

Adult Children as Caregivers: Preliminary Study on the Experiences and Coping Strategies of Adult Children as Primary Caregivers of Parents with Alzheimer's Disease in Malaysia

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Abstract

Alzheimer's Disease (AD) is an irreversible brain disorder that affects thinking, memory, reasoning, and daily functioning. According to World Health Organization (2020), there are approximately 50 million people diagnosed with AD, and nearly 60% of them are living in low- and middle-income countries. In Malaysia, the prevalence of dementia is 8.5% among older adults aged 60 and above. Listed as one of the leading causes of death in 2020, curbing AD is not only a burden to the public health system but also brings perpetual stress to the family members who often undertake the primary caregiving role. The research has indicated that adult children as AD patients' primary caregivers (adult-child caregivers) experience higher psychological burdens than other caregiver groups. This qualitative study intended to explore the experiences and coping strategies of adult children as the primary caregivers of AD patients in Malaysia. The recruitment was conducted with the assistance of the Alzheimer's Disease Foundation Malaysia, whereby eight participants took part in the in-depth interviews. Both face-to-face and telephone interviews were conducted to facilitate the full engagement of the participants in the research. Thematic analysis technique was used to analyze the data. The results showed that, at the personal level, adult children constantly felt emotional burnout, as they were overwhelmed by not knowing how to manage the stress they experienced. The findings reflected that caregiving for parents with AD involves a process that was depicted as the discovery of behavior changes, having difficulties accepting the diagnosis, making an adjustment to the role of a caregiver, and finally accepting their function and the reality of the disease. Recommendations for interventions and further research have been discussed.

Keywords: Adult children, Alzheimer's Disease, primary caregivers

1. Introduction

Alzheimer disease (AD) is an irreversible disease or progressive brain disorder that affects memory, cognitive reasoning, and daily functioning behaviors (Galvin, 2013; Millán-Calenti et al., 2000). According to WHO (2020), it contributes to about 60-70% of dementia cases. There are around 50 million people with dementia, and nearly 60% of them are living in low- and middle-income countries. The number is projected to reach 82 million in 2030 and 152 million in 2050. Nearly 10 million new cases arise every year. It is estimated that the cost of dementia was US\$818 billion in 2015, approximately 1.09% of the global GDP. Up to now, it has increased to US\$1 trillion. The figure consists of unpaid care provided by family and other social care which is provided by community care professionals and residential settings, and direct medical costs (Alzheimer Disease International, 2020). Despite the high costs of care for dementia, more than 50% of caregivers have expressed positive sentiments towards their roles as a caregiver, though deterioration of health has also been disclosed. (World Alzheimer Report, 2019; Alzheimer's disease facts and figures, 2020). The mixed dynamics of poor health and positive sentiment deserve to be further understood.

In Malaysia, the total population is approximately 32.7 million. There are 7% of the population aged more than 65 (Department of Statistics, 2020). An aging population is defined as having 15% of its total population aged above 65. Malaysia will be estimated to reach an aging population in 2030. Research reports have shown that, although there have been some government initiatives to manage the fast-growing aging population, more still needs to be

done to create a seamlessly integrated system for care provision (Chai & Hamid, 2015; Poi, Forsyth, & Chan, 2004; Tey et al., 2015). Notably, in many developing nations, due to bureaucracy and hierarchy, various systems in education, social care, and health care are disjointed (World Health Organization, 2015). Nevertheless, due to the changes in family structure, family support for the elderly has become a worrisome social concern (National Population and Family Development Board, 2014).

On the other hand, according to the National Health and Morbidity Survey 2019, about 5.7% of the population provides informal care and 85% of it goes to their household members. The number of female caregivers is higher than the number of male caregivers. More than 15% of the caregivers have expressed that their health condition is affected, both physically and mentally. Caregivers' health is highlighted as important as the care recipients. Among the caregiving roles, caregiving strain is significantly higher among the caregivers of Alzheimer's Disease patients than in others (Chan, Yap, & Khalaf, 2019).

The fabrics of cultures and ethnicities are diverse in Malaysia. Caregivers' burden is influenced by ethnicity. The Chinese and Indian were shown to have higher caregivers burden as compared to the Malay (Choo et al., 2003). Each culture acquires its own system in caregiving. For example, the Malays in Malaysia are Muslims by law. In the Islamic culture, Muslims follow their own distinctive rules, values as well as specific traditions, according to the Al-Quran, which are different from other religions (Begum & Seppänen, 2017). Religious belief is expected to be incorporated into daily life. Notably, the vital system in the Islamic perspective and the ethical quality support many conventions in elderly care (Bensaid & Grine, 2014). In other words, these cultural understandings may support caregivers to persevere through illness or any life challenges, particularly acceptance towards these challenges is perceived as a cycle of life or destiny. Studies in the West have also converged that religious beliefs are a crucial support for family caregivers when they feel burdened (Chan, 2010; Wilks, 2006).

The number of people who have dementia in Malaysia was 123,000 in 2015. It is projected to rise to 590,000 in 2050 (Alzheimer Disease International, 2014). Care for dementia patients will not only be a public health burden, but the strain on family members who provide informal care for AD patients also cannot be overlooked; as the number of dementia patients is staggering (Hamid et al., 2010). Adult children (adult-child caregivers) often assume the responsibility of caring for their parents who have AD (Faronbi et al., 2019). However, the experiences and wellbeing of adult children receive less attention from society (Adams & Sanders, 2004), particularly considering the angle of cultural differences.

Studies have also shown that the experience of caregiving is influenced by cultural and religious values (Lavretsky, 2005). Miyawaki's study (2015) showed that Japanese American caregivers are receptive to employing both formal and informal care, with the belief that both types of care would uphold the quality of care for dependent older people. Meanwhile, some Chinese in Hong Kong believe that anything in their lives is accepted as beneficial because it is out of heaven's will. Acknowledging what comes in their lives and accepting it wholeheartedly is essential. Thus, they willingly accept the illness and its caregiving responsibilities. In India, Punjabi-speaking caregivers believe the symptoms of dementia came from the need for exertion by the family. Hence, when older parents become dependent, they believe that the family should be responsible for solving their own issues (Chan, 2010).

Besides cultural and religious experiences, the caregivers also underwent a deep sense of grief and loss (Chan et al., 2019), and physical and financial difficulties. The stages of illness also influenced the demand of caregiving. Often the care demand increases as the patient's life approach the end (Alzheimer's disease facts and figures, 2020). In other words, caregivers' experiences vary widely. It is influenced by personal adherence to one's cultural and religious values, physical state, financial resources, as well as the stages of the disease. These experiences also affect the coping mechanism of caregivers (Ott, Sanders, & Kelber, 2007).

Folkman and Lazarus (1985) have pointed out that a coping mechanism is not a unilateral emotional process but involves a complex and even conflicted emotional process. A wide range of cognitive and behavioral strategies which entail problem-solving and emotional regulating functions can be triggered when one is under stress or threat. Both problem-focused and emotion-focused forms of coping can change the emotional experience. In other words, ways to cope and emotions are interrelated (Hawken, Turner-Cobb, & Barnett, 2018).

Chan and colleagues (2019) have highlighted that male and female coping strategies are different. Women tended to adopt an emotion-focused strategy, which is perceived to incur a higher level of caregivers distress. Male caregivers often use task-oriented strategies, which is associated with a lower level of caregivers' burden. However, the context of the stressful event should be considered when evaluating the effectiveness of coping strategies (Folkman & Lazarus, 1985).

Social support is frequently associated with positive adjustment among caregivers (Hawken et al., 2018). Besides, the quality of the relationship between the caregivers and the care receivers was found to be positively associated with good adjustment (Wong et al., 2015). Studies have also shown that the opportunities for caregivers to share information and experiences benefit their adjustment (Kita & Ito, 2013; McCausland Kurz & Cavanaugh, 2001).

Although the caregiving stress is prevalent, when the caregiving responsibilities ended, the caregivers reported changes in health status and experienced ongoing depressive symptoms for many years. They go through a transition to rebuild their lives after they have ended their caregiving responsibilities (Corey & McCurry, 2018). In other words, caregivers' health in post-caregiving cannot be underestimated.

Caregivers are challenged physically and mentally during caregiving and post-caregiving. Religious and cultural values provide pivotal support for caregivers. However, caregiving experience from the perspectives of spouses and children differs, but the difference is often not much discussed. Thus, more understanding of adult children's experiences is needed, particularly in a multi-ethnic cultural context such as Malaysia. Therefore, this study aims to understand the experiences of adult children when they undertake the role of the primary caregiver of parents when they become Alzheimer's patients.

2. Method

The qualitative research method was used in this study as the main aim of this research was to have a deeper understanding of the experiences of adult children as the primary caregiver of parents with Alzheimer's disease. The information obtained in this research was through face-to-face and phone interviews. Purposive and snowball sampling was adopted to recruit adult-child caregivers. The participants were invited through the Alzheimer's Disease Foundation Malaysia's personnel, who assisted through their organization's events. Some face-to-face interviews were conducted during the organization's events, and some participants chose to conduct the interviews by phone at their feasible time. The interview sessions lasted between 40 minutes to an hour. Semi-structured interview questions were used to elicit data. The interview sessions were audio recorded.

2.1 Sampling Procedures

Table 1 summarizes the basic demographic information of the participants. The selection criteria for this study include: both genders of Malaysian adult children as primary caregivers of AD; adult children who take care of their AD patient for more than one year in the moderate or severe stage of AD, which means AD patients have any of these symptoms: unable to provide food for themselves; inability to remember occasions, names, and places; difficulty wearing their own clothes; unable to clean and shower; depending on others for all daily activities; and adult children as primary caregivers who could speak fluently in Bahasa Malaysia or English. The caregiver exclusion criterion was adult children with any pre-diagnosed mental illness or psychiatric disorder.

Table 1. Participants' demographic data

Participants	Age	Ethnicity	Total years of care of Alzheimer's parents
1	38	Malay	3
2	21	Malay	1
3	59	Malay	3
4	22	Malay	3
5	22	Chinese	7
6	39	Chinese	12
7	63	Chinese	5
8	64	Chinese	4

In addition, Google form was used to select the participants. The link of Google form was circulated among potential participants. The interested potential participants filled in the form. The researcher contacted the participants after receiving the information. Eligible participants were invited for interviews.

A briefing was conducted before the interview to explain the study's objective; confidentiality (a pseudonym was assigned for labeling the file and audio-recorded materials); the risks and benefits in this study; participants' refusal rights and the usage of the data. Written informed consent was obtained after the participants consented to

participate in this research. A token of appreciation was offered to each participant after the interview. The data was transcribed verbatim. The Bahasa Malaysia recording was translated and back translated. To ensure the trustworthiness of the research, peer reviews, triangulation, and cross-checking with the research advisor were conducted.

2.2 Data Analysis

Thematic analysis was used to analyze the data (Braun & Clarke, 2006). Six steps were involved in the process of thematic analysis: 1) the data needed to be familiarized by the researchers- the transcripts were read and re-read a few times; 2) the initial codes were generated and cross-checked with peers; 3) after the initial codes were generated, a theme- search was carried out; 4) initial themes were generated; 5) the themes were reviewed and cross-checked with literature, peers, and research advisor; 6) the themes were defined.

2.3 The Validity and Reliability of the Qualitative Research

Various strategies were adopted to ensure the validity and reliability of this qualitative research. The researchers had a *prolonged involvement* with the research participants through the in-depth interview and follow-up sessions to ensure that thick and descriptive data was collected. The *triangulation* technique was used throughout the entire research process, meaning three researchers worked together in order to prevent personal biases during data collection, data analysis, interpretation of data, and reporting the results. *Peer-debriefing* was conducted to present the different stages of the research to the experts, in order to reduce researcher bias. *Member checking* was applied to test the emerging findings with the research participants, in order to increase the validity of the findings (Robinson, 2002).

3. Results

The findings of this research have been summarized in four themes which represent the experiences of adult children as the caregivers of AD patients and how they cope with their caregiving experiences. It seemed like their experiences went through a process that stands with four stages. The stages showed the adult children's experiences from the beginning of the caregiving process until the end of the process. Figure 1 presents the summary of the results.

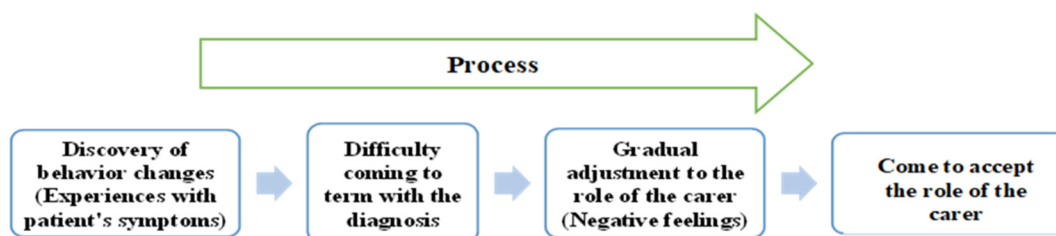


Figure 1. The process of going through the experiences of adult children as primary caregivers in Malaysia

Stage 1: Discovery of Behavior Changes

At this point, the adult children started noticing the changes in their parents, and they could not understand why their parents suddenly behaved differently, as most of them experienced forgetfulness.

As quoted by P7, P5, and P3:

"Oh, they are forgetful. They have personality changes, even they hear voices and experience hallucinations. And they always think back about their old stories." P7

"At first she had mood swings in a way she was like simply pinpoint you, like just blame you for no reason even though you did not do that particular thing, but she would assume that you are the one that did it." P5

"He would start shouting, he would start running away from the house that we have to even lock our gate, you know? And to the extent that he can climb over the fence, because he is a man." P3

This stage showed that the adult children as the primary caregivers started to discover the differences in their parents' behaviors. The parents started to become very forgetful, they had mood swings from time to time, and even their behaviors noticeably changed in a few months. Some of them had hallucinations and wanted to run away from the house multiple times.

It is indeed a confusing phase when parents start to develop AD symptoms when they reach old age. Adult children find a way to cope with these sudden changes in their parents' behaviors by applying a problem-focused coping strategy to learn more about the disease and caregiving methods. As stated by P5 and P7:

"I was still very curious about it, because that at the time, I was not [aware]. I did not know much about Alzheimer's. All I knew was that people tend to be very forgetful. But after I took care of her for so many years, then the things changed and I learned how to manage it." P5

"We do hear about this Alzheimer's disease. And therefore, by going through this experience, I realized that it is quite difficult. So, it makes me more aware that I need to know more about that and how to cope and how to prepare myself and how to prevent it." P7

Hence, problem-focused coping strategies help caregivers find solutions to what needs to be done gradually and do the decision-making for themselves in those caregiving situations (Snyder et al., 2014). Undertaking problem-focused coping strategies will let the adult-child caregivers try to effectively play out an errand that will expel the issue or improve it.

Stage 2: Difficulty Coming to Terms with the Diagnosis

At this stage, adult-child caregivers do not know what exactly Alzheimer's Disease is. The participants had a hard time believing that their parents had developed the disease. When most of them feel confused about this situation, they begin to explore more about AD, as stated by P1, P7, and P6.

"But at the beginning, we cannot accept actually, but then, we try to digest it and try to accept it. And now, I think we just accept, because nothing we can do." P1

"When she reacts in such a manner, you are able to say, oh okay. This is not her; it is the disease that is causing her to think like that. Put it in that perspective, then you will not lose your mother." P7

"But among your colleagues or friends, the close ones, you can share the experience. I am sharing my experiences with someone who is inexperienced and do not understand Alzheimer's. So, I am sharing with him or her what Alzheimer's is. So, they kind of interested and they understand and are able to take initiative to help others." P6

This stage indicated that the doctor had diagnosed the parent's AD and the adult children had to go through a sense of grief. A past study showed that adult children had to undergo a deep sense of grief and loss when they knew about the conditions of their parents; this made them feel frustrated (Chan et al., 2019). However, another study showed that adult children hardly recognize their feelings of grief before the family members pass away (Adams & Sanders, 2004). The feeling of grief and loss was not experienced by the adult children recruited in this research. The adult children felt a bit hard to accept the truth that their parents had Alzheimer's disease and they were having some difficulties adapting to the role as caregiver. Some participants emphasized how important it is to do their own research about AD so that the adult-child caregiver and the rest of the family members can chip in and try their absolute best to help their parents.

For instance, P1 and P6 mentioned that:

"Just now I said, I was Googling and I found a bit about Alzheimer's, and then, what I found is that we need to take care of her feelings; we cannot force her. What we can do is that we give support and we cannot just leave her alone for a long time." P1

"So, when I first attend the Dementia Care training in Sarawak, it was uhh very good that I was given the awareness about this training, and then, we know how to cope on that very early stage. It was a few years ago, I forgot how many years already. More or less 8 years ago. First dementia training in Sarawak. I am able to accept Alzheimer's but do not really know a lot about Alzheimer's yet, but at least I know a bit." P6

"You have to share responsibility in terms of taking care of her. Like so far, my family, my brother, sister, and my niece understand it. When one is cooking, she will do the house chores, and he cleans. I do not have to instruct; you do this and I do that. I already told them that mum has Alzheimer's and all, they know it." P6

Therefore, Stage 2 is mainly focused on how the adult-child caregivers tried their best by exploring more about AD through attending care training and learning about AD through reliable sources. Apart from that, sharing the burden with the rest of the family members helped the adult-child caregivers decrease the emotional burden that they felt. As much as the sense of despair could make people feel demotivated but they are still standing on their grounds for taking the responsibilities of care of their AD parents (Carver, Scheier, & Weintraub, 2020). In addition, these coping techniques that are strikingly various and naturally assorted; for instance, remembering good fortune, avoidance, hoping and doubting one's self as well as forgiveness, could really help the adult-child caregivers to

cope accordingly to their own situations (Worthington & Scherer, 2004).

Stage 3: Gradual Adjustment to the Role of Carer

At this stage, adult-child caregivers have tried to gradually adjust their role as carer, but at the same time, they experienced a lot of negative feelings. The adult-child caregivers struggled to find a balance to take care of their AD parents and their own family. As quoted by P3, P8, and P4, they sincerely expressed how they felt during this stage:

“Then I feel so sad, ... so very sad... when you see a person who is well dressed, after that, he became so childish, tend to like ... make you realize that the world is not all about happiness as I told you.” P3

“Really too tired! Imagine I had to wake up at 5 am something. By the time I come back from the hospital[workplace], it could be 6 pm, so the whole day I was out. It was not easy; it was very tough. That’s why I decided I would retire at 55, no more (laughing).” P8

“First, less sleep. And then, I also have my health problems, so I have to go back to the hospital from time to time for a medical check-up. But... doesn’t affect me at all. Just a bit tired. Just a minor part of my life.” P4

In Malaysia, while adult children take care of their parents, they usually hold their own job, and some have their own families to take care of. Studies showed that adult children spent at least 46 hours per week taking care of the daily living of their parents with AD (Faronbi et al., 2019). This causes a great physical and emotional burden for them. Studies show that adult children do not have a break for themselves; they need to take care of their own children while taking care of their parents (Miller-Ott, 2018). A research study showed that chronic stress makes the physical health status of adult children become worse and it increases the chance of developing other diseases (Galvin, 2013).

At this stage, religious coping played an important role in adjusting to the role of the carer. As the adult-child caregivers started to feel a sort of emotions in their care process, they had their own religious coping with being able to think straight again. They had reasons to believe and had faith in caregiving, as they accepted this as a test from God. As stated by some participants, such as P3, P6, and P7:

“We are Muslim. We are aware that ... everything in the world is only temporary. So, God has given us a few years of his life. His good life with us. So now we need to repay back what he gave us then. It’s just that we are resigned to it.” P3

“[Sighs and talks in a low sad voice] Sometimes, I would say that... depends on... really... I will ask God... If the time has come, we just open the door for her and let her go peacefully. [Participant is in tears] Don’t want to let her suffer anymore. So, when it’s time, then, I should be very happy already....” P6

“I believe that God is sincere. He will bring us through, indeed, he does. Because we can only do so much with our own ability. But I believe supernaturally; here if you pray and commit your burdens and say ‘God, I do not know what to do here but can you help me? I got a situation like that.’” P7

In a way, Theme 3 focuses on expressing how important religious coping is as one of the ways to cope in caregiving. One of the important elements emphasized by Ott and colleagues (2007) is that adult-child caregivers can manage misery-related loss through religious coping. This might be especially important and versatile for managing the pressure of thinking about an individual with dysfunctional behavior. As a rule, adult-child caregivers describe the elevated levels of religious factors and explore some religious coping methods (Pearce et al., 2015). Spiritual components such as having strong faith are related to intervening and directing the connection between stress and asking for strength from God so that the caregivers are able to cope from within, which was stated by the rest of the participants.

Stage 4: Come to Accept the Role of the Carer

Adult children start to accept and adapt to their role as carers at the last stage. They have learned how to appreciate the time that they spent together with their parents and make these experiences memorable in their lives, as stated by P8, P5, and P7:

“To me, I have done my best. I do whatever I feel is right. I have done my best; I was the only one looking after him for so many years.” P8

“I am not blaming others; we just accept it because we try to digest this situation, and we try to accept it. Other than that, I also felt happy when I took care of her because sometimes, she completed her meal, then you felt the feeling of satisfaction.” P5

“So, I think we have to give more love to her like what she gave to us. Not sure whether we can do or not... [Silence]”

[Participant is holding her tears, face turns red] *We try... To give back* [In a slow, sobbing voice]. [Participant is crying] [Pause] *Because we don't know how long we can spend our time accompanying her, or how long she can live.*" P7

Adult children learned to adapt to their role as carers and believed that God helped them through all the challenges. They cherished the moment they spent with their parents and became more understanding and patient with them. They did not feel regret because they knew they had done their best. Throughout the adapting process, support from family members and friends was necessary in order to help the adult children to adapt to their roles.

Moreover, when the adult-child caregivers had reached the last stage of accepting their role as carers, they often talked about how reminiscing the past and thinking of good memories could help them cope with all the struggles of taking care of their parents. They have developed a good sense of positivity throughout their experiences of caring. As mentioned by P5, P3, and P2:

"So yeah, because my mum is also working, so the time I had with my own mum was also actually quite less. But because we take care of our grandma, there is where we spend more time with each other to talk more. I had no regrets and she would also be very happy throughout the time that I took care of her." P5

"Always remember Allah. What we will give out, we will get it back; so, if we abuse our father, we would know that God will then put us in the same shoe later. That is eye-opening." P3

"I was thinking, thank God I was there throughout the process. I know I had no right to make any decisions, but I was there through the whole thing. And I don't resent my grandpa. So, whatever I did, In Shaa Allah, for him will be enough. Basically, I did not regret anything I did for him. Or, whatever I did with him." P2

For Stage 4, adult-child caregivers found their experiences in taking care of their parents unlike anything else. The reason is that they sense the loss of their loved one since the beginning of the disease. Therefore, rather than attempting to avoid the real feelings, the way they cope is by letting themselves express their feelings and finally coming to accept this situation. The adult-child caregivers feel relief because the sense of immersing in the emotions goes deep inside (Wagner, 2020). Although it could take a long time from the grief stage, adult-child caregivers find that they can cope better with slow healing processes. There is a propensity to imagine that what the adult-child caregivers have gone through has shaped them to be better people now. Nevertheless, the experience of taking care of parents with AD can be in a state of confusion. It is usually normal throughout the journey; and each and every one of the participants is coping differently, depending on the difficulties that they are facing.

4. Discussion and Conclusions

As reflected in the title of this study, adult children contributed most of their time to caring for their parents with AD. Each of the participants had similar experiences throughout the process of taking care of their parents. They faced many challenges throughout the process, but enjoyed taking care of their parents. In fact, the relationship between adult children and parents became much closer and they cherished the time they spent together. The adult children felt a lot better after they had experienced going through the stages of taking care of their parents from the beginning, while coming up with their own coping strategies. They felt burdened when they had to take care of their parents alone, however; they were able to manage stressful situations in a positive way. The study implies that the feeling of loss is a natural process, and adult children receive a lot of support from family, peers, and society. Although in Malaysia, the government does not provide enough formal support services such as education, organizational assistance, and counseling (Dionne-Odom et al., 2017). The caregivers who had a family member with Alzheimer's disease feel stress, anger, and frustration easily. They suffer from the burdens for a long time, and some of them may experience some symptoms of depression due to the high emotional stress. In the process of taking care of parents with Alzheimer's Disease, family caregivers experience poor health conditions such as headaches due to stress, lack of rest, weight loss, or weight gain due to poor eating pattern (Faronbi et al., 2019). Family caregivers cannot attend to their health needs, resulting in further deterioration. The government should provide check-up services for family caregivers, and society should pay more attention to family caregivers. With the government's help, adult children will have less burden and can focus better on caring for their parents. Throughout this study, researchers found that the adult-child caregivers emphasized that no one would actually understand how to deal with a parent with Alzheimer's Disease unless someone experiences it on their own. The social and community resources are very limited and the government does not have the policy to support families who have a patient with Alzheimer's Disease. Furthermore, educational programs and awareness training are necessary, since the family caregivers lack the required knowledge to deal with the immediate needs of patients with Alzheimer's Disease.

4.1 Limitations of the Study

In every research, there are indeed a few limitations and areas to improve for future research. Due to the time constraint and the research being a preliminary study, the researchers were able to recruit only eight participants. Although the sample was a small group, their sharing provided learning about the issues and coping strategies of adult-child caregivers. In addition, researchers were not able to find Indian participants during the data collection period due to limited resources. Hence, it is highly recommended that future research should extend the sample to recruit Indian participants to make it possible for the differences in ethnicity to be identified. Furthermore, studies are required to target those caregivers with limited resources in rural areas.

Competing Interests Statement

The authors declare that there are no competing or potential conflicts of interest.

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