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RESEARCH PAPER

The Family as Care Unit: Exploring the Psychological and Cultural Dimensions of Mental Illness Care in Pakistan

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ABSTRACT

This study aimed to explore the lived experiences of family caregivers providing long-term care to mentally ill relatives within a Pakistani sociocultural framework. Mental illness is a major contributor to the global burden of disease and disability, with approximately 57.8 million adults currently affected. In low-resource contexts like Pakistan, the deinstitutionalization of psychiatric care has transferred caregiving responsibilities to families, often without adequate support or training. A qualitative phenomenological approach was employed, using semi-structured interviews with 12 purposively selected caregivers. Thematic analysis revealed four major themes: Psychosocial Affliction, Coping Tactics, Blaming the Mentally Ill, and Embracing Reality. Caregivers reported emotional exhaustion, social isolation, and stigma, yet many adapted through religious coping and meaning-making. Some expressed culturally embedded attributions of blame. The findings highlight the urgent need for culturally sensitive caregiver support systems and mental health education. The study's scope was limited by sample size and regional focus.

Keywords: Caregivers, Mental Illness, Family, Pakistan

Introduction

Mental disorders significantly contribute to the global disease burden and stand as a leading cause of disability worldwide, accounting for a substantial proportion of years lived with disability (Sakwape et al., 2025). Almost 57.8 million adults are suffering from some form of mental condition (NIMH, 2023). While the deinstitutionalization of psychiatric patients is crucial for honouring their autonomy, statistics from developing countries reveal that many patients are discharged even when they still require care, largely due to the scarcity of available psychiatric facilities (Silva et al., 2022; Udoh et al., 2021). Consequently, individuals with mental illness are often cared for in home settings by their families (Ayalew et al., 2019). Family caregivers thus become an indispensable component in the ongoing support and care of people living with mental illness (Paradis-Gagné et al., 2020). In many cases, the caregiving responsibilities that would typically fall to mental health professionals have been transferred to family members (Sakwape et al., 2025).

As a result of this shift, families frequently assume both the practical and emotional responsibility of managing their loved one's mental health condition (Ong et al., 2021). According to statistics, one out of four in families is involved in providing care for a family member who has a mental illness (WHO, 2013). But there are many difficulties in this role. To meet the demands of caregiving, family caregivers frequently need to rearrange their lives, giving up leisure time, career ambitions, and personal goals, particularly when dealing with moderate to severe mental health issues (Andrade et al., 2021). Caregivers face social and psychological isolation due to courtesy stigma, also known as stigma by association, in addition to logistical and emotional stress (Siddiqui & Khalid, 2019).

The idea of "caregiver burden," coined by Treudley in the 1940s to characterize the detrimental effects of caring for chronically ill people on the caregiver's physical and mental health as well as on family dynamics, has long recognized this difficult and complex role (Chadda, 2014; The Specialist Forum, 2020). The most frequently mentioned causes of this burden are conflicting responsibilities, financial strain, and a disturbed social life (Liu et al., 2020). In environments with limited resources and little access to institutional support, these stressors are exacerbated.

To understand caregiver burden, it is also important to know the cultural frameworks that shape caregiving roles. Kleinman's (1980) model of the health care system identifies three overlapping sectors: the public, private, and professional sectors. The private sector, which includes individuals, families, and local social networks, is crucial for illness management, especially in non-Western societies. According to Kleinman (Hovland et al., 2025), 70% to 90% of health-related decisions and caregiving efforts happen in this area, which shows how important informal caregiving is within culturally embedded norms.

Caregivers often report emotional and psychological distress, such as social disengagement, depression, and anxiety. This is a clear sign of the effects of caregiver burden. Specialist Forum (2020) reports that the World Federation of Mental Health (WFMH) indicates 80% of female caregivers manage both job and family responsibilities, which leads to increased risk of exhaustion and worsening mental health. There is a lack of research concerning the mental health needs of caregivers. Also, it complicates the establishment of effective support networks (Ndlovu et al., 2023; Stanley et al., 2017).

The understanding of the caregiving burden is gradually increasing in Pakistan, particularly regarding mental illness (Dawood, 2016). Molu et al. (2016) indicate that informal and family-based caregiving is the most common mode of care in Pakistan, with immediate relatives undertaking responsibilities without formal training or external assistance. However, there is a lack of empirical research concerning their actual experiences. This qualitative study investigates the emotional, psychological, and social challenges faced by family caregivers of individuals with mental illness in Pakistan. The development of culturally sensitive mental health policies and caregiver support systems within the Pakistani context is important.

Literature Review

Recent research has increasingly highlighted the challenges faced by family caregivers of individuals with mental illness, especially in environments with few resources. A qualitative study conducted in Botswana by Sakwape et al. (2025) found Basic requirements for caregivers, which include immediate interventions, informational guidance, and emotional support. The results of this study highlight the importance of established support networks, demonstrating that the burden of caregiving significantly impacts the emotional, financial, and social well-being of caregivers. Meanwhile, a systematic review conducted by Sakwape et al. (2025) examined 18 studies across various continents. According to this review, psychoeducation, peer and social support, and community acceptance are common needs for caregivers, indicating the need for caregiver-sensitive healthcare practices on a global scale.

In a related cultural context, Hovland et al. (2025) examined caregiving experiences in Tanzania using ethnographic methods. Family members made up the majority of caregivers, who also reported low mental health literacy, stigma, and reliance on both conventional and biomedical healing methods. This cultural blending of care pathways adds to the complexity of caregiving and emphasizes the importance of culturally relevant psychoeducational programs. Similarly, Akcam and Sarikaya (2025) examined healthy lifestyle practices among caregivers in Turkey and discovered that burnout, financial stress, education level, and prior experience providing care all had an impact on lifestyle quality.

These findings again draw attention to the indirect consequences of caregiving on physical health and lifestyle choices.

Other studies in 2025 have reinforced these concerns from different angles. Wang et al. (2025), in a Chinese cross-sectional study, confirmed that patients' quality of life (QoL) had a direct and indirect (via caregiver social support) impact on the family's disease burden. The mediating role of social support was statistically significant, suggesting that strengthening caregivers' support networks could ease the caregiving burden. Similarly, Bhattacharya et al. (2025) assessed perceived stigma among caregivers of armed forces personnel in India and found higher stigma scores among caregivers with lower education and income levels, older age, and when the patient had diagnoses such as psychosis or substance abuse. Stigma, therefore, emerged as a crucial factor that complicates caregiving roles, reinforcing findings from other regional contexts.

Naamara et al. (2025) extended the discourse by focusing on caregivers of individuals with schizophrenia in Uganda. They found that while caregivers had a basic biomedical understanding of the illness, community members showed mixed but mostly accepting attitudes toward both patients and caregivers. This shift towards acceptance, at least in urban areas like Kampala, presents an encouraging contrast to earlier stigma-heavy narratives, though support systems remain underdeveloped. These results highlight regional similarities in caregiving experiences and are consistent with the psychosocial and cultural subtleties discussed in the Tanzanian and Botswanan studies.

Semaan et al. (2023) provided an in-depth evaluation of the factors influencing caregivers' physical and mental quality of life in Lebanon through statistical methods. Increased levels of depression, anxiety, insomnia, and caregiving for children with intellectual disabilities or depressive disorders were significant predictors of poorer quality of life outcomes. Higher levels of spirituality were correlated with improved physical and mental quality of life, indicating that internal coping mechanisms could reduce the negative consequences of caregiving stress.

Material and Methods

Research Design

This research used a qualitative design to examine the experiences of individuals providing care for family members with mental illness. The phenomenological approach was used to gain deep understanding into the psychological, emotional, and social components of caregiving.

Sample

A sample of (N=12) were purposively selected for the study. All participants were adult caregivers, aged between 18 to 60 years, who had been providing regular support for family members suffering from mental disorders.

Measures

Demographic Sheet: To gather data about the participants, a demographic sheet was created. Age, education, occupation, work history, marital status, the patient's diagnosis, the participant's relationship to the patient, and the duration of time spent providing care had been included in the demoghraphic sheet.

Interview Schedule: To explore the lived experiences of providing care for family members with mental illness, a semi-structured interview schedule was developed. A review of the body of existing literature informed the schedule.

Data Collection and Procedure

Data was collected through in-depth, semi-structured interviews with caregivers of individuals with diagnoses of mental illness. The aim of this study was to thoroughly understand the caregivers' social, emotional, and psychological experiences. Participants were selected using purposive sampling according to with predefined inclusion criteria, such as having served as the primary caregiver for a family member with a mental illness for a considerable period of time. Participants were contacted through mental health facilities and provided with a clear and respectful explanation of the purpose of the study.. Each participant gave their informed consent, guaranteeing both their voluntary involvement and the privacy of their response.

Each participant first filled out a demographic sheet. It asked about age, education, marital status, occupation, job experience, relationship to the patient, caregiving duration, and the patient's diagnosis. This information gave background for comparing the narratives. After this, a semi-structured interview was held in a private setting. The place was chosen to ensure comfort and psychological safety. Each interview lasted 30 to 60 minutes. With the participant's permission, all interviews were audio-recorded.

Transcription: In this study, all interviews were audio-recorded with the participants' consent and later transcribed verbatim to preserve the richness and authenticity of their narratives. All interviews were audio-recorded with the consent of participants. Later, they were transcribed word for word to keep their original meaning and depth. Transcription was done manually to ensure accuracy. This process also helped in understanding the data and noticing early patterns. For participants who spoke in Urdu, translations into English were done carefully. Cultural context and intended meaning were kept in mind during translation.

Table 1
Braun and Clarke's six-step thematic analysis (Braun & Clarke, 2006).

Phase	Description
1. Familiarization	Transcribing data, reading and re-reading the data, noting initial ideas.
2. Generating Initial Codes	Coding interesting features across the dataset in a systematic way.
3. Searching for Themes	Collating codes into potential themes, gathering relevant data for each theme.
4. Reviewing Themes	Checking if themes work concerning coded extracts and the full dataset.
5. Defining and Naming Themes	Refining the specifics of each theme, and developing clear names and definitions.
6. Producing the Report	Final analysis, selection of vivid examples, relating to the research question.

Ethical consideration

Participants were informed about the voluntary nature of their participation, their right to withdraw at any stage, and assured confidentiality. Written or verbal consent was obtained prior to data collection. To protect anonymity, pseudonyms were used during transcription and reporting.

Results and Discussion

Thematic analysis revealed four overarching themes reflecting the complex experiences of caregivers providing long-term care to mentally ill family members: *Psychosocial Affliction, Coping Tactics, Blaming the Mentally Ill,* and *Embracing Reality*. Each theme consisted of several major and sub-themes that reflected recurring patterns across the interviews.

Table 2
Super Themes, Sub-themes, and Initial Coding Relevant to the Caregiving Experience of Individuals Living with Mentally Ill Family Members

Super Theme	Sub-themes	Initial Coding
Psychosocial Affliction	Emotional Strain	Guilt, sadness, helplessness, anger, disappointment
	Physical and Mental Fatigue	Sleep disturbance, anxiety, emotional exhaustion, body pain
	Social Withdrawal	Isolation, stigma, strained relationships, loneliness
Coping Tactics	Religious and Spiritual Coping	Prayers, belief in divine tests, surrender to Allah's will
	Problem-Solving Behavior	Seeking treatment, managing household, keeping the family functional
	Emotional Coping	Avoidance, self-talk, cigarette use, escapism, emotional distancing
Blaming the Mentally Ill	Perceived Moral Failing	"She brought it upon herself," disobedience to family norms
	Attributing to Personal Weakness	Lack of religious belief, inferiority complex, jealousy
	Comparison with Others	"Others went through the same but stayed strong"
Embracing Reality	Acceptance of Illness	Adjusting to lifelong caregiving role, understanding cyclical nature of illness
	Hope and Meaning	Finding strength in children, prayer, future reconciliation
	Resignation and Continuity	"This is how life is now," continuing despite hardships

Psychosocial Affliction

Caring for someone over a long period took a heavy emotional, mental, and physical toll on many participants. They spoke about feeling guilty, helpless, and often sad. One caregiver explained, *"It feels like I've spent my whole life just running—after him, after money, after medicine."* Many also described poor sleep and constant tiredness from the stress building up over the years. These struggles were made worse by feeling socially cut off. Some stopped going to family gatherings or visiting relatives because they were afraid of being judged or questioned. What hurt even more was the lack of real support from their extended families—sometimes reduced to nothing more than *"a few hundred rupees once in a while."*

Even in the middle of so much difficulty, caregivers found ways to cope. For many, faith and spirituality were the strongest anchors. They often saw their struggles as a test from God, finding comfort in prayer or reciting from the Quran. As one caregiver put it, *"I believe Allah only tests those He loves."* Others managed their emotions in different ways—some by smoking, some by crying, and some by pulling back emotionally from the patient when it all became too overwhelming. On the practical side, caregivers worked hard to keep things together: arranging hospital visits, shifting household responsibilities, and making sure children were looked after. These efforts reflected not just survival but a quiet resilience in the middle of an unstable and demanding home life.

Blaming the Mentally Ill

A recurring theme was the tendency of some caregivers to blame the patient for their illness. A few believed it was linked to moral or religious shortcomings. One husband said, *"If she had trusted Allah more, she wouldn't be like this."* Another described his wife's struggles as the result of jealousy and lack of gratitude, suggesting it was something she brought on herself. These opinions are a reflection of cultural ideas that link mental illness to weakness or disobedience, which feeds stigma in families. These viewpoints frequently exacerbated family conflicts and made it more difficult for patients to get support and empathy.

Embracing Reality

Many caregivers displayed a remarkable sense of acceptance despite all the difficulties. Some said things like, "This is how life is now," acknowledging that caring would always be a part of their lives. Others clung to the hope that their perseverance and hard work would eventually be rewarded, or they found strength in their kids. Many spoke of a sincere emotional bond that sustained them, while others continued to provide care primarily out of obligation or fear of what others would think. "I can't leave him like this—I just pray for peace," one caregiver said. The delicate balance between resiliency and resignation in their lives was emphasized by this theme.

Discussion

This study explored the lived experiences of family caregivers of relatives with mental illness. A qualitative thematic approach was used. From the interviews, four main themes were found: Psychosocial Affliction, Coping Tactics, Blaming the Mentally Ill, and Embracing Reality. These themes show the caregiving burden, cultural meanings, and coping strategies which shape caregiving in Pakistan.

Psychosocial Affliction

In addition to being physically tired and having trouble sleeping, caregivers often said they felt helpless, anxious, and emotionally drained. Their comments showed how hard and personal it is to give care. Some said they were "always running after hospitals, medicines, and prayers," which is a phrase that describes both mental and physical fatigue. These findings align with Aryal's (2025) observations that caregivers frequently display stress and depression symptoms comparable to those of the patients. Prior research has also highlighted the long-term health risks of caregiving, including immunological problems and chronic fatigue (Schulz & Sherwood, 2008; Bevans & Sternberg, 2012). This burden is multi-layered, as evidenced by the lack of consistent systemic support (Northouse et al., 2012) and the reliance on spiritual practices for relief (Kim et al., 2020).

Coping Tactics

Despite these difficulties, many caregivers were able to cope. Religion and spirituality stood out as being important. Because they provided meaning and comfort. Faith was not only a personal strength but also a framework for caregivers to justify their work. Phrases like *"only those whom Allah loves are tested"* demonstrate how spirituality served as both a coping mechanism and a source of strength. Similar trends have been documented elsewhere; for example, Chireshe (2024) discovered that during the COVID-19 pandemic, Christian caregivers in Zimbabwe mainly relied on prayer. Wilson et al. (2025) also showed that prayer and meditation can strengthen resilience among caregiver–adolescent pairs dealing with racial or socioeconomic stress. Taken together, these findings suggest that spirituality is often not peripheral but central to caregivers' emotional survival and sense of duty.

Blaming the Mentally Ill

Another recurring theme was the tendency of some caregivers to hold the patient responsible for their illness. This was often framed in religious or moral terms. Phrases such as *"If she had trusted Allah more, she wouldn't be like this"* illustrate how mental illness was seen as self-inflicted or as punishment for spiritual weakness. Such beliefs are not unique in Pakistan. Mohamad et al. (2012) found similar attitudes in Malaysia, although Yin et al. (2020) observed that caregivers in collectivist cultures sometimes blamed personal shortcomings or upbringing. According to Dardas & Simmons (2015), mental illness became stigmatized in Arab families as well, where it was seen as a form of punishment from God or a source of shame for the family. Moralized justifications decreased empathy and caused family conflict in each of these situations, sometimes resulting in the patient and caregiver becoming disconnected from one another.

Embracing Reality

Some of the caregivers are believed to have evolved through experience in a more tolerant manner. Instead of simply viewing themselves as victims, they started to see themselves as the agents of moral, spiritual, and even social empowerment. One caregiver expressed this shift by saying, "You notice that, this is what life is now." These observations highlight the difficult balancing act that brings resignation and resiliency against one another. According to Mungall's (2020) research, parents of children with complex needs also found that the process of finding meaning helped them become more resilient. On the other hand, Casaleiro et al. (2022) discovered that spirituality helped families change caregiving over time. This meaning-making may be an effective coping in the case of chronic illness as it was mentioned by Ahmadi & Ahmadi (2018). All these findings suggest that the long-term adjustment in the roles of caregiving is reliant on acceptance and reframing.

Conclusion

In a Pakistani cultural setting, this study investigated the lived experiences of those who provide care for family members who suffer from mental illness. Four main themes—Psychosocial Affliction, Coping Strategies, Blaming the Mentally Ill, and Embracing Reality—have been discovered through in-depth interviews and thematic analysis. These are providing understanding of the social, spiritual, and emotional complexities involved in providing care.

The findings reveal the complexity as well as challenges of caring for individuals with mental illnesses. Moreover, caregivers are dealing with social stigma, misconceptions about mental illness, and insufficient support systems in between physical and emotional stress. However, many showed amazing resilience in the face of these challenges, often using their inner strength, familial responsibilities, and religious beliefs to care for people they love.

Importantly, these results additionally shown that stigma and incorrect assumptions about mental illness are still prevalent in Pakistan, resulting in a lack of patients and those who provide care for them. Cultural explanations such as personal failure or spiritual possession usually take first place over medical knowledge, delaying treatment and increasing the burden on caregivers. However, several participants displayed signs of change and acceptance, suggesting that caregiving may eventually evolve into a new identity grounded in emotional resilience and moral responsibility.

This study concludes to the growing body of research highlighting the importance of culturally competent mental health services and caregiver support in low-resource settings. More comprehensive, long-lasting models of mental healthcare can be promoted by recognizing and incorporating the psychological and emotional needs of caregivers into treatment plans.

Recommendations

There is a pressing need to improve public understanding of mental illness through culturally appropriate awareness campaigns. These programs should challenge supernatural and moralistic explanations of mental illness and promote medical and psychological literacy among caregivers and the broader community. Mental health care programs should formally include caregivers in the treatment process, offering psychoeducation, counseling, and emotional support. Hospitals and clinics should designate caregiver liaison officers or organize support groups to help caregivers manage stress and avoid burnout.

Caregivers would benefit from training in emotional regulation, stress management, and effective communication with patients. Workshops led by mental health professionals can empower caregivers with practical tools to navigate daily caregiving challenges. Community-based interventions should work to reduce stigma through storytelling, public discussions, and religious leader involvement. Addressing stigma not only improves patient outcomes but also helps caregivers feel less isolated and more accepted. Many caregivers reported difficulty in accessing consistent, affordable care. Expanding mental health services in rural and underserved areas—through mobile clinics, telepsychiatry, or community mental health workers—can reduce delays in treatment and caregiver distress.

Government and non-governmental organizations should consider financial relief for families caring for long-term mentally ill individuals. Monthly stipends, medication subsidies, or transportation support could ease the financial burden that many caregivers endure. Further research should explore diverse caregiving experiences across gender, age, and socio-economic groups. Policy frameworks must be developed through interdisciplinary collaboration between healthcare providers, social scientists, and policymakers to ensure caregiver voices are heard in mental health planning.

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