable	Category	PCS	p	MCS	p	SF-12	p
Caregiver sex	Female	42.64	0.576*	39.32	0.132*	81.96	0.061*
	Male	43.97		43.52		87.51	
Religion (caregiver)	No	42.21	0.789*	37.19	0.323*	79.38	0.360**
	Yes	42.97		40.46		83.43	
Lives with older adult	No	39.84	0.016*	37.57	0.094*	77.41	0.005*
	Yes	44.42		41.34		85.76	
Relationship to older adult	Spouse	40.39		42.81	0.529**	83.20	0.997***
	Son/Daughter	43.77	0.470**	39.18		82.95	
	Other	42.83		40.03		82.86	
Occupational status	Active (employed/self-employed)	44.30	0.159***	39.18	0.898**	84.76	0.692***
	Inactive (retired/other)	37.85		41.66		82.69	
Illness prior to caregiving	No	44.09	0.069*	40.44	0.635*	84.53	0.129**
	Yes	40.43		39.31		79.75	
Health follow-up	No	33.32	0.002*	34.01	0.121*	67.34	0.002**
	Yes	43.12		39.70		82.83	

to be continued...

continuation - Table 5.

Variable	Category	PCS	p	MCS	p	SF-12	p
Health deterioration after assuming caregiving	No	44.85	0.315*	45.71	0.010* *	90.59	0.010** *
	Yes	42.44		38.63		81.06	0.360**
Illness after assuming caregiving							
	No	42.61	0.761*	39.18	0.383*	81.80	0.400**
	Yes	43.17		41.05		84.22	
Social activities before caregiving							
	No	41.73	0.533*	42.98	0.274*	84.71	0.542**
	Yes	43.16		39.35		82.52	
Social activities after assuming caregiving							
	No	42,36	0.177*	38.95	0.011*	81.31	0.005**
	Yes	45,83		46.51		92.33	
Sex of older							
	Female	43,68	0.165*	40,6	0.466*	84,24	0.154**
	Male	40,88		38,4		79,74	
Religion of older adult							
	No	43,71	0.739*	35,27	0.098*	78,97	0.308**
	Yes	42,76		40,72		83,49	

*Student's t-test; **One-way ANOVA; ***Kruskal-Wallis test.

DISCUSSION

The growth of the older adult population poses numerous challenges to health systems, due to the greater incidence of chronic non-communicable diseases (NCDs) and the consequent increase in the number of hospitalizations and institutionalizations, resulting in reduced functional capacity and dependency²⁰.

The family typically assumes the care of its relatives, constituting a unit for the provision of care and individual and social development²¹. Studies indicate that those who assume this role are generally women over the age of 30²². The relationship between the caregiver and the care recipient is usually filial or conjugal, a finding corroborated by this research, in which the majority were women and daughters.

Despite contemporary social changes, the role of women continues to be associated with the care of the home and family, as caregiving involves tasks culturally characterized as feminine, learned since childhood²³. Conversely, assuming the position of caregiver for an older adult may be influenced by cultural or social factors. In a study conducted in China, 55.4% of caregivers of older adults were male²⁴.

Maintaining the quality of care for older adults requires an active support network to prevent an increase in perceived burden. When caregivers express religiosity, they tend to accept and face everyday adversities with faith and greater resilience²⁵. Similarly, educational attainment and social engagement are positive predictors of caregiving performance, as they enable greater adaptability derived from experience and knowledge²⁶.

Family income is a factor that contributes to caregiver stress and burden, since caregiving often

takes place under conditions of financial scarcity. It should be noted that caregivers who are also formally employed tend to underperform both in their caregiving tasks and in their professional role. In some cases, they reduce their working hours or even leave their jobs due to the difficulty of reconciling the demands of caregiving and employment, which may result in financial hardship for their own family²⁷. In view of other possible solutions, the literature shows that families would like to receive financial assistance from organizations or voluntary groups committed to helping individuals in these circumstances²⁸.

In this study, health deterioration after assuming caregiving and the lack of time for social activities were reported by the majority of family caregivers. Prioritizing the care of the older adult ends up impacting the caregiver's lack of time to care for themselves, as well as their participation in physical and social activities²⁹.

The majority of caregivers participating in this study presented moderate-to-severe burden. The lack of resources and the absence of an active support network singularizes care, centering it on a single family member who, among their various activities, assumes the caregiving role, thereby contributing to the increase in burden³⁰.

A study conducted with senescent caregivers found that the majority devoted all their time to caregiving, and of these, only a portion received some form of assistance²³. It should also be noted that high caregiver burden is directly related to the lack of time for self-care: the greater the degree of dependency of the older adult in basic activities of daily living, the more the caregiver neglects their own health and personal satisfaction – due to the need for full dedication to the care of the older adult

– while the remaining time is directed toward other tasks, such as caring for children and/or a spouse²⁹.

The quality of life of family caregivers has been measured to assess the impact of caregiving burden on both the physical and psychological dimensions³¹. In this study, the mean score of the physical component was 42.88 points and that of the mental component was 40.07 points. An international study evaluating the quality of life of family caregivers of older adults using the SF-12 obtained physical component scores ranging from 61.7 to 28.2 points and mental component scores ranging from 39.6 to 44.3 points³². A Brazilian publication³¹ that used the same instrument to assess the quality of life of family caregivers of bedridden older adults reported mean values close to those found in this study: 43.26 and 50.98 points for the physical and mental components, respectively.

Physical and mental exhaustion is not related solely to the emergence of disease, but also to the deterioration of the individual's self-perceived health status. Physical and mental burden directly impacts the caregiver's quality of life and overall health and well-being³³.

Regarding the characteristics of the older adults receiving care, the vast majority were women and octogenarians. According to data from the Brazilian Institute of Geography and Statistics³⁴, 55.7% of older adults in households are women. Old age has a strong gender component: the female mortality rate is lower, older women are more likely to become widowed and to face economic disadvantage, and they live a longer period with physical frailty before death – making them dependent on care, despite having traditionally been caregivers themselves^{23,25,30}.

In the correlation analyses of burden measured by the Zarit Scale, statistically significant results with a negative correlation were found for the degree of independence of older adults and family income. The independence of the older adult is related to their capacity to carry out basic and instrumental activities of daily living without assistance, as well as to their autonomy. An older adult may be dependent, requiring assistance with self-care, while still preserving their autonomy³⁵. The complexity of the caregiving task leads caregivers not to prioritize their own needs. Feelings of anxiety, fear, insecurity, and concern about the financial situation are consistent with caregiver burden and emerge as a consequence of uninterrupted care for the dependent older adult³⁶.

Providing nutritional care, acquiring and purchasing medications and necessary caregiving products may result in financial losses due to the high costs arising from the demands of care. Most caregivers stop working to dedicate themselves

exclusively to caregiving and household tasks, which results in greater financial hardship for the entire family. The limitation of resources may translate into a stress-generating factor for the caregiver, who feels compelled to adapt the quality of care to their economic conditions, thereby impacting caregiving quality and, consequently, caregiver burden^{37,38}.

In the comparative analyses of burden with the variables, statistically significant results were found for developing illness and perceiving health deterioration after assuming caregiving – findings consistent with those of a previously conducted study³⁹. Caregivers tend to devote most of their time to this activity. Senescent family caregivers may be associated with higher levels of burden and a decline in physical quality of life, due to the accumulation of responsibilities and the reduction of functional capacity³⁹. Reconciling personal health follow-up with caregiving becomes exhausting; appointment cancellations and rescheduling occur routinely, as the older adult is always the priority²⁹.

In this study, the correlation analyses of variables with the physical, mental, and total SF-12 score domains indicated that family caregivers of more advanced age tend to perceive a worsening of their physical health. The literature mentions several factors associated with caregiver quality of life, such as caregiving burden, degree of dependency of the older adult, length of time in the caregiving role, and the presence of sequelae and diseases in the older adult^{40,41}.

Regarding educational attainment, 36.63% of caregivers reported having eight years of schooling. A higher level of education may be significantly related to the understanding required for caregiving performance, which encompasses knowledge ranging from the performance of instrumental and basic caregiving activities to understanding the diagnosis, prognosis, and complications of the diseases of dependent older adults⁴².

The degree of functional independence of the older adult correlated positively with the physical component of caregiver quality of life; therefore, the more independent the older adult, the lower the perceived burden by the caregiver, resulting in better physical quality of life scores. The functional dependency of the older adult is directly associated with an increase in caregiver burden and deterioration of quality of life⁴³.

Caregivers who resided with the older adult receiving care obtained higher mean scores in the physical dimension of quality of life. Living with a dependent older adult can be advantageous, as caregiving demands can be promptly met. On the other hand, it can have a negative impact due to the exposure to the effects of the caregiving process that

cohabitation entails⁴². Significant changes in daily routine arising from the demands of caregiving for the older adult directly affect the family caregiver's quality of life. The need to reorganize everyday life often leads to the renunciation of habitual activities, which may result in self-neglect^{42,43}.

Finally, another aspect deserving emphasis is the fact that caregivers cease to participate in social activities after assuming the caregiving role – evidenced by worse quality of life mean scores. Among the main challenges faced in the daily caregiving routine, the limitation to leave home

and engage in leisure activities stands out, as the caregiver is constantly involved in responsibilities and concerns related to the older adult's illness and demands. The continuous care of a dependent individual imposes a transformation in the caregiver's lifestyle, which becomes organized around the needs of the other person. Regardless of the caregiver's age, these changes directly affect their social interactions and opportunities for recreation, often generating a sense of loss of autonomy and the feeling that their own life has been relegated to the background⁴⁴.

CONCLUSION

It is concluded that the family caregivers of older adults were, in their majority, women in their fifties, daughters, employed, who perceived a deterioration in their health status and ceased performing physical, social, and leisure activities after assuming caregiving responsibilities. These findings corroborated the results of the applied scales, which demonstrated moderate-to-severe burden and an impact on quality of life.

With regard to the older adults, they were predominantly women, octogenarians, independent or with mild dependency, and lived with their caregivers. The fact of living with the older adult and maintaining personal health follow-up was reflected in higher mean scores in the physical domain of family

caregiver quality of life.

This research made it evident that family caregivers are adults who are approaching the age at which they will themselves be considered older adults. Thus, there is an urgent need to raise awareness among these caregivers to maintain healthy habits, leisure activities, and well-being, in addition to health follow-up, even while bearing caregiving responsibilities. Similarly, health professionals must be attentive to developing health education actions focused on healthy aging and the maintenance of quality of life among caregivers of older adults. Health managers and decision-makers must invest resources in developing specific policies to support family caregivers.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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