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Research Article

EXPERIENCES OF THE MALE CAREGIVERS OF SCHIZOPHERIC PATIENTS: PHENOMENOLOGICAL STUDY

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Abstract

Purpose: In this study, it was aimed to determine the experiences of male caregivers of people with schizophrenia.

Methods: The study had a phenomenological design as a qualitative research method. Using the purposeful sampling method, 19 male caregivers were included in the study. In-depth interviews were conducted with participants using a semi-structured interview form.

Results: In the thematic analysis, three categories were identified: "The effect of the disorder on male caregivers", "male caregivers' perceptions about the disorder", and "coping patterns of male caregivers". In addition, three themes and 15 sub-themes were determined.

Conclusion: The study has revealed that male caregivers of schizophrenic patients face many problems in their emotional, social, economic, family and work lives; they need support and information in coping with these problems; and they tend to receive institutional and social support and use spiritual coping strategies in their caregiving. ***ASEAN Journal of Psychiatry, Vol. 24 (3) March, 2023; 1-13.***

Keywords: Schizophrenia, Caregiver burden, Male caregivers, Qualitative research, Phenomenological design

Introduction

Schizophrenia is a chronic psychiatric disorder with relapses and remissions, and it causes disruptions in patient's emotions, thoughts, behaviours, interpersonal relationships, work and education life, and daily functioning [1]. The problems, which occur in many areas of experience of the patient and which sometimes arise from impaired reality testing capacity, lead to the need for care and assistance from another person. People that provide such care are usually first-degree relatives. Therefore, schizophrenia dramatically affects not only patients but also their family members [2]. With the discovery of antipsychotics and the consequent deinstitutionalization of psychiatric patients, families have become a part of the care system and are necessarily responsible for the provision of care previously received from the institution [3]. Symptoms of the disorder and the impaired functionality of the patient have led family members to take on new responsibilities in various areas and to assume responsibility for the provision of care [4,5]. However, the responsibility for the management of unpredictable patient behaviours, including agitation and aggression, the need to adapt to new routines and lifestyles and changes in daily plans, and the development of several emotions, including anger, inadequacy, guilt and sadness aggravate the burden of care on family members [6,7]. Such challenges in the provision of care may increase the levels of stress, anxiety and depression in caregivers, and cause difficulties in several areas of their lives, including work, social relations and economic status [8].

Although any family member can take responsibility for providing care to the patient, it is usually women, mostly the mother or spouse, who assume the caregiver role [9]. When the patient is a woman or when women are unavailable to provide care to the patient, the caregiver role may be assumed regardless of gender, and men in the family may provide the care. Being a caregiver has not been seen as a suitable role for men with respect to gender roles in society; therefore, it has not been as easy for men as it has been for women to adapt to the caregiver role [10]. Women have generally tended to assume the caregiver role because they are mothers, more affectionate, and able to provide better care compared to men, and because of the general perception about the caregiving task as the customary responsibility of women. On the other hand, the multiplicity of roles of men outside the house and their masculine liabilities, such as earning money and supporting the family, have created a distance from the caregiver role, which would otherwise include domestic responsibilities. This situation may cause men to be unfamiliar with caregiving responsibilities and challenge them [11,12]. A study has shown increased rates of institutional support by male caregivers for individuals with chronic conditions and increased rates of hospital admissions for such patients [13].

Caregivers with several unmet needs, or those experiencing the caregiver burden, encounter various psychosocial problems due to undertaking caregiving processes and having a family member with schizophrenia. These problems affect both the caregiver and the individual receiving the care adversely [14]. In the literature, there is a study examining the experiences of only female caregivers for schizophrenic patients, but studies on male caregivers experiences are needed too [15]. This study aims to examine the experiences of male caregivers of schizophrenic patients. Thus, it will help identify and better understand male caregivers' experiences and contribute to the development of preventive and constructive mental health services for male caregivers.

Materials and Methods

Aim of the research

The aim of this study is to examine the experiences, difficulties, and burdens of male caregivers of patients diagnosed with schizophrenia.

Research design

The qualitative research method and a phenomenological research design were used in the study to explain the experiences of male caregivers of patients with schizophrenia [16]. Following the phenomenological research model, it is aimed to reveal common experiences about the phenomena of "the provision of care for a patient with schizophrenia" and "being a male caregiver" in regard to male caregivers of schizophrenia patients. Accordingly, the common experiences of male caregivers were evaluated in depth using the phenomenological approach, and the common experiences of caregivers regarding the phenomena are explained in a universal manner based on data obtained. For the purpose of the research, a search was performed to find an answer to the question: “What are the caregiving experiences of men that provide care for schizophrenia patients?”

Population and sample of study

The population of the study consisted of men that provided care for schizophrenic patients registered with Kırsehir Community Mental Health Center (CMHC), which is located in a medium developed city in the Central Anatolian Region of Turkey. In Turkey, including the Central Anatolia Region, the role of being a caregiver for individuals with chronic mental illness is usually assumed by women. Because of gender roles, men usually assume a secondary position in the caregiving. This study has focused on the experiences of male caregivers. The research sample consisted of male caregivers of schizophrenic patients. To be included in the study, it was required to be a man providing care for a relative with schizophrenia; a volunteer to participate in the research; to provide care for at least one year; to provide care for patients other than those with first-episode schizophrenia; not to have any mental disorders; and to be able to understand and speak Turkish. The exclusion criteria were to provide care for a patient with another mental disorder; to be a female caregiver; and not to volunteer to participate in the study. The population of the study consisted of 68 men that were caregivers of schizophrenic patients registered with the Kırsehir CMHC. First, the author called the individuals of the population, stating the purpose and method of the research, and explaining that participation in the research would be voluntary and that such interviews on the phone were conducted as part of an individual research project. All eligible male caregivers that met the study inclusion criteria and volunteered to participate in the study were included in the study. Subjects were excluded that did not answer the phone (n=25), stated that they did not have adequate time (n=11), or did not volunteer to participate in such a study. The sample of the study consisted of 19 participants who agreed to participate in the study and met all the inclusion criteria. Following the inclusion and exclusion criteria specified for the research, the purposeful sampling method was used to select the research sample. Qualitative researches, particularly those with a phenomenological design, focus on individual participant experiences. Therefore, we focused on selecting participants with similar experiences, and the sample was selected purposefully based on the characteristics of the participants. By the purposeful sampling method, the study included only male caregivers of schizophrenic patients to achieve a reliable, in depth exploration of participant experiences [17,18]. After the collection of research data from each participant, we evaluated whether the obtained data reached saturation. This is because the sample size cannot be calculated in qualitative research, and it is determined by data saturation as reported in the literature [19,20]. Thus, the sample size was determined based on data saturation in this study. To determine whether the data reached saturation or not, the audio recordings obtained with each interview were transcribed verbatim by the second author, a male researcher. Then all researchers read and analyzed each transcript and determined important statements contained therein. In cases of the repetition of data, statements and themes, it was decided that the research data had reached saturation.

Data collection tools

Research data were collected through the demographic characteristics questionnaire and the semi-structured ınterview form.

Demographic characteristics questionnaire

The demographic characteristics of caregivers were evaluated using a questionnaire developed by the researchers. The questionnaire included nine questions to collect information about the caregiver, such as the caregiver’s age, economic status, education level, employment status, length of the period of caregiving, the degree of relatedness to the individual receiving care, etc.

Semi-structured ınterview form

A semi-structured, in-depth individual interview form was developed by the researchers. It was created based on the researcher’s observations, academic and clinical experiences, and a review of the literature. To test the comprehensibility of the questions, a pilot interview was conducted with two participants. Then relevant questions were revised accordingly. Data from the pilot interviews were not included in the study results. The questions were posed to the male caregivers of schizophrenia patients in consecutive order, and they were asked to convey their experiences in caregiving. The semi-structured interview form consisted of eight questions to assess caregiver’s perceptions and attitudes towards schizophrenia, and how the caregiver was affected by this process as a man providing care for a schizophrenic patient. The form also aimed to identify difficult situations, and evaluate how caregivers coped with difficulties encountered in caregiving. Caregiver experiences were explored by the following questions: “How were you affected by having a relative with schizophrenia?”, “what kind of changes occurred in your daily life after your relative was diagnosed with the disorder?”, “what were the most challenging factors for you, as a patient's relative, in the caregiving?”, and “how did you, as a patient’s relative, cope with the changes in the caregiving?”

Collection of research data

The qualitative research checklist, the Consolidated Criteria for Reporting Qualitative Research (COREQ), was used for study planning, as well as the data collection, analysis and reporting [21]. Research data were collected by the first author, who is a female researcher and a psychiatric nurse. Using the purposeful sampling method, eligible participants that met the inclusion criteria were selected from the population of male caregivers of schizophrenia patients registered with the CMHC. Information about the research was provided, and the purpose of the research was explained to eligible participants. Then they were asked to read the informed consent forms, which would allow them to declare that they had participated in the research voluntarily, and their consent was requested. Interviews were conducted with participants present at the CHMC. Interviews were held in a meeting room where there were no third parties, so that the participant would feel comfortable and express himself easily and his privacy would be ensured. Before starting the semi-structured individual interviews, male caregivers filled out the questionnaire that consisted of questions about the demographics of participants. Then qualitative data were collected using the in-depth individual interview method. Before posing questions to participants, it was explained that the interviews would be recorded with a voice recorder, only the researchers would listen to the recordings, and the interview would be conducted only once. The researcher conducting the interview took notes during each interview. All interviews were conducted by the same researcher in order to ensure data reliability and to prevent participants from being affected by the different attitudes and questioning styles of different interviewers. Research data were collected in the period between August 2021 and November 2021. Each interview lasted between 20 and 30 minutes.

Analysis of research data

For the analysis of the research data, no statistical software was used. Data analysis was manually carried out with the COREQ qualitative research checklist by the researchers. As the first step in the data analysis, the audio recordings of each interview were transcribed and analyzed word for word by the second author. For the prevention of potential errors and faults in the written text derived from the collected data, recordings were repeatedly listened to in order to compare the transcribed statements with those from the recorded interviews. Then the transcripts of the interviews were sent to the respective participants in order to ask them to evaluate the accuracy of the statements and whether their experiences had been accurately conveyed. Consequently, the thematic analysis of the data was commenced. The thematic analysis consists of six steps: classifying data, identifying important statements, reviewing, evaluating and defining themes, and reporting research findings [22]. Each researcher analyzed the data independently so as not to influence the other. All of the transcribed audio recordings were read repeatedly by the researchers to ensure that they had a good command of the data and to determine important expressions. Next, the researcher’s codes were assigned to the identified important statements. The identified important statements were read over and over by the researchers, and the themes were defined. Then participants statements were added under the determined themes and sub themes. After each researcher carried out this process independently, all researchers discussed and decided on the suitability of the important statements, themes, sub themes and participant expressions at a meeting. Then they completed the data analysis by delivering the final version of the research data. To obtain the final version of the research results, each theme and sub theme determined by an individual researcher was discussed in terms of the appropriateness of the participants statements underneath. A coding tree was created by classifying the obtained data under categories, themes and sub themes.

Reliability of research data

Various approaches are available to ensure the reliability of data in qualitative research. These include credibility, reliability, confirmability and transferability. The reliability of the research data was checked with these items in this study [23]. Firstly, for credibility, researchers hold specialist degrees in mental health nursing and psychiatry. The third researcher, who is a psychiatrist, works at the CMHC and provides specialist healthcare services to patients with schizophrenia. The first and the second researchers in the field of mental health nursing hold doctorate degrees in this field, and previously conducted research on schizophrenic patients and their caregivers. The researchers planned this research in line with their areas of specialty, theoretical knowledge, and observations about schizophrenia. For the reliability of the research data, the following was ensured: that participation in the study was voluntary; semi structured interview questions were posed to participants in an open ended form during the collection of the research data; and participants answers were objectively listened to by the researchers without any confirmation or rejection. Thus, participants were able to express themselves, their experiences, and their emotions freely. After each interview, the researchers checked the voice recordings and the transcribed content repeatedly to prevent possible mistakes. Finally, in order to ensure the reliability of the research, each researcher carried out the data analysis independently of the others. After completing the analysis of the data, all researchers came together to determine categories, themes and sub themes. To ensure confirmability, audio recordings were transcribed verbatim after each interview, and key statements were identified by each researcher. The same steps were applied for all interviews. Furthermore, at least one participant's statement was given under each theme to ensure the confirmability of the data. Finally, the purpose, method, data collection and analysis sections of the research are presented in detail to ensure transferability.

Results

The evaluation of the demographic characteristics of the participants showed that the mean age of the participants was 53.52 ± 10.43 years and the caregiving duration was 12.42 ± 9.38 years of the caregivers, 42.10% (n=8) were university or primary school graduates and 84.2% (n=16) were of middle economic status, as reported of the caregivers, 52.6% (n=10) were actively working, 63.2% (n=12) were living in nuclear families, and 60.0% (n=12) provided care for their fathers, as reported (Table 1).

Table 1. Participant's demographic characteristics.

Demographic characteristics	**N**	**%**
Age	53.52 ± 10.43 (min=23, max=77)	
Length of caregiving duration	12.42 ± 9.38 (min=1, max=35)	
Education level		
Primary school	8	42.1
High school	3	15.8
University	8	42.1
Economic status		
Middle	15	84.2
High	3	15.8
Working status		
Student	1	5.3
Retired	8	42.1
Working	10	52.6
Family type		
Nuclear family	12	63.2
Extended family	6	31.5
Fragmented family	1	5.3
Relatedness with the patient		
Father	12*	60
Husband	4*	20
Brother	2	10
Other (cousin etc.)	2	10
*One caregiver reported that he provided care for both his wife and daughter.		

The thematic analysis of the obtained qualitative data yielded the following three categories, which were "the impact of the disorder on caregivers", "caregiver perceptions about the disorder", and "coping patterns of caregivers". Under these categories, three themes and 15 sub-themes were found (Table 2).

Table 2. Categories, themes, sub-themes identified in interviews with male caregivers.

Category	**Theme**	**Sub-theme**
Impact of the disorder on caregivers	Caregiver burden	Emotional burden. Economic burden and changes in work life. Deterioration in family relationships. New responsibilities. Changes in social life. Physical and verbal violence.
Caregiver perceptions about the disorder	Attitudes and beliefs about the disorder	Refusal to accept the disorder. Lack of knowledge. Inappropriate treatment search. Devastating nature of the disorder.
Coping patterns of caregivers	Coping	Institutional support. Social support. Spiritual ways of coping.

Impact of the disorder on male caregivers

The theme “burden of care” was obtained under this category. Participants described the difficulties they experienced in the caregiving process under this theme.

Burden of care: Under the theme of burden of care, seven sub-themes were determined, which were "emotional burden", "economic burden and changes in work life", "deterioration of family relationships", "physical and verbal violence", "changes in social life", "new responsibilities", and "medication nonadherence". Findings related to the sub themes are given below, respectively.

Emotional burden: Under this sub theme, the participants talked about the emotional difficulties they experienced in the caregiving process. Most caregivers reported that they were the parents of those for whom they provided care, adding that their hopes and dreams about the future of their children had been shattered due to the disorder, and that many things had changed in their lives due to the diagnosis of the disorder. Participants reported that the situation challenged them emotionally, and they worried about who would take care of their children if something happened to them. One caregiver expressed her feelings as follows: “This is a difficult disorder. It has taken my child from me; it takes away my child's future. When I see my child like this, I can't stand it; I feel shattered. As a father, I had a lot of hopes for my child. Now I wonder what will happen when we die. I swear to god, I have become ill with stress and distress”.

Economic burden and changes in work life: Under this sub theme, participants reported that they had experienced a considerable economic loss due to their efforts to provide care for their relatives with the disorder, had difficulties in meeting basic living needs, and that they had retired and interrupted their work life in order to provide care, even though they were willing to continue working. One participant expressed the economic losses he suffered in the process as follows: “I went through all kinds of financial and emotional difficulties. My life was ruined. I spent a lot of money, and was in need of bread at times. I borrowed money several times to take the patient to the hospital”.

Physical and verbal violence: Under this sub theme, participants reported that patients inflicted verbal and physical violence on them, with an increased degree of violence during periods of medication non adherence. They were afraid of such situations. One participant described his experiences and feelings in the caregiving process as follows: “He inflicts extreme violence. He is like a ticking time bomb, a stray mine; he is unpredictable. He can do anything hang, slash or stab a person. At times like these, I feel frightened”.

Changes in social life: Caregivers also reported the occurrence of impaired social relationships because of the disorder of the person they provided care for. They reported that they could not visit relatives and friends, and that the patient did not want visitors at home at times. Caregivers reported that they had a limited social life. One participant reported the change in his social life as follows: We cannot establish a proper family life. We cannot visit friends or go out as we wish. When she deteriorates and starts holding false beliefs, the situation affects everyone around her. Also, I don't want to visit relatives or friends accompanied by a sick woman.

New responsibilities: Caregivers reported that they had assumed many new responsibilities in their daily lives, such as the provision of care to the patient and following up on the treatment process and obligations the patient should fulfil, adding that such new responsibilities challenged them at times. One caregiver shared his experiences in the process as follows: “During this process, I look after her more than usual. I take her to the doctor or I have her examined, meaning that my responsibilities have increased. I have accepted that it is a persistent disorder. Despite all the challenges, we are making our best efforts to achieve a recovery. But in any event, we have to take care of her.”

Deterioration in family relationships: Caregivers reported that deteriorations in family relations, stress overload, and conflicts had occurred due to the symptoms of the disorder and the patient's inability to fulfil their responsibilities. One participant reported the deterioration of family relationships resulting from the nature of the disorder as follows: “At the start of the disorder, my wife got jealous, suspecting everyone, even my mother. She kept blaming me, taking offense… When I refuse to do whatever, she wants, she starts causing trouble. She suspects everything. This limits me a lot. She's jealous of me, suspecting even my mother and my brother. When she started suspecting my brother and my mother out of jealousy toward me, my family relations were affected and family members took offense. I have become detached from them.”

Male caregiver’s perceptions of the disorder

Under this category, the theme of “attitudes and beliefs about the disorder” was obtained. The findings about the theme are presented below.

Attitudes and beliefs about the disorder: Under this theme, four sub-themes were obtained, which were "refusal to accept the disorder", "lack of knowledge", "inappropriate treatment seeking" and the "devastating nature of the disorder". Findings related to sub-themes are given below.

Refusal to accept the disorder: Participants reported that, although the medical diagnosis was reported as schizophrenia, they did not believe that the individual they provided care for was ill, that they did not believe in the existence of such a disorder, that they did not accept the disorder, and that they could not imagine the individual having this disorder. A caregiver expressed his feelings about the disorder as follows: “To be honest, I don't believe that he has schizophrenia either. His elder sister did not have any problems. We could not associate this disorder with him. We did not understand how such a thing, a deficit in my son, occurred. Indeed, I don't know much about schizophrenia, but ever since I was told that my son had schizophrenia, I have never accepted it. I can't believe. I, as his father, haven't accepted it yet.”

Lack of knowledge: Under this sub-theme, it was determined that participants had incorrect information about the development of both the disorder and the symptoms, and that they developed inappropriate attitudes toward the treatment of the disorder. One participant described his feelings and the lack of information as a caregiver as follows: The most challenging thing is that our social life has come to an end. We still cannot believe that she has the disorder. She knows the lyrics of all songs by heart. Girl, are you kidding us? You know these things. But then why do you soil your pants? Why don't you put on your clothes yourself? She doesn't ask us to cut her nails, even if her nails become this long (showing with his hand). She doesn't ask us to give her a bath, even if she becomes physically dirty. I don't expect her to take any responsibilities; she's like a child now.

Inappropriate treatment seeking: Participants reported that they had sought help from religious functionaries or providers of traditional treatment, or that they had tried religious practices for a cure upon the first manifestation of the disorder. Participants stated that they first took the patient to a traditional mystical treatment provider, but that it did not work. One participant described a treatment approach advised by relatives of the patient as follows:

"My son had stopped speaking for a while. At that time, an aunt said to me, 'take the key to the mosque door on a Friday. Be the first with your son to open the door of the mosque in the morning. After you unlock the door, have the lock touch your son's tongue, so that the lock on your son's tongue will be opened.' I didn't do this because I didn't feel comfortable about it. Another friend of ours advised the following: 'On an empty stomach, has your son taken a teaspoon of consommé of a nightingale or a canary that sings very well'."

Devastating nature of the disorder: Under this sub-theme, participants metaphorically described the disorder's various devastating effects on their daily lives. Caregivers usually described the disease process by using metaphors, such as nightmare, explosion, bomb, deterioration or storm. One participant described the process and the nature of the disorder as follows: "It resembles a time when a storm comes, destroying everything. I think it is this disorder." Another participant expressed the process as follows: "I would say an explosion; it's like a time bomb…"

Coping patterns of male caregivers

Under this category, the theme "coping" was obtained. Findings related to this theme are given below.

Coping: Under this theme, three sub-themes were determined as "institutional support", "social support", and "spiritual coping". Findings related to these sub-themes are given below.

Institutional support: Participants reported that they received a lot of help and support during the illness process from the mental health staff of the CMHC. They added that both themselves and the patients were very satisfied with the practice performed in this center. One participant described the support he received from mental health staff members as follows: "I had no idea how to deal with this disorder. Here, nurse Y and psychologist H assisted us remarkably. In other words, the patient further improved after attending the CMHC visits. Doctors from many cities provided treatment. This CMHC has provided considerable care. The patient is currently pretty much back to normal."

Social support: Participants reported that receiving support from social support sources for care and treatment, and for emotional, economic and social aspects, had helped them and relieved them during the process. A participant described the social support he received from his colleagues, after changes occurred to his work life during the treatment and care processes, as follows: "I had to interrupt my work while taking my son to the hospital and rehabilitation centers for treatment, but my colleagues were always there to take over my responsibilities. They kept supporting me by doing so. If I had been fired, everything would have been much worse."

Spiritual ways of coping: In this sub theme, participants reported that the disorder came from Allah, that this illness was destiny or a test, that there was nothing they could do, and that they coped with the difficulties they experienced in the process by giving thanks, praying, and embracing spirituality. One participant expressed his way of coping with the difficulties they had experienced in the process as follows: "We are used to it now. It came from god. There is nothing to reject or reproach. She is our sibling, after all. Although I'm worn out, there's nothing we can do." Another participant described his coping method as follows: "I took refuge in spirituality. I had the strength to endure. I prayed to God that he would get well."

Discussion

Schizophrenia not only affects the patient, but also has important effects on the family. In this process, it is of great importance that healthcare team members understand the experiences of caregivers to provide them with the needed support, as well as to patients. The assumption of the caregiver role, especially by male caregivers, can be challenging and cause mental problems because of the lack of information and preparedness, which has its roots in the gender roles of a society. Therefore, in this study, the experiences of male caregivers were evaluated. Three themes were identified in this study: the burden of care, attitudes and beliefs toward the disorder, and coping.

The theme "burden of care" was identified under the category of the effect of the disorder on male caregivers. Male caregivers reported that they took on new responsibilities and experienced emotional and economic burdens while performing the caregiver role. Furthermore, this role caused deterioration and changes in work life, family relationships, and social life. A review of the literature reveals that having a family member diagnosed with schizophrenia disrupts family dynamics, adversely affects family members, and causes a significant change in the family [24]. It is reported that this process gives rise to both emotional and economic problems. Compared to men, female caregivers may readily internalize the responsibility of providing care, and tend to devote themselves to the individual with the psychiatric disorder. In this way, they give up their jobs and social relationships more easily than do men. Consistently, male caregivers experience problems in social relationships and work life, and suffer from economic problems during the caregiving process to a greater extent when compared to women. Masculine responsibilities, such as earning money and providing financial support for the family, are the predominating responsibilities of male caregivers. The functional impairment in the schizophrenic patient causes the caregiver to devote all his time to the patient, making it impossible for him to pursue a full time job [25]. Consequently, emerging financial problems will potentially affect family dynamics and increase the unfavorable effects of the disorder. Consistent with the research findings, it has been reported that family members providing care for schizophrenic patients experience a high level of burden of care [26].

Secondly, the theme of “attitudes and beliefs about the disorder” was identified under the category of the perception of the disorder by male caregivers. It has been observed that male caregivers of schizophrenic patients do not accept the illness, lack knowledge, search for inappropriate means of treatment, and are challenged by the devastating effects of the disorder. It is recognized that after a diagnosis of schizophrenia, family members exhibit emotion based reactions, such as denial, avoidance or despair, and they may turn to spiritual coping mechanisms, especially to cope with stigma [27]. The caregiver's negative beliefs about the disorder, lack of knowledge, and the search for inappropriate treatment alternatives further increase the burden of care [28]. Studies in the literature report that negative caregiver beliefs about the disorder affect medication adherence unfavourably, cause individuals to seek help other than medical management, and develop an internal stigma about social exclusion [29,30]. In the study conducted by Sarıkoc, et al. 89.1% of the relatives of individuals with mental illness reported that they preferred non-medical spiritual practices for treatment purposes. A study has shown that male caregivers of schizophrenic patients suffer from a lack of knowledge about this complex and challenging disorder, creating grounds for a search for inappropriate means of treatment [31]. Having a son is a significant aspiration and social expectation for most men in some regions of Turkey, where the research was conducted. However, having a son with an illness and the resulting disappointment can lead male parents to resort to denial as a coping mechanism, and cause them to look for different ways of treatment. Furthermore, the long term nature of the psychiatric treatment, and the occurrence of relapses during the treatment process, may lead parents to look for alternative means of treatment. Schizophrenia patients and their families face many emotional, social and economic problems, and they need support, information and cooperation to cope with these problems. One study reported that the relatives of the patients, especially those providing care, did not have adequate information about the disorder, and that this situation increased the burden of care [32].

The 'coping' theme was found under the category of coping patterns of caregivers. It has been observed that caregivers utilized institutional support, social support, and spiritual coping in the process of coping with the disorder. With the diagnosis of schizophrenia, the changing responsibilities of family members, the assumption of new responsibilities, and an emerging new lifestyle may cause various difficulties in the emotional, economic and social aspects of caregiver experiences. Ineffective coping strategies used in these processes increase the problems experienced by caregivers and cause them to perceive an increased burden. Magliano, et al. found that a reduced family burden was associated with professional and social network support provided for the family [33]. Similarly, in a study examining caregivers of patients with schizophrenia, it was found that male caregivers who received social support had a high quality of life and a low burden of care [34]. This is compatible with the research findings and shows that social resources, such as institutional support and social support to be provided to male caregivers, are effective means of support for coping, and that they reduce the burden of care.

Both the quality and the continuity of institutional support are critical for successfully coping with the problems resulting from the disorder. Because male caregivers usually assume a secondary caregiver’s role, they may not effectively internalize the responsibility for caregiving. Moreover, compared to women, men cannot express their feelings freely; they cannot cry or share their sorrow within the framework of social support systems. Therefore, men may not achieve catharsis as effectively as women do. Such factors increase the need for institutional and social support for male caregivers during the caregiving process. In one study, the burden of care on family members of schizophrenic patients was compared between those who received institutional support and those who did not. It was found that the care burden was lower in the patients relatives who received institutional support, and that there were significant differences between the groups in terms of mental stress, disruption of private life, irritability, limitations and the deterioration of social relations [35]. The regular participation of schizophrenic patients in institutional rehabilitation services changes caregiver's beliefs about the disorder favourably, and reduces the perceived burden of care [36]. For this reason, healthcare team members should support caregivers, provide necessary information about the disorder, and organize family support programs to reduce the burden of care. In addition, it can be suggested that the provision of rehabilitation services, necessary information and support to patients relatives by the healthcare staff in the institution may contribute to the improved functioning of patients, and help caregivers cope with the disorder effectively.

In this study, it was found that another coping method used by caregivers was turning to spirituality. It is reported that coping skills have become of great importance in chronic mental disorders such as schizophrenia, that caregivers often turn to spirituality as a coping method, and that religiosity contributes significantly to the adaptation to the caregiver role [37,38]. However, in our study, we observed that religious coping methods led male caregivers to reject the disease and seek different modes of treatment for patients. The caregivers stated that they did not believe in such a disease and the psychiatric treatment. They added that this condition was sent to them by Allah, who would also send the cure. Due to such reasons, male caregivers frequently employed religious methods besides psychiatric treatment. Although spiritual coping is an effective method for caregivers to cope with the perception of the burden, it can be suggested that efforts should be made by healthcare professionals to help caregivers develop effective problem solving skills and emotion focused coping methods. We suggest that such efforts will successfully contribute to the increased effectiveness of coping with the burden of care.

Conclusion

A better understanding of the caregiving experiences of male caregivers of schizophrenia patients and the identification of the factors associated with the burden of care are necessary for the protection and improvement of the mental health of caregivers. It is observed that male caregivers of schizophrenia patients face many problems in their emotional, social, economic, family and work lives; that they need support and information to cope with these problems; that they usually turn to institutional and social support; and that they rely on spiritual coping mechanisms during the provision of care. Effective control of the symptoms of the disorder, improved social functioning of patients, implementation of initiatives for the reduction of the care burden on patients relatives, and social support practices, including support from healthcare professionals, will help reduce the burden of care on male caregivers. It was found that, in general, male caregivers preferred ineffective methods to cope with the sense of burden they experienced during the caregiving process. In order to protect and improve the mental health of caregivers within the scope of their consultancy roles, psychiatric nurses should identify the areas where male caregivers experience difficulties, and help them gain problem oriented and emotion oriented coping skills while also providing the necessary knowledge and support. Furthermore, family to family support programs and psychoeducational groups are recommended to allow male caregivers to express their feelings and develop effective coping skills during the caregiving process.

Limitations of the Study and Suggestions for Future Research

This study has some limitations. Firstly, the caregivers in the study were selected from a population registered with only one institution, which was a CMHC. To evaluate the experiences of caregivers receiving rehabilitation services more comprehensively, it is suggested that future studies include different sample groups. Furthermore, patients attending a CMHC usually have increased levels of functioning and fewer positive symptoms compared to patients experiencing an acute episode. Moreover, during an acute episode, there may be increased non-adherence to treatment and an increased need for the provision of medical care and hospitalization. Therefore, it may be argued that caregivers of patients attending a CMHC might experience low levels of caregiver burden. Secondly, because men are generally expected to be strong due to gender roles, male caregivers in the study avoided talking about compelling feelings they experienced during the caregiving process. When some participants were asked how they were affected by the process emotionally, they stated that they did not want to talk about it. This prevented the expression of deep feelings experienced by them during the caregiving in terms of data collection. When asked how they were emotionally affected by the caregiving, some participants stated that they did not want to talk about it. Therefore, it is suggested for future research that interventional studies should focus on a better expression of the feelings, experiences and difficulties experienced by male caregivers with a view to reduce the burden of care.

Ethical Approval

Ethical approval of the study was received from the human research ethics committee. After receiving the ethical approval, permission was obtained from the institution where the research would be conducted. All participants of the study were informed about the study to obtain their written and verbal consent. The interviewer was a researcher who did not work actively in the CMHC. Thus, potential ethical issues were avoided. All participants were informed that participation in the study would be on a voluntary basis, and that they could leave the research at any time without giving any reason. Participants were also informed that if a participant did not agree to participate in the study, this would not adversely affect the treatment process of the patient.

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