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Review Article

Clinical Indicators of the Nursing Diagnosis Caregiver Role Strain: A Systematic Review of Accuracy

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Introduction. Increased life expectancy leads to consequent long-term care needs, where informal caregivers may experience overload and strain associated with caregiving, influencing the well-being and health of individuals and eventually leading to an effort to fulfill their role. Within this context, a condition called caregiver role strain has been identified. *Objective.* To investigate the clinical indicators of the nursing diagnosis caregiver role strain as described in the literature. *Materials and Methods.* This study is a systematic review of diagnostic accuracy conducted in October 2023, following the recommendations of the Joanna Briggs Institute. The review protocol was registered and approved in the Prospective International Register of Systematic Reviews under registration number CRD42022377411. The QUADAS-2 tool was used to assess the risk of bias and quality of the studies. The databases included SciVerse Scopus (Elsevier), MEDLINE/PubMed (via National Library of Medicine), Latin American and Caribbean Health Sciences Literature (LILACS), CINAHL with Full Text (EBSCO), and PsycINFO (APA), with 48 articles included for quantitative synthesis. *Results.* Fourteen defining characteristics were identified from the literature, with a predominance of the following indicators: depressive symptoms (45.8%), anxiety (41.6%), physical decline (31.2%), fatigue (22.9%), disturbed sleep pattern (20.8%), emotional disturbance, and irritability (16.6%). The findings suggest that, within the defined circumstances and limitations of the study, examining defining characteristics for the diagnosis caregiver role strain holds potential for advancing scientific knowledge regarding human responses to the challenges experienced by caregivers. *Evidence for Practice.* The study aligns with clinically relevant indicators crucial for refining and updating the diagnosis, thereby enhancing its level of evidence and clinical accuracy. Simultaneously, it supports addressing the gap in caregiver support and standardized nursing care plans.

1. Introduction

The increase in life expectancy due to the emergence of new treatments, improved quality of life, and health policies is associated with rising social and economic costs, as well as an increase in the prevalence of chronic and hereditary diseases and the need for long-term care. When out-of-hospital care is provided primarily by family members, these individuals are referred to as informal caregivers [1].

An informal caregiver is defined as a person who provides care, especially in the home environment, by family members or close associates without remuneration [2]. The Integrated Care for Older People (ICOPE) program developed by the World Health Organization (WHO) includes among its guidelines the implementation of interventions to support caregivers [3]. Such support should be based on the most recent scientific evidence available on the subject [1].

Extensive studies have examined the burden and strain experienced by informal carers. Caring for a dependent person changes the caregiver's lifestyle according to the needs expressed during the person's illness. In addition to the physical demands, it is critical for the caregiver to have emotional stability and to be able to balance caregiving with other activities, whether related to household responsibilities or employment. If not effectively balanced, this situation can lead to overburdening that negatively impacts both physical and mental health, especially if the caregiver is also going through the aging process or has developmental disabilities [4].

The condition known as "burden" can trigger the manifestation of psychiatric, physical, emotional, and social symptoms, as well as an increase in medication use. At the same time, it can have an impact on economic life and affect the provision of care. It is noteworthy that the level of burden correlates with the degree of dependence of the individual [5].

The aforementioned complications can affect the well-being and health of the individual, ultimately promoting efforts to fulfill the caregiving role in the long term. In this context, a condition known as caregiver role strain (CRS) has been established [6]. Over the years, the study of CRS has grown, revealing different types of caregivers providing care for different demands related to chronic kidney disease, heart failure, dementia, individuals with developmental disabilities, and those in palliative care [7–11].

The phenomenon caregiver role strain is also a nursing diagnosis (ND) listed in the NANDA-I taxonomy, belonging to the role relationship domain and the caregiving roles class. Within the classification and categorization of diagnoses established by the taxonomy, levels of evidence are highlighted for each diagnosis. These levels are divided into two main levels: level 1, which corresponds to the initial stage of development of the diagnosis prior to its inclusion in the taxonomy, and level 2, which includes subsequent stages that consider the strength of the available evidence, including expert opinion studies or studies conducted on populations susceptible to the occurrence of a given diagnosis [12]. Each level has structured subdivisions based on study methods. Therefore, a caregiver diagnosis has higher levels of evidence when the available evidence is more robust. Currently, the ND caregiver role strain (00061) is classified at level 2.1, which represents the initial phase of an approved diagnosis for inclusion in the classification, requiring initial theoretical studies supplemented by content validation and clinical confirmation to establish its validity and diagnostic accuracy [12].

Among the elements used to construct nursing diagnoses in NANDA-I, clinical indicators stand out, which are clinically expressed through signs and symptoms manifested by the individual and related to the circumstances of the event. Currently, the defining characteristics of CRS consist of 32 clinical indicators grouped into four dimensions: caregiving activities, caregiver health status, caregiver-care receiver relationship, and family processes. In addition, factors associated with this diagnosis are grouped into six subclasses. There are also six at risk populations and two associated conditions linked to the diagnosis [12].

Despite recent updates, it is evident that the diagnosis remains at a level of initial evidence (2.1), which, based on theoretical studies, requires scientific strengthening to develop its conceptual core and thereby improve its diagnostic accuracy. Therefore, it promotes the evolution of the level of evidence and improves clinical recognition in the practice of nursing professionals [1]. Based on this, this systematic accuracy review aims to address the following guiding question: "What are the clinical indicators, defined by expert opinion, evaluation committees, or latent variable analysis, that constitute the nursing diagnosis caregiver role strain, as described in the literature?" Thus, the study aims to investigate the clinical indicators of the nursing diagnosis caregiver role strain as described in the literature.

2. Materials and Methods

2.1. Study Type, Data Sources, and Search Strategy. This study is a systematic review of diagnostic accuracy conducted according to Joanna Briggs Institute (JBI) guidelines. Its protocol was submitted to and approved by the Prospective International Register of Systematic Reviews (PROSPERO) on November 11, 2022, and approved on November 30, 2022, with registration number CRD42022377411 [13].

The review protocol for the study was systematically conducted, following the collaborative Cochrane approach to accurately assess the diagnostic tests. The study selection process was conducted by two independent reviewers (BECB and MTML) in adherence to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [14]. In cases of disagreement, a third researcher was appointed to decide on the inclusion or exclusion of the study. The involvement of a librarian professional was deemed unnecessary.

The PIRD framework was used to construct the research question: Population ("Caregivers" OR "Family Relationships"); Index test ("Signs and Symptoms"); Reference test ("Expert Opinion" OR "The Panel of Evaluators" OR "Latent Variable Analysis"); and Diagnosis of interest ("Caregiver Diagnosis" OR "Caregiver Burden"). The research question was: "What are the clinical indicators, as defined by expert opinion, panel of evaluators, or latent variable analysis, that comprise the nursing diagnosis caregiver role strain?" Descriptors and Boolean operators "OR" and "AND" were used in the search.

The cross-referencing strategy included English MeSH descriptors: "family caregiver" OR "caregiver" OR "caregiving behavior" OR "care dependency" OR "caregiving relationship" OR "family relationship" AND "signs and symptoms" OR "clinical indicator" OR "fatigue" OR "exhaustion" AND "expert opinion" OR "panel of raters" OR "latent variable analysis" AND "care diagnosis" OR "care diagnoses" OR "caregiver burden" OR "caregiver stress."

Some of the words used are not considered descriptors; therefore, keywords were used to obtain a higher percentage of studies. These were obtained based on previous systematic reviews in the field of caregiver stress and according to the researchers' expertise in the phenomenon and the study of the NANDA-I taxonomy.

The search was conducted in October 2023 through the periodicals portal of the Coordination for the Improvement of Higher Education Personnel (CAPES) with validated access through the Federated Academic Community (CAFe). The databases SciVerse Scopus (Elsevier), US National Library of Medicine (MEDLINE/PubMed), Latin American and Caribbean Health Sciences Literature (LILACS), CINAHL with Full Text (EBSCO), and PsycINFO (APA) were searched.

2.2. Eligibility Criteria. Exclusion criteria for this review included full text not available in electronic databases and nonempirical studies such as commentaries, editorials, letters to the editor, and abstracts. Inclusion criteria consisted of complete studies available in the data sources, studies addressing the research topic with exposure of clinical indicators interpreted as human responses to the highlighted phenomenon, and studies identifying the nursing diagnosis caregiver role strain, irrespective of time frame, whether the diagnosis was proposed by NANDA-I or not. It is noted that there were no restrictions regarding study designs, languages, or temporal scope.

2.3. Bias Assessment. Researchers assessed the eligibility of titles and abstracts and proceeded to read the full text of the selected studies. The methodology and quality of the selected studies were evaluated using the adapted Quality Assessment of Diagnostic Accuracy Studies (QUADAS-2) instrument to assess methodological biases [15].

The assessment comprises four main domains: patient selection, index test, reference standard, and flow and timing, structured according to the PIRD framework. The research team required a minimum performance of 70% across all four domains for inclusion in the final sample. Any discrepancies during the dual screening process were resolved by a third researcher.

2.4. Study Selection. Initially, 4,244 records were retrieved from the online databases and forwarded to Rayyan [16]. Following the screening of titles and abstract content, 4,151 records were excluded for being irrelevant to the subject. Subsequently, 93 articles were preselected for full-text screening based on exclusion criteria. After eligibility assessment and the application of QUADAS-2, 34 full-text articles were excluded. Finally, 48 journal articles were included for quantitative synthesis in this review. Figure 1 displays the search and selection procedure for this review.

3. Results

The systematic review of diagnostic accuracy integrated 48 studies. Table 1 displays the data that characterize the studies based on publication year, language, continent, database, method, and disciplinary area.

From the displayed results, it is observed that 30 publications (62.5%) fall within the 2020–2023 period, indicating a predominant focus on research in the last decade. Simultaneously, there is a prevalence of 19 studies in the European continent (39.5%). However, there is a tendency towards equal distribution between research conducted in the Americas, comprising 14 studies (29.1%), and Asia with 14 publications (29.1%).

Regarding the databases, there is a prevalence of articles from PubMed/MEDLINE, constituting 29 articles (60.4%) as the primary data source, while 19 studies (39.5%) have a cross-sectional nature.

Concerning clinical indicators, the review facilitated the identification of 14 consequents (defining characteristics) presented in Table 2.

Among the identified indicators, it is noteworthy that 22 studies (45.8%) correlated depressive symptoms with CRS, while 20 studies (41.6%) highlighted anxiety as another strong clinical indicator of this ND. Alongside emotional indicators, 15 articles mentioned physical decline (31.2%), and 11 publications mentioned fatigue (22.9%).

The relationship of each clinical indicator was defined according to the literature, as outlined in Table 3, to provide a comprehensive understanding of its association with CRS.

4. Discussion

The data obtained demonstrate that clinical indicators for caregiver role strain are extensively studied, and among those found in this review, the most prevalent were depressive symptoms, anxiety, deterioration of self-esteem, disturbed sleep pattern, and emotional disturbance. Such psychological signs and symptoms may give rise to other clinical indicators, such as distress, guilt, and sadness, or contribute to the recognition of a sense of loss of identity, thereby instigating role conflicts, low self-esteem, loneliness, and irritability, all attributable to the caregiving process and the phenomenon of burden [27, 32–34, 44, 45, 48, 58].

Regarding the defining characteristics identified with higher prevalence, only depressive symptoms are explicitly mentioned by NANDA-I. However, the other indicators are more commonly associated with caregiver role strain, as they emerge due to the lack of attention to caregivers' fundamental emotional needs. Additionally, the manifestation of disorders such as anxious symptoms creates a disruptive condition that may be caused by the worsening health status of the care recipient [34, 50, 59].

Depressive feelings are defined as somatic symptoms and slowed activity, which may reflect the impact of mood on physical health and decreased motivation to be active. Decreased activity can perpetuate altered self-concept, increase perceived stress and burden, and ultimately lead to feelings of helplessness [60].

In a previous study, data suggest that caregiver anxiety and depression, along with the severity of the illness, may interact bidirectionally. Therefore, the progression of the illness can lead to increased anxiety and depression among caregivers, and more depressed and anxious family members tend to adhere less to prescribed treatments, resulting in a worsening condition for the patient [61].

Anxious feelings entail constant monitoring of one's own behavior and actions related to other individuals. It is characterized by frequent concerns regarding safety, caregiving actions, and the well-being of the care recipient [8].
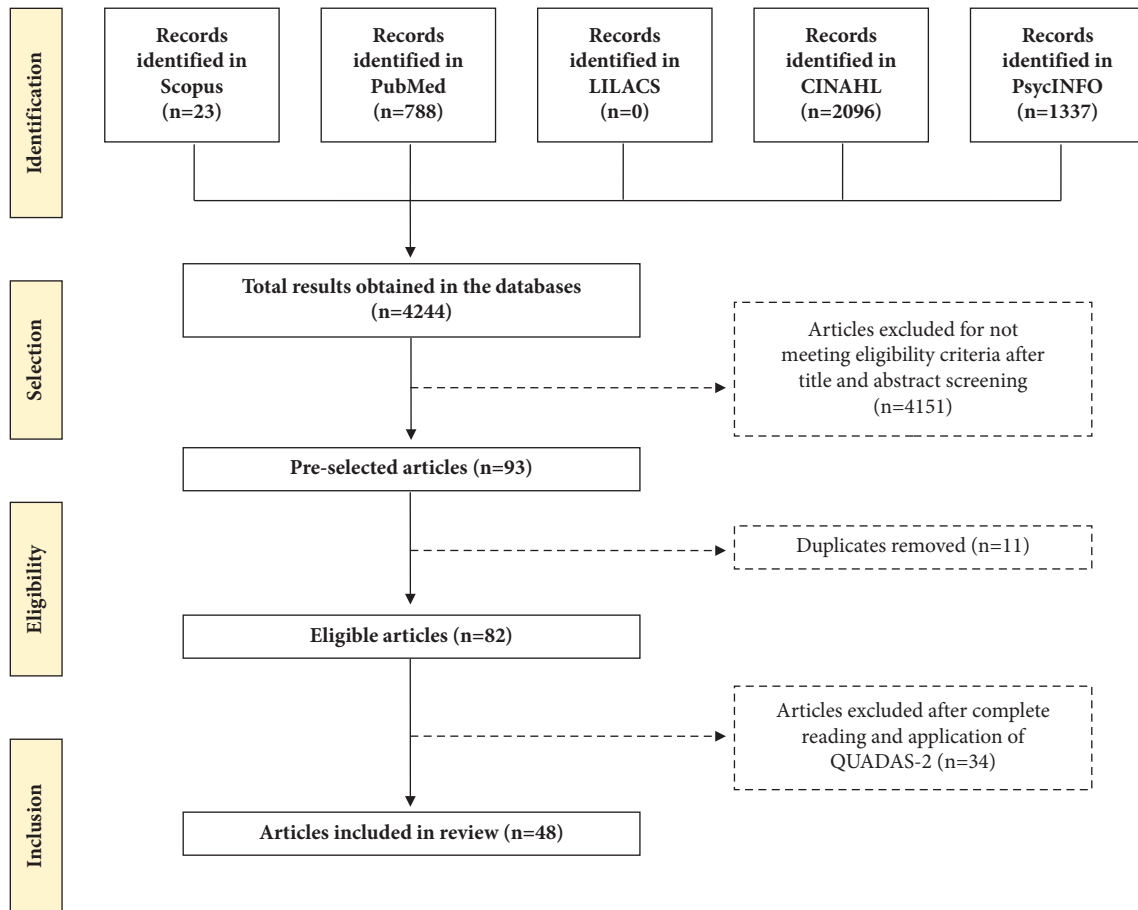
FIGURE 1: Flowchart of the final sample selection process for the accuracy review.

In a previous systematic review with meta-analysis, it was discerned that the subjective burden experienced by caregivers correlated significantly with heightened levels of clinically significant anxiety. Furthermore, the robustness of the observed association suggests that subjective burden serves as a crucial indicator of anxiety-related psychological distress among caregivers [27]. Feelings of guilt also cause severe emotional distress; caregivers feel as if they are on an "emotional rollercoaster," feeling guilty for not living up to the expectations of their role as a caregiver or family member, especially in social contexts, for not providing adequate care, and for not working enough to improve the patient's health. In Belgium, a study revealed that 45.9% of caregivers experienced persistent feelings of guilt associated with caregiving obligations [62].

The presence of physical health deterioration and fatigue often leads to pain and alterations in dietary patterns, which constitute repercussions of caregiver burden and exert a negative impact on physical activities, thereby impairing the ability to carry out daily tasks. These factors collectively affect the caregiver's perception of their quality of life and health, while also increasing the likelihood of encountering physical and social problems. Examples include emotional exhaustion and the fragility of support networks [35, 46].

A study conducted in Serbia found that caregiver burden was predicted by the physical health status of the caregivers.

Consistent with findings from other studies, which have demonstrated that heavier caregiver burden is associated with poorer physical health, some individuals report neglecting their physical health or completely forgoing exercise due to the constant need for support and care. These results provide evidence that functional capacity in activities of daily living is an important indicator of caregiver role strain [63, 64].

Additionally, the manifestations of fatigue experienced by caregivers arise from the excessive physical demands of caregiving and represent another significant challenge. Consequently, the expression of this indicator is a result of sleep deprivation due to the physical burdens of caregiving. One study identified loneliness as an independent risk factor for frailty. Moreover, loneliness was associated with depression, sleep disturbances, and fatigue [41].

A study conducted in China with caregivers of oncological patients suggests that family members diagnosed with chronic illnesses often assume caregiving roles, leading to obvious physical strains due to their poor health conditions. These individuals reported experiencing loss of appetite and fatigue, as the high physical burden of caregiving disrupted their daily routines, resulting in physical overload characterized by sleep disturbances, lack of appetite, and low energy. Furthermore, the findings also indicate that caregivers with chronic illnesses experienced higher levels of

TABLE 1: Overview of the selected studies for the diagnostic accuracy review based on year, language, continent, database, method, and disciplinary area.

Variables	n	%
Year of publication		
2009–2014	6	12.5
2016–2019	12	25
2020–2023	30	62.5
Language		
English	48	100
Continent		
Europe	19	39.5
America	14	29.1
Asia	14	29.1
Oceania	1	2.0
Database		
PubMed/MEDLINE	29	60.4
CINAHL	18	37.5
PsycINFO (APA)	1	2.0
Design		
Cross-sectional	19	39.5
Review	11	22.9
Cohort	4	8.3
Validation	4	8.3
Comparative	3	6.2
Mixed methods	1	2
Qualitative	1	2
Clinical trial	1	2
Others	4	8.3
Disciplinary area		
Other	21	43.7
Nursing	17	35.4

TABLE 2: Clinical indicators of caregiver role strain identified in the diagnostic accuracy review.

Clinical indicators*	n	%
Depressive symptoms	22	45.8
Anxiety	20	41.6
Physical health decline	15	31.2
Fatigue	11	22.9
Disturbed sleep pattern	10	20.8
Emotional disturbance	8	16.6
Irritability	8	16.6
Role conflict	7	14.5
Anguish	6	12.5
Guilt	5	10.4
Sadness	3	6.2
Loneliness	2	8.3
Feelings of helplessness	2	8.3
Deterioration of self-esteem	1	2.0

*Multiple answers.

burden because their poor physical conditions hindered them from performing caregiving tasks [65]. Nurses are health educators. They undertake educational activities aimed at communities, groups, and individuals. Their role is to address the needs presented by caregivers, emphasizing the importance of self-care, prevention, and health promotion with the goal of empowering and strengthening the caregiver. This role should focus on developing skills that target the caregiver population, planning, and transitioning roles to ensure continuity of care [66].

The quality of sleep for caregivers is often disrupted due to insomnia, sleep fragmentation, hallucinations, or sleep disorder activity, resulting from the additional nighttime care demands placed on the patient [67]. Simultaneously, feelings of helplessness emerge due to a sense of being unsupported, stemming from facing an illness, often progressive and incurable. This dynamic transforms interpersonal relationships, leading to a role reversal that frequently engenders conflict for the caregiver and translates into increased time demands on the caregiver, impacting relationships with other members of the social or family nucleus [68].

In summary, among the recognized consequents, only "fatigue" and "sadness" are currently in the NANDA-I taxonomy. The consequent "irritability" was a finding from the reviews of this research that closely resembles "expresses anger," which is already in the classification. Depressive feelings were considered as a manifestation of undesirable human response, differing from their organization within NANDA-I, where they are conceptualized as a related factor [12].

This study elucidates that caregiver role strain can lead to detrimental outcomes for both caregivers and care recipients. The findings contribute to understanding the mental and physical repercussions experienced by caregivers, as previous literature data did not comprehensively present such indicators and their relationships.

Through this study, it is also evident that recognizing the clinical indicators of the caregiver role strain phenomenon aids professional healthcare by clarifying diagnosis and enabling relevant, resolution-oriented interventions based on scientific evidence. Considering that illness influences both the patient and those providing care, acknowledging these indicators facilitates the theoretical development of an undesired human response as a nursing diagnosis. This is often overlooked or not widely disseminated in healthcare institutions, thus hindering its visibility or understanding in recent research.

Lastly, it is noted that the literature on caregiver role strain, particularly as a nursing diagnosis, is still in its early stages. The predominance of publications only in recent years introduces the concepts surrounding the caregiving context in an introductory manner, potentially leading to ambiguity in its clinical manifestations and similar concepts. This ambiguity can hinder the recognition of this phenomenon in professional practice.

Therefore, the presented results facilitate a comprehensive understanding of a human response present within the realm of caregiving individuals. The findings regarding clinical indicators as manifestations of caregiver strain allow for the development of a theoretical construct of the concept, especially given the scientific method adopted in the research and the relationships highlighted. Thus, this update contributes to a better recognition of the manifestations exhibited by caregivers and the development of NANDA-I as a standardized language system, as it stems from a study that showcases the best and most recent available evidence.

TABLE 3: Clinical indicators and studies included.

Clinical indicators	References
Depressive symptoms	Hejazi et al. [8]; Suksatan et al. [9]; Bachner et al. [17]; Goodwin et al. [18]; Rodrigo-Baños et al. [19]; Alshammari et al. [20]; Pousada et al. [21]; Paek et al. [22]; de Wit et al. [23]; Graessel et al. [24]; Shankar et al. [25]; Martire et al. [26]; Del-Pino-Casado et al. [27]; Guthrie et al. [28]; Çevik Özdemir and Şenol [29]; Reuvers et al. [30]; Liu et al. [31]; Hu et al. [32]; Lee et al. [33]; Rajagopalan et al. [34]; Brennan et al. [35]; Lindt et al. [36]
Anxiety	Pattison et al. [4]; Hejazi et al. [8]; Suksatan et al. [9]; Goodwin et al. [18]; Alshammari et al. [20]; Pousada et al. [21]; Paek et al. [22]; Del-Pino-Casado et al. [27]; Çevik Özdemir and Şenol [29]; Bradshaw et al. [37]; Oosterveer et al. [38]; Doss and Popejoy [39]; Reuvers et al. [30]; Liu et al. [31]; García-Martín et al. [40]; Del-Pino-Casado et al. [27]; Hu et al. [32]; Rajagopalan et al. [34]; Brennan et al. [35]; Bonin-Guillaume et al. [41]
Physical health decline	Pousada et al. [21]; Martire et al. [26]; Del-Pino-Casado et al. [27]; Bradshaw et al. [37]; Landfeldt et al. [42]; Chang et al. [43]; Doss and Popejoy [39]; Reuvers et al. [30]; Liu et al. [31]; Fekete et al. [44]; Hayashi et al. [45]; Maple et al. [46]; Bonin-Guillaume et al. [41]; Koopman et al. [47]; van Roij et al. [48]
Fatigue	Hejazi et al. [8]; Suksatan et al. [9, 27], Çevik Özdemir and Şenol [29]; Bradshaw et al. [37]; Latheef et al. [49]; Reuvers et al. [30]; Liu et al. [31]; Hayashi et al. [45]; Rand et al. [50]; Maple et al. [46]
Disturbed sleep pattern	Hejazi et al. [8]; Suksatan et al. [9]; Paek et al. [22]; Landfeldt et al. [42]; Küçükgüçlü et al. [51]; Reuvers et al. [30]; Liu et al. [31]; Fekete et al. [44]; Bonin-Guillaume et al. [41]; Lindly et al. [52]
Emotional disturbance	Bachner et al. [17]; Martire et al. [26]; Latheef et al. [49]; Ribeiro et al. (2021), Fekete et al. [44]; Hayashi et al. [45]; Maple et al., [46]; Lindly et al. [52]
Irritability	Pattison et al. [4]; Tsai et al. [10]; Bradshaw et al. [37]; Guthrie et al. [28]; Doss and Popejoy [39]; Reuvers et al. [30]; García-Martín et al. [40]; Rajagopalan et al. [34]
Role conflict	Pattison et al. [4]; Suksatan et al. [9]; Çevik Özdemir and Şenol [29]; Boumans and Dorant [54]; Konerding et al. [55]; Doss and Popejoy [39]; Lindt et al. [36]
Anguish	Wang et al. [11]; Iype et al. [56]; Namasivayam-MacDonald and Shune [57]; Guthrie et al. [28]; Reuvers et al. [30]; Maple et al. [46]
Guilt	Pattison et al. [4]; Bradshaw et al. [37]; Doss and Popejoy [39]; Reuvers et al. [30]; Rand et al. [50]
Sadness	Bradshaw et al. [37]; Namasivayam-MacDonald and Shune [57]; Reuvers et al. [30]
Loneliness	Bonin-Guillaume et al. [41]; Koopman et al. [47]
Feelings of helplessness	Doss and Popejoy [39]; Reuvers et al. [30]
Deterioration of self-esteem	Landfeldt et al. [42]

This study has limitations, such as the lack of access to certain research that could have been included in the sample and the predominance of studies from other scientific fields, not exclusively nursing. This may indicate a restriction regarding the diagnosis and the definition of its indicators. At the same time, because caregiver role strain is a nursing diagnosis with behavioral characteristics, there may be difficulty in establishing cause-and-effect relationships between the consequences and the phenomenon of interest.

Conducting a systematic review poses challenges in managing the vast volume of generated information and extracting relevant findings. The time dedicated to these stages and the available human and operational resources emerged as limitations encountered during the course of the research. Therefore, another limitation that may restrict the generalization of the results is the difficulty in reconciling studies that exhibit diversity in populations, interventions, secondary variables, instruments used to infer the phenomenon, and the definition of outcomes. Since these

studies are not conducted using the same protocol, they introduce heterogeneity through clinical diversity.

Despite these limitations, this research offers significant contributions to the nursing literature and knowledge structure, particularly in the recognition of signs and symptoms associated with caregiver role strain by nurses. This is particularly noteworthy because it includes recent literature in building the clinical basis for nursing diagnosis evidence.

5. Implications

This study offers significant implications for nursing practice, research, management, and policies, as healthcare professionals, researchers, and managers are responsible for decision making. In the realm of research and study development, diagnostic development is directly linked to its evidence. Hence, the accumulation of evidence supporting the accurate interpretation of human responses aligns with the accuracy of the attributes of the phenomenon itself.

A literature synthesis adhering to high methodological rigor can provide a better understanding of the caregiver role strain concept, facilitating the development of a standardized professional language system as a tool for assessing the level of manifested strain or susceptibility to this phenomenon.

Therefore, the study aligns with clinically relevant indicators essential for the development of the diagnosis, contributing to its review, updation, and enhancement of evidence and clinical accuracy. It also recognizes a complex and multidimensional system in which each element can establish caregiver role strain. When not recognized, these elements converge towards the deterioration of caregivers' physical and mental health. Simultaneously, it facilitates addressing the gap in caregiver support and standardizing nursing care plans.

Furthermore, the study emphasizes critical aspects for nursing managers and organizations, highlighting the immediate need to generate and implement effective interventions to improve healthcare assistance for caregivers, given the repercussions of illness. These individuals belong to a neglected and understudied group in the nursing profession, especially concerning their undesirable human needs. Therefore, nurse managers should promote evidence-based education and standardization of language through the development of taxonomies to understand phenomena such as caregiver role strain and its implications.

Management must serve as a committed model for diversified and inclusive action, organizing care structures across all levels of the nursing hierarchy. This approach aims to mitigate and prevent strain by shifting focus from individual interventions to systemic and personalized approaches, informed by the best available evidence. Politically, nurses play a critical role in shaping healthcare policies to prioritize effective communication among patients, families, and professionals, ensuring assertive and efficient care. They excel in care coordination and articulating patients' needs with available healthcare resources. In political decision making, professionals can utilize this study to address caregiver role strain in managing care providers and their environments more effectively.

6. Conclusion

The findings indicate that within the CRS diagnosis, key clinical indicators—such as depressive symptoms, anxiety, and physical health decline—are notably prominent. These align with a globally acknowledged pattern of emotional and psychological susceptibility rooted in lifestyle and social environments. These elements notably impact sleep disruptions, leading to fatigue and reduced self-care practices.

This research aligns clinical indicators that are relevant to the development of the nursing diagnosis CRS, contributing to its review and updating, converging in increasing the level of its evidence and clinical accuracy. Simultaneously, it aids in addressing the gap in caregiver support and establishing standardized care plans. A deeper comprehension of these stressors fosters betterment in caregivers' quality of life through diagnosis and tailored interventions, reinforcing its recognition as an undesired human response manifestation.

Data Availability

The data used to support the findings of this study are available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare that there are no conflicts of interest regarding the publication of this paper.

Acknowledgments

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