
A Phenomenological Study on the Experiences of Caregivers of the Mentally Ill on a Mental Health Facility in the Philippines

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ABSTRACT

The phenomenon of caring for a mentally ill family member was explored in this qualitative study. It aims to help families, mental health professionals and the community, gain an understanding of the experiences of caregivers and the challenges in sustaining their roles. Findings of the study showed that, in general, care giving a mentally ill family member is a burdensome experience. Data analysis revealed four super ordinate themes under the experiences of caregivers, these consists of care giving difficulties, various emotional reactions, attitude towards the situation, and the positive care giving experiences. Several support programs and services such as provision of mental health education and counseling regarding facts about the illness, its treatment and management, and leniency on watcher requirements during hospital admission are recommended by the authors to facilitate better care giving experience of carers of the mentally ill.

Keywords: *care giving experience; mental illness; caregiver; Philippines; henomenological research*

INTRODUCTION

Leaving mentally ill people untreated can create a huge toll of disability, suffering and economic loss. This gets even worse because mental disorders have already affected hundreds of millions of people globally. WONCA and WHO (2008) reported that in every four people in the world, one will be affected by a neurological or mental disorder. There are currently around 450 million people who suffer from such conditions which have placed mental disorders among the top causes of disability worldwide (WHO, 2001).

Mental illness remains a stigmatized, under-researched topic in the Philippines. Few studies on the area of mental health are available, and at present, there is scant literature concerning the experiences of people living with and giving care to mental ill people. Even more scarce are the accounts of families and caregivers who mainly provide for their needs.

It is reported that one in five Filipinos will suffer mental illness (Magtubo, 2016). Currently, there are 700 psychiatrists and an estimated 1,000 psychiatric nurses for a population of 100,000 who can cater to the needs of these people. Further statistics showed that about 17% to 20% of Filipino adults have experienced psychiatric illness, and 10% to 15% percent of children aged five to fifteen years-old suffer from a mental health disorder. There is a total of 50 outpatient care and 32 inpatient care mental health facilities in the country that provides

primary interventions such as drug administration, psycho-diagnosis & therapy (Mental Health Atlas Country Profile, 2014). The Philippine Health Information System on Mental Health (PHIS-MH), recently released some figures showing schizophrenia as the leading mental illness in the Philippines which has affected 42% of the study cohort.

Despite the glaring statistics, only a few resources can be found on the care giving experiences of people living with mentally ill persons. This lack of knowledge is seen to be a result of the strong belief in spiritual and otherworldly causes of physical and mental problems wide spread throughout the Philippines and the Western Pacific Region. This amplifies and reinforces the reliance of Filipinos on traditional and folk healers since they offer a cheaper and accessible alternative to mental health professionals (Tuliao, 2014). The early stages of the professionalization of counselors and psychologists in the country do not provide much help, thus, making mental health services inaccessible and momentarily prohibitive.

Given these, this research aims to help families, mental health practitioners, and society as a whole, to explore the lived experiences of primary caregivers and to recognize the things that help them sustain their caring role. Specifically, this research tries to:

1. Explore and describe the experiences of caregivers of the mentally ill.
2. Formulate recommendations to support caregivers and families of mentally ill.

MATERIALS AND METHODS

Theoretical Frameworks. This study utilized a combination of theoretical and conceptual frameworks that helped in the analysis and presentation of findings. Specifically, the frameworks used are *Stages of Grief Model* and *Four Stages in Caregiving Experience*.

A. Stages of Grief Model

The original proponent of this model is Elizabeth Kubler-Ross who suggested the importance of gaining insight on the different reactions that family members experience which can lessen tension and possibly increase acceptance of various responses in a family (Bolden, 2007). The stages do not necessarily follow a sequence, nor is it universal. Family members may get stuck in a particular stage or repeat stages because they might respond differently to mental illness. These stages apply to people experiencing any significant life events such as the death of a loved one, divorce, suffering from a terminal illness or the onset of a chronic illness. The authors strongly believe that this is applicable to people working as caregivers to mentally ill persons.

The progression of stages is given an acronym of D.A.B.D.A.:

- a. **Denial** or the “*I feel fine*” state- Denial is a temporary feeling and defense for an individual which is later on replaced with the heightened awareness of the situation.
- b. **Anger** or the “*Who is to blame?*” state- The individual finally recognizes that denial cannot continue who then experiences misplaced feelings of rage and jealousy to anyone who symbolizes life or energy.
- c. **Bargaining** or the “*I will do anything*” phase- The third stage is where the individual hopes to postpone the illness or death. It involves negotiation with a higher power to extend life or improve the physical condition in exchange for a reformed lifestyle.

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- d. **Depression** or the “*Why go on?*” state- At this stage, the individual fully understands the certainty of the illness. As a result, he/she may become aloof, silent, avoid social contact and grieve.
 - e. **Acceptance** or the “*It is going to be okay*” phase- The final stage is where the person begins to come to terms with their loved one’s condition.

B. Four Stages in the Caregiving Experience

This second model was theorized by a sociologist named David Karp (Anusha et.al, 2017). Karp based his findings through his interviews with many family members about their experiences in the process of caregiving (Karp & Tanarugasachock, 2000). Karp argues that there are four interpretive stages which correspond to the paths that caregivers and mentally ill people take in the caregiving process.

1. **Experiencing Emotional Anomie**- This characterizes the first few moments in the shared experience of the mentally ill and family caregivers. Family members may feel extremely puzzled and confused by the person’s behavior and have no idea how to respond, emotionally or behaviorally.
2. **Getting a Diagnosis**- Caregivers struggle to empathize with their sick family member after a diagnosis has been made. They often believe that combining both medical treatment and utmost care to their family member will solve the problem.
3. **Perceiving Illness Permanency**- Once a clear picture of the family member’s chronic illness is seen, the kinder emotions of concern and sympathy usually recede replaced by deeper feelings of anger and frustration. These hostile emotional reactions are likely to surface if caregivers perceive that their ill family member does not take responsibility for their recovery.
4. **Acceptance**- In the end, some caregivers may admit that the illness is beyond their control. Recognizing this can release family members of guilt by validating their withdrawal feelings.

Research Locale. This study was conducted from January to March 2018 at the Acute Crisis Intervention Service (ACIS) Unit of Schistosomiasis Hospital (SH) formerly Schistosomiasis Control and Research Hospital (SCRH) in Palo, province of Leyte in the Eastern Visayas region of the Philippines. ACIS is an immediate short-term psychological care which aims to assist an individual under a crisis situation to restore stability or equilibrium to their biopsychosocial functioning. It aims to minimize the potential long-term psychological disturbance and maladaptive behavior and return the individual to their usual level of pre-crisis functioning. It has a bed capacity of 8 males and 8 females aside from its emergency and outpatient consultation services. Admitted patients are managed within 14 days. Drug administration, psycho-diagnosis & therapy are the primary interventions for SH-ACIS inpatients.

Research Design. Anchored on a qualitative research design, phenomenological method was employed for this research to explore the phenomenon under study which are the experiences, coping, and support to caregivers of the mentally ill patients in the Acute Crisis Intervention Service. In this study, mentally ill individuals shall be referred to as those diagnosed with a mental illness for at least 6 months prior to the interview. The primary data were collected through in-depth interviews with caregivers or relatives of a mentally ill person who visit the said hospital. Library and internet desk research in its related literature were also employed.

Phenomenological researches are interested in the analytical and descriptive experience of phenomena by individuals in their everyday world (Eddles-Hirsch, 2015). Therefore, this study is more concerned with first hand descriptions of caregivers than in resolving why caregivers of mentally ill persons experience life the way they do. Phenomenological research differs from other modes of qualitative inquiry because it attempts to understand the essence of a phenomenon from the perspective of participants who have experienced it (Christensen et al., 2010; Khan, 2014; Eddles-Hirsch, 2015). The focus, then, in this type of research, is not on the participants themselves or the world that they inhabit, but rather on the meaning or essence of the interrelationship between the two (Merriam, 2014). Thus, this phenomenological research seeks to uncover the essence of the experiences of caregivers of the mentally ill patients at the Acute Crisis Intervention Service (ACIS) Unit of the Schistosomiasis Hospital in Palo, Philippines.

The authors utilized and adapted the questionnaire used by Monyaluo et al. (2014) and translated it to the local language of *Waray-Waray* in Leyte, Philippines for a better understanding of the participants. The questions were semi-structured followed by specific questions that probed deeper into their experiences in order to gain more valuable information. The interview and dialogue were also conducted in Waray-Waray. A pilot interview was first conducted to test the questionnaire.

Data Collection and Sampling. The researchers utilized purposive sampling, considered as the most important kind of non-probability sampling (Welman and Kruger, 1999), to identify the primary participants. The authors selected the sample based on their judgement and the purpose of the research (Babbie, 1995; Greig & Taylor, 1999; Schwandt, 1997; Groenewald, 2004) looking for those who “have had experiences relating to the phenomenon to be researched” (Kruger, 1988 p. 150). Relatives, family members and or significant others of admitted ACIS patients were directly approached and asked to participate in the study. These interviewees are the primary unit of analysis (Bless & Higson-Smith, 2000), with their ‘informed consent’ (Bailey, 1996; Arksey & Knight, 1999; Street, 1998).

To ensure ethical research, the authors made use of informed consent (Holloway, 1997; Kvale, 1996). Bailey (1996) cautions that deception may be counter-productive. However, not asking the leading (Kvale, 1996) central research question (given under the next heading) is not regarded as deception. Based on Bailey’s (1996) recommended items, the authors developed a specific Informed Consent Agreement to gain the informed consent from participants, namely, a) that they are participating in the research, b) the purpose of the research (without stating the central research question), c) the procedures of the research, d) the risks and benefits of the research, e) the voluntary nature of research participation, and f) the procedures used to protect confidentiality (Arksey & Knight, 1999; Bless & Higson-Smith, 2000; Kvale, 1996, Street, 1998).

The Informed Consent Agreement form was explained to subjects at the beginning of each interview. Most potential subjects signed the agreement and those who did not were not pressured to participate in the study. All who ended up being participants were in agreement with its content and signed.

There is no right answer to the question of the sample size. It partly depends on several factors: the degree of commitment to the case study level of analysis and reporting, the richness of the individual cases, and the constraints one is operating under. The author heed

the advise of Boyd (2001) and Creswell (1998). Boyd (2001) said that two (2) to ten (10) participants or research subjects are sufficient to reach saturation, and Creswell (1998) recommended “long interviews with up to 10 people” for a phenomenological study, hence, a sample size of 5 relatives and caregivers of mentally ill patients voluntarily participated in this study. To qualify as a participant, each participant swore that they were the principal caregiver of the patient i.e. someone who spends most of his time taking care of the patient for at least 1 year. The family members interviewed were parents, specifically mothers (3), spouse (1), and child (1) of the mentally ill person. All participants were adults between 30 to 60 years old.

One researcher served as the facilitator of the discussions while the other one operated the voice recorder and took notes. Each interview lasted for about 30 minutes to 1 hour, all the while ensuring that there were no interruptions. The names of informants and their relatives in this study have been changed to protect their anonymity. The non-verbal reactions and observation during the interviews were also noted to blend with other field notes and recorded data. After having recorded the interviews, the audiotaped data were transcribed verbatim by typing and transferring it to the *Microsoft Excel* and *Word* program. The transcripts were translated from *Waray-Waray* to English. In the process of transcription (Smith and Osborn, 2008), the participants’ words were recorded as close as possible. To ensure the correctness of data, the transcriptions were checked against the voice record a number of times. The initial notes were transformed into short and summarized phrases aimed to grasp the critical points found in the text. The researchers encoded the emergent themes on the same computer applications while looking for connections between them. The transcript was subjected to repeated counterchecking against the participants’ actual words to make sure that the connections work. The process helped capture the thematic arrangement of concerns for each participant. The clusters were then assigned a name to represent the superordinate themes.

As a practicing psychologist and a social sciences academician, the authors’ biases revolved around the clinical practice of psychology and sociology- its theories and applications as well as inclination to relate the findings to the context of psychology and sociology. The researchers believe that the topic is very important to guide mental health and psychiatric institutions in formulating policies concerning care and support to caregivers of the mentally ill.

RESULTS

Presented here are the results of the study which includes a description of the participants and their experiences as the primary caregivers of their mentally ill family member. Four major themes were drawn out from the final analysis of the care giving experiences namely, (1) the care giving difficulties, (2) their various emotional reactions, (3) attitudes towards the situation, and the (4) positive care giving experiences.

Most of the participants were females, 80% (4/5), and 80% of them were between the age of 30 to 65 years (4/5). 80% of the participants did not reach college level (4/5) and only 2 of them have a gainful occupation. All participants claimed to have been taking care of their patients for at least 2 years. On the other hand, 3 out of 5 mentally ill patients suffered from schizophrenia while 2 were diagnosed with Bipolar 1 Disorder.

Experiences of caregivers of the mentally ill

Theme 1: Caregiving Difficulties

Internal Struggles.

Caregivers report high levels of burden and stress concerning patient behavior. They struggle with taking care of the patient by forcing and pleading them to comply with treatment. Most patients only take their medication e.g. neuroleptic drugs when admitted at the inpatient ACIS Ward. A few months or even weeks after discharge, patients would willfully discontinue taking these medicines and even refuse to go to their monthly consultation. As reported, all patients of these caregivers had already relapsed at least twice over for the past 3 years. Caregivers carry the weight of these recurring problems, resulting in declaring the situation as a “big cross to carry” for their family. As one caregiver put it “*Only very few men can handle her (wife) situation*”. Carers do their best to persuade their ill family member to comply with the treatment by reminding or even admonishing them. They sacrifice a lot for the sake of these patients by working for longer hours and enduring the lengthy process of seeking financial aid from charitable institutions or government agencies (e.g. DSWD). They also experience impaired family functioning since they tend to prioritize the needs of the sick family member first before the needs of others. It is very difficult for them to sustain the provision of medicines due to lack of financial capacity considering that most of them have no regular income.

Another hindering factor in helping patients gain insight is the irony that caregivers themselves lack the appropriate knowledge to take care of the patient. They sometimes associate the behavioral oddities of the mentally ill as caused by supernatural forces or of physical cause. Caregivers admit to seeking help and treatment from faith healers prior to pursuing medical intervention. Oftentimes, hospitalization is sought when symptoms worsen such as patient already tried to harm himself, another person or has caused havoc in their family or community. Even when they seek hospitalization, carers still lack the understanding of the nature, etiology, and treatment of their family member’s illness. This leads them to be surprised and confused on how to respond to their patient’s behavior.

External Struggles.

Among the struggles described by the participants, the following situations have caused the greatest external problems for them, these include patient’s poor insight, other people teasing and making fun of the patient, counterproductive patient behavior and patient misunderstanding with watchers. These circumstances contribute negatively to the fast recovery of patients. Whereas, the lack of patient watcher (caregiver inside the Ward) is regarded as the greatest difficulty upon hospitalization. This is because there is an absence or lack of a qualified same-sex watcher within the family or that no one simply volunteers for fear of their safety or well-being. Thus, caregivers resort to hiring an able-bodied watcher for 14 days which adds to their financial burden. Oftentimes, watchers are forced to take care of the patient and set all other obligations aside.

Theme 2: Various Emotional Reactions

In spite of the longstanding illness of their family members, caregivers are still in utter disbelief of the gravity of their situation. Most of the participants expressed difficulty comprehending and accepting why mental illness came to have settled on their family. They have trouble processing everything they are going through and somehow questions their integrity as a family or whether there is something wrong with them. Initial reactions of caregivers upon noticing that patients had relapsed are difficulty in sleeping, stress, fear of danger, helplessness, irritation, impatience, and an overwhelming sadness. Caregivers feel heavily burdened and obliged to take care of their patients even if it means enduring the pain and shame of repetitive hospitalization. Some feel that all their efforts to create a good life for the patient have been put to waste. They also feel hurt when patients show an indifferent and uncaring attitude towards them despite everything they do for them. Few of the participants also reported disappointment towards other family members' uncaring and dismissive attitude towards the patient.

Putting the Blame on the Patient.

Blame emerged as a central theme in the patient-carer relationship. As a consequence, caregivers feel angry towards their patient for not complying with medications, not heeding the advice of professionals, taking on vices and being generally defiant and stubborn with treatment. One caregiver felt that the patient is faking it and only wants to be treated like a baby. Despite numerous efforts, some patients would ignore the help given to them. Most of the carers expressed frustration and disappointment towards their mentally ill for not helping themselves and not taking responsibility for their actions. Even constant reminders to help them gain insight, accept their illness, and stop with vices, goes to no avail. One caregiver expressed her anger for the inconveniences and trouble the patient has caused their family and other people. Hate was directed to the patient for giving the family nothing except pain.

Putting the Blame on Other Factors.

Caregivers recognize that there are things beyond their control, thus, they identified issues that have shifted the focus away from the patient. Caregivers believe that work is a notorious illness-causing or relapse-causing factor in mental illness. They highly discourage their patients to work because they associate physical strain to emotional distress. They even blame and feel angry towards people offering work to the patient. This results to lack of healthy or gainful activities for their mentally ill family member and in turn compromises the steady recovery and return of patient to their normal pre-crisis functioning. Being a woman in its essence is also viewed as a contributing factor to mental illness. One caregiver views the female species as being more emotional than men. Lastly, primary caregivers feel that the rest of the family members do not support the steady recovery of their patients thereby resulting in more relapse.

Giving up and Surrendering.

Further analysis revealed that caregivers have already given up hope on their ill patient. To them, the future looks bleak and there is nothing they can do but to surrender everything to a Higher Being. Thoughts of abandoning their patient and forsaking all obligations are not a far-fetched idea. The previous caregiver of one patient has in fact abandoned all responsibility and left the patient to the care of another family member. They consider their

situation as too much to bear and they feel an overwhelming tiredness and brain-drain from absorbing all information. One caregiver considered placing their sick in a homecare and wanted to ask forgiveness from God because as she said, “...*the love is probably gone, I only have pity for her*”. Also, conditional love has surfaced in the findings. The carer plans on leaving the patient if she relapses due to noncompliance with medication. The caregiver feels that it is the ultimate way to correct the irresponsible behavior of the mentally ill patient.

Theme 3: Attitude towards the Situation

Kind Gestures towards the Mentally Ill

Participants described various compassionate gestures towards the patient- they become more understanding, compromising and accommodating. Caregivers understand that showing hostility and criticisms towards patients do not help alleviate the symptoms, in fact, it aggravates their symptoms. They tend to reprimand their patient less often, provide a caring and supportive environment and promote healthy habits for the patient to emulate. In explaining the complexity of the situation, one respondent said while crying: “...*taking care of my son is like holding an egg. I treat him like a baby and I am very careful and sensitive to his needs.*”

Participants primarily facilitate the compliance to treatment of the patient by reminding the mentally ill to help themselves, warning them of the dangers of noncompliance and practically helping them gain insight into their condition. Furthermore, they do their best to accommodate the requests of the patient by giving them whatever they want and allowing them to do what they please including independence of decision, material things, work, and support with studies. However, some caregivers do not always give these luxuries for free- they only allow as much freedom in exchange for patient compliance with treatment. This symbiotic mechanism is seen as vital in keeping the behavior of patients in check with the promise of a reward for every good deed.

Taking extreme measures.

Despite the kindness and considerate attitude of caregivers, they also report going great lengths to ensure the steady recovery of their mentally ill family member. They monitor everything about the patient especially when it comes to their compliance with medication. They make sure nothing goes wrong, vigilantly observing patient activities and avoiding things that could worsen the situation. Participant’s paranoia towards the situation is a means of exhausting all possible means of treatment and perseverance to provide the needs of the patients. Some caregivers even employ deceit just so their delusional patients would eat the food they offer, down their medicines, or seek consultation and avoid going to work.

Apprehension vs Hope for the Future

Fear and uncertainty of the future shrouds the care giving process. They are unsure whether to expect a full recovery or an endless relapse of the patient which is why they constantly check patient activities such as vices, unhealthy behavior, and employment conditions. Most importantly, respondents fear that no one will take over their caring roles once they leave this world. They fear that other family members do not understand the patient’s condition well enough to shoulder the responsibility. They also worry whether their mentally ill family member will raise their own family. The poor economic conditions of the family resulting in the inability to provide for the medical needs of the patients is also one of their greatest fear.

Nevertheless, a good number of respondents believed that there is still hope to the grim conditions they described.

Theme 4: Positive Caregiving Experiences

Respondents claim to receive support such as prayers from church members, support from friends and community members, assistance from in-laws and other members of the family, and lack of discrimination from the public. They also expressed appreciation to the hospital staff in helping the patients recuperate during their stay in the mental health facility. Finally, caregivers experience joy when they see their patients responding positively towards treatment. Witnessing their sick family member become easy to deal with, having good insight, helping provide for the family and showing care towards others, gives them hope and optimism.

DISCUSSIONS

This study provides a culturally sound and in-depth understanding of the phenomenon of caring for a family member with mental illness in the Philippines with an emphasis on analyzing their experiences, coping strategies and needed assistance to sustain them in their caring roles. The richness of data in this study provided support that caregiving is indeed a difficult and burdensome responsibility while discounting some claims of researches on the topic.

Similar to the findings of Ayuurebobi Ae-Ngibise et. al. (2015), participants described various caregiving difficulties and emotional reactions towards caring for their mentally ill family member. The lack of knowledge and information on how to take care of their patients also adds to their stress and anxiety such that the caregivers become confused with how to handle the situation. They respond by attributing this illness to otherworldly and physical causes which do not relate in any way to the facts about the disease. This is consistent with the finding of Lakeman (2008) and Wang et. al. (2017) claiming that insufficiency of information constitutes an obstacle to families in taking care of their mentally ill member.

Participants also experience various physical and emotional reactions that can already be classified as a form of emotional disturbance, specifically depression (Wrosch, 2011). Meanwhile, other reported emotional and behavioral changes may already qualify as an anxiety disorder due to symptoms such as difficulty in sleeping, negative thought insertion, agitation and over vigilance. As described in the Stages of Grief Model (Bolde, 2007) and the Four Stages in the Caregiving Experience (Anusha et.al, 2017), caregivers experience the following: they have difficulty comprehending or accepting the state of their patient or family to the point of idleness (denial/ experiencing emotional anomie); they have grown to hate the patient for their noncompliance to treatment (anger/ perceiving illness permanency); they agree, compromise, and accommodate the wishes of the patient in order to negotiate terms where both parties will be happy (bargaining); they question their efforts, they experience extreme sadness, hopelessness, exhaustion and other symptoms associated with emotional problems (depression); finally after going through all four stages, caregivers come to understand the whole situation and accept wholeheartedly the patient's condition (acceptance). As a result, they plan for the future and ensure that their patient receives the best treatment for their illness.

On the other hand, some caregivers also recognized that their problems are not their own and that not everything has a solution, thus, they have decided to place lesser pressure on their selves and attribute it to other factors. High expressed emotion inside the family also surfaced as a behavior to be avoided to reduce the challenging behavior of patients (Endley and Berry, 2011). Most caregivers have come to realize that being harsh and imposing to their mentally ill family member do not always result to better compliance. In fact, they become more stubborn and difficult to deal with. With this, caregivers have developed a more caring and understanding attitude towards their patient. Showing less hostility and criticism is their approach to effectively manage and facilitate the treatment of their family member.

Interestingly and contrary to the findings of Caqueo-Urizar et al. (2011), participants in the study who have been taking care of their mentally ill family members for longer years show a more positive attitude towards the patient and the illness. In the long run, mothers become better in understanding and supporting the needs of the patients because longer exposure to the illness has given them a wider perspective and acceptance of the family situation. Impairment in family functioning has indeed become evident especially during times of relapse and admission. Caregivers tend to focus and involve themselves more on the concerns of the patient while putting all other responsibilities at bay (Iseselo et.al., 2016). The theory on help-seeking behavior is also strengthened by the findings that the participants, though lacking in education, promote a strong drug compliance and acceptance thereby resulting in a low help-seeking attitude. They tend to rely on their own capacities as caregivers and helps their patients to empower themselves. Caregivers are adamant and unforgiving when it comes to noncompliance to medications, employing extreme measure to ensure the steady recovery of their patients and persuading the rest of the family to do the same.

Despite all reasons to feel hopeless, caregivers and families of the mentally ill claimed to have so much to be thankful for. The professional and institutional services they have received count as essential resources in fulfilling their roles as primary caregivers (Monyaluoe et al., 2014). The kindness of the people around them and the lack of discrimination has helped these families flourish and become unrestricted in giving everything they can for their patients.

CONCLUSIONS AND RECOMMENDATIONS

The researchers conclude that caring for a mentally ill family member is indeed a burdensome experience. This research revealed the interplay of various factors affecting the caregiving process and recommends further research related to the coping strategies and support needed by caregivers providing an in-depth understanding of the phenomenon. Consistent with the objectives of this study, the following recommendations have been proposed to effectively support caregivers of the mentally ill.

Mental health institutions should strengthen their health education and counseling services to families to help them gain sufficient understanding and awareness of the psychiatric diagnosis of the patient. Mental health education should be intensified to minimize stigma brought about by various psychiatric conditions, thereby increasing family & community involvement in patient's therapy. At the same time, patient and family counseling should be a continuous endeavor to improve compliance with the medication regimen and decrease patient's involvement in vices which pose as a huge risk factor for recovery.

Further studies on coping and needed support services and programs for carers of the mentally ill are also recommended.

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