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Omani Families Caring for a Member with Mental Illness: A Descriptive Qualitative Study

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Abstract

The aim of this qualitative descriptive study was to gain an in depth understanding and knowledge regarding how Omani families care for a member with mental illness including how they supported the later in self-care activities. Data was collected from participants using a purposive sample consisting of ten family caregivers whose member was in Sultan Qaboos University Hospital in Muscat. Each caregiver participated in one semi-structured interview. The interviews were analyzed using qualitative content analysis. The findings included two major themes: The first theme was “caring and empowering with empathy, love, and understanding.” The second theme was “self-denial and giving without limitations.” In conclusion, Omani family caregivers for a mentally ill family member provided optimum level of care to help and empower their family members to manage the mental illness. However, in so doing, those caregivers denied and neglected themselves for taking care of their mentally ill members. Several appropriate clinical interventions and policies are needed to support those family caregivers, to create a situation recently referred to as becoming “care partners.”

Keywords

family caregivers, qualitative content analysis, mental illness, Oman, self-care management

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Omani Families Caring for a Member with Mental Illness: A Descriptive Qualitative Study

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The aim of this qualitative descriptive study was to gain an in depth understanding and knowledge regarding how Omani families care for a member with mental illness including how they supported the later in self-care activities. Data was collected from participants using a purposive sample consisting of ten family caregivers whose member was in Sultan Qaboos University Hospital in Muscat. Each caregiver participated in one semi-structured interview. The interviews were analyzed using qualitative content analysis. The findings included two major themes: The first theme was “caring and empowering with empathy, love, and understanding.” The second theme was “self-denial and giving without limitations.” In conclusion, Omani family caregivers for a mentally ill family member provided optimum level of care to help and empower their family members to manage the mental illness. However, in so doing, those caregivers denied and neglected themselves for taking care of their mentally ill members. Several appropriate clinical interventions and policies are needed to support those family caregivers, to create a situation recently referred to as becoming “care partners.”

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Introduction

In Arabic culture, the family is expected to play a significant role in caring for members who have mental illness. Loza and Effat (2017) indicated that in traditional communities like Arabic ones, the family is expected to take care of its members in wellness and illness, including family members who are mentally ill. In Arabic culture, the core of the community is the family, and it is not the patient who makes essential decisions and consultations regarding treatment, therapy, hospitalization, and type and form of medical care required (Attum et al., 2019). El-Islam (2005) emphasizes that it is the role of the family in Arab culture to interact and consult with the health care providers to provide or seek health information regarding its patient's physical and mental health. Therefore, involving the family in every step of the patient's care plan, from the assessment phase to the recovery/rehabilitation phase, is very important to promote the patient's mental health and to help them gain the self-management of their chronic condition (Chovil, 2003).

Literature Review: The Role of Families in Managing Ill Member

Most mentally ill patients in Arabic countries live with their families who provide support and care at home and during short term hospitalizations. The family as a social unit is often the first to identify any changes in its members' behavior or physical and mental health status. Subsequently, as the primary care giver, they connect their loved one with mental health services. In this context, the family serves several roles: (1) Serving as an informal case manager; (2) coordinating the members' care; (3) suggesting management decisions; (4) observing for the signs of relapse; and (5) providing advice and direction to their member when to seek medical help (Chovil, 2003; Loza & Effat, 2017). These caregivers also help their mentally ill member to manage the illness condition such as: taking medications as prescribed, connecting to health services and community self-help groups, adopting new coping mechanisms to deal with the illness condition and side effects of their medications, and promoting healthy lifestyle (e.g., sleeping, exercise, stress, work, emotions, food, etc.; Chadda, 2014; Chovil, 2003).

The collaborative relationship between families, health care providers, and the mentally ill member not only enhances the outcomes of treatment and self-management, but also alleviates the family suffering. This collaborative relationship supports the family caregivers in their efforts to help their loved relative's recovery (McFarlane et al., 2003). Given the important role that family members play in the care of their loved one, it is crucial that they are given the necessary support from the healthcare staff by providing them with knowledge, skill development, and engagement in the treatment process to care for their relative (Chadda, 2014; Reinhard et al., 2008). This contention was emphasized by Jewell et al. (2009): "the main goal in working with families is to help them develop the knowledge and skills instrumental in promoting the recovery of their family member while eschewing family dysfunction etiological theories of the past" (p. 870).

Another important feature of family caregiver support pertains to family psychoeducation (FPE), which is one of the alleged most important treatment models in Western countries for engaging family caregivers, friends, and other caregivers in treating mentally ill patients (McFarlane, 2016). FPE includes a group of evidence-based models that aim to engage the family in the mental health treatment process as a key implementer, or crucial partner with different expertise and potential skills to help their relatives manage their mental illness (McFarlane, 2016; Murray-Swank & Dixon, 2004).

Family Psychoeducation

Five common characteristics of FPE models are the following: (1) provides family members with information, assistance and support to help their ill relatives cope with the challenges related to their mental illness, (2) helps the family to behave in a positive manner toward their relatives, thereby avoiding behaving in a manner that negatively impacts the well-being and outcomes of the recovery of their relatives, (3) are led by mental health professionals who use a combination of information and techniques (i.e., cognitive, behavioral, communication, and problem-solving) as part of the clinical treatment plan to help families deal effectively with their relatives' mental illness, (4) focuses on alleviating confusion, frustrations, and distress among patients and their families to achieve best outcomes of the treatment, and (5) includes knowledge about mental disorders, medications, and treatment management; health and social services coordination; observation to all parties' expectations, emotions, and distress; family communication and problem-solving skills, enhancing individualized coping and rehabilitative techniques; expanding social support networks; and

preparing for crisis planning with professional involvement (Jewell et al., 2009; McFarlane, 2016, p. 461). In conclusion, FPE forms a solid base for the self-management of people who live with mental illness and contributes to managing the symptoms, reducing the length of admission and readmission, enhancing functioning and quality of life, and maximizing the outcomes (Lean et al., 2019).

Self-Management

To turn now to the concept of self-management. It is defined as the capacity of the individual to control the symptoms, therapies, lifestyle modifications, emotional, cultural, and spiritual effects of health issues in collaboration with family, community, and healthcare professionals (Richard & Shea, 2011). Further elaboration has been provided by Schulman-Green et al. (2012), who referred to this concept as: the ability of patients and their families to observe the disease using their cognitive, behavioral, and emotional strategies to keep a satisfactory quality of life. These strategies:

Include dealing with symptoms and disability; monitoring physical indicators; managing complex medication regimens; maintaining proper levels of nutrition, diet, and exercise; adjusting to the psychological and social demands, including difficult lifestyle adjustments; and engaging in effective interactions with health care provider. (Grady & Gough, 2014, p. 25)

Applying self-management intervention to mental illness and other chronic diseases has many benefits. For example, self-management improves health-promoting behaviors of patients, enhances communication with healthcare providers, and reduces the feeling of pain, disability, fatigue, health stress, stigma, and care costs (Wolf, 2011). However, self-management in mental health care also requires applying advanced skills and strategies of collaborative and cooperative partnerships between health care providers, patients, and their families to empower patients and their families and alleviate the stigma of mental illness.

Challenges Face Family Caregivers

Families of mentally ill members always have considerable responsibility and experience a range of suffering related to caregiving pressures (i.e., physical, mental, and social) and the issue of managing the social stigma related to mental illness. Unfortunately, in the Sultanate of Oman, there is limited knowledge on how families take care of their mentally ill members and how to support them to teach their family member regarding self-management strategies. Although the Mental Health Plan for 2005 insisted on promoting mental health in Oman to make it more comprehensive, accessible, and equitable, there are no outpatient facilities that provide follow up care in the community for those who need it (WHO-AIMS, 2008).

Moreover, there is an absence of interaction between mental health facilities and families or consumer associations of mentally ill patients. WHO-AIMS (2008) reported that less than 20% of mental health services in Oman interacted with community family associations to aid activities. Although in 2022, there are many health services spread over the Sultanate of Oman, Al-Adawi (2017) discussed that maldistribution of these services hinders many Omanis, especially in isolated and rural areas, from seeking help from mental health facilities. Given this context, there was an urgent need to conduct this study, which aimed to gain a deep understanding and knowledge of how Omani families take care of their members

who live with mental illness and how these families support their patients to perform self-management for this illness condition.

Problem Statement and Significance of the Study

There are currently no known empirical studies in the existing literature that use a qualitative methodology to investigate how Omani families care for their mentally ill members. This gap in literature makes this original study a significant contribution to the main body of nursing and health knowledge. By conducting this qualitative study, a deep understanding and new knowledge were gained about the unique role of Omani families in caring and supporting their mentally ill members in self-managing themselves. This knowledge is significant for healthcare providers and policymakers to develop health policies to involve Omani families as an important ally and partner in mental healthcare. Involving families as a partner will empower both families and their mentally ill patients to take care of and perform self-management to deal with the mental illness based on families and families' own needs. That is, empowering families will enhance the quality and guarantee the continuity of care that is provided to mentally ill patients in their homes. Therefore, empowered and supported families will be able to help their patients to perform self-management to deal with their mental illness. Understanding the role of families in caring and empowering them will contribute to deinstitutionalizing mental healthcare from hospitals to community and home care. It is hoped that the results of this study can be used to develop specific family patient-oriented mental health promotion programs and disease prevention to the entire family. Finally, the clinicians and researchers may use the results of this study to develop clinical protocols or research programs related to the role of families in caring and supporting their mentally ill members to perform self-management. Therefore, the two-fold research questions for this qualitative study were: (1) How do Omani families care for of their mentally ill members, and (2) How do they support them to learn to perform self-management of their mental illness?

Researchers Positionality

All authors are doctorally prepared qualitative researchers and have personal, academic and ethical commitments to conduct health and nursing research using qualitative methods to gain in-depth knowledge and to understand different health and behavioral phenomena. The first two authors experienced relocating to the Sultanate of Oman to work there. They noticed that Omani families are so attached to and supportive of their members in sickness and wellness. This phenomenon raised a question about how Omani families care for their mentally ill members. With the help of the second author, the first author developed the conception and designed the study, collected, assembled, and analyzed the data, wrote the discussion, and contributed to providing the study materials. All researchers contributed equally to refining the data analysis, rewriting the discussions, and writing and final approval of the manuscript. The first author (Dr. Aldiabat) is a faculty member and the Assistant Dean for Research and scholarship at the School of Nursing at Cape Breton University- Canada. He is a scientist affiliate in three research centers. Among his research interest areas are mental health nursing and self-management using qualitative methods. The second author (Dr. Alsrayheen) is a qualified qualitative researcher and health outcome scientist at Research, Innovation, and Discovery, Nova Scotia Health Authority, Cape Breton Regional Hospital, NS, Canada. The third author (Dr. Alshammari) is the Head of the Bachelor of Science Department, College of Nursing, Public Authority for Applied Education and Training- Kuwait. In addition to her contribution to refining the data analysis, Dr. Alshammari provided many cultural explanations of the results and why and how people and families during illness behave in the Arab Gulf area. The fourth author (Dr. Le Navenec) is an Associate Professor Emerita in the Faculty of

Nursing, University of Calgary- Canada. She critically contributed as a qualitative researcher, family sociologist specialist, gerontologist and registered nurse. And the fifth author (Dr. Griscti) is an associate professor at Cape Breton University. She is interested in helping with this paper because her area of expertise is qualitative research. She critically read and revised the manuscript as a researcher, nurse, and peer reviewer.

Methods

Design

This study was designed and conducted using a qualitative descriptive content analysis approach (Hsieh & Shannon, 2005; Sandelowski, 2000). According to Sandelowski, this method is used when the researchers do not want to use one of the traditional qualitative methods (e.g., grounded theory, ethnography, or phenomenology) to understand a poorly understood phenomenon by describing in depth the perceptions and experiences of the people who have experienced the phenomenon. She emphasized that qualitative description provides comprehensive summaries of the phenomenon where the researchers stay closer to the data to describe the facts and meanings of the phenomenon. Other features about qualitative descriptive studies are that they tend to be naturalistic without performing deep philosophical, theoretical, or interpretive approaches because the aim is to hear the voice of participants when describing the meaning of their experiences in their own words using everyday terms with less abstraction (Hsieh & Shannon, 2005; Sandelowski, 2000).

Sample

Purposive sampling was used to recruit the participants who were most representative and informative of the phenomenon of interest and was based on the inclusion criteria for this study (Polit & Beck, 2012). The inclusion criteria for the study were as follows: the participants had to have been caring for one or more family members who had been living with mental illness for over a year. They also needed to have been able to converse, write, and understand Arabic, capable of providing informed consent, and aged 20 years or older.

The participants (N=10) included two male and eight female family caregivers. Most family caregiving of a member is the traditional responsibility for women in Arabic culture. Three participants had paid employment (two males and one female), and seven were homemakers. All participants had at least a secondary school certificate, and their average age was 45 (between 32 and 65 years). In their relationship with the patients, two female participants were sisters; six female participants were mothers, one male participant was a brother, and one was a father. Participants provided family care for an average of seven years for a member who had one of the following conditions: major depression (N=3), schizophrenia (N=4), bipolar disorder (N=1), mania (N=1), and generalized anxiety disorder with suicidal thoughts (N=1).

Data Collection

Data were collected from family caregivers while their members were hospitalized in the Department of Behavioural Medicine at Sultan Qaboos University Hospital, Muscat, Oman from January 2021 to August 2021. Semi-structured face-to-face recorded interviews were performed with ten eligible participants for almost one hour for each interview in a quiet, undisturbed room inside the hospital. Parse (1990) recommended two to ten participants to achieve “redundancy or saturation” (p. 10). Although data saturation was almost reached after

the seventh interview, more participants were recruited to avoid premature data collection closure. The data saturation occurred when all themes and summaries of experiences of participants emerged and the researcher could not obtain any new data, nor gain further insights from data sources, and a detailed description of the phenomenon was readily achieved (Aldiabat & Le Navenec, 2018; Charmaz, 2014; Corbin & Strauss, 2008; 2015; Sandelowski, 1995). Five open-ended focused questions and probes were asked to each participant to describe their lived experiences in caring for and helping in self-managing their mentally ill family member: (1) Would you please let me know about your experiences in caring for your family member who is living with mental illness? (2) What do you do at home to help your family member to manage his/her diseases (e.g., controlling their behavior/mood/thoughts, side effects of medications and other treatments, medications, exercise, diet, coordinating and organizing their medical appointments, their emotions, and body image)? (3) How do you make decisions about what mental illness conditions or symptoms to manage first for your family member? (4) What helps and facilitates you to help your family member in managing his/her mental illness (i.e., technology, health services, health care providers, people, resources) at home? And (5) What hinders you from helping your family member in managing his/her mental illness at home?

Data Analysis

Data collection and analysis occurred concurrently. All interviews were transcribed verbatim and then translated to the English language to unify the language of analysis by the first author. Descriptive quantitative analysis was used to analyze the demographic data of the sample. In the qualitative content analysis, six steps were followed as described and summarized by Erlingsson and Brysiewicz (2017). These steps included: First step: The transcribed interviews were read and re-read many times to get a sense of the whole and to understand what the participants talked about. Their ideas and main points were grabbed during this step. Second step: during this step, the text was divided up into smaller parts called the meaning units. Third step: the meaning units were condensed further without losing the core meaning as it was reported by the participants. Fourth step: the condensed meaning units were labelled and formulated as codes. Fifth step: the formulated codes were grouped into categories. Sixth step: in this last step, the categories were condensed more to develop the two major themes and their subcategories.

Approaches to Achieve Rigor

The four significant criteria for achieving rigor or trustworthiness in qualitative data are credibility, dependability, confirmability, and transferability (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Lincoln & Guba, 2000; Speziale & Carpenter, 2007). For credibility, enough time was spent and prolonged engagement with the subject matter during data collection, consultations were made with peer researchers, and reflexivity and bracketing previous knowledge were used by the first author. Dependability can be achieved immediately if the researcher demonstrates the credibility of the findings (Speziale & Carpenter, 2007). According to Lincoln and Guba (1985), there is no dependability without credibility. For confirmability, the first author in this study documented in detail the research process, such as data description collection and analysis-synthesis methods, and the research activities (e.g., discussion, brainstorming, feedback, and report of the researcher). And for transferability, the first author immersed himself in data and wrote a thick description where other individuals in a similar situation may find it relatively easy to identify with the findings of this study.

Ethics

This study was approved by the Research and Ethics Committee at the College of Nursing (# Ref. No. CON/IG/2020/02) and the Medical Research Ethics Committee at Sultan Qaboos University (# REF. NO. SQU-EC/060/2020). Before signing the consent form, all the participants reviewed carefully the entire form, including the study's aim, data collection process, how their anonymity was protected and how confidentiality was ensured, their right to participate was voluntary, and their right to withdraw from the study at any time without penalties.

Results

Two major themes and seven categories have emerged from the data analysis. These were: (1) Caring and empowering with empathy, love and understanding, and (2) self-denial and giving without limitations. The first theme was comprised of 5 categories: (a) understanding the nature of the mental illness, (b) building a trusting relationship, (c) understanding and meeting the patient's needs, (d) rebuilding the positive patient self-concept, and (e) managing the case empathetically; spiritually and emotionally. The second theme was made up of two categories: (a) continuous giving without expecting anything in return, and (b) sacrificing self to put the needs of beloved one first. Omani family caregivers for a mentally ill member were trying to provide an optimum level of care to help and empower their members to manage the mental illness. However, those caregivers denied and neglected themselves while caring for their mentally ill members.

Caring and Empowering with Empathy, Love, and Understanding

Omani family caregivers of the mentally ill member were eager to understand the nature of the mental illness. They sought information by reading and by asking health care providers to provide comprehensive and trusting care. Understanding and meeting their members' needs, as well as empowering them to reconstruct their self-concept was a key finding in relation to their approach to family caregiving. The following subsections will address an elaboration for each subcategory of the first theme.

Enhanced Understanding the Nature of the Mental Illness

Family caregivers searched extensively mental health websites, in attempt to understand the nature of the mental illness of their beloved ones and how they provide support to their family member to control and manage their symptoms and/or discover pathways to recovery. They also kept asking the healthcare providers and other people in similar situations regarding knowledge to enhance their understanding, as well as advice on how to deal with and help their patients manage their illnesses. This information seeking behavior provided support to the family caregivers, thereby promoting their provision of empathetic and knowledge-based care to their mentally ill family members. One participant said:

At the beginning of his illness, we [family members] had a misunderstanding with little to no knowledge about the mental illness's nature, causes and treatment. The psychiatrist kept frequently prescribing and changing his medication plan without fully explaining the treatment plan. It was challenging for me to take care of him without understanding his strange behaviors and thoughts. I was lost and confused about dealing with a vague and unknown

health condition for me. Therefore, I decided to search, read, and educate myself by refereeing to Google resources and YouTube videos, and I learned a lot about mental illness; I understood the signs and symptoms, the treatment options and medications' side effects.

Another participant emphasized how seeking and gaining knowledge empowered and enhanced her caring skills:

Knowledge about mental illness powered me and helped me to provide her [the relative] with the proper care to create a successful treatment plan at home that does not conflict with her medical treatment plan. Seeking more knowledge about her illness from the healthcare providers made me feel and understand how vulnerable she is and to which degree she needs our support and advocacy.

Building a Trusting Relationship

A trusting relationship was viewed here as a situation wherein the family caregiver and the member shared mutually their thoughts and feelings on a progressive basis. Omani family caregivers mentioned that interacting and building a trusting relationship with their mentally ill members is crucial for effective and efficient care. They believed that although a trusting relationship is inherent within family members; during the illness, the trusting relationship must go above and beyond their normal limits, for they need to adapt to the changes in their relative's behaviors, emotions, and relationships. This kind of trusting and reliance relationship was beneficial in managing the relative's behaviors, particularly when they became aggressive, or when they relapsed. This relationship helped family members to care better for their loved one, and also helped their loved one to comply with treatment, thereby facilitating a closer family connection. Family caregivers were always there to support and help their patients, and they were responsive, listened to them carefully, and engaged them in all conversations, events, and gatherings. Caregivers reported that showing their relatives respect and empathy without blaming was the core of building a successful, trusting relationship. One participant said:

I realized that mental illness hurts like physical illness. We treat her [family member] normally with respect and love, and we engage her in all family activities or social gatherings; we ask her opinion on certain issues and listen to her perspective carefully and respectfully. Our aim is not to hurt her feelings or make her feel like she is sick, ... using power and force with mentally ill patients escalates the conflict and creates a mistrusting relationship that leads to uncontrollable aggressive behaviors and increases the relapse episodes.

Another participant provided a description about how different her style of family caregiving as a teenager and at present was from care previously provided by other family members, she said:

When my mother was diagnosed with mental illness, I was a teenage girl and did not understand behaviours; they chained mom most of the time and fed her whatever they wished to feed, not what she liked to eat; they screamed at her to scare her and to control her behaviours. They invited traditional healers and religious men to treat her condition without her permission. They treated her in an unmerciful manner, like a sick dog. I was the only one who cared for her because I was her oldest daughter, showed her my love and empathy, cleaned

her and met her personal needs, released her chain and was proud of her. I am the only one she trusting the most, the only one who can calm her down during the relapsing episode, and the only one who trusting to give her medications and arrange her medical appointments, and she is obedient to go for a walk almost every day.

Understanding and Meeting the Patient's Needs

The needs of the sick relative pertained to physical, emotional, spiritual and related aspects. The participants believed that the mentally ill members are still valuable family members with physical, emotional, psychological, social, and spiritual needs and as family members, they worked hard to meet these needs of their loved one. They addressed the member's needs in a number of ways, namely by: helping them to learn specific ways to control their behavior, enhancing their skills to promote positive self-image, acknowledging their loved one as significant and respected family members, promoting physical and social activities to enhance the overall wellbeing of their loved one, and minimizing mental illness relapse. Omani family caregivers believe that attending to their loved one's needs in sickness and in health, is one of their core family responsibilities. Families believe that they must take more responsibility to perform these needs on behalf of their patients or empower their patients to meet these needs by themselves during the illness period. Some aspects of this belief are reflected in the following participant's comments:

Although my daughter [the patient] sometimes does not know who we [family members] are, at least we still know who she is; she is still my only daughter and occupies a special status in our family, we are one family, and we have to trust and support each other in illness and wellness. She is a human being with many needs; there is nobody in the world better than mothers to understand and meet their daughters' needs. I know when she feels hungry, sleepy or tired, angry and frustrated, sad or happy, and scared or secured ...I try to meet all her needs; otherwise, I feel guilty and do not perform my duty in caring for her perfectly. I feel like mentally ill patients are like soft dough; their compliance to medications, their behaviours, their bizarre thoughts and speech can be easily controlled by the person who takes care of them and provides them with what they need, treat them nicely, and be patient with them. All these are keys to accelerating the recovery process and making her feel supported and appreciated by her family.

In contrast to the above-described beliefs, one participant indicated that the role of the family in empowering family members with mental illness is crucial. This belief posits that empowered individuals possess heightened capability to independently address their own needs, thus diminishing their continuous dependence on familial caregivers. He said:

Although I love him [my brother/the patient] so much, I do not want to spoil him and make him rely on me all the time. I am not always available for him, I have my work, and I often travel outside the country. He must learn to be independent and not rely on anyone to do his things. Unfortunately, all other family members volunteered to take care of him, and each family member had their care style. For example, my parents and sisters are very emotional and sympathetic, and they do not say no and do whatever he asks them to do instead

of encouraging him to do things by himself because they are always anxious if they do not meet his needs, he would be aggressive or relapsed.

Rebuilding the Positive Patient Self-Concept

Self-concept is viewed here as how one perceives one's behavior, abilities, and unique characteristics in positive or negative manners. To provide optimal family care to a mentally ill member, the participants made a concerted effort to help their members reconstruct their self-concept by following specific guidelines they had reviewed to promote positive self-perception/self-image, self-confidence and self-esteem, and role performance. By focusing more on rebuilding the self-concept as part of their family management care, family caregivers noted that their relatives' mental health status and compliance with the therapy improved, and they became more independent and capable of looking after themselves. These practices are reflected in the following quotation by a mother:

Five years ago, I travelled with her [daughter patient] to India, and we met a famous psychiatrist there who advised me to rebuild her self-concept because medications treat the symptoms but do not heal the self. He taught me a protocol for rebuilding her self-concept. I have tried to enhance her perception of body image by encouraging her to take care of herself and hygiene, take care of her beauty and select and put on clean, elegant clothes and accessories. I make honest and timely compliments about things she is good at, like organizing and cleaning the home. I feel like these simple acts make her proud of herself and boost her self-confidence and minimize her feeling of stigma because of her mental illness. I noticed that she got better by engaging herself with others, taking care of her kids, and being compliant with the therapy. After she was diagnosed with schizophrenia, her husband divorced her and left her alone with three kids; he [her husband] damaged how she perceived herself as a woman and a mother. She blames herself because she thought the divorce was her fault, and I am trying to empower her from inside to focus on herself first and not feel guilty for others' faults, not blame herself and be kind to herself.

A mother of a teenage patient reflected on how she could build her son's self-concepts using an approach that focused cognitive and related abilities:

My son was diagnosed with mental illness ten years ago, he was in grade nine. Students in the school bullied him and called him "crazy." He was brilliant, but because of the bullying incidents, his performance was diminished, and he hated the school and decided not to return to school. That was a shocking decision for me, and I realized that my son needed someone to help and support him regain his self-esteem and confidence in his abilities. I showed him that I believe in his abilities, and I am proud of him and love him as he is; I made him feel that other family members and I were always on his side to support him and that we understand his mental illness and we do not blame him, and we all loved him unconditionally. After one year, I noticed that he became more independent in his decisions and actions, more confident and optimistic. Although he refused to return to school, he could decide to commit to homeschooling, and he did it.

Managing the Case Spiritually, Emotionally, and Empathetically

The participants mentioned that they keep praying to God to heal their loved members, to promote their relative's spiritual health and practices, and to bless them with love and affection. The family caregivers also reported that praying for these qualities enhanced their relative's health and controlled their behaviors. They believed that they were able to provide optimum care for their mentally ill members because they always put themselves in their relative's shoes and manage their care by focusing on their emotional needs. This approach is reflected in the following quotation:

Sometimes I feel disappointed and hopeless about caring for my son; caring for a mentally ill family member is demanding and tiring and needs enormous support and commitment. In this case, I refuted to Allah (God) to seek His help and support and to ask Him to recover my son. In every prayer, I ask Allah to supply me with the power and patience needed to continue providing the care. I encourage him (son) to recite Quran [the holy book for Muslims] or listen to it because it gives him peace and calmness. I also remind him to practice all obligatory prayers and do charity with the intention of recovery. Spirituality heals the soul and empowers individuals to face and handle life challenges peacefully.

Another participant believed that nourishing the member's spirituality and being an empathetic caregiver helped in controlling the member's behaviors:

From my long experience taking care of my daughter, I learned a very effective strategy to help her control her behaviours and get rid of evil thoughts, which is to keep her busy remembering and praising Allah using a rosary; I always put myself in her shoes to meet her needs with compassion and love, and this technique helped in controlling her bizarre behaviors.

To turn now to the second theme and its subcategories.

Self-Denial and Giving without Limitations

Omani family caregivers were willing to sacrifice themselves to help and support their sick members. They deprived themselves of engaging in social events or living their life to the full in order to be there for their relative. Caregivers reported that they do not feel satisfied or were not able to enjoy life if their beloved one was suffering or was not feeling happy. Family caregivers felt guilty and sorry for their loved one, and these feelings hinder them from leading a happy and fulfilled life. The following discussion focuses on the two subcategories of this theme.

Continuous Giving without Expecting Anything in Return

Omani family caregivers dedicated time and were always available for their mentally ill relatives; they gave their money and tried to meet their loved one's needs in every possible way. Over the period of their members' illness, they keep giving continuously and unconditionally, and they wished even they could give more than what they have given. They did not seek any reward or expect anything back from anybody; they only wished to see their

loved one get better or recover. This kind of unconditional giving is reflected in the following quotation:

I have been caring for her (daughter/ patient) for almost four years without raising complaints and showing anybody, I am exhausted. Taking care of her is one of my duties toward my sick daughter, and I do not wait for thank you words for doing my duty. Only Allah [God] will reward me for doing and performing this duty in such a perfect manner. I will keep caring for her, supporting and helping her forever until one of us dies. I am her mother and the closest person to her; if I stop taking care of her or meeting her needs, no one else will do it on my behalf.

One participant emphasized that unconditional giving from the family caregiver aims to provide dignified care until the full recovery of the sick relative:

She [the patient] is my oldest sister and raised my brothers and sisters and me after my mum had died. Whatever I do for her, I will never pay back what she did for us [family]. I do not care about the time, money or tremendous efforts I make to take care of her; what matters is providing her with dignified care that helps her get rid of this disease and restore her health.

Sacrificing Themselves to put the Needs of Beloved Patients First

Omani family caregivers struggled to balance their own and their relative's' needs; however, they always put their relative's needs first. Giving their patients' needs priority over theirs makes caregivers feel proud, satisfied, and resilient. In the following quotation, a father participant indicated how he scarified himself to meet his son's needs:

Although I exhausted all means of seeking solutions for his case, I feel guilty and feel what I do for him is still little. I wish I could do more for him [his son], I wish I could grant my health to him, I wish I could get this disease but not him. He is still young, and this disease destroyed his future. He is number one in my life; I always think about him before I think about myself; I will sacrifice myself and time for him until he fully recovers.

A mother participant reflected on how meeting her daughter's needs was a priority over the other tasks:

Meeting her needs and taking care of her [daughter/patient] are the most prioritized things to do in my life. When I notice she is getting better, I feel proud and satisfied that I could do something for her, which boosts my power to give more and more.

Discussion

This study explored the experiences of ten Omani family caregivers who had a mentally ill member. Since they were the main caregivers for persons with mental conditions, they took full responsibly of the daily life needs of their loved ones. Besides physical needs they also observed the progression of their mental condition, monitored the early signs of illness; relapse and deterioration, and took responsibility for accessing the health services for

their patients and the attendant financial costs. In addition, the family caregivers also took responsibility for the management of their loved one's illness condition, such as adherence to medications and observation for their side effects as well as the psychosocial needs of their ill members. Similar results of mental healthcare by families of a relative were reported in the literature for a variety of ethnic groups in other countries (Chadda, 2014; Chovil, 2003; Jones, 2010; Loza & Effat, 2017; Onwumere et al., 2008; WHO, 2013).

Another finding that emerged from this study was that Omani family caregivers showed an evolving journey of caring for their sick family members with empathy, love and understanding; however, at the same time, they denied themselves and sacrificed their life for their beloved ones. This finding was also documented in previous studies that reported how family members such as parents, siblings, and spouses play a significant role in caring for and supporting mentally ill family members (Peng et al., 2022; Yu et al., 2018; Yu et al., 2019). Interestingly, this notion of collectivism and families operating as one unit in wellness and in illness, was also evident in literature relating to Eastern Asian cultures (Chovil, 2003; Loza & Effat, 2017; Peng et al., 2022).

In addition, a noteworthy finding that came to light in this study was that Omani family caregivers believed that successful caregiving must involve being knowledgeable about the nature of mental illness and its treatment. Although at the beginning of the illness trajectory their knowledge was more limited, these caregivers mentioned how they empowered and educated themselves over time, particularly when healthcare providers failed to meet their health education needs and involving them in the treatment care plan. This finding is consistent with findings in the literature, that reported how families who play a salient role in caring for adults with mental illness often lack the required knowledge and skills to help and support their family members (McFarlane, 2016). Other studies reported how family caregivers want to be knowledgeable and skilled in helping their relatives in managing their mental illness, controlling their behaviors, and being involved in treatment decisions and care plans (Chadda, 2014; Jack-Ide & Amegheme, 2016; Jack-Ide et al., 2013; Jewell et al., 2009; McFarlane, 2016; Murray-Swank & Dixon, 2004; Zegwaard et al., 2017).

Building a trusting relationship with the mentally ill relative has been addressed in previous studies. Participants in this study emphasized that building a trusting relationship with their mentally ill relatives is fundamental in order to optimize the care they provide. Although trusting relationships naturally exist among the family members, they need to be reinforced when caring for mentally ill relatives. Family caregivers in this study were always there to support and help their mentally ill member. They responded to their needs, listened to them carefully, and engaged them in all conversations, events, and gatherings. Caregivers reported that showing their loved one's respect and empathy rather than accusing them, was core to building a successful, trusting relationship. This finding corresponds to a study by Tilburgs et al. (2018), who reported that a trust-based relationship and therapeutic communication between caregivers and patients are essential to address medical and non-medical issues in patients suffering from non-physical conditions. Likewise, Gilbert et al. (2008) reported that therapeutic communication, culturally sensitive care, and the absence of coercion are core pillars for mental health care providers to build trusting relationships with patients, which promotes a safe and therapeutic milieu for the treatment of people with acute mental health problems.

Clay and Parsh (2016) explained that family caregivers can contribute towards enhancing their health outcomes by empowering their relative by making them aware of their strengths and weaknesses, and how to work towards achieving their personal needs. Findings in this study revealed how Omani family caregivers believed that meeting their patients' needs is one of their core family responsibilities during wellness and illness. Prioritizing and meeting their patients' physical, emotional, psychological, social and spiritual needs is required to

manage the care of their loved one, to control their behavior, help them to perceive themselves positively as significant and respected family members. In addition, this approach also promotes the health status of their loved one, accelerates the healing process, and minimizes mental illness relapse. These findings are supported by earlier studies that reported when patients' needs are prioritized and met by caregivers, they engage better in their treatment protocols with better outcomes (Clay & Parsh, 2016; Loza & Effat, 2017).

In this study, Omani family caregivers emphasized that they gave special attention to reconstructing the self-concept of their mentally ill members by enhancing their self-perception and image, self-confidence and self-esteem, and role performance. By focusing more on rebuilding the self-concept as part of their family management care, family caregivers realized and noticed their relatives' mental health status and compliance with the therapy were improved, and their patients became more independent regarding their self-care. Katz et al. (2020) discussed that enhancing a mentally ill individual's self-concept positively improves self-awareness and self-esteem, promotes resiliency across the lifespan and suppresses suicidal thoughts. Likewise, Henriksen et al. (2017) found and recommended that promoting the self-concept by caregivers of adolescents with mental illness effectively controls symptoms of depression, anxiety, and attention deficit.

Participants in this study explained how they helped their mentally ill relative spiritually, emotionally, and empathetically. In Omani Arabic/Islamic culture, it is normal for family caregivers and patients to find refuge in Allah (God), seeking His help, support, and recovery during illness or difficult times when they feel stressed or helpless and hopeless. Literature indicated the importance of integrating Islamic religion and spirituality beliefs and values to treat mental illness and enhance drug adherence among Muslim mentally ill patients (Sabry & Vohra, 2013). The previous studies discussed the importance of providing empathetic care to mentally ill patients. That is, understanding the patient's situation and showing empathy toward mentally ill relatives reinforces their cooperation and compliance with the treatment plan, positively enhancing their satisfaction and experience (Moudatsou et al., 2020).

However, a salient finding in this study was that Omani family caregivers sacrificed themselves to help and support their patients. They deprived themselves of engaging in happy and social events or living their life to the full during their relatives' illness trajectory. These caregivers reported that they did not feel satisfied or enjoyed life if their beloved mentally ill member was suffering or was emotionally upset. Family caregivers felt guilty and sorry for their relative, and this feeling hindered them from pursuing their own happiness. On these lines, Reinhard et al. (2008) raised the red flag and noted that family caregivers for a mentally ill member are forgotten and unseen patients themselves. They mentioned that family caregivers often suffer silently and as a result their physical and mental health deteriorates because they drain their emotions and neglect their health needs to assist their mentally ill members and meet their relatives' demanding needs.

One of the major implications of this qualitative study is that it provides an in-depth understanding and new knowledge about the unique role of Omani families' caregivers caring for and supporting their mentally ill relatives. Hence, this knowledge will help healthcare providers and policymakers to develop health policies to involve Omani families with the necessary support to fulfill this role and to partner with them in mental healthcare management in home settings. If the health professional care providers involve families as a partner, it will empower both families and their mentally ill relatives to perform self-management of their mental illness. Empowering families will enhance the quality and guarantee the continuity of home care. Greater awareness about the role of families by the professional staff will empower them and thereby contribute to deinstitutionalizing mental healthcare from hospitals to community and home care.

Currently, family caregivers are provided with little support from healthcare providers in managing their tasks and the emotional demands of caregiving (Reinhard et al., 2008). Likewise, they also get little to no knowledge or skills from healthcare providers on managing their patients' mental illnesses (Chadda, 2014). It is hoped that the results of this study can be used to develop more specific family and patient-oriented programs that promote mental health for both patients and their families. Finally, the clinicians and researchers may use the results of this study to develop clinical protocols or research programs related to family provision of home care and self-management of mental illness.

To turn now to the limitations of this study. First, only one homogeneous cultural group (Omani family caregivers) was involved. Secondly, the participants included two male participants and no spousal caregivers. Thirdly, participants were non-English speaking participants; therefore, the transcribed interviews were translated into English before starting the qualitative analysis. Translation into English was done by the first author, who is a bilingual but not culturally aware about the interpretation of the slang words in the Omani culture. Hence, some Omani expressions may have lost their impact because the translation was not context based. Fourth limitation is related to conducting interviews with participants who accompanied their patients in the hospital settings, which may have influenced their responses. All these limitations need to be addressed in future research to enhance the findings' transferability and minimize bias.

In conclusion, understanding the lived experiences of Omani family caregivers caring for mentally ill family members, provides insights on how Omani family caregivers endeavor to provide optimum level of caring, empowerment and empathy, love and understanding to help and empower their family members in managing their mental illness. The caregivers, in this study are hidden patients who sacrifice and neglect their health and needs in order to provide optimal care and support to their loved ones. Therefore, society and health care providers have an obligation to support these family caregivers to continue to provide care to their loved ones, to alleviate their burden and to prevent burnout. To this end, policies, and clinical protocols in the health care section of Sultanate of Oman are urgently needed. Engaging caregivers in their patient's treatment plan to create a situation recently referred to as becoming care partners, empowering them with sufficient knowledge and skills on managing and caring for their sick relatives, and enhancing the communication and collaboration between family caregivers and health care providers will contribute significantly to the patient's and their caregivers' outcomes, and will be of benefit to all. Future studies are needed to explore the best ways to engage family caregivers in the formulation and implementation of health care policies related to family health. Awareness about the knowledge and skills needed to help family caregivers provide care for their loved ones, as well as knowledge about the actual and potential health risks that family caregivers face when caring for a mentally ill relative are important for a sustainable health care system. Finally, the limitations of this study also need to be taken into consideration when conducting future studies.

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