

FAMILY CAREGIVING FOR SCHIZOPHRENIA IN SARAWAK: CHALLENGES, COPING, SUPPORT, AND SHARED RESPONSIBILITIES

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Abstract

Family caregiving plays a vital role in supporting individuals with schizophrenia, particularly in settings where mental health resources are limited. This study aimed to explore the challenges, coping strategies, sources of support, and family dynamics experienced by family caregivers of individuals with schizophrenia in Sarawak. A qualitative phenomenological approach was employed. Five family caregivers were recruited through purposive sampling, and data were collected through semi-structured interviews. The data were analyzed using Braun and Clarke's six-phase thematic analysis framework. Four major themes emerged: (1) The Value of Caregiving, (2) Challenges in Caregiving, (3) Sources of Support, and (4) Coping and Family Caregiving Practices. Participants described caregiving as both challenging and meaningful. They experienced financial strain, emotional distress, social limitations, and practical caregiving demands, while also finding fulfilment through sustaining care, witnessing patient progress, and fulfilling moral and spiritual responsibilities. Family members, healthcare services, religious communities, and government assistance were identified as important sources of support. Coping strategies included prayer, acceptance, emotional regulation, family cooperation, and reliance on professional treatment. Family dynamics significantly influenced caregiving experiences, with shared responsibilities helping to reduce caregiver burden. The findings suggest that family caregiving for individuals with schizophrenia involves both challenges and resilience. Greater family involvement, community support, culturally sensitive interventions, and improved mental health services are essential to enhance caregiver wellbeing and sustain long-term caregiving.

Keywords: Schizophrenia, family caregiving, coping strategies, social support, resilience, Sarawak.

Introduction

Mental health has become a pressing public health concern in Malaysia, with 29.2% of adults experiencing mental health problems (Sarawak Tribute, 2024). Despite policy initiatives, services remain limited in accessibility, professional resources, and community-based support, leaving families to assume primary caregiving roles. Schizophrenia, affecting about 1% of the population or 300,000 individuals (Relate Malaysia, 2023), requires long-term family assistance including daily care, emotional support, treatment monitoring, and crisis management.

Caregiving for individuals with schizophrenia is consistently linked to psychological distress, financial burden, reduced quality of life, and family disruption (ZamZam et al., 2011; Ahmad et al., 2025). Yet, most studies emphasize caregiver burden, with limited exploration of coping strategies, support systems, and family dynamics. In Sarawak, caregiving practices are further shaped by multicultural values, diverse family structures, and uneven access to services, but these contextual realities remain under-researched.

This study addresses two gaps: the empirical gap in understanding caregiving experiences within Sarawak's multicultural context, and the counselling gap, where current interventions are urban-centered, culturally mismatched, fragmented, and rarely family-focused (Ivan et al., 2019; Wulandari

et al., 2024; Kamarulbahri et al., 2022; Ong et al., 2016; Ahmad et al., 2025). Guided by Lazarus and Folkman's Stress and Coping Theory (1984), the study explores how caregivers appraise demands, mobilize coping strategies, and navigate family dynamics.

The objective is to examine the lived experiences of family caregivers of individuals with schizophrenia in Sarawak—focusing on challenges, coping strategies, support, and shared caregiving responsibilities—to inform culturally sensitive, family-centered counselling interventions that strengthen resilience and sustain long-term caregiving.

Literature review

Family Caregiving for Individuals with Schizophrenia

Schizophrenia is a chronic mental disorder that often requires long-term treatment and continuous support. Due to limited mental health resources and the recurrent nature of the illness, family members frequently assume primary caregiving responsibilities. These responsibilities include supervising treatment adherence, managing daily activities, providing emotional support, and responding to relapse episodes. Previous studies have shown that caregiving can significantly affect caregivers' psychological wellbeing, physical health, and quality of life (ZamZam et al., 2011; Ahmad et al., 2025). Within the stress and coping framework, these caregiving demands represent ongoing stressors that require appraisal and adaptive responses.

Challenges in Family Caregiving

Family caregivers commonly experience emotional distress, financial strain, stigma, and social restrictions. The unpredictable nature of schizophrenia and the need for continuous supervision often increase caregiver burden. Research has consistently reported that caregiving responsibilities may negatively affect caregivers' mental health, family functioning, and social relationships (Ahmad et al., 2025; Ong et al., 2016). From the perspective of Lazarus and Folkman, these challenges reflect primary appraisals of caregiving as threatening or overwhelming, which in turn influence the coping strategies employed.

Coping Strategies and Sources of Support

To manage caregiving demands, caregivers employ various coping strategies, including acceptance, spirituality, problem-solving, emotional regulation, and seeking information about the illness. Both formal and informal support systems have been identified as important protective factors. Support from family members, healthcare professionals, religious communities, support groups, and government services can reduce caregiver burden and strengthen resilience (Kamarulbahri et al., 2022; Rafiyah et al., 2022). In line with Stress and Coping Theory, these strategies represent secondary appraisals, where caregivers evaluate available resources and select coping mechanisms to mitigate stress.

Family Dynamics and Shared Responsibilities

In collectivistic societies such as Malaysia, caregiving is often viewed as a shared family responsibility. Cultural values such as filial piety, reciprocity, and family obligation influence how caregiving roles are distributed among family members. Shared caregiving responsibilities may reduce individual burden, whereas unequal role distribution can contribute to family conflict and caregiver stress (Wulandari et al., 2024; Ivan et al., 2019). Integrating Lazarus and Folkman's framework, family dynamics can be understood as contextual factors that shape both appraisal and coping, influencing whether caregiving is experienced as a collective resilience or a source of conflict.

Methodology

Research Design

This study employed a qualitative phenomenological approach to explore the lived experiences of family caregivers of individuals with schizophrenia in Sarawak, focusing on caregiving challenges, coping strategies, sources of support, and shared responsibilities.

Participants

Participants were recruited through purposive sampling. Five family caregivers of individuals diagnosed with schizophrenia in Sarawak participated in the study. Eligible participants were aged 18 years and above, had at least six months of caregiving experience, and were able to communicate in Bahasa Malaysia, Mandarin, or English. The participants varied in age, ethnicity, occupation, relationship to the care recipient, and duration of caregiving, providing diverse perspectives on family caregiving experiences.

Data Collection Methods

A pilot interview was conducted to refine the semi-structured interview guide and ensure the clarity and cultural appropriateness of the interview questions. Subsequently, semi-structured interviews were conducted with the participants. Each interview lasted approximately 30–60 minutes and was audio-recorded with participants' informed consent.

Ethical Considerations

This study was conducted in accordance with established ethical standards for qualitative research involving vulnerable populations. Ethical approval was obtained from the Universiti Malaysia Sarawak (UNIMAS) Human Research Ethics Committee, ensuring compliance with institutional and national requirements. All participants were provided with clear information about the study's purpose, procedures, potential risks, and benefits, and written informed consent was obtained prior to participation. Participation was voluntary, and participants were reminded of their right to withdraw at any stage without penalty.

Confidentiality was strictly maintained by anonymizing all identifying information and using pseudonyms in transcripts and reporting. Audio recordings and transcripts were securely stored and accessible only to the research team. Given the sensitive nature of schizophrenia caregiving, interviews were conducted with careful monitoring of participants' emotional states. If distress was observed, interviews were paused, and participants were offered the option to continue, take a break, or terminate the session. At the conclusion of each interview, participants were debriefed to ensure emotional stability and reassured about the confidentiality of their responses.

Data Analysis Procedures

Interview recordings were transcribed verbatim and analyzed using Braun and Clarke's (2006) six-phase thematic analysis framework. The transcripts were systematically coded to identify recurring patterns and themes related to caregiving experiences. The final themes were reviewed, defined, and organized according to the study objectives.

Table 1: Demographic of Five Research Participants (Caregivers) for Schizophrenia

Caregivers Pseudonym	Age	Ethnicity	Occupation	Education	Monthly Income	Caregiving Duration	Relationship to Patient
Ahmad	38	Malay	Glass workshop worker	Not specified	Not specified	About 20 years	Younger brother
Fatimah	27	Malay	Teacher	Degree	RM2,500	13 years	Younger sister
Peter	41	Chinese	Gospel ministry worker	Diploma	RM2,000	5 years	Institutional caregiver
Yip	71	Chinese	Retired government officer	Diploma	RM6,000–7,000 (before retirement)	About 15 years	Father

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Song	43	Chinese	Teacher	Degree	RM8,000	1–2 years	Younger brother
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The patients with Schizophrenia also differed in terms of illness duration, family background, and current living arrangements. Most patients had experienced schizophrenia for more than ten years, indicating long-term caregiving responsibilities among participants.

Table 2: Demographics of Five Patients with Schizophrenia in Sarawak

Patients with Schizophrenia	Patient Age	Gender	Duration of Illness	Age at Onset	Current Status	Notes
Abu	45	Male	~20 years	Early adulthood	Lives independently, occasional police involvement	Behavioural issues (aggression, wandering, property damage)
Fitri	33	Female	~13 years	Detected around 2013	Lives at home with mother	Aggressive episodes, nocturnal disturbance, requires hospitalisation (Sentosa)
Paul	40	Male (institutional patient)	5 years	Not specified	Lives in gospel ministry home	Severe insomnia, hallucinations, requires sedatives and prayer support
Yoyo	45	Male	~15 years	University years (depression onset)	Lives with parents, stable with medication	Artistic talent, requires constant supervision for medication adherence
Shine	45 (second elder sister)	Female	>20 years	Age 23–24	Married, continues medication, stable	Hospitalised 2–3 times, relapse after stopping medication, cultural family tensions

All interviews were audio-recorded and transcribed verbatim. The interview transcripts formed the primary data source for analysis. Thematic analysis was conducted following Braun and Clarke's (2006) six-phase framework. First, the researcher familiarized herself with the data by repeatedly reading the transcripts to gain an overall understanding of participants' caregiving experiences. Initial codes were then generated by identifying meaningful segments of text related to caregiving challenges, coping strategies, sources of support, and family caregiving practices.

The coded data were subsequently reviewed and organized into potential subthemes and broader themes. Themes were refined through an iterative process of reviewing, comparing, and defining patterns across participants' narratives. The final themes were organized into interconnected hierarchies consisting of themes, subthemes, and illustrative categories. This process enabled the identification of both shared and unique caregiving experiences among family caregivers of individuals with schizophrenia in Sarawak.

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To enhance trustworthiness, the coding process and thematic interpretations were reviewed by the research supervisor. Emerging codes, subthemes, and themes were discussed until consensus was reached. Reflexive notes were maintained throughout data collection and analysis to support transparency and reflexivity. These procedures helped ensure the credibility, dependability, and consistency of the findings.

A semi-structured interview guide (Table 3) was developed based on the study objectives and relevant literature on caregiving challenges, coping strategies, support systems, and family caregiving practices. Open-ended questions and follow-up prompts were used to facilitate in-depth exploration of participants' experiences.

Table 3: Interview Guide, Questions, and Prompts

Section	Main Questions	Prompts
1. Background Information	Can you tell me about yourself and your role as a caregiver?	Relationship to care recipient; caregiving duration; daily caregiving responsibilities
	How long have you been caring for your family member with schizophrenia?	Years of caregiving; changes over time
	What caregiving responsibilities do you usually handle?	Medication management; emotional support; daily living assistance
2. Challenges in Caregiving	What are the main challenges you face in your caregiving role?	Emotional stress; financial difficulties; social stigma; healthcare access
	How do these challenges affect your daily life and wellbeing?	Physical health; emotional wellbeing; family relationships; work-life balance
3. Coping Strategies	How do you usually cope with the challenges of caregiving?	Problem-focused coping; emotion-focused coping; support-seeking behaviours
	Can you share an example of a time when your coping strategy worked well?	Successful experiences; positive outcomes
	Are there times when coping feels difficult or less effective?	Barriers to coping; feelings of helplessness
4. Sources of Support	What kinds of support do you receive in your caregiving role?	Family support; community support; religious support; professional support
	Which sources of support are most helpful to you, and why?	Perceived usefulness; accessibility; satisfaction
	Are there any supports you wish were available but are currently lacking?	Unmet needs; service gaps; policy recommendations
5. Family Dynamics and Shared Responsibilities	How are caregiving responsibilities shared within your family?	Role distribution; primary caregiver responsibilities
	Who helps you most in caregiving tasks?	Family members; relatives; friends
	How do you negotiate caregiving roles and responsibilities?	Cooperation; conflict; decision-making processes

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	How do cultural values or family traditions influence caregiving in your household?	Family obligation; filial responsibility; cultural expectations
6. Reflection	What does caregiving mean to you personally?	Meaning-making; personal growth; values and beliefs
	What advice would you give to other caregivers in similar situations?	Lessons learned; coping recommendations
	What changes or improvements would you like to see in support for caregivers in Sarawak?	Service improvement; policy suggestions; community initiatives

Result

Participant Characteristics

Five family caregivers of individuals diagnosed with schizophrenia in Sarawak participated in this study. Participants varied in age, ethnicity, caregiving relationship, and duration of caregiving, providing diverse perspectives on family caregiving experiences.

Themes Identified

Thematic analysis identified four major themes and twelve subthemes: (1) The Value of Caregiving, (2) Challenges in Caregiving, (3) Sources of Support, and (4) Coping and Family Caregiving Practices.

Table 4: Themes, Subthemes, and Illustrative Categories

Theme	Subtheme	Illustrative Categories
The Value of Caregiving	Sustaining Care Despite Constraints	Endurance, caregiving commitment, financial hardship, limited family involvement
	Family Solidarity	Patient improvement, family encouragement, shared hope, collective support
	Fulfilling Moral and Spiritual Duty	Love, compassion, family responsibility, faith, spiritual meaning
Challenges in Caregiving	Emotional and Behavioural Crises	Aggression, hallucinations, medication refusal, emotional distress
	Lifestyle Strain and Social Burden	Social restriction, caregiver exhaustion, disrupted routines, reduced personal freedom
	Practical and Safety Demands	Hygiene management, crisis intervention, hospitalization, patient safety concerns
Sources of Support	Family and Community Support	Emotional support, practical assistance, family solidarity, religious community support
	Medical and Institutional Support	Psychiatric services, healthcare professionals, treatment monitoring, crisis management
	Government and Welfare Support	Financial assistance, welfare programmes, long-term care facilities, policy support
Coping and Family Caregiving Practices	Self-Initiated Coping	Prayer, acceptance, patience, emotional regulation, self-care
	Family Roles and Responsibilities	Shared caregiving, role negotiation, caregiving distribution, family cooperation
	Family Duty and Values	Filial obligation, family commitment, compassion, cultural values

Theme 1: The Value of Caregiving

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Despite numerous difficulties, caregivers described caregiving as a meaningful and valuable experience. Value was reflected in their ability to sustain caregiving despite financial and social constraints, witness patient progress, and fulfil moral and spiritual responsibilities. Caregivers viewed perseverance itself as an achievement, while small improvements in patients' conditions reinforced their sense of accomplishment. Many participants also framed caregiving as an expression of love, compassion, faith, and family responsibility.

One participant reflected,

"It is really meaningful that I can take care of her," (Fatimah)

while another described caregiving as

"a channel of God's love." (Yip)

Sustaining Care Despite Constraints

One of the most significant values identified by caregivers was their ability to sustain care despite persistent financial, social, and emotional constraints.

For Ahmad, the act of continuing to care for Abu was itself meaningful, though he acknowledged its conditional nature:

"I am willing, except... if he has financial assistance". (Ahmad)

His statement reveals how caregiving is not simply a matter of willingness or love, but is deeply tied to economic feasibility. Sustaining care under such conditions becomes valuable because it requires balancing limited resources with enduring responsibility. This theme also highlights the resilience of caregivers who persist even when family support is minimal. Ahmad lamented that

"only my wife supports... the others do not want to get involved". (Ahmad)

In this context, sustaining care meant shouldering responsibilities largely alone, transforming endurance into a form of moral value. Yip's reflections extend this notion of sustainability to the systemic level. He worried about what would happen when parents are gone:

"I hope the government can set up facilities... when parents are gone". (Yip)

His words show that sustaining care is not only a personal struggle but also a collective challenge requiring institutional support. For Yip, value lies in envisioning structures that ensure continuity beyond the lifespan of individual caregivers.

Taken together, these accounts illustrate that sustaining care under constraints is not passive endurance but an active expression of value. It involves negotiating financial insecurity, coping with limited family support, and imagining systemic solutions. In this way, caregivers redefine success as the ability to continue care against the odds.

Family Solidarity

Another dimension of achievement in caregiving was the ability to witness tangible signs of patient progress and to experience solidarity within the family. These moments, though often incremental, were deeply meaningful to caregivers, serving as validation that their efforts were not in vain.

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Yip provided one of the clearest examples of this perspective. He assessed his child's improvement numerically, stating:

"He has already improved a lot... six or seven points out of ten". (Yip)

This evaluation shows how caregivers measure achievement through small but noticeable changes in behaviour, stability, or functioning. For Yip, progress was not about complete recovery but about gradual improvement that could be observed and celebrated. His words reflect the way caregivers recalibrate expectations, finding achievement in partial gains rather than absolute cures. Family solidarity was also highlighted as a form of achievement. Yip described how siblings contributed gifts and money:

"His brothers and sisters buy things for him... during festivals they give him money". (Yip)

These gestures, though modest, reinforced the sense that caregiving was not borne alone but shared across the family network. The act of giving, even symbolically, became an achievement in sustaining morale and affirming collective responsibility. Fatimah echoed this collective dimension, emphasizing the family's united hope:

"Everyone... all the family want her to be healthy like normal". (Fatimah)

Her statement illustrates how value is not only measured by the patient's condition but also by the family's ability to remain cohesive in the face of strain.

Taken together, these accounts show that witnessing patient progress and family solidarity transforms caregiving from a solitary burden into a shared value. These moments provide caregivers with affirmation, reinforcing their sense of purpose and sustaining their commitment to care.

Fulfilling Moral and Spiritual Duty

For several caregivers, caregiving value was not only measured in practical or medical terms but also in the moral and spiritual meaning attached to caregiving. The act of caring itself was framed as a duty, a calling, and a source of personal fulfilment. Yip articulated caregiving as a spiritual mission. He explained:

"It is a channel of God's love... to show them God also loves them". (Yip)

His words reveal that value was experienced through alignment with faith, transforming caregiving into a moral accomplishment. Fatimah similarly emphasized the moral meaning of caregiving. She reflected:

"Yes, it has meaning... it is really meaningful I can take care of her". (Fatimah)

For her, value lay in the act of fulfilling responsibility toward her sister, regardless of the difficulties. Song also underscored the ethical dimension of caregiving, stressing patience and compassion:

"We must care for him with love... leave a heart of compassion". (Song)

His words highlight how value was measured by the ability to uphold kindness and empathy, even when faced with frustration or setbacks. Taken together, these accounts show that fulfilling moral and spiritual duty was a central dimension of caregiving value. For Yip, it was about embodying God's love; for Fatimah, it was about finding meaning in responsibility; and for Song, it was about sustaining compassion. These reflections demonstrate that caregiving is not only about patient progress but also

about caregivers' ability to transform hardship into moral fulfilment, thereby reaffirming their identity as responsible and loving family members.

Theme 2: Challenges in Caregiving

Caregivers reported substantial emotional, social, and practical challenges. Emotional and behavioural crises, including aggression, medication refusal, sleep disturbances, and poor self-care behaviours, created considerable stress. Caregiving responsibilities also restricted personal freedom, disrupted social activities, and contributed to exhaustion. In addition, caregivers frequently managed practical concerns such as hygiene, safety, hospitalization, and crisis intervention.

Participants described caregiving as emotionally demanding, with one caregiver stating,

"It is stressful to care for him," (Ahmad)

while another shared experiences of exhaustion due to recurring behavioural disturbances.

Emotional and Behavioural Crises

Participants vividly described the emotional toll of unpredictable behaviours. Fatimah recalled:

"When she is too aggressive... shouting, rebelling... completely out of control". (Fatimah)

Her words highlight the sense of helplessness when aggression escalates beyond family control.

Yip added:

"If they don't sleep at night... their emotions become unstable, very hard to communicate", (Yip)

It is showing how insomnia destabilizes both patient and caregiver.

Ahmad's account,

"In terms of his personal hygiene... he is quite difficult to get to bathe. He needs to be told and forced first, only then he will do it." (Ahmad)

It illustrates how even routine hygiene becomes a site of conflict. Taken together, these voices show that crises are not isolated incidents but recurring disruptions that define the rhythm of caregiving, leaving caregivers emotionally drained and constantly on alert.

Lifestyle Strain and Social Burden

Caregiving also reshaped participants' social lives and personal freedom. Yip lamented:

"Sometimes I see relatives and friends traveling... but I cannot, because at home there is a child with illness". (Yip)

His words capture the sense of exclusion and sacrifice, where leisure and mobility are curtailed. Ahmad admitted:

"It is stressful to care for him... usually I distance myself from Abu, take the children out", (Ahmad)

It is reflecting how caregivers carve out temporary relief by withdrawing from the patient. Fatimah described exhaustion:

"She will shout every night... it is hard to sleep, I feel dizzy and exhausted". (Fatimah)

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These accounts converge on the idea that caregiving narrows life trajectories, limiting participation in social activities and eroding wellbeing. Achievement in caregiving is thus shadowed by the cost of isolation and fatigue.

Practical and Safety Demands

Beyond emotional and lifestyle strain, caregivers faced practical and safety challenges that required them to act as crisis managers. Ahmad recounted:

“He slept in front of the shop, then defecated and urinated there... and left without cleaning”, (Ahmad)

It is illustrating how public incidents create stigma and require intervention. Peter explained:

“We need to bathe them regularly... many cannot manage themselves, they just sleep and neglect hygiene”, (Peter)

It is showing the constant vigilance needed to maintain basic dignity. Fatimah described calling external authorities:

“We call the police and hospital to calm her down”. (Fatimah)

These examples reveal how caregiving extends beyond the household, involving coordination with institutions and law enforcement. The caregiver’s role becomes multifaceted — part family member, part health aide, part crisis responder.

Across participants, caregiving challenges were not simply personal struggles but systemic issues. Emotional crises destabilized family life, lifestyle strain eroded social participation, and practical demands required external intervention. Together, these accounts show caregiving as a paradoxical role: deeply rooted in love and duty, yet constantly tested by crises that demand resilience, adaptation, and external support.

Theme 3: Sources of Support

Family members, healthcare professionals, religious communities, and government welfare services were identified as important sources of support. Family support varied across participants, with some describing strong family solidarity and others reporting limited involvement from relatives. Professional support from psychiatric services and healthcare providers was considered essential in managing crises and treatment adherence. Government welfare assistance provided some financial relief, although participants expressed the need for more comprehensive long-term support.

Family and Community

Family support was experienced in contrasting ways. Ahmad lamented:

“Only my wife supports... the others do not want to get involved”. (Ahmad)

His words highlight the isolation felt when caregiving is concentrated in one household, with siblings disengaging from responsibility. In contrast, Fatimah described a more collective effort:

“Everyone... all the family want her to be healthy like normal”. (Fatimah)

For her, achievement lay in the family’s ability to remain united despite the strain. Yip offered yet another perspective, noting:

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"His brothers and sisters buy things for him... during festivals they give him money". (Yip)

These gestures, though modest, reinforced solidarity and validated caregiving as a shared accomplishment. Taken together, these accounts show that family support can either fracture caregiving responsibilities or reinforce them, shaping caregivers' sense of burden and achievement.

Medical and Institutional Support

Institutional support was described as indispensable during crises. Peter emphasized structured teamwork:

"We have a team... to accompany, counsel, and distribute medication". (Peter)

It is illustrating how external intervention becomes necessary when aggression escalates beyond family control. Fatimah explained:

"We call the police and hospital Sentosa to calm her down", (Fatimah)

Her words highlight how organized routines and professional collaboration provide stability. Song stressed the role of doctors:

"Doctors helped a lot... they are professionals". (Song)

These accounts converge on the idea that caregivers cannot manage alone; medical institutions and professional expertise are critical scaffolding that allow families to survive crises and maintain care.

Government and Welfare Support

Government assistance was acknowledged but often critiqued for its limitations. Ahmad mentioned:

"Sometimes he has financial aid... JKM assistance", (Ahmad)

It is pointing to the importance of welfare payments in sustaining basic needs. Yip described:

"The government supports... every month he gets RM350... sometimes year-end bonuses", (Yip)

It is showing how financial stipends provide relief but remain modest. Peter voiced a broader concern:

"I hope the government can set up facilities... so when parents are gone, patients still have somewhere to live, with care." (Peter)

His words highlight the gap between short-term financial aid and long-term structural solutions. Collectively, these accounts suggest that caregivers view government support not merely as financial relief but as a moral responsibility to ensure continuity of care beyond the lifespan of individual caregivers.

Across participants, support was experienced as a fragile lifeline. Family solidarity could either reinforce or weaken caregiving, institutional support was indispensable during crises, and government aid provided partial relief but lacked structural depth. These findings reveal that caregiving is sustained not only by individual resilience but by the interplay of family, institutional, and state support — each shaping caregivers' capacity to endure and find meaning in their roles.

Theme 4: Coping and Family Caregiving Practices

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Caregivers employed various coping strategies to manage caregiving demands. These included prayer, acceptance, patience, emotional regulation, and reliance on professional treatment. Family role distribution also influenced caregiving experiences, with shared responsibilities reducing burden while unequal caregiving arrangements increased stress. Across participants, caregiving was consistently viewed as a moral obligation grounded in love, compassion, family commitment, and spiritual values. One caregiver emphasized,

“We must care for him with love and compassion,” (Yip)

illustrating the importance of personal values in sustaining resilience.

Self-Initiated Coping

Caregivers developed personal strategies to regulate emotions and relieve stress. Song explained:

“One time, after dinner, I took her out for a drive. When we arrived at church, she refused to get out of the car. I felt helpless... but I prayed silently, stayed with her, talked gently. We stood outside for half an hour... she looked blank, didn’t speak much. Finally, she calmed down, and I managed to bring her inside. That moment was very moving... I felt God’s grace helped me cope.” (Song)

His reliance on prayer shows how spirituality functioned as an emotional anchor, transforming distress into faith-based resilience. Ahmad described distancing himself from Abu:

“Usually I distance myself from Abu... take the children out”. (Ahmad)

This illustrates a pragmatic coping mechanism, where temporary withdrawal provided relief and preserved his own wellbeing. Yip emphasized patience:

“I would say... don’t scold them, don’t abandon them. Must have love, patience.” (Yip)

His words highlight how emotional regulation was achieved through values of kindness, reframing caregiving as an act of love rather than frustration. Together, these accounts show that coping was both spiritual and practical, enabling caregivers to endure daily strain.

Family Roles and Responsibilities

Coping also depended on how caregiving responsibilities were distributed within families. Ahmad noted:

“Only I care for him... the other siblings do not”, (Ahmad)

It is revealing the stress of unequal responsibility and the sense of isolation when caregiving is concentrated in one person. Fatimah described:

“Most of the time my mother is the one caring for her”, (Fatimah)

It is showing how caregiving roles were centralized in a primary caregiver, often the mother, while others provided limited support. In contrast, Peter explained:

“We have a team... distribute medication, accompany, counsel... everyone shares responsibility”. (Peter)

His account illustrates a more structured and collective approach, where caregiving was shared among a group. These variations highlight how family dynamics shape coping: some families reinforce

resilience through shared responsibility, while others exacerbate strain by leaving caregiving to one individual.

Family Duty and Values

Finally, caregiving was consistently framed as a moral and spiritual duty, which itself functioned as a coping resource. Fatimah reflected:

“Yes, it has meaning... it is really meaningful I can take care of her”. (Fatimah)

Her words show how caregiving was imbued with purpose, transforming hardship into meaningful responsibility. Yip stressed:

“We must care for him with love... leave a heart of compassion”, (Yip)

It is emphasizing that caregiving was not only a task but an ethical commitment rooted in love. Peter described caregiving as

“a channel of God’s love... to show them God also loves them”, (Peter)

It is situating caregiving within a spiritual framework that gave transcendental meaning to his role. These reflections demonstrate that coping was sustained not only by strategies but by values — love, compassion, and faith — which reframed caregiving as a moral accomplishment.

Across participants, coping practices were multi-layered: personal strategies like prayer or withdrawal, family dynamics that shaped responsibility, and moral frameworks that infused caregiving with meaning. These accounts reveal that coping was not passive endurance but active adaptation, where caregivers drew on spirituality, family solidarity, and ethical values to transform strain into resilience.

Discussion

The findings of this study highlight that family cohesion plays a central role in sustaining long-term caregiving for individuals with schizophrenia in Sarawak. This cohesion is not merely a practical arrangement but is deeply rooted in the region’s cultural context. In Sarawak, caregiving practices are strongly influenced by collectivistic values, where family solidarity and shared responsibility are considered moral obligations. Cultural expectations such as filial piety and reciprocity reinforce the belief that caring for a relative with mental illness is a collective duty rather than an individual burden. These values encourage family members to pool resources, rotate caregiving tasks, and provide emotional support to one another, thereby reducing the strain on any single caregiver.

Moreover, the multicultural fabric of Sarawak—comprising Malay, Chinese, Iban, Bidayuh, and other ethnic groups—further shapes caregiving dynamics. Each cultural tradition emphasizes relational interdependence, whether through extended kinship networks, communal living arrangements, or spiritual practices that frame caregiving as meaningful and purposeful. This explains why caregivers in the study often described their roles as both burdensome and fulfilling: the challenges were mitigated by a sense of belonging, shared identity, and moral responsibility embedded in cultural expectations. Thus, family cohesion emerges not only as a coping resource but also as a culturally constructed resilience mechanism that sustains caregiving across generations.

Another significant implication of these findings concerns the integration of culture and spirituality into counselling practice. While stigma associated with mental illness remains a source of distress (Ong et al., 2016; Aulia et al., 2025), many caregivers in this study demonstrated resilience by reframing caregiving through cultural, moral, and spiritual perspectives. Prayer, religious rituals, and faith communities were frequently described as sources of strength and meaning. For counselling

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practitioners in Sarawak, this suggests that interventions must move beyond purely clinical or burden-focused models to incorporate spiritual resources as legitimate coping mechanisms. Counsellors should cultivate greater awareness of local religious practices, explore clients' spiritual beliefs during assessment, and, where appropriate, integrate prayer, meditation, or collaboration with faith leaders into counselling sessions. Such culturally sensitive approaches acknowledge the collectivistic values and spiritual traditions that shape caregiving in Sarawak, thereby enhancing therapeutic relevance and accessibility. By embedding spirituality into counselling protocols, practitioners can better support caregivers in finding meaning, sustaining resilience, and navigating the challenges of long-term caregiving.

Limitations and Recommendations for Future Research

Although this study provides valuable insights into the lived experiences of family caregivers of individuals with schizophrenia in Sarawak, several limitations must be acknowledged. First, the use of a phenomenological approach with a small sample of five participants limits the generalizability of the findings. While phenomenology is well-suited for exploring depth and meaning, the results reflect subjective experiences and may not capture the full diversity of caregiving practices across Sarawak's multicultural population. Second, the reliance on self-reported data introduces the possibility of response bias, as participants may have emphasized socially desirable aspects of caregiving, such as family obligation or spiritual resilience, while underreporting negative emotions or conflicts. Third, the study's focus on caregivers who were willing and able to participate may exclude those experiencing severe distress or burnout, thereby skewing the findings toward more resilient caregiving narratives.

Future research should address these limitations by employing larger and more diverse samples, including caregivers from different ethnic, socioeconomic, and geographic backgrounds in Sarawak. Comparative studies across urban and rural settings could illuminate how access to mental health services influences caregiving experiences. In addition, mixed-methods designs that combine qualitative interviews with quantitative measures of caregiver burden, resilience, and quality of life would provide a more comprehensive understanding of caregiving outcomes. Longitudinal studies are also recommended to examine how caregiving experiences evolve over time, particularly in relation to relapse episodes and changes in family dynamics. Finally, future research should explore the effectiveness of culturally sensitive counselling interventions, including family counselling models that integrate spirituality, collectivistic values, and community-based support systems. Such studies would not only strengthen theoretical applications of Lazarus and Folkman's Stress and Coping Theory but also provide practical guidance for developing interventions tailored to the Sarawakian context.

Practical Implications for Counsellors

The findings of this study highlight the need for counselling interventions in Sarawak to move beyond burden-focused models and adopt culturally sensitive, family-centered approaches. Counsellors should actively integrate spiritual resources into their practice, recognizing prayer, religious rituals, and faith communities as legitimate coping mechanisms for caregivers. Greater awareness of local religious traditions and collectivistic values is essential, and practitioners are encouraged to explore clients' spiritual beliefs during assessment and, where appropriate, collaborate with faith leaders to strengthen support. In addition, counselling services should emphasize family cohesion by involving multiple family members in sessions, facilitating dialogue on shared responsibilities, and addressing potential conflicts arising from unequal caregiving roles. Training modules for counsellors should include cultural competence, spiritual integration, and family systems approaches to ensure interventions resonate with Sarawak's multicultural context. Finally, collaboration with community organizations and NGOs can extend the reach of counselling services, bridging gaps in accessibility and providing caregivers with holistic support networks. By embedding these practices, counsellors can enhance therapeutic relevance, sustain caregiver resilience, and promote long-term wellbeing in families affected by schizophrenia.

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Caregiving for individuals with schizophrenia in Sarawak was experienced as both a burden and a source of meaning. Participants reported emotional strain, financial difficulties, and exhaustion while managing medication, monitoring symptoms, and balancing caregiving with work and family commitments. Yet, caregiving was also described as an expression of love, compassion, and spiritual responsibility. Religious beliefs and practices such as prayer and devotion provided comfort, reframed stigma, and strengthened resilience, allowing caregivers to sustain hope despite ongoing challenges. These findings align with Lazarus and Folkman's Stress and Coping Theory (1984), showing how caregivers employed both problem-focused coping—such as monitoring treatment, seeking information, and managing routines—and emotion-focused coping—including prayer, acceptance, patience, and positive meaning-making. Coping was not only individual but collective: family cohesion emerged as a critical protective factor. Shared caregiving responsibilities, emotional encouragement, and practical assistance from siblings, spouses, and extended family reduced stress and prevented burnout. Conversely, unequal distribution of duties heightened strain and conflict, underscoring the importance of family dynamics in caregiving outcomes.

This extends Stress and Coping Theory by highlighting social and relational resources as central to resilience. Family cohesion provided emotional reassurance, collaborative problem-solving, and a sense of collective duty, transforming caregiving into a shared process rather than an isolated burden. Support systems—including healthcare professionals, religious communities, and government welfare services—were valued but often described as fragmented and insufficient, with gaps in financial aid, respite care, and community-based resources.

The findings suggest that caregiver wellbeing depends not only on personal resilience but also on the availability of structured support. Counseling interventions should therefore target families, not just patients. Family counseling can promote cohesion, facilitate communication, resolve conflicts, and encourage shared responsibility, reducing burnout and strengthening resilience. In Sarawak's multicultural context, culturally sensitive counseling that integrates collectivistic values and spirituality is particularly relevant. By embedding cultural and spiritual resources into counseling protocols, practitioners can enhance therapeutic relevance and provide caregivers with meaningful support.

Conclusion

Overall, this study demonstrates that family caregiving for individuals with schizophrenia in Sarawak is a complex and multidimensional experience characterized by both challenges and resilience. Guided by Lazarus and Folkman's Stress and Coping Theory (1984), the findings show that caregivers are not passive recipients of stress but active agents who continuously appraise situations, mobilize resources, adapt coping strategies, and construct meaning from their experiences. Most importantly, the study highlights family cohesion as a key factor in sustaining caregiving and reducing caregiver burden. Strong family relationships, shared responsibilities, and collective support were found to enhance coping capacity and promote resilience among caregivers. Therefore, future mental health policies and interventions should move beyond a sole focus on caregiver burden and recognize the importance of strengthening family cohesion, promoting shared caregiving responsibilities, and providing culturally sensitive support services for families caring for individuals with schizophrenia.

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