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# Family Caregiving as a Moral and Spiritual Commitment in Zambia's Mental Health Care Setting

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## *Abstract*

*Family caregivers of individuals with chronic psychosis often navigate cultural, social, and emotional challenges while providing care. This study explored the moral and spiritual dimensions of caregiving, focusing on how family, cultural values, and spiritual beliefs shape caregivers' commitment and coping approaches. Using an interpretive phenomenological design, in-depth interviews were conducted with 30 caregivers, and data were analysed using interpretive phenomenological analysis by Smith et.al (2009) criteria. The results had four superordinate themes; Providing care as a religious duty; Moral duty rooted in kinship and culture; Psychological and emotional strain; Coping through resourcefulness and faith. Findings showed that caregiving is viewed as a moral duty grounded in family and cultural expectations. Caregivers formed their roles as acts of love, loyalty, and responsibility, reinforced by spiritual beliefs that endure perseverance despite stigma, discrimination, and societal opposition. The study highlights that moral commitment serves as both motivation and ethical compass, guiding caregivers through demanding circumstances. However, the findings also showed risks of emotional exhaustion and self-neglect, pointing to the need for institutional and social support. Recognizing caregiving as a moral and culturally informed commitment provides insights for health professionals and policymakers to develop culturally sensitive interventions that support family caregivers' well-being while strengthening their moral stance.*

**Keywords:** *Cultural Values, Chronic Psychosis, Family Caregiving, Faith and Caregiving, Moral Commitment, Resilience, Stigma.*

## Introduction

Mental health caregiving has been found to be among the largely neglected health services both globally and in Zambia [1, 2]. Zambia is among the African countries that has lagged with the integration of mental health services into primary care, resulting into informal caregivers harbouring the responsibility in the communities with limited support and several challenges linked to the nature of the mental illness [3]. In many cases, caregivers compromise their own well-being for the sake of their loved ones, exposing themselves to stressors that may impair their capacity to provide sustained, quality care [4].

Studies worldwide have highlighted the significance of examining caregivers' roles, the burdens they carry, and the strategies they adopt to cope with these demands [5, 6]. In Zambia, family caregivers have been made to be the backbone of mental health support, filling in the gaps where the health system is struggling to cope as they provide daily care, emotional support, and even financial assistance to loved ones battling chronic mental

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illnesses. Yet, existing research has mainly focused on the financial, emotional, and psychological pressures of caregiving, with relatively little exploration of the moral and spiritual aspects of this role [7, 8]. In Zambia, caregiving is often understood not only as a cultural obligation but also as a spiritual act that carries meaning for both the family and wider society, helping caregivers to balance its practical demands [9]. Despite this, little empirical research has examined caregivers' moral and spiritual perspectives. Addressing this gap is important for developing streamlined interventions that strengthen coping mechanisms and foster more supportive care environments [10].

Despite the challenges of mental health caregiving, families continue to play a vital role in caring for their loved ones, providing essential emotional, physical, and financial support, often in the absence of sufficient formal services [11]. Religion and spirituality also play a significant role in helping caregivers cope, providing them with a sense of purpose and the strength to persevere despite ongoing stress [12]. Furthermore, religious practices like rituals, spiritual healing, and prayer not only bring comfort but also reinforce caregivers' sense of duty. In many communities, caring for loved ones is seen as a moral obligation and an act of devotion, driven by values of reciprocity and responsibility [13]. Consequently, this makes caregivers rely on home-based care and community support when formal health care is inadequate [14]. It is observed that the importance of faith-based support networks, like church-based counselling and religious organisations, is also becoming more widely acknowledged. This is evident in Zambia, where mental health care by caregivers combines traditional beliefs, religious practices, and modern medicine, reflecting the country's deep-rooted faith and spirituality to create a culturally sensitive support system [15]. Ultimately, Caregivers draw strength from deeply ingrained cultural and religious values that guide them in supporting their loved ones with mental illness as they navigate the challenges of caring.

Evidence indicate that combining professional mental health services with culturally relevant faith-based practices may contribute to more responsive care [12, 13]. By recognising caregivers' moral and spiritual commitments alongside their practical challenges, such approaches could strengthen caregiver well-being and support more consistent care for individuals living with mental illness. In addition, participation in community and religious groups offers caregivers vital emotional support and helps to reduce feelings of isolation, further reinforcing their resilience in the caregiving role [16]. Broader evidence also shows that caregiving has both positive and negative effects on caregivers' mental and physical wellbeing, with factors such as gender, age, and caregiving role shaping their vulnerability. Notably, negative outcomes can be offset when caregivers receive adequate social support and draw on religious or spiritual resources, which highlights the need for interventions that integrate cultural and spiritual dimensions alongside professional care [17].

This study has several important limitations. Family caregivers continue to face persistent stigma, economic challenges, and fragmented health systems, while formal services often overlook the value of traditional and spiritual care [14, 18]. Many caregivers lack training, resources, and institutional support, leaving them to shoulder complex responsibilities largely on their own. Spiritual care, though central to the caregiving role, is rarely offered by healthcare professionals, even when they are competent to provide it, limiting the integration of moral and spiritual support into formal services [19]. These gaps emphasize the need for interventions that acknowledge the practical, moral, and spiritual dimensions of caregiving while addressing service level obstacles. The study shows that family caregivers are a cornerstone of mental health recovery, providing vital emotional, practical, and spiritual support. Their dedication, often rooted in a sense of moral and spiritual duty, helps keep patient care going even when formal health services are limited [12, 20]. The commitment of these caregivers also highlights the importance of developing mental health policies that are culturally aware and inclusive, reflecting local values and community expectations [13].

The figure below shows how caregiving interacts with the caregivers' environment in order to facilitate the caring process that yields better health outcomes if well managed.

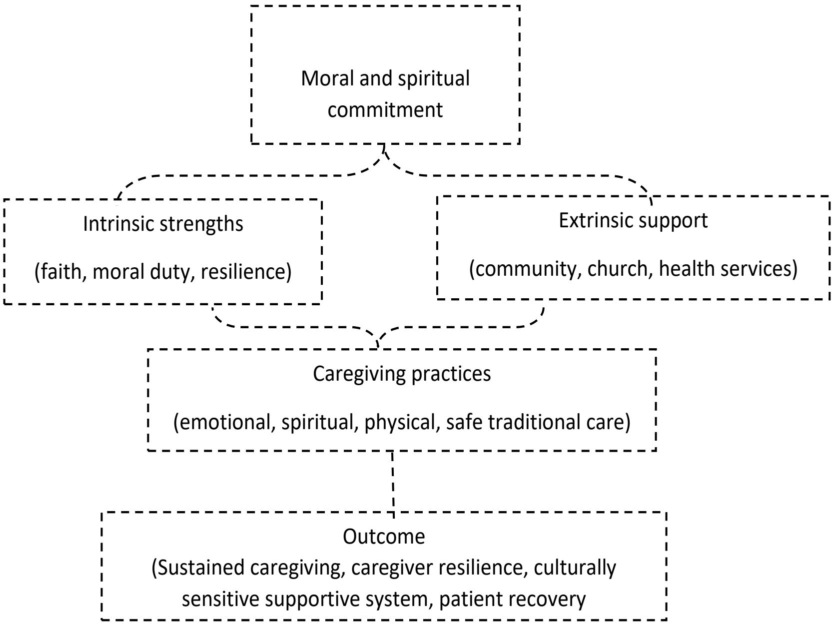

**Figure 1.** Schematic Diagram showing Moral and Spiritual Dimensions of Family Caregiving

The objective of the study was to explore how moral and spiritual commitments guide family caregiving for individuals with mental illness in Zambia and how these commitments work with formal health services and community support to promote caregiver well-being and patient care. This study uniquely highlights the moral and spiritual dimensions of family caregiving in Zambia, showing how local cultural and religious values shape care practices. It emphasizes how caregivers integrate prayer, traditional healing, and medical care, framing caregiving as both a practical duty and a deeply moral and spiritual commitment. By combining qualitative insights with existing literature, the study offers culturally sensitive strategies that bridge formal health services with faith-based and community support, providing guidance for policy and interventions aimed at strengthening caregiver support and patient outcomes in low-resource settings.

## Materials and Methods

### Research Design

This study adopted a qualitative approach using an interpretive phenomenological design to explore the lived experiences of family caregivers supporting individuals with chronic psychosis in Zambia. Interpretive Phenomenological Analysis (IPA) acknowledges the interpretive role of the researcher in making sense of participants' narratives while attempting to comprehend and characterize the essence of human experiences as experienced by those who have lived them [21, 22]. With emphasis on how people understand, create meaning, and express their lived experiences within their cultural and social contexts, this design gives priority to first-person viewpoints [23].

## Study Setting and Sampling Procedure

This study was conducted at Chainama Hills Hospital, a tertiary mental health facility in Lusaka Province, Zambia, where patients receive comprehensive psychiatric care. As the national referral hospital, it admits patients from diverse backgrounds, exposing caregivers to varying moral and spiritual views on caring for individuals with chronic psychosis. This diversity provided a broad perspective for the research.

The determination of the sample was based on the principles of interpretive phenomenological studies which stipulate that there is no strict rule as sample size can be based on context [24, 25]. Factors that influenced sample size include the depth of analysis, richness of individual narratives, and the potential for meaningful insights into participants' experiences and perceptions. In line with the interpretive phenomenological study principles, this study aimed to engage participants that would provide comprehensive and rich experiences into the phenomenon under study. While smaller samples are typical in IPA, recruiting 15-30 participants can provide an in-depth understanding of the experiences being explored [26, 27]. To further understand their lived experiences in Zambia, this study focused on a sample size of 30 family caregivers.

## Data Collection Methods and Techniques

Data was collected through semi-structured, in-depth interviews with family caregivers who met the inclusion criteria. This approach enabled participants to share their experiences and perceptions in detail, guided by open-ended questions that encouraged free expression and rich, contextual insights.

The interview guide had two sections: the first captured demographic information, while the second explored participants’ caregiving experiences. The core research question was: *“Can you describe your experience of caring for a family member with chronic psychosis at Chainama Hills Hospital?”* Probes were used to elicit clarification and depth.

Participants were recruited with the assistance of health professionals and support staff at Chainama Hills Hospital. All sessions were audio-recorded and supplemented with researcher notes on non-verbal cues. To safeguard emotional well-being, interviews were paused when distress arose, and empathetic listening techniques were employed. Where necessary, participants were referred to mental health professionals for additional support.

The interview guide used English language and was also translated into Chichewa (Nyanja), one of Zambia’s primary local languages, to ensure inclusivity and authenticity. This process facilitated meaningful engagement and enriched the data.

## Data Management

All audio recordings from the interviews were stored in password-protected files and backed up on an external drive to ensure data preservation. The researcher’s notes were kept in locked cabinets for physical security. To protect confidentiality, all identifying information was removed or replaced with participant codes (e.g., Participant #1) prior to transcription.

Data access was restricted to researchers and academic supervisors and used exclusively for scholarly purposes. These measures safeguarded the confidentiality, integrity, and security of the data throughout the study.

This qualitative study adhered to the four criteria proposed by Lincoln and Guba (1985) to ensure rigor and trustworthiness: credibility, dependability, confirmability, and transferability. These criteria are essential in interpretive research to uphold the quality of findings [28].

To ensure dependability, a detailed description of the caregiving experiences was obtained from the caregivers lived experiences at Chainama Hills Hospital within the Zambian healthcare context. An audit trail was maintained throughout data collection, coding, and analysis to allow for authentication of the interpretive process. The supervisor's regular audits and feedback further ensured consistency and dependability in the research process.

Credibility was managed through a detailed and rich descriptions of the participants' experiences of caregiving providing context to the readers. Data triangulation was achieved through the engagement of different caregivers on their experiences of caregiving and literature reviews to validate the information. Furthermore, the use of interpretive phenomenological analysis and caregiving verbatims provided additional clarity throughout the research process. Reflexivity was further attained through continuous interactions with peers and research supervisors to ensure the integrity of the information obtained.

Confirmability was achieved through audit trails as the researcher demonstrated the link between emerging themes and caregivers' accounts of their experiences as well as using field notes and reflexive journaling. Research supervisors' reviews provided further guide in ensuring the analytical process and decisions where reflective of the results obtained.

A detailed description of the caregiving process at Chainama Hills Hospital underline the Zambian context and its sociocultural influences providing clarity of the phenomenon to the readers. While purposeful sampling further provided divergent views across variant factors that may be common in the general population thereby enabling the transferability of this study.

## Data Analysis

Data analysis for this study was conducted using Interpretative Phenomenological Analysis (IPA), a methodology that seeks to understand the lived experiences of participants. IPA is rooted in the hermeneutic circle, which involves an iterative process of moving between the whole and the part, enabling the researcher to interpret participants' accounts while acknowledging that participants themselves are engaged in making sense of their experiences.

The analysis followed the six-step framework outlined by Smith et al [27]. The process began with reading and re-reading transcripts to achieve immersion, allowing the researcher to become familiar with the data. Initial noting was then used to capture descriptive, linguistic, and conceptual observations, providing a comprehensive understanding of participants' narratives. Emergent themes were developed grounded in participants' narratives, identifying patterns and meanings in the data.

As the analysis progressed, connections across emergent themes were explored, and relationships and patterns within the data were identified. Each participant's account was treated individually, ensuring that their experience was understood. Finally, patterns across cases were identified to build shared meanings while respecting unique voices, enabling the researcher to develop a clear understanding of the caregiving experience.

To support this process, NVivo version 11 was utilized for data management. The software facilitated efficient organization, coding, and retrieval of data. Its visualization tools, such as word clouds and thematic charts, complemented manual analysis, enabling the researcher to represent patterns clearly and provide a comprehensive interpretation of caregivers lived experiences.

## Participants

The study recruited 30 participants who were family caregivers consisting of parents, sisters, brothers, children and spouses. These caregivers should have taken care of these patients for at a minimum duration of one (1) year to give comprehensive experiences of the phenomenon under study. Table 1 below illustrates the sociodemographic characteristics of the participants. The age of the participants had a wide range from 30 to 85 years with a representation across critical life stages offering a variance of caregiving experiences. The female represented 23 (76.7%) including mothers, sisters, daughters, wives while males had 7(23.3%) with fathers, brothers and husbands. The study had a 90% geographical coverage of participants from nine provinces, which included Lusaka 10 (33.3%), Eastern 5 (16.7%), Central 4(13.3%), Copperbelt and western each had 3(10%), Southern 2 (6.6%), while Muchinga, Luapula, Northern had 1 each (3.3%).

**Table 1.** Demographic Characteristics of Participants

| **Participant** | **Relationship to Patient** | **Age** | **Residence** | **Marital status** | **Education Level** | **Employment** |
|---|---|---|---|---|---|---|
| P001 | Wife | 44 | Mansa | Married | Secondary | Self employed |
| P002 | Mother | 60 | Kabwe | Married | Secondary | Formal |
| P003 | Sister | 35 | Lusaka | Married | Primary | Formal |
| P004 | Sister | 66 | Lusaka | Single | Tertiary | Retired |
| P005 | Brother | 33 | Ndola | Married | Tertiary | Formal |
| P006 | Sister | 64 | Kitwe | Married | Secondary | Formal |
| P007 | Mother | 54 | Kasama | Single | Secondary | Formal |
| P008 | Sister | 40 | Chongwe | Widow | Secondary | Formal |
| P009 | Mother | 57 | Kaoma | Divorced | Primary | Self-employed |
| P010 | Husband | 48 | Monze | Married | Primary | Self-employed |
| P011 | Mother | 70 | Mpika | Widow | No formal | Self-employed |
| P012 | Sister | 50 | Kalomo | Divorced | Primary | Formal |
| P013 | Mother | 44 | Lusaka | Married | Primary | Self-employed |
| P014 | Sister | 30 | Kafue | Married | Secondary | Self-employed |
| P015 | Sister | 41 | Lusaka | Married | Secondary | Self-employed |
| P016 | Sister | 38 | Lusaka | Single | Secondary | Self-employed |
| P017 | Mother | 67 | Chipata | Widow | Primary | Self-employed |
| P018 | Sister | 43 | Luangwa | Divorced | Primary | Formal |
| P019 | Mother | 50 | Chipata | Married | Secondary | Formal |
| P020 | Father | 74 | Katete | Married | Tertiary | Formal |
| P021 | Husband | 49 | Kabwe | Married | Tertiary | Self-employed |
| P022 | Mother | 59 | Lusaka | Married | Secondary | Self-employed |
| P023 | Daughter | 34 | Liteta | Single | Secondary | Self-employed |
| P024 | Sister | 39 | Mumbwa | Single | Tertiary | Formal |
| P025 | Mother | 78 | Mongu | Widow | Secondary | Retired |
| P026 | Brother | 51 | Ndola | Married | Tertiary | Formal |
| P027 | Mother | 69 | Mongu | Married | Primary | Formal |

| | | | | | | |
|---|---|---|---|---|---|---|
| P028 | Wife | 44 | Lusaka | Married | Tertiary | Formal |
| P029 | Father | 85 | Chongwe | Widower | Tertiary | Retired |
| P030 | Father | 81 | Lusaka | Widower | Secondary | Retired |

Many of the participants were married 16(53.3%, widowed 6(20%), single 5(16.7%) and divorced 3(10%). The educational background spanned from secondary 13(43.3%), primary and Tertiary each had 8(26.7%) to normal education 1 (3.3%). Most of the caregivers had some form of employment which included formal 14(46.7%), self-employed 12(40%) while retired 4(13.3%).

## Results

The results reveal insights from 30 family caregivers supporting individuals with chronic psychosis at Chainama Hills Hospital in Lusaka. The findings are presented through themes that reflect how caregivers see their responsibilities as moral obligations, how they draw on spiritual motivation, the ways they cope, and the influence of cultural expectations. In presenting these themes, the caregivers' own words are included to give voice to their struggles and strengths, allowing their lived realities to be heard in their own terms. Below is the table illustrating the study's emergent themes.

**Table 2.** Superordinate and Subordinate Themes

| **Superordinate themes** | **Subordinate themes** |
|---|---|
| Providing care as a religious duty | Belief in divine responsibility |
| | Prayer as a coping mechanism |
| | Spiritual reasons for illness |
| Moral duty rooted in kinship and culture | The importance of cultural values and family |
| | Fighting off negative cultural influences |
| | Ignoring discrimination and criticism |
| Psychological and emotional strain | Emotional pain and loneliness |
| | Personal life disturbance |
| | Stress in marriage and family |
| Coping through resourcefulness and faith | Managing with constrained resources |
| | Dependence on oneself and one's spirituality |

## Theme 1: Providing Care as a Religious Duty

The caregivers' narratives on their experiences of caring are being illustrated as being grounded in a form of spirituality. This is guided by the values obtained through shared values of love rooted in their religious beliefs. Caring is practiced as an obligation that is performed with the hope of securing blessings for self and the entire family.

### Belief in Divine Responsibility

> *"Certain things happen to us because it's God's will….I do all these things because God started it with me ……He shall never leave me alone….Never!".(P22).*

The narrative expresses an assurance of the presence of a superior being in their life's challenges. This deeper affirmation expresses how the caregiver is ready to care for their loved one believing that they will never be alone and that they are chosen for this duty for a greater prize. The caregiver demonstrated this with passion of faith as she paused to confirms the importance of this disclosure to her.

> *"I am a Jehovah's witness…. for me I really give thanks to the message of God because when it is read, it gives me the strength to wake up,". (P4)*

This reflects the caregiver's commitment to continuously read values engrained in the religion as a staff that keeps the focus and strength. By acknowledging the religious denomination, the caregiver is not ashamed to express the comfort obtained in the daily reflection of religious teaching and their significance in their caring role.

> "Me*…I have suffered no……without God, this one wouldn't have been alive up to this time.". (P8).*

The caregiver expresses how their belief in a superior being has kept their patient alive, reflecting a deeper strength that shines through the darker moments of caring, and in turn helps them to cope despite the psychological and emotional strain that the illness presents.

> *"Some people say whoever did this is advanced in witchcraft…. You know for me my sister the level I have reached is where some pastors are even scared to help me I call them they don't answer my calls.". (P19)*

The caregivers express a belief and fear in the darker supremacy that can be overwhelming to them and those expected to offer power. It saliently shows how faith in God is their only source of strength in the face of adversity.

> *"And I can't just say no its just prayers….no…. but I should also take him for hospital where it needs hospital.". (P25).*

The caregiver expresses an understanding to balance spirituality with medical care approaches, as they are both necessary components in the care of the patient.

### Prayer as a Coping Mechanism

> *"My only prayer is that they almighty God will help him to be better one day because he has really suffered …………I just pray that my husband one day will be fine ………because it's a very good man there's a very good heart". (P14).*

Prayer is viewed as a source of comfort that transmits resilience in the face of emotional strain for caregivers.

> *"Spiritual battles are real……sometimes my son starts responding to treatment….they attack. I just hold on to prayer". (P11).*

P11 illustrates an understanding of the disease process and the need to never relent even when the condition worsens. This shows prayer as a resistance strategy.

> *"Before the situation gets worse, we rush to the mountain. Otherwise, we usually go to pray there and the condition becomes manageable……prayer really helps". (P2).*

The caregiver shows that trust in communal gatherings provides spiritual interception of the condition before it worsens when biomedical solutions are not adequate.

### Spiritual Reasons for Illness

> *"As I earlier explained that it's a spiritual battle. The father and his young brother entered into an agreement….curses were spoken upon their family …. My Son is the one suffering". (P13).*

P13 expresses a deeper believe on spiritual causes of mental illness for her son as being from witchcraft and punishment. The conviction that words spoken can manifest in physical illness, and that these can present in any family member because they are binding in the spiritual world.

> *"You know there is also satanism, satanism is there you can't just say that…. just because you are doctors ….no satanism is there". (P5).*

The caregiver demonstrates mistrust in medical explanations of mental illnesses, indicating that science does not give chance to other possible causes such as spirituality.

> *"But it's like a phase, you pray over this, another spell is cast on him….ah…ah… again, you fight this another spell". (P11)*

The caregiver expresses emotional exhaustion and the toils that the disease process has to undergo. It shows the doubt and the hopelessness in the unending uncertainty and healing of the loved one.

> *"Now you see at first healing took place very fast. I told you he became lame, he became blind, he became deaf. But through prayers…. prayers they helped him. So, after they saw that I had gained strength in prayers, they casted a spirit of anger onto my son. That spirit of anger made him to refuse prayers. So, when a pastor shows up for prayers, they can't manage him because he could even him together with me." (P11)*

P11 shows confusion and a lack of understanding of the disease process. She wonders the progression of symptoms from being healed to many other complications that the child had to undergo. She is even further saddened by the anger and aggression it presents with, while still choosing to associate it to the spirits that keep tormenting the patient.

## Theme 2: Moral Duty Rooted in Kinship and Culture

In the Zambian context, caring of viewed as a sole responsibility of any family member to ensure that the patient is well provided for and protected. The society seems to judge the love in the family based on the care provided to the weaker members. Failure to care for the ill family member breeds judgement and ridicule, and it is seen as a sign of neglect hence the obligation to care for ailing members against all odds.

### The Importance of Cultural Values and Family

> *"I got married to my husband 19 years ago… and unfortunately the family never told me that he is psychotic I only got to know two years later when he relapsed. What made me to stay is that my husband was very good to me he accepted to keep my four children that I came in with and I was able to take care of his two children." (P28)*

P28 expresses disappointment on the betrayal by the husband's family not revealing the sickness to her before marriage. But she quickly turns it into a transaction based on the loving and caring nature of the husband she has come to learn over time. This makes her to feel obligated and reciprocate this love back to him in the moments of his ailment.

> *"I really feel very bad and I cry a lot. Sometimes it gets very bad that you find that she would be moving naked………remove these clothes, she would say., and you see when I look at her nakedness and it's in public I always cry to God asking him why my child should be going through such kind of things." (P17)*

The caregiver narrates the pain associated with seeing a loved one in undignified state I public, something that leads her to seek understanding from the superior being on the nature of the illness as she watches helplessly.

> "*For me not every child is spoiled, ok they are there, yes, because of marijuana drugs but others it's because of the family battles…… whereby you find someone giving you warnings that you will see." (P20)*

Parental instincts are observed as the caregiver struggles to justify the causes of mental illness, not neglecting the protective nature of a father. The caregiver feels the need to care for the patient as it is perceived that other powers have led this problem.

### Fighting off Negative Cultural Influences

> *"I pray for strength all the time….so many voices telling me I do not need to keep my wife because I am a man……but how do leave her in this state." (P10)*

The caregiver narrates how external pressure to abandon their ailing spouse, destabilizes them. They express a dilemma of the possibility of leaving a spouse in a sick state. This shows how cultural teachings have shaped their duty to care for the loved ones despite negatives influences.

> *"Sometimes….Sometimes people have told me that if it were them with the things I'm going through, they are going to bewitch whoever or someone, so all these things I…I avoid…. I avoid listening to them because I know they can mislead me." (P15)*

The caregiver battles with avoiding the ideas that society presents to her, acknowledging how detrimental they are likely to interfere with her ideas of believed revenge. She radiates an opposite choice of sticking to medical care instead of focusing to the ideas that could stray her from what is right.

> "*One thing I've realised with tradition is that if you follow this tradition too much you can kill all the enemies that's why it's…. it is better using a Bible because sometimes the tradition influences to do a lot of things that can be bad." (P26)*

P26 hangs on religious values to navigate the pressure faced from society to associate the cause of mental illness to devilish powers. The teachings of love thy enemies and all that persecute you serve as a guide to follow than transmitting hate.

### Ignoring Discrimination and Criticism

> *"Love helps caregivers to take care of their loved ones because if you start thinking of the things that they do…. destroying things, getting things from people then you can leave them, but you must understand them …. because we should know that if it were me, they would have gone all the way just to help me but now I have to continue taking care of him because it's not their wish." (P30)*

The caregiver highlights the difficulties that are faced in their caregiving process, avoiding focusing on the negatives that present with the mental illness helps them to cope and minimise criticising negative actions from the patient.

> *"People don't like being associated to someone who has a patient with mental illness…. It's sad how they treat you like the condition is transmissible." (P27)*

The caregiver acknowledges the pains and the isolation that comes with managing a mentally ill patient due to the unfair treatment the society presents. It shows how they have to focus on caring for their patients despite all that they face.

> *"The hospital should engage the community by educating them that stigmatising or laughing at those patients and their caregivers discourages the little strength that caregivers have to take care of their patients, so they have to be told that psychosis can affect anyone and so we need to take care of each other in the community." (P24)*

The caregiver expresses the emotional and psychological strain that ridiculing the mentally ill does to the caregivers especially because they comprehend the reality of the illness. Additionally, they urge health care professionals to intervene by offering health education to communities against stigma and discrimination in order to support caregivers in their role.

## Theme 3: Psychological and Emotional Strain

The excerpts further show that caregivers are exposed to profound psychological and emotional strain as they care for their loved ones. This is presented I different forms including loneliness, pain, family and relationship strain.

### Emotional Pain and Loneliness

> "*The pain of watching him moving aimlessly is unbearable……. i get to have a lot of thoughts in my head in trying to accept this……. from a strong dignified person to one with no control….God why…. why…its hard." (P01)*

The caregiver bemoans the loss of honour their loved one is exposed to due to the disease process. This harbours feelings of loneliness and shame which leads to them to watch helplessly. They tend to combine with religious questioning in the hope for answers and understanding of their suffering.

> "*So, as it is now no one takes care of me no relative takes care of me no outsiders there's no other form of support apart from myself so if I don't work hard then nothing happens for my family." (P09)*

Loneliness is demonstrated though the absence of relatives, friends, church and a lack of support from the community. The caregiver is seen relying on oneself as being a better option in order to survive daily struggles.

> *"I reached the level where I lost my……my strength I lost the faith I went through a lot of things and the troubles at the start were beyond me, that I could not understand. I lost words…. I could not work because I realised that sometimes I was …. I was just praying but even then, nothing is working." (P26)*

The caregiver illustrates how desolate and overwhelming the emotional pain could be, that even spiritual comfort could not be felt despite all efforts to be in control of the situation.

### Personal Life Disturbance

> "*So, like it happened last time, I went to South Africa trying to improve my business. I was called back that my son is sick…. had to come back and abandoned whatever I was doing that side so when I reached Lusaka and I got home I had I had some money with me which I ended up using." (P22)*

The caregiver narrates the disruptions that mental illness presents, and how financial stability is almost impossible to maintain. She is found negotiating between caregiving and survival duties exposing a persistent financial burden and personal distress as all needs depend on them.

> *"So now my money is finished, and I'm confused I don't know where I'm going to get money…. I'm just hoping that they'll be able to lend me something….so that I can buy thrift at least it helps me to get a bit of profit for me to take care of my family." (P28)*

The caregiver expresses how overburdened they are financially as they have to depend on lenders every time their business is disrupted by the illness demands. They do not allow us themselves to moans by giving up instead constant engagement helps them to gain control of the situation.

> "*Unfortunately, people from the church that I worship with do not even help me in any way. I have tried communicating to them, but they have not done anything just the same as for my neighbours." (P01)*

Lack of community support further contributes to the life disturbances the caregiver goes through because no form of help is rendered in any form even after its sought. This leads to caregivers' feeling of isolation as they perceive the absence of support which affects the nature of care provided to their loved ones.

### Stress in Marriage and Family

> *"So, you know traditionally psychosis faces a lot of stigma so some people advise me to leave him was so encourage me to persevere in taking care of him. There are very few women that can take care of a psychotic patient you may wish to know…. that I'm the second wife, first wife abandoned him because she was not patient enough to take care of the condition." (P01)*

Caregiving possesses numerous challenges that when coupled with marital demands it becomes a significant stress. The caregiver expresses the essence of accepting silent suffering which is defined by patience to take care of the loved ones in order to remain faithful to the commitment of marriage.

> *"It's like these drugs affect my husband's feelings for me. Anyway, I am doing my best to make sure that I don't trigger my sexual feelings or even have thoughts of having any contacts with other men I've really tried to avoid that one. So sometimes I get to*

> *massage him just so maybe something can happen.” (P28)*

Marriage faces complex pressures such as faithfulness, sexual restrain and loyalty to the family. The spouse demonstrates frustration as her role is overstrained amidst other challenges mental illness presents.

> “*I'm sort of done recently I worked so hard I got a piece of land, and I managed to build a 5 roomed house so I give thanks to God because I don't like seeing him panicking.” (P09)*

It is observed that illness disrupts the family structure, as women are converted into providers a role they are never prepared for as they try to shield the male counterpart from psychological strain and feelings of failure. The caregiver feels that taking over family responsibility may contribute to better health outcomes for the loved one

## Theme 4: Coping through Resourcefulness and Faith

The narratives show that daily survival requires clinging to adaptive resourcefulness and spirituality in order to manage the struggles encountered throughout the caring process. This co-existence provides a balance for caregiving even in limited resources such as financial and community support. The caregivers are expected to adopt systems that can work in their environment as they manage their daily duties.

### Managing with Constrained Resources

> “*You see in most days I have to plan for my family on my own because we don’t have enough. ... when the condition gets worse, I can’t rush to the hospital immediately because transport is expensive…..so I must find a way to balance especially that I have to think of the children as well.” (P07)*

The caregiver notes that the process of caring especially in chronic conditions brings with it economic strain. Caregiving is interpreted as being performed with limited resources and sacrifices. The caring process presents with scarcity and is navigated through improvisation showing a survival-oriented resilience formed by poverty.

> *There are moments when I have to borrow money from my neighbours so I can buy his medication. Sometimes it is embarrassing….but what can I do……if I put pride before me then my family will suffer. So …I just have to swallow my pride because no one will help and also the responsibility still lies in me.’ (P09)*

In this narration, caring is perceived as a duty that overrides shame. The caregiver interprets borrowing as a moral act that protects the family, exposing the convergency of cultural desperation and desperation. Caregiving in this context is interwoven with sacrifices to reserve family dignity.

> *“This condition can take a stretch on me ……sometimes there is not enough food to feed the whole …. I give him the food first because his medication requires that he eats.” (P12)*

Caregiving is presented as an engagement of painful decisions that prioritises the family member who is ill. This shows the self-sacrifices and dilemmas caregivers go through in which maintaining stability for the ill family member is more central.

### Dependence on Oneself and One's Spirituality

> *“I pray when things get too heavy for me……I even cry in my prayers because that is the only place where I feel safe….my God will never judge because he is always there for me….he listens.” (P15)*

Spirituality is used as a coping strategy where the caregiver seeks emotional refuge and draws strength. The caregiver makes sense of the suffering by keeping to the faith that empowers their endurance.

> *“My boy reached a level where you couldn't even stand they looked like he was lame and my past I was even tired of helping*

> *his prey and he told me I think we should just stop but I told the password my child is going to work one day I'm not going to relent in prayer continuing to my child is fine again." (P13)*

The caregiver applies spiritual dialogue to control and maintain fear and psychological stress. Spirituality therefore reflects a sense of surrender and partnership with a superior being.

> *"I have been advised several times by people to take him to traditional healers….but my Christian doctrine doesn't allow me to trust the witch doctors. Mine is to trust God and the hospital….I don't want to confuse things." (P20)*

The caregiver uses spirituality as a moral compass for their day-to-day decision making. It is observed that caregivers have negotiate competing choices of care for their ill family members, as seen that spirituality, traditional and biomedical care are options that are met in the caring processes.

## Discussion

The study aimed to explore personal values influence caregivers of individuals with chronic psychosis, and how the contribute to their moral and spiritual commitment in Zambia. The study provides a deeper understanding of how these values shape family caregiving by revealing gaps in the current systems to promote family centred interventions. The key findings of the study are providing care as a religious duty; moral duty rooted in kinship and culture; psychological and emotional strain; and coping through resourcefulness and faith.

The findings of this study help to explore the various stressors and challenges that influence caregivers in their caregiving process and their general wellbeing as illustrated by Betty Neumann's system theory [29]. The theory emphasises how caregivers' experience and interacts with their environment. Similarly, caregivers of individuals with chronic psychosis face several challenges as they interact with their cultural and spiritual values in meaning making process of caring in the mental health context.

The study results reviewed a demographic trend of caregivers' age between 30 and 85 years with 76.7% being females (mothers, wives, sisters, daughters) as reflected in the regional trends in the distributions of caregiving roles. This is consistent with evidence that caregivng responsibilities are often gendered, with mothers, wives and sisters disproportionately bearing the burden. Similarly [30], reported 83.5% of caregiver burden among informal caregivers of individuals with severe mental disorders in rural South Africa were female caregivers, with the largest group (45.3%) being parents falling between the ages of 45 and 64. The age and gender distribution observed in this study, reflects the broader sociocultural expectations that adults in their Mid to late years assume primary responsibility of caring for family members suffering from mental illness. This gender imbalance has led to further socioeconomic burdens as most women have to abandon their work in order to supervise the care of their loved ones [31].

The study results also revealed that caregivers perceived their role as a religious obligation grounded in divine duty and maintained through constant prayers while concurrently depending on biomedical care. This dual consideration is also observed in cultural contexts in which carrying both spiritual and social expectations is a norm [9]. This further magnifies the pressure to fulfil these roles despite the limited support and resources faced by caregivers. Caregivers tend to turn to spiritual or religious traditions as a coping strategy acknowledging that spirituality can offer emotional healing, power and purpose during stressful times [12]. It's further suggested that the negative effects of caregiving can be balanced by considering personality, strong social support and applying spiritual beliefs to buffer emotional strain and improve overall wellbeing [32]. Additionally, studies have proposed that the engagement of caregivers in positive religious coping have shown to improve both their mental and spiritual wellbeing [33]. This indicates the need for institutional involvement into supporting caregivers' religious stance to provide guidance on nature of religious coping while paying attention to those that impact the management of their patients positively.

The study results affirm that caregiving requires moral commitment that delves into family teachings, spiritual values and society expectations providing caregivers with perseverance despite the stigma and sacrifices endured. Furthermore, while family caregiving has been found to be morally meaningful and an identity enhancer, it exposes caregivers to profound emotional strain and therefore providing strong support systems is imperative to shielding their wellbeing and moral identity [34]. Subsequently, caregiving as a moral commitment boosts caregivers' self-esteem while concurrently satisfying their urge to fulfil their marital and family duties [35].

The dual reliance on prayer and biomedical care possess a challenge for caregivers as they lack formal guidance from health institutions. This reliance has shown to contribute to poor health seeking behaviours which ultimately undermines the essence of medical care hence the need to engage communities to provide understanding of mental illnesses and their management [36]. Furthermore, studies have found that higher levels of spiritual wellbeing have been substantially associated with increased resilience among caregivers reinforcing the notion that spirituality serves as a protective factor in the provision of care [37]. This indicates the need to incorporate caregiver's spirituality into the therapies offered to alleviate caregiving difficulties and improve mental health outcomes for a variety of populations. To further harmonise the challenges between spirituality and biomedical care, health care providers must engage families and communities in open dialogues about their views to create psychoeducation and care plans that incorporate their viewpoints to offer best care to the individuals with mental illness [38].

## Conclusion

The study explored the moral and spiritual commitments of family caregiving in the context of Zambian mental health. Caregivers face various challenges as they navigate care for their loved ones, and to combat them they use religion and culture to cope. Studies have shown that caregivers' beliefs about the causes and management of mental illnesses are modelled by their religious beliefs which aid them to manage and sustain resilience. Their responsibility and moral commitment to care is guided by their cultural teachings that guide define caregiving as a familial and ethical obligation. In addition to exploring how family caregiving is influenced by culture and spirituality, it also poses negative effects as it has potential to undermine medical care. It is then imperative to continuously engage communities in formulating mental health interventions that are specific to the needs of caregivers by offering institutional support that will in turn improve patient outcomes. Therefore, study findings highlight the need for mental health interventions that acknowledge the moral and spiritual commitments caregivers', engage actively with communities and guarantee institutional support throughout out the care process.

To gain more insight, there is need to conduct longitudinal studies on how caregivers' experiences change over time. The need for male caregivers to be studied cannot be overemphasized. The study was conducted at a national mental hospital, providing a variance of experiences with a wide range of country representations. The methodology further provided an in-depth exploration of the phenomenon under study. It also has limitation with bias representation of females than male as well as reliance on self-reported experiences may have affected objectivity.

## Ethical Approval

Ethical approval was obtained from ERES Converge IRB *Ref no.2025-Mar-001* and approval to conduct the study from National Health Research Authority *Ref no.NHRA-2080/27/03/2025*.

## Conflict of Interest

The author declares no conflict of interest, as no external funding or relationships influenced this study.

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## Author Contribution

The leading and corresponding author of this paper was Virginia Simasiku, responsible for data collection, storage, analysis and writing. Professor Catherine Mubita Ngoma and Professor Rajesh Konnur were co-authors and responsible for supervision throughout the research process and manuscript writing.

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## Data Availability

The data used in this research is available upon request, though anonymized to protect the privacy of the participants.

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