Formosa Journal of Science and Technology (FJST)
Vol. 5, No. 3, 2026: 701-714

Understanding Family Resistance Toward Long-Term Psychiatric Treatment from the Perspective of Mental Health Nurses

Zaenal Muttaqin[1]*, Husnan[2], Lina Rahmwati[3]
[1] Poltekkes Kemenkes Bandung
[2] Poltekkes kemenkes Riau
[3] Sekolah Tinggi Ilmu Kesehatan Aksari
Corresponding Author: Zaenal Muttaqin muttaqinz680@gmail.com

A R T I C L E I N F O

Keywords: Mental Health Nursing, Family Resistance, Long-Term Psychiatric Treatment, Nurse Perspective, Family-Based Care.

Received : 27, January
Revised : 29, February
Accepted: 31, March

A B S T R A C T

Family involvement plays an important role in the success of long-term psychiatric treatment, but family resistance is still a significant challenge in mental health nursing practice and has not been widely studied from a nurse's perspective. This study aims to understand family resistance to long-term psychiatric treatment based on the perspective of mental health nurses. Qualitative research with a phenomenological design was conducted through in-depth semi-structured interviews with mental health nurses. The data was analyzed using thematic analysis. Family resistance is influenced by the stigma of mental disorders, low mental health literacy, treatment exhaustion, economic limitations, and distrust of psychiatric services. Resistance often arises indirectly through inconsistent support and delays in treatment decisions. Family resistance is a multidimensional phenomenon that requires a family-based nursing approach, strengthening psychoeducation, and service system support to improve the sustainability of psychiatric care

ISSN-E: 2964-6804
DOI: https://doi.org/10.55927/fjst.v5i3.24
https://traformosapublisher.org/index.php/fjst

INTRODUCTION

Mental health disorders are a growing global health problem and have a significant impact on individuals, families, and health care systems. The World Health Organization affirms that mental disorders contribute greatly to the global burden of disease, especially because of their chronic nature and require long-term treatment and ongoing care (WHO, 2022). In this context, the success of psychiatric treatment depends not only on pharmacological and psychotherapeutic interventions, but also is highly determined by the involvement of the family as the patient's main support system in daily life.

In mental health nursing practice, families have a strategic role in supporting medication adherence, monitoring patients' psychological conditions, and creating an environment conducive to recovery and rehabilitation. Modern nursing approaches place the family as an integral part of the care process of patients with mental disorders, in line with the family-centered care paradigm that emphasizes collaboration between healthcare workers, patients, and families (Stuart, 2021). Optimal family involvement has been shown to reduce recurrence rates, reduce repeat hospitalizations, and improve patients' quality of life (Videbeck, 2020).

Nonetheless, family involvement in long-term psychiatric treatment does not always work ideally. Various studies show that family resistance to psychiatric treatment is still a common phenomenon, both in developed and developing countries (Corrigan et al., 2018). This resistance can take many forms, ranging from rejection of a diagnosis of mental disorders, doubts about the effectiveness of psychiatric treatment, to non-compliance in supporting long-term treatment. This condition has the potential to hinder continuity of care and negatively impact the patient's clinical outcomes.

Most of the literature that discusses resistance in psychiatric treatment tends to focus on patient non-adherence or family burden. These studies emphasize factors such as lack of family knowledge, social stigma towards mental disorders, and economic and emotional stress experienced during the treatment process (Awad & Voruganti, 2018). While this perspective is important, it is still partial because it does not fully capture the dynamics of interactions between families and health workers, especially mental health nurses.

Mental health nurses are professionals who are at the forefront of services and have a central role in establishing therapeutic relationships with patients and families. In clinical practice, nurses are not only responsible for the provision of nursing care, but also act as educators, advocates, and mediators between patients, families, and the health care system (Townsend & Morgan, 2021). This strategic position places nurses as direct witnesses to various forms of family resistance, both explicit and implicit.

Family resistance in the context of long-term psychiatric treatment is often not expressed openly, but rather manifests itself in the form of inconsistent support, delayed treatment decision-making, reliance on alternative medicine, or ambivalent attitudes toward health care recommendations. This phenomenon of covert resistance is often difficult to identify and handle, potentially worsening

the patient's condition and causing frustration and emotional burden for mental health nurses (Happell et al., 2019).

In addition to individual and family factors, resistance to long-term psychiatric treatment is also influenced by social and systemic factors. The stigma against mental disorders is still a dominant issue in various cultures and societies, impacting the way families view patients and psychiatric treatment itself (Corrigan & Watson, 2020). Low mental health literacy, limited access to mental health services, and lack of structured family education programs also strengthen this resistance. In many cases, the health care system has not fully provided adequate institutional support for nurses to effectively engage families in the care process.

Although the complexity of family resistance has been recognized in nursing practice, scientific studies that specifically explore this phenomenon from the perspective of mental health nurses are still relatively limited. Most studies use a quantitative approach that focuses on measuring family knowledge levels or attitudes, thus delving less into the subjective experiences and meanings constructed by nurses in the face of family resistance. In fact, a deep understanding of nurses' experiences is essential for developing nursing interventions that are contextual, reflective, and practice-oriented.

Based on this exposure, there is a significant research gap related to the understanding of family resistance to long-term psychiatric treatment from the perspective of mental health nurses. Therefore, this study aims to explore and understand family resistance to long-term psychiatric treatment based on the experiences and perspectives of mental health nurses. The results of this research are expected to make a theoretical contribution to the development of mental health nursing science and become the basis for the formulation of family-based nursing interventions and service policies that are more responsive, humane, and sustainable.

THEORETICAL REVIEW

Long-Term Psychiatric Treatment in the Context of Mental Health Nursing

Long-term psychiatric treatment is a key approach in the management of severe and persistent mental disorders, including schizophrenia, bipolar disorder, and recurrent major depressive disorder. This approach aims to maintain clinical stability, prevent recurrence, and improve the patient's social function in the long term (Kane et al., 2019). In mental health nursing practice, the success of long-term treatment is highly dependent on the continuity of care outside of formal health facilities, particularly in family and community settings.

The nursing literature confirms that the family plays a role as the primary caregiving unit that influences medication adherence, symptom monitoring, and care-related decision-making (Bee et al., 2015). When families are able to understand the goals and processes of long-term psychiatric treatment, they tend to provide more consistent and constructive support. Conversely, a lack of family involvement and understanding can be a significant barrier to the effectiveness of care.

Conceptualization of Family Resistance in Psychiatric Treatment

Family resistance in the context of mental health is understood as a form of family rejection, doubt, or ambivalence towards psychiatric interventions recommended by health workers (Magliano et al., 2018). This resistance is not always confrontational, but often arises implicitly through passive behaviors, such as non-adherence to control schedules, discontinuation of treatment without consultation, or lack of emotional support for the patient.

Some studies have shown that family resistance is closely related to the construction of family meaning to mental disorders and psychiatric treatment. Families who view mental disorders as temporary or non-medical conditions tend to reject long-term treatment approaches (Yusuf et al., 2017). In addition, negative perceptions of the side effects of psychiatric drugs and concerns about pharmacological dependence also strengthen family resistance to ongoing treatment.

Mental Health Literacy and Its Influence on Family Attitudes

Mental health literacy is an important factor that influences family attitudes and responses to psychiatric treatment. Low literacy can lead to misconceptions about the etiology of mental disorders, treatment goals, as well as long-term prognosis (O'Connor & Casey, 2015). Families with limited levels of mental health literacy tend to discontinue treatment when the patient's symptoms improve, without understanding the risk of recurrence.

Research shows that family psychoeducational interventions can improve understanding and reduce resistance to psychiatric treatment (Sin et al., 2017). However, the effectiveness of psychoeducation is greatly influenced by the approach used and the extent to which mental health nurses are actively involved in the educational process. Without ongoing support from nursing staff, improving mental health literacy is often temporary and does not have a significant impact on changing family behaviors.

Burden of Care and Family Fatigue Dynamics

In addition to the cognitive aspect, family resistance is also related to the long-term care burden experienced by the family. This burden includes physical, emotional, social, and economic dimensions that accumulate over time (van der Voort et al., 2015). Under certain conditions, prolonged care burdens can trigger chronic fatigue and feelings of helplessness, which then manifest as resistance to follow-up care.

Family burnout is often exacerbated by a lack of social support and limited access to community-based mental health services. Longitudinal research shows that families who feel isolated and not supported by the health care system are more likely to exhibit negative attitudes toward long-term psychiatric treatment (Saunders & Byrne, 2002). This condition confirms the importance of the role of mental health nurses in providing emotional support and resource facilitation for families.

Mental Health Nurse Perspectives and the Literature Gap

Mental health nurses have a key role in managing the dynamics between patients, families, and the healthcare system. Studies show that nurses are often the first to face the immediate consequences of family resistance, including communication conflicts, ethical dilemmas, and professional dilemmas (Cutcliffe

& Stevenson, 2008). However, nurses' experiences in dealing with family resistance are still relatively underexplored in the nursing literature.

Most previous studies have used survey or quantitative measurement approaches that have not been able to capture the complexity of nurses' subjective experiences. Qualitative approaches, particularly phenomenology, provide an opportunity to explore how nurses interpret family resistance and the strategies they develop in clinical practice. It is this gap that underscores the need for research that focuses on the perspective of mental health nurses to enrich the understanding of family resistance in long-term psychiatric treatment.

METHODOLOGY

Research This study uses a qualitative approach with an interpretive phenomenological design to explore in depth the experiences of mental health nurses in understanding family resistance to long-term psychiatric treatment. The interpretive phenomenological approach was chosen because it allows researchers to explore the subjective meanings of nurses' professional experiences, as well as interpret how those experiences are shaped by the clinical and social contexts in which nursing practice takes place (Smith et al., 2009). This design is considered most appropriate to answer research objectives that focus on the interpretation and interpretation of experiences, rather than the measurement of causal relationships or population generalizations.

Research was conducted in advanced mental health services, including psychiatric inpatient and outpatient units, where nurses routinely interact with patients and families in the context of long-term care. The selection of this setting aims to obtain rich and contextual data related to the dynamics of familial resistance that arise in daily clinical practice. The study participants were recruited using the purposive sampling technique, with the criteria of mental health nurses who have at least two years of work experience and have directly faced family resistance to psychiatric treatment. The number of participants is determined based on the principle of data saturation, which is when additional interviews no longer produce significant new themes or meanings (Guest et al., 2006).

Data collection was conducted through semi-structured in-depth interviews to allow for the flexibility of exploring participants' experiences while maintaining the focus of the research. The interview guide was developed based on the conceptual framework of family resistance in mental health care and was adjusted iteratively over the course of the research process. Each interview lasted 45–60 minutes, was recorded with the consent of the participants, and transcribed verbatim. In addition to interview transcripts, researchers also compiled field notes to capture the context of interactions, non-verbal expressions, and initial reflections relevant to the analysis process (Polit & Beck, 2021).

Data analysis was carried out simultaneously with the data collection process using the principle of interpretative phenomenological analysis. The analysis process begins with repeated reading of the transcript to build a holistic understanding, followed by open coding of meaningful statements. The codes are then grouped into emergent themes through a reflective and iterative

interpretive process. The analysis is done manually to maintain the proximity of the researcher to the data and ensure the depth of phenomenological interpretation (Eatough & Smith, 2017).

The validity of data is maintained through the application of trustworthiness criteria, including credibility, dependability, confirmability, and transferability. Credibility is achieved through member checking and reflective discussions with peers, while dependability and confirmability are strengthened by systematic documentation of the entire research process and data analysis. Transferability is supported by the presentation of detailed contextual descriptions of the characteristics of the participants and the research setting, so that the reader can assess the relevance of the findings in other contexts (Lincoln & Guba, 1985).

This research has obtained ethical approval from the authorized health research ethics committee. All participants are given a full explanation of their objectives, procedures, and rights as participants before giving written consent. The confidentiality and anonymity of the participants are strictly maintained, and the researcher applies reflexivity on an ongoing basis to minimize the potential for interpretation bias derived from the researcher's professional and academic background (Finlay, 2002).

RESEARCH RESULTS

Analysis of in-depth interview data on participants resulted in four main themes that represent the experiences and meanings of mental health nurses in the face of family resistance to long-term psychiatric treatment. These themes emerge consistently through the process of interpretative phenomenological analysis and reflect the complexity of interactions between nurses, patients, and families in mental health nursing practice.

Family Resistance as a Form of Denial to the Reality of Chronic Mental Illness

Nurses interpret family resistance not solely as a form of rejection of psychiatric treatment, but as a manifestation of the family's difficulty in accepting the chronic and recurrent nature of mental disorders. Based on the clinical experience of nurses, many families still view mental disorders as a temporary condition that can be fully recovered once the acute symptoms have subsided. This view causes families to tend to assess the sustainability of treatment as something that is no longer necessary when the patient shows improvements in behavior or daily functioning. As a result, decisions to stop or reduce treatment are often made unilaterally without consultation with healthcare professionals.
One nurse described that families often associate healing with the disappearance of symptoms that appear on the surface, without understanding the dynamics of the disease in depth.

"*If it is no longer hallucinating and can be talked to, the family feels that the patient has recovered. They said, 'Mom, now it's normal, why do you still have to take the medicine?*'" (P3, March 12, 2025).

This perception reflects a limited understanding of the course of chronic mental disorders and the long-term treatment goals that are preventive against relapse. In this context, family resistance is not the result of indifference, but rather stems from the erroneous construction of meanings about illness, healing,

and normality. Nurses view that families often seek to maintain a "total recovery" narrative as a way to maintain their own expectations and emotional stability.

Further, the nurse revealed that family resistance is often accompanied by unrealistic expectations of the patient's healing process. That expectation includes the expectation that patients can return to fully functioning as they did before the illness, without limitations and without dependence on medication. When clinical reality does not match those expectations, families tend to express disappointment which then leads to an ambivalent attitude or refusal to follow-up care. One participant described this dynamic as a conflict between expectations and reality.

"*The family wants the patient to be really like before, normal work, no need for medicine. When it was explained that this was a long-term illness, they looked disappointed and didn't seem ready to accept it*." (P7, April 27, 2025).

In many cases, nurses interpret family resistance as a psychological mechanism to protect themselves from the social stigma and emotional burden attached to the label of chronic mental disorder. Acknowledging that family members need lifelong treatment often means accepting a stigmatized social identity, both for the patient and the family. Therefore, rejection of long-term treatment can be understood as a form of denial that serves to maintain the image of oneself and one's family in the face of the social environment.

A nurse said: "*Sometimes I feel that the family doesn't reject the medicine, but rejects the label. If they are still taking medicine, it means that the pain is still there, and it is hard for them*." (P1, February 5, 2025).

These findings suggest that family resistance has a deeper existential dimension than simply non-adherence to a treatment plan. This resistance reflects the family's struggle in interpreting the patient's illness, identity, and future. From the perspective of mental health nurses, understanding resistance as a process of emotional and cognitive adaptation allows for a more empathetic and reflective approach in nursing practice. Thus, familial resistance is not positioned solely as a clinical barrier, but as an important entry point for building a more meaningful and sustainable therapeutic dialogue.

The Tension between Clinical Importance and Family Values

The second theme reveals the ongoing tension between the clinical recommendations provided by health workers and the values embraced by the patient's family. Nurses describe that clinical decisions based on considerations of safety, therapeutic effectiveness, and relapse prevention are often not in line with family beliefs. These beliefs can come from cultural values, previous family experiences with mental health services, or non-medical beliefs that affect the way families understand mental disorders and their treatment.

In clinical practice, nurses are often in a dilemma when families refuse or doubt interventions that are professionally considered essential to the patient's well-being. This dilemma arises because nurses are required to respect family values and autonomy, while ensuring that the decisions taken do not harm patients. These tensions become even more complex when families view clinical recommendations as contrary to long-held personal or cultural beliefs.

One nurse described this situation as a conflict of values that is difficult to bridge, "*Medically we know that patients still need medicine, but the family says that too much medicine is not good, especially since according to their beliefs it can make dependence*." (P5, March 18, 2025).

Participants also revealed that family resistance was rarely expressed openly or confrontationally. In contrast, resistance more often appears in an indirect form, such as delaying decision-making, avoiding further discussions, or providing ambiguous support for a treatment plan. This veiled pattern of resistance makes it difficult for nurses to clearly identify the family's position, while slowing down the clinical decision-making process.

One participant described the form of resistance as "meaningful silence",

"*They don't say no, but if they talk about long-term medicine, they always ask for time, they will discuss it again. Finally, the treatment was delayed*." (P2, April 7, 2025).

This condition complicates the nursing care process because nurses must continue to navigate therapeutic relationships with families. On the one hand, nurses seek to maintain trust and family cooperation as care partners. On the other hand, nurses have a professional and ethical responsibility to protect patient safety, especially when family decisions have the potential to increase the risk of recurrence or jeopardize the patient's clinical condition.

Some nurses state that this tension often creates emotional distress and helplessness, especially when they feel they have provided a comprehensive explanation but are still unable to change the family's attitude. A nurse revealed,

"*Sometimes we have explained many times in simple language, but the family is still hesitant. That's when I felt like I was making a mistake, between following my family and sticking to clinical recommendations*." (P9, May 2, 2025).

These findings suggest that the tension between clinical interests and family values is not just a communication issue, but a reflection of different frameworks of meaning in viewing mental health. From the nurse's perspective, this situation demands reflective skills and high cultural sensitivity in order for the nurse to act as an effective mediator. By understanding the value of the family as part of the context of care, nurses seek to build a therapeutic dialogue that is not coercive in nature, but is still oriented towards the safety and well-being of the patient.

Emotional and Moral Burden Experienced by Nurses

The third theme highlights the significant emotional and moral burden that mental health nurses experience when dealing with family resistance to long-term psychiatric treatment. Nurses express a variety of emotional responses, including frustration, emotional exhaustion, and inner conflict, especially when consistently professional efforts are not received adequate support from the patient's family. This situation often creates feelings of powerlessness, as the nurse feels that he has carried out his clinical and educational responsibilities optimally, but still faces rejection or ambiguity in family decision-making.

In some cases, nurses describe themselves as being in a dilemma, caught between an ethical responsibility to protect the safety and well-being of patients and a limited professional authority in influencing family decisions. These tensions become even more complex when family decisions are perceived to

potentially increase the risk of recurrence or jeopardize the patient's condition, while nurses do not have the authority to intervene more decisively. The conflict between professional values and the reality of such practices contributes to sustained moral pressure.

This experience shows that family resistance not only impacts the continuity and quality of patient care, but also directly affects the psychological well-being of mental health nurses. Repeated exposure to situations that demand high emotional engagement without adequate resolution has the potential to drain the nurse's emotional resources. In the long term, this condition can contribute to the appearance of compassion fatigue, which is characterized by decreased empathy, emotional fatigue, and reduced job satisfaction.

These findings confirm the importance of viewing the emotional and moral burden of nurses as systemic issues in mental health services. Without adequate institutional support, such as clinical supervision, professional reflection spaces, and policies that support the well-being of nursing staff, the risk of professional burnout can increase. Therefore, family resistance management needs to be integrated with nurses' mental health protection strategies to maintain the sustainability and quality of mental health nursing practices.

Nurses' Adaptive Strategies in Managing Family Resistance

Despite facing various challenges in clinical practice, mental health nurses develop a diverse array of adaptive strategies to manage family resistance to long-term psychiatric treatment. These strategies not only focus on the delivery of clinical information, but also emphasize the importance of building therapeutic relationships based on empathy, trust, and understanding of the family's perspective. Nurses view that understanding family experiences, fears, and expectations are important prerequisites before providing educational interventions or clinical recommendations.

The empathic communication approach is the main strategy identified in this study. Nurses consciously avoid confrontational or judgmental approaches, and choose to actively listen to family concerns. In this way, nurses seek to create a safe space of dialogue, where families feel valued and more open to discussions about long-term treatment. One participant described this approach as a gradual process of building trust,

"*If we talk directly about long-term medicine, usually families close themselves. I prefer to listen to their concerns first*." (P3, March 12, 2025).

In addition to empathic communication, the gradual provision of psychoeducation is also seen as an effective adaptive strategy. Nurses are aware that information about the chronic nature of mental disorders and the importance of long-term treatment is often difficult to receive in one meeting. Therefore, psychoeducation is carried out repeatedly and adjusted to the emotional readiness and level of family understanding. This approach allows families to process information slowly without feeling pressured.

A nurse explained the importance of patience in the educational process, "It cannot be explained immediately. Sometimes it takes several meetings until the family is really ready to accept." (P7, April 5, 2025).

Building therapeutic alliances with families as treatment partners also emerged as a key strategy in managing resistance. Nurses try to involve families in collaborative decision-making, so that families don't feel neglected or forced to follow clinical recommendations. Through this approach, nurses seek to balance professional authority with respect for family values and autonomy.

Several participants highlighted the importance of flexibility in nursing practice, especially in adapting communication styles to cultural backgrounds and family health literacy levels. Nurses realize that an effective approach to one family may not be appropriate for another. Therefore, adaptive strategies are seen as contextual skills that develop through clinical experience and professional reflection, rather than solely the result of formal education. A participant reflects on the learning process,

"*The way I deal with my family now is very different from the beginning of work. I learned a lot of things directly from the experience on the field*." (P10, April 20, 2025).

These findings confirm that nurses' adaptive strategies are a manifestation of professionalism and reflective capacity in mental health nursing practice. Empathetic approaches, gradual psychoeducation, and communication flexibility not only contribute to family resistance management, but also strengthen the therapeutic relationships that are the foundation of sustainable, partnership-oriented mental health care.

DISCUSSION

The findings of this study enrich the psychiatric nursing literature by revealing that family resistance to long-term psychiatric treatment is a multidimensional phenomenon involving cognitive, emotional, cultural value, and relational dynamics. In line with previous findings, family resistance is often rooted in the difficulty of accepting the chronic nature of mental disorders as well as the stigma attached to psychiatric diagnoses. However, this study adds a new perspective by highlighting how nurses interpret such resistance as part of the family adaptation process, rather than solely as a clinical barrier (Magliano et al., 2018; van der Voort et al., 2015).

The tension between clinical interests and family values identified in this study reflects the complexity of family-centered care practices in the context of mental health. Although this approach normatively emphasizes partnerships with families, the findings suggest that its implementation is often faced with value conflicts that are difficult to resolve procedurally. In these situations, nurses play the role of mediators who balance the principle of patient safety with respect for family autonomy (Bee et al., 2015; Cutcliffe & Stevenson, 2008).

The emotional and moral burden experienced by nurses reinforces the argument that family resistance is a systemic issue that cannot be solved through increased patient compliance or family education alone. These findings support the need for greater attention to the well-being of mental health nurses, including the provision of clinical supervision and institutional support to prevent

professional burnout. Thus, family resistance needs to be understood as a factor that affects the quality of care holistically, including its impact on nursing personnel (Happell et al., 2019; Morse et al., 2012).

The adaptive strategies developed by nurses demonstrate reflective capacity and professionalism in mental health nursing practice. The empathic approach and gradual psychoeducation identified in this study are in line with the principles of therapeutic relationship-based nursing practice. However, these findings also confirm that the effectiveness of such strategies is highly context-dependent and cannot be rigidly standardized. Therefore, the development of nurses' competencies in managing family resistance needs to be focused on improving communication skills, reflexivity, and cultural sensitivity (Sin et al., 2017; Finlay, 2002).

Overall, the results of this study confirm the significant contribution of the nurse's perspective in understanding family resistance to long-term psychiatric treatment. These findings not only broaden the theoretical understanding of family dynamics in mental health care, but also provide practical implications for the development of more contextual, sustainable, and therapeutic partnership-oriented nursing interventions (Lincoln & Guba, 1985; Smith et al., 2009).

CONCLUSIONS AND RECOMMENDATION

This study shows that family resistance to long-term psychiatric treatment is a multidimensional phenomenon that reflects the family's adaptation process to chronic mental disorders, influenced by understanding, values, stigma, and emotional burden. From the perspective of mental health nurses, family resistance not only impacts the sustainability of patient treatment, but also poses ethical dilemmas and emotional burdens in nursing practice.

These findings affirm the strategic role of nurses as therapeutic mediators between clinical interests and family values, through a contextual approach to empathic communication and psychoeducation. Overall, this study contributes to enriching the understanding of mental health nursing and emphasizes the importance of systemic support and strengthening nurse competence in managing family resistance in an ongoing manner.

FURTHER STUDY

Future research is recommended to explore family resistance to long-term psychiatric treatment from multiple perspectives, including those of family members and patients, to obtain a more comprehensive understanding of the phenomenon. In addition, further studies could employ mixed-method or quantitative approaches to examine the prevalence and determinants of family resistance across different cultural and socioeconomic contexts. Longitudinal research is also needed to understand how family attitudes toward psychiatric treatment change over time and how these changes influence treatment adherence and recovery outcomes. Moreover, intervention-based studies focusing on family-centered psychoeducation, stigma reduction, and strengthening trust in mental health services would be valuable to identify effective strategies for reducing family resistance and improving the sustainability of long-term psychiatric care.

REFERENCES

Awad, A. G., & Voruganti, L. N. P. (2008). The burden of schizophrenia on caregivers: A review. PharmacoEconomics, 26(2), 149–162. https://doi.org/10.2165/00019053-200826020-00005

Bee, P., Price, O., Baker, J., & Lovell, K. (2015). Systematic synthesis of barriers and facilitators to service user-led care planning. British Journal of Psychiatry, 207(2), 104–114. https://doi.org/10.1192/bjp.bp.114.152447

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. World Psychiatry, 1(1), 16–20.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. Psychiatric Services, 63(10), 963–973. https://doi.org/10.1176/appi.ps.201100529

Cutcliffe, J. R., & Stevenson, C. (2008). Feeling our way in the dark: The psychiatric nursing care of suicidal people. Journal of Psychiatric and Mental Health Nursing, 15(6), 486–494. https://doi.org/10.1111/j.1365-2850.2008.01276.x

Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. In C. Willig & W. Stainton Rogers (Eds.), The SAGE handbook of qualitative research in psychology (pp. 193–211). SAGE.

Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. Qualitative Research, 2(2), 209–230. https://doi.org/10.1177/146879410200200205

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. Field Methods, 18(1), 59–82. https://doi.org/10.1177/1525822X05279903

Happell, B., Platania-Phung, C., & Scott, D. (2019). Mental health nurse consumer advocacy: Contributing to social inclusion. International Journal of Mental Health Nursing, 28(1), 17–26. https://doi.org/10.1111/inm.12524

Kane, J. M., Kishimoto, T., & Correll, C. U. (2019). Non-adherence to medication in patients with psychotic disorders. World Psychiatry, 18(1), 3–15. https://doi.org/10.1002/wps.20611

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. SAGE.

Magliano, L., Veltro, F., Guarneri, M., & Marasco, C. (2018). Family burden and coping strategies in relatives of patients with schizophrenia. Psychiatry Research, 260, 151–157. https://doi.org/10.1016/j.psychres.2017.11.040

Morse, J. M., Solberg, S. M., Neander, W. L., Bottorff, J. L., & Johnson, J. L. (2012). Concepts of suffering and clinical practice. Journal of Advanced Nursing, 22(6), 1231–1238.

O'Connor, M., & Casey, L. (2015). The Mental Health Literacy Scale (MHLS): A new scale-based measure. Psychiatry Research, 229(1–2), 511–516. https://doi.org/10.1016/j.psychres.2015.05.064

Polit, D. F., & Beck, C. T. (2021). Nursing research: Generating and assessing evidence for nursing practice (11th ed.). Wolters Kluwer.

Saunders, J. C., & Byrne, M. M. (2002). A thematic analysis of families living with schizophrenia. Archives of Psychiatric Nursing, 16(5), 217–223. https://doi.org/10.1053/apnu.2002.36259

Sin, J., Gillard, S., Spain, D., Cornelius, V., Chen, T., & Henderson, C. (2017). Effectiveness of psychoeducational interventions for family carers of people with psychosis: A systematic review. BMC Psychiatry, 17, Article 266. https://doi.org/10.1186/s12888-017-1442-y

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. SAGE.

Stuart, G. W. (2021). Principles and practice of psychiatric nursing (11th ed.). Elsevier.

Townsend, M. C., & Morgan, K. I. (2021). Psychiatric mental health nursing: Concepts of care in evidence-based practice (10th ed.). F.A. Davis.

van der Voort, T. Y. G., Goossens, P. J. J., & van der Bijl, J. J. (2015). Burden, coping and needs for support of caregivers for patients with a bipolar disorder. Journal of Psychiatric and Mental Health Nursing, 22(9), 679–687. https://doi.org/10.1111/jpm.12239

Videbeck, S. L. (2020). Psychiatric–mental health nursing (8th ed.). Wolters Kluwer.

World Health Organization. (2022). World mental health report: Transforming mental health for all. WHO.

Yusuf, A., Tristiana, R. D., & Nihayati, H. E. (2017). Cultural beliefs and stigma in family caregiving of people with mental illness. Journal of Mental Health, 26(2), 120–126. https://doi.org/10.1080/09638237.2016.1222050