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Empathy in Married Women Caregivers: A Comparative Analysis Across Psychiatric, Medical, And Non-Caregiver Groups

Sanya Sinha

Amity Institute of Behavioural and Allied Sciences

Seema Rani Sarraf

Amity University Uttar Pradesh, Lucknow, India

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Abstract

Caregiving is a challenging role that impacts the emotional well-being of women, however it remains the most neglected area in clinical and social research. The present study aims to examine and compare the empathy among three various groups of married women: psychiatric patient caregivers, medical patient caregivers and non-caregiving women.

Methodology: Purposive sampling was used to assess 389 married women (mean age 40.5). The sample comprises psychiatric caregivers (n = 122), medical caregivers (n = 137), and non-caregiving women (n = 130). To collect desired response for empathy Toronto empathy questionnaire developed by Spreng et al. (2009) was used. Data was analyzed using descriptive statistics and one-way ANOVA.

Results: One-way ANOVA represents high significant results, which denotes significant differences in empathy scores across three groups. Descriptive statistics reveal that non-caregiver women's empathy level was highest, followed by medical caregivers and psychiatric caregivers respectively.

Implication: The findings emphasized that women who were actively involved in caregiving, especially for psychiatric patients, demonstrated low empathy among all the groups. This can be due to the absence of adequate amount of societal and institutional support systems for female caregivers. Psychiatric patient caregivers in particular face severe stigma, isolation and high levels of exhaustion and burden with no societal support. While medical caregivers experience only partial support structure.

These results highlight the urgent need for the intervention such as social support programs for caregivers and policy level initiatives that acknowledges the unseen burden carried by women caregivers in Indian society.

Keywords: Empathy, Caregiver Burden, Married Women Caregivers, Psychiatric Caregiving

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1. Introduction

Empathy is a term that means the ability to understand other's feelings, and it talks about the fundamental dimension that how people interact with each other, build relationships with one another and help others (Davis, 1994; Spreng et al., 2009). It includes both an effective response to others' emotional state and builds a cognitive understanding of their experiences. Empathy not only plays a crucial role in personal relationships but also plays a major part in caregiving, where persistent emotional awareness to the suffering and needs of patients is very important (Decety & Jackson, 2004; Klimecki & Singer, 2012).

In India, the informal caregiving system is very dominant. It is fully family based, and stays within the framework of women particularly. Often married women are assigned with caregiving duties. A huge amount of burden of caregiving is put on their shoulders. Traditionally gender roles, social norms and familiar expectations are assigned as women's responsibility of caretaking, irrespective of severity of the patient's condition (Rathi & Bhatt, 2018; Böge et al., 2018).

Caregiving for mentally ill patients involves a huge responsibility of physical tasks, medications, and every kind of support. However, caregiving for psychiatric patients takes more social, emotional and psychological dimension (Grover et al., 2015).

The literature on caregiver burden has constantly demonstrated that sustained caregiving often leads to heightened, psychological distress, anxiety, depression and poor quality of life. life (Srivastava et al., 2017; Gupta et al., 2025).

A crucial but unexplored aspect of burden is its impact on empathy- which is the very emotional source which extends the caregiving relationship. It is so just done different fields of health psychology and social neuroscience suggest that the prolonged encounters to the suffering of others, where there is no support of copying resources or no institutional support, often leads to compassion fatigue, emotional burnout and empathy erosion (Figley, 1995; Klimecki & Singer, 2012; Sukut et al., 2022).

Despite an ample amount of research on caregiver burden in India, the systematic studies that compares the different level of empathy across different types of caregiving such as psychiatric versus medical- with non-caregiving women, a control group remains insufficient and unexplored.

The present study addresses this research Gap by utilizing A. Standardized Psychometric instrument the 'Toronto empathy questionnaire' (TEQ; Spreng et al., 2009), which is used to assess the empathy across all three different groups of married women.

1.1 Research Gap

The existing review of literature has highlighted caregiver, burden, anxiety, depression and quality of life in caregivers of psychiatric patients in India (Koujalgi & Nayak, 2021; Soni et al., 2024).

The term empathy has got very little attention. Most of these studies have examined professional caregivers or the healthcare workers, which has left out the huge domain of informal caregivers- especially the ones which focus on women, as in India women are the main source of caregiving in the Indian families.

Additionally, the comparative research between empathy levels of psychiatric caregivers, Medical Caregivers and non-caregiving women is basically absent in Indian literature. This present study focuses on this research Gap and addresses it

1.2 Current Study

The current study measures the empathy level among three different groups of married women: psychiatric disorders caregivers, medical patient caregivers and the last group is women who were not involved in caregiving. Three hundred and eighty- nine married women from Lucknow chose using purpose sampling and were employed with the Toronto empathy questionnaire for the standardized assessment. Later, the findings were analyzed using the descriptive statistics, one-way ANOVA and post-hoc Tukey HSD, which is used to determine the nature and significance of different groups.

1.3 Rationale of The Study

The rationale of the current study surfaces from the interaction of three critical concerns: The under view of informal caregivers in Indian psychological research, the deprive of empathy as an outcome of the valuable in caregivers' well-being literature, the last will be the social culture specification of India that expand on women which will result in caregiver burden. In Indian society, psychiatric caregivers are often characterized by strong stigma and social isolation and thus they get no social support from society. Which results in diminishing empathy capacity over time.

On the other hand, medical caregiving is like a burden which typically attracts more societal sympathy and practical support. Documenting these differences not only makes us theoretically understand the stress of empathy but also offers the insight to design the caregiver support system and intervention in the Indian context.

2. Method

2.1 Sample

In the present study Three hundred and eighty- nine married women were chosen using purposive sampling. The sample was divided into three groups (1) Psychiatric patient caregiver (n=122), (2) Medical patient caregiver (n=137). And, (3) non-caregiving women (n=130).

The first group was psychiatric patient caregiver, in which the women provided primary informal caregiving, to a family member who was diagnosed with psychotic disorders including schizophrenia, bipolar disorder, major depressive disorder, or any other psychotic conditions. The second group was the medical patient caregivers and in this also women provided primary informal caregiving to the patient who was diagnosed with chronic illness like kidney diseases, cancer, diabetes, etc. and in the last group which was the non-caregiving woman growth married but they didn't give any formal or informal caregiving to anyone. The mean age of the total sample was 40.5 years that showed no statistically significant age difference across groups.

The present studies consisted of three groups- psychiatric patient caregivers, medical patient caregivers and non-Caregivers group, which combined made a total sample of 389 participants. All the participants across these three groups were married females.

In the terms of education medical caregivers' group 77 participants (56.2%) were undergraduate, 60 (43.8%) were postgraduate; In Psychiatric caregiver group 34 (27.9%) were undergraduate, 30 (10.7%) were postgraduate and 75 (61.5%) were considered in other categories (Like High School or below education); And non- caregiver group 24 (18.5%) were undergraduate, 2 (1.5%) work postgraduate and 104 (80%) fell into other categories

In locality, the Medical Caregiver group had 18 (13.1%) participants from rural areas, 108 (78.8%) From urban, 11 (8.0%) from semi urban; In the psychiatric caregiver group 41 (33.6%) were from rural areas, 50 (41.0%) from urban and 31 (25.4%) from semi urban; Now in the non-caregiver group 44 (33.8%) from rural area, 62 (47.7%) from urban area and 24 (18.5%) from semi-urban

Socioeconomic status, in this medical caregivers, 17 (12.4%) were from high socioeconomics background, 105 (76.6%) were from middle socioeconomic status, 15 (10.09%) belong to low socioeconomic background; In psychiatric caregiver group 4 (3.3%) belong to high socioeconomic background, 86 (70.5%) were from middle socioeconomic status, 32 (26.2%) were from low socioeconomic status; In the non-caregiver group, none were from high socioeconomic 111 (85.4%) were from middle background and 19 (14.6%) were from low socioeconomics background

In the employment category, Medical Caregiver group, 33 participants (24.1%) were employed in jobs, government or private areas, 18 (31.1%) we're doing business and 57 (41.6%) were unemployed; In the psychiatric patient caregiver group, 14 (11.5%) were employed in jobs, 9 (7.4%) in government and private sectors, 3 (2.5%) were doing business and 96 (78.7%) were unemployed; In the non-caregiver group 15 (11.5%) were employed in jobs but, 7 (5.4%) in government or private sectors, none were doing business and 108 (83.1%) were unemployed

Family analysis shows that 39 medical caregivers (28.5%) lived in a joint family while 98 (71.5%) lived in nuclear families; In psychiatric caregivers 51 (41.8%) lived in joint family, 64 (49.2%) in nuclear family; In non-caregiver group 66 (50.8%) lived in joint family and 64 (49.2%) in nuclear family.

Lastly, birth order distribution showcases that the medical caregiver group, 50 (36.5%) were eldest, 40 (29.2%) were middle children, 36 (26.3%) were

youngest and 11 (8.0%) were single children; In the psychiatric caregiver group, 30 (24.6%) were eldest children, 59 (48.4%) were middle children, 30 (24.6%) were youngest children and 3 (2.5%) were single children; Lastly, in non-Caregivers groups 25 (19.2%) were eldest children, 63 (48.5%) were middle children, 41 (31.5%) were youngest children and 1 (0.8%) was single child

2.1.1 Inclusion criteria

Participants were only included if they were married women and have been residing the caregiving role for a minimum six months period of time and they were the primary caregiver of the patients

2.1.2 Exclusion criteria

Participants were excluded, if they were not the sole caregiver of the patient. The professional healthcare workers were also excluded and lastly those who

themselves had some kinds of chronic illness were also excluded.

2.2 Tools

A demographic sheet was employed to record details regarding the subject’s age, sex, educational qualifications, occupation, locality, socio-economic status, family type, and birth order.

The Toronto empathy questionnaire (TEQ; Spreng et al., 2009) was used to assess empathy across all three different groups. The Toronto empathy questionnaire is a 16 item self-report instrument that primarily focuses on measuring empathy. Items are rated on a five-point linker scale which ranges from 0 (never) to 4 (always). Some items were reverse scored also. Total score ranges from 0 to 64 with 64 being the highest indicating empathy level. The Toronto empathy questionnaire strongly indicates internal consistency (Cronbach's $\alpha = .85$) and high test-retest reliability ($r = .81$).

3.Result

The present study assesses empathy levels among three groups of married women. Descriptive statistics and ANOVA were used for the empathy scores across the three different groups presented in table 1.

Table 1: Descriptive Statistics and ANOVA for Empathy Scores Across Three Groups

Group	N	Mean	SD	F value	p value
Psychiatric	122	43.93	7.54	89.99	.001
Medical	137	44.05	11.89		
Non-Caregiver	130	56.55	4.96		

A one way between group ANOVA was conducted to highlight the differences in empathy scores across the three groups. The analysis highlighted the significant results ($F(2, 386) = 89.99, p < .001$). Groups differed significantly from others with a large effect size ($\eta^2 = .318$), which indicates that group membership has a strong influence on empathy scores. Caregiving experience is strongly linked to empathy development.

Turkey’s HSD post-hoc was conducted which highlighted that the mean difference between the psychiatric care group and the non-caregiving group was 12.62 ($p < .001$), which strongly indicates the non-caregiving woman group scored high on empathy level in comparison to psychiatric caregivers. Similarly, the mean difference between the medical caregiver group and the non-caregiving group was also done and their mean difference was 12.50 ($p < .001$), that also signifies that non-caregiving women scored higher empathy than medical caregivers. But on the other hand, it was observed that the mean difference between psychiatric caregiver group and the medical care group was 0.12 ($p = .994$), that signifies no statistically significant difference in empathy between these two groups.

Table 2: Post hoc mean comparison for groups on empathy

Group	Means	Psychiatric Care giver	Medical Care givers	Non-caregivers
		43.93	44.05	56.55
Psychiatric Care giver	43.93	X	0.125	12.620*
Medical Care givers	44.05		X	12.495*
Significant at $p < .05$				

Psychiatric patient caregiver and medical patient caregiver will have no significant difference. Psychiatric caregivers will have lower empathy than both the groups. Both medical and psychiatric caregiver groups will have significant differences with non-caregiving groups.

4. Discussion

The psychiatric patient caregiver, in which the women provided primary informal caregiving, to a family member who was diagnosed with psychotic disorders including schizophrenia, bipolar disorder, major depressive disorder, or any other psychotic conditions. The second group was the medical patient caregivers and in this also women provided primary informal caregiving to the patient who was diagnosed with chronic illness like kidney diseases, cancer, diabetes, etc. and the last group which was the non-caregiving woman married as they didn't give any formal or informal caregiving to anyone. The mean age of the total sample was 40.5 years that showed no statistically significant age difference across groups.

The finding highlighted that both psychiatric caregivers and Medical Caregivers showed significantly lower empathy in comparison to non-caregiving women's, which intersects with the large amount of literature, linking caregiver burden, emotional depletion and compassion fatigue (Figley, 1995; Klimecki & Singer, 2012; Zhang et al., 2018). Sustained exposure to the suffering of a family member when combined with no institutional support results in empathy erosion which is basically gradual reduction in caregivers' ability to emotionally connect with their patients (Franza et al., 2015; Thomas & Hazif-Thomas, 2020). Liu, Heffernan, and Tan (2020) identified key attributes of caregiver burden, including self-perception of strain, emotional and physical exhaustion, and the cumulative stress that arises from prolonged caregiving responsibilities. Their study emphasized that caregiver burden has significant

consequences, such as deterioration in physical and psychological health and a reduction in overall quality of life. Akdoğan and İlhan (2024), revealed that female gender, poor mental health, low levels of social support, and the dependency of care recipients significantly increased the burden experienced by caregivers.

The lack of significant difference between the psychiatric caregivers in medical caregivers despite the theoretical expectation that psychiatric caregiving would be heavier in burden, needs to be looked at carefully. There is a common thing between both the caregiving firms that when overused for a long period of time without any kind of external support, the person becomes emotionally drained. This finding is also shown in the Koujalgi and Nayak's (2021) that carefully cites care-given burden is elevated across chronic illness caregiving in India, Though higher in psychiatric context.

On the other hand, there is one more explanation that Medical Caregivers show more variation in experiences. This means medical caregiving can vary from person to person, where some caregivers deal with their patients in an easy manner like they can control the blood pressure or diabetes of the patient, while on the other hand, some patient Caregivers deal with serious illnesses which are cancer or chronic heart diseases. Because of this variation in the illness level, the empathy varies also from person to person. Well, some medical caregivers can find caregiving emotional, connected and meaningful, that helps them maintain their empathy. Others may face heavy challenges similarly to those in psychiatric caregiving.

Although the difference of empathy level is very small between psychiatric caregivers score to the medical caregiver score, these finding matches with the previous studies such as Sukut et al.'s (2022) that carefully said that psychiatric nurses has very low empathy level due to the higher emotional exhaustion when seen in general nursing. Similarly, other founding by Franza et al.'s (2015) also state that there is a higher level of burnout in psychiatric caregiving this can be due to the stigma often faced by psychiatric caregivers and the social isolation too. (Koschorke et al., 2017; Böge et al., 2018) even though at this time of the research, there is not a large significant difference between the empathy level of medical and psychiatric caregivers. But later over a longer period of time, the difference can grow and the empathy can gradually reduce.

4.1 Gender and socio-cultural context

The present study highlighted and interpreted within the social culture context of married women in India. Women are expected to take care and do the main and primary role of caregiving. At the current times there is limited access to social support and financial resources. This makes the caregiver more and the gradually lose empathy (Rathi & Bhatt, 2018; Böge et al., 2018). It was clearly seen that non-caregiving women from the same background such as they were also married also of the similar age showed higher Empathy which clearly shows that a caregiving role depletes empathy in a person, not the factors such as marital status or age.

Studies such as Paul (2016) and Böge et al. (2018) also highlight the gender roles in India about caregiving responsibilities and how the lack of support increases the psychological stress in caregivers. And this present study also highlights this statement by showing a higher level of pressure that reduces the empathy level in caregivers. This is an important thing that needs to be logged on because it affects the quality of life of the caregivers and as well as the patient.

4.2 Implications for Intervention and Policy

The result clearly highlighted the need for the urgent support and a well-structured intervention for the informal caregivers of both psychiatric and medical patient caregivers in India. Lipsa et al. (2024) their study highlighted that psychological programs that focus on resilience, managing emotions and self-compassion can reduce the compassion for geeks and improve empathy level, which can help the professionals. So according to

this, the similar program also can be adopted for the informal female caregivers in India, they can be provided with the community health centers, primary health Care services, or even the online support if they need any, with this intervention, we can surely look over the reduced empathy levels and healthy caregivers.

The policies can be also implemented, as the study highlighted the importance of strengthening India's mental health system, especially when India has laws like the health mental health Care act 2017, to include caregiver well-being. The intervention can include the temporary relief care, support group for caregivers, and some educational programs about mental health, basically the psycho-education.

Gupta et al. (2025) finding highlights the need for caregiver burdens in situations like schizophrenia in India. Similarly, Praharaj and Arahamthabailu (2024) also pointed out the same stigma, lack of community support and financial difficulty that needs to be addressed to reduce the burden of informal caregivers.

5. Limitations

Since the study used cross-sectional design, due to that it shows the cause and effect. So, we cannot fully share whether a low empathy level came before caregiving due to any other reasons or whether the stress of caregiving reduced the empathy levels gradually over time. Purposive sampling was used which clearly means that participants were selected on the basis of specific needs. Because of this, the result cannot be applied to the people outside of the study area.

6. Conclusion

The current study clearly showed that married women caregivers, whether they are caring for psychiatric patients. All the medical patients have significantly lower empathy level compared to those women who are not doing any kind of caregiving roles. This difference is quite large

Which is both statistically important and meaningful in real life. This study clearly highlighted that women giving informal caregiving to a patient can gradually reduce empathy in India. On the other hand, it was seen that there is no difference in empathy between these psychiatric caregivers and medical caregivers, this can be due to the strain long period of caregiving given to the patients, without any social support by the society and

stigma faced by them which affects in the same way emotionally and physically no matter the type of illness.

The findings are very important for the intervention as it clearly needs mental healthcare programs of their own and the public policies for the caregivers. A multi-dimension intervention can be enforced via the psychologist, social workers and healthcare workers can work together for an intervention program and they can pay attention to empathy which is equally important to the stress of burden.

In India, women caregivers generally go unnoticed whereas it needs to be the most recognized and well-supported area. Women who care for psychiatric patients, especially need some kind of intervention as the offer deals with stigma, isolation and emotional exhaustion. So the policies can be implemented that not only focuses on patients but clearly make a priority for caregiver roles

For the future studies, the research can be turned over a longer period of time and can be helpful in noticing the empathy level changes. How throughout the caregiving journey. The factors like, handling stress and personality building can be also studied in respect to the effect of empathy level. There is a strong need for more research on empathy and how we can store them and even prevent caregivers from depletion of empathy or emotional exhaustion. Informal caregivers in India are the area which is not well explored.

Data Availability: The data are available with the authors.

Declaration: The authors hereby declare that the manuscript submitted for consideration is an original work and has not been published or submitted elsewhere for publication. The authors take full responsibility for the integrity, accuracy, and ethical compliance of the work presented in the manuscript, including all revisions made in response to reviewer comments.

AI Usage Statement: Authors declare that AI tools, if used, were solely employed to improve the clarity, grammar, and language of the manuscript (as indicated in the reviewer's comments). No data, results, or scientific content were generated or altered using AI.

Conflict of Interest and Ethical Compliance: All authors confirm that: Any potential conflicts of interest, whether financial or non-financial, have been fully

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Ethical Approval: As the study involved the participation of a non-clinical, non-vulnerable sample; only informed consent was obtained from the participants after explaining the purpose of the study to them.

Consent to Participate: Informed consent was obtained from all the participants.

Consent for Publication: All the authors consent to publication of this paper.

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