Jurnal Psikologi
Volume 52, Number 3, 2025: 223– 249
DOI: 10.22146/jpsi.105504

ISSN 0215-8884 (print)
ISSN 2460 867X (Online)

Spousal Caregiver Resilience: Husbands' Experiences in Caring for Wives with Schizophrenia

Iswaranisita Yudhaningrum[1,2], Tina Afiatin[2*]
[1]*Faculty of Medicine, Dentistry, & Health Sciences, University of Melbourne, Australia*
[2]*Faculty of Psychology, Universitas Gadjah Mada, Indonesia*

Submission 18 March 2025 **Accepted 16 December 2025** **Published 31 December 2025**

Abstract. This study aims to explore the resilience experiences of husbands who take on the role of spousal caregivers for wives diagnosed with schizophrenia. A qualitative descriptive approach was employed to capture a rich, straightforward, and low-inference account of participants' caregiving experiences without imposing predetermined theoretical interpretations. A four-phase thematic analysis was conducted to analyze the data. Five male participants, aged 30–60 years, were included in the study. Each had been a spousal caregiver for more than five years. The findings revealed seven themes: onset transition, adaptation to caregiving tasks, maintaining the marriage, spiritual discipline, active participation in community and society, challenges from family and the wider community, and contribution to society. In addition, the study found that cultural factors significantly influence the dynamics of resilience, particularly in decision-making processes. This research can support health professionals and academics in understanding the lived experiences of male spousal caregivers. Nonetheless, the study is limited by its small, homogeneous sample of Javanese Muslim caregivers from a local community in Yogyakarta, which may limit the generalizability of the findings. Future research should consider more diverse samples and use mixed-method approaches to broaden insights into resilience across different caregiving contexts, including those involving child-rearing and other vulnerable family settings.

Keywords: qualitative descriptive; resiliency; schizophrenia; spousal caregiver

World Health Organization (2022) states that mental health disorders have a widespread impact on the world's population and were one of the leading causes of global disability before the COVID-19 pandemic. The mental disorder with the highest prevalence worldwide is depression, followed by bipolar disorder and schizophrenia. Although the prevalence of schizophrenia is lower than that of depression and bipolar disorder, this disorder still imposes a significant burden of disease and disability-adjusted life years (DALYs) (Fan et al., 2025; World Health Organization, 2022).

Schizophrenia is a major psychiatric disorder that affects approximately 1% of the world's population (World Health Organization, 2022). This disorder manifests itself in the form of profound dysfunction in thought, language, and personality, accompanied by characteristic symptoms such

*Address for correspondence: afiatin04@ugm.ac.id

Copyright ©2025 The Author(s). This is an Open Access article distributed under the terms of the Creative Commons Attribution-ShareAlike 4.0 International License (https://creativecommons.org/licenses/by-sa/4.0/)

as psychosis, hallucinations, and delusions (American Psychiatric Association, 2022). Schizophrenia patients must cope with and manage a disorder that is fluctuating in nature, accompanied by severe and debilitating social disability consequences that affect both physical and mental health (Kate et al., 2013). In addition, the deinstitutionalization of mental health care has changed the dynamics of care and the recovery process for patients in the community (Zauszniewski et al., 2009). Families, as informal caregivers, are responsible for patients' well-being during treatment and recovery in the domestic environment (Boritz et al., 2021). Thus, families need skills and adaptation processes to carry out their role as informal caregivers of schizophrenia patients (Sahu et al., 2020).

Dilehay and Sanchez as cited in (Caqueo-Urízar et al., 2009) define informal caregivers as individuals who care for and are responsible for the welfare of someone with limited personal autonomy due to chronic illness or long-term symptomatic remission. Caring for individuals with unstable mental conditions in societies such as Indonesia can be challenging. The tradition of mutual dependence (*gotong royong*) and caring for loved ones who are in difficulty, coupled with the lack of trained mental health workers to serve a large population, are two reasons why families are involved in the care of people with mental disorders (Stanley & Balakrishnan, 2023). The role of informal caregivers also carries social and cultural expectations, and informal caregiving is seen as a moral obligation borne by parents, children, or spouses.

The involvement of spousal caregivers reduces national healthcare costs and hospitalizations and improves patients' quality of life (Martyr et al., 2023). Identifying and developing resilience and related psychological factors helps reduce the burden of care and stress and improves the well-being of caregivers and patients (Palacio G et al., 2020).

Previous studies have found that caregivers of schizophrenia patients experience high levels of burden, social isolation, and stigma, accompanied by low quality of life and psychological distress resulting from anxiety or depression (Sahu et al., 2020). Gupta et al. (2015) found that 80% of caregivers experienced moderate or severe caregiving burden. The highest average level of caregiving burden was experienced by spousal caregivers. Spousal caregivers are the spouses of patients with schizophrenia who provide care in the domestic sphere and are responsible for the well-being of individuals with schizophrenia (Mott et al., 2019). Spousal caregivers or partners of schizophrenia patients tend to experience chronic burdens such as insecurity and ambivalence in relationships (Jungbauer et al., 2004). In addition, caring for a partner with schizophrenia has consequences such as reduced intimacy and greater burdens and responsibilities with regard to parenthood (Fidyalmi, 2020).

In the researcher's preliminary research (February 2, 2022), participants reported receiving minimal information about their wives' conditions before marriage. Five years of caregiving experience was chosen as a criterion because building resilience requires long-term exposure to caregiving stress. Bonanno (2004) explains that there is a repressive coping phase in the resilience of individuals exposed to prolonged stress, and it takes one to two years to recover. Windle (2011) adds that resilience varies, as it represents an individual process of bouncing back from difficulties throughout one's life. This was experienced by participants facing unexpected, dangerous events that required professional intervention.

"In the early years of our marriage, I slowly began to realize what the situation actually was. But the most critical moment happened after she gave birth. Because pregnant and breastfeeding mothers cannot take psychiatric medication, her condition relapsed. It reached the point where she almost drowned our baby and herself in the well. Fortunately, the neighbors rescued them. This happened around 2004, and until now, I still carry the trauma, especially because my first child was still a baby at that time.

"After that incident, I took her to a *pesantren* (Islamic boarding school) to undergo a full-day *ruqyah* ritual, from morning until night, conducted by several different people. But she didn't improve, because it turned out the cause was not supernatural; she was actually suffering from a medical condition. She was diagnosed with schizophrenia. After that, her medical treatment continued, and she was hospitalized at Grhasia for two weeks." (Mr. Suryo, Preliminary Interview, lines 18–23).

The interview results show that spousal caregivers face major challenges in caregiving, social functioning, work, and concerns related to the hereditary nature of the disorder. This requires conscious effort to adapt and manage daily tasks, which the researchers interpret as a process of resilience in coping with caregiving stress.

Resilience is the process and outcome when individuals successfully adapt to challenging problems and experiences, especially those related to mental, emotional, and behavioral flexibility, as well as adjustment to internal and external demands (Robertson & Cooper, 2013). Bonanno (2004) defines resilience as the ability of adults to maintain healthy psychological and physical functioning despite experiencing or being exposed to events that have the potential to disrupt well-being and cause feelings of isolation. Regarding these challenging events, there are two factors: protective factors and risk factors.

Protective factors consist of external and internal factors. External factors include socioeconomic status and social support from family, friends, and community. Internal factors consist of personality traits, motor skills, self-help skills, and neuroplasticity (Garcia-Dia et al., 2013). Meanwhile, risk factors hinder resilience. Schoon (2006) states that risk factors can increase vulnerability to stress. The concept of risk in resilience research refers to the possibility of an inability to adapt or adjust due to stressful conditions. Risk factors can originate from genetic, psychological, environmental, and socio-emotional factors (Garcia-Dia et al., 2013).

Several studies have examined resilience among caregivers of individuals with schizophrenia. Qualitative research shows that, in the process of developing resilience, caregivers go through the phases of deteriorating, adapting, recovering, and growing, and are supported by factors such as self-belief, social support, and problem-solving abilities (I am, I have, I can) (Garcia-Dia et al., 2013). Quantitative studies have also found a positive relationship between family support and caregiver resilience (Schoon, 2006). In addition, self-efficacy has been shown to play an important role in enhancing resilience, although caregiving burden may negatively impact quality of life (Kocabaş et al., 2025). Descriptive research indicates that most caregivers—including spousal caregivers—have resilience levels within the moderate category. Recent studies also report gender differences in resilience, with husbands as spousal caregivers often demonstrating different characteristics compared to wives (Sun et al., 2025).

However, most research still focuses on family caregivers in general or does not specifically examine spousal caregivers. Studies that highlight husbands as spousal caregivers remain limited, though this role involves unique dynamics related to gender, economic responsibility, and psychological stress. Therefore, this study aims to provide an in-depth understanding of the resilience of spousal caregivers caring for partners with schizophrenia. The research question proposed is: How do husbands experience the process of developing resilience while caring for a spouse diagnosed with schizophrenia, and what factors influence this process? By addressing this question, the study is expected to serve as a foundation for developing gender-based interventions to enhance family well-being.

The Concept of Resilience in Caregiving Relationships

Resilience is the process of negotiating, managing, and adapting to significant stressors or trauma. Assets or support within individuals, their lives, and their environments facilitate the capacity to adapt and "bounce back" in the face of adversity. Throughout the lifespan, experiences of resilience can vary (Windle et al., 2012). Resilience can be understood as a series of psychological phenomena that emerge at certain periods in life and may be present in some areas but not in others. The theoretical framework of resilience is not aimed at directly measuring resilience, as adaptive capacity is complex, involving psychological, cultural, technical, financial, social, and political factors (Fernandes et al., 2021; Kocabaş et al., 2025).

Some literature asserts that resilience is not an end result but rather an intermediary process formed through a combination of skills and assets that, in turn, influence well-being (Fernandes et al., 2021; Rutten et al., 2013). According to Garcia-Dia et al. (2013), the process of resilience begins with antecedents. Antecedents are events or things that trigger imbalance or difficulties in an individual's life. The antecedents repeatedly identified as necessary for the development of resilience are traumatic events or other forms of adversity. Antecedents must be interpreted as physically and/or psychologically traumatic events by the individual. Meanwhile, adversity is an event—such as a natural disaster, a disease pandemic, or the loss of a loved one or a job—that can trigger stress in daily life. In this framework, what is perceived as an antecedent is the challenge of caregiving in a certain period of life, such as caring for a wife who has been diagnosed with a psychiatric disorder.

This study adopts the theoretical framework of caregiving resilience developed by Windle et al. (2012). This framework provides a multidimensional model that emphasizes the interaction among individual resources, social support, and environmental factors in building caregivers' ability to develop resilience. In other words, this framework highlights the roles of internal assets (e.g., coping skills, self-confidence) and external resources (e.g., family support, community support) in helping caregivers cope with long-term pressures and challenges while caring for individuals with psychiatric disorders. However, though spousal caregiving is a crucial form of informal care for individuals diagnosed with schizophrenia, knowledge about resilience in the context of spousal caregiving remains limited. Guided by this theoretical framework, this study aims to explore the retrospective experiences of spousal caregivers in long-term interactions with partners diagnosed with schizophrenia, particularly in relation to stress management and the process of managing mental disorder symptoms.

In line with these objectives, this study uses a descriptive qualitative approach because it allows researchers to obtain a direct and detailed picture of the authentic experiences of caregiver husbands. Unlike phenomenology, which focuses on the essence of experience, or grounded theory, which aims to construct new theories, a descriptive qualitative approach is appropriate when the study presents real descriptions in the participants' everyday language. Therefore, this approach was chosen to provide a clear, practical understanding with minimal theoretical interpretation of the dynamics of resilience in complex and rarely studied couple caregiving.

Within the framework of resilience, Windle (2011) identifies several resources that can support caregivers' capacity to develop resilience. These resources include individual resources, community resources, and societal resources. These resources interact with each other and have consequences, such as increased well-being, the creation of additional caregiving challenges, and the decision to place the care recipient in intensive medical care (institutionalization).

Windle et al. (2012) found that the availability or unavailability of these resources determines the capacity for resilience. A lack of resources is considered a risk or obstacle to the formation of resilience capacity. This framework is very general and comes from a literature review conducted through a systematic review of studies on caregiver resilience (Windle et al., 2012).

Method

This study uses a qualitative approach with a descriptive qualitative design, which aims to understand the formation of psychological resilience in male spousal caregivers whose wives have been diagnosed with schizophrenia. This approach is suitable for exploring human experiences in a naturalistic manner and providing factual descriptions of individuals' feelings, opinions, and attitudes toward a phenomenon (Colorafi & Evans, 2016; Creswell & Poth, 2023). Caring for a partner with schizophrenia is a complex process, so this method is considered the most appropriate one for understanding the variety of caregiving responses.

Participants

Participants were recruited using a snowball sampling technique with a non-probability sampling method. After obtaining approval from the Ethics Committee of the Faculty of Psychology, Universitas Gadjah Mada (Number 2735/UNI/F.Psi.1.1/SD/PT.01.04/2022), the researcher sought participants who met the following criteria: (1) men in middle adulthood (30-60 years old), (2) married and living in the same household as a wife diagnosed with schizophrenia, and (3) having served as a spousal caregiver for a minimum of five years. This duration was selected because the development of resilience requires prolonged exposure to stress and sustained adaptive processes. A shorter caregiving period would not allow sufficient exploration of changes in coping strategies, emotional adaptation, or the dynamics of the caregiving relationship (Bonanno, 2004; Windle, 2011).

The five-year criterion is based on the assumption that for both the spousal caregiver and the partner to develop resilience, they must maintain healthy and stable functioning over time, have

sufficient opportunity to strengthen internal and external resources that contribute to psychological growth, and demonstrate commitment to continuing the marital and family relationship despite an understanding of the condition of schizophrenia and its effects on themselves and their family (Fernandes et al., 2021). Additional criteria included: (4) an intact nuclear family, consisting, at minimum, of husband and wife; (5) the ability to articulate or independently narrate personal experiences and events; and (6) the willingness to voluntarily participate in the research process until completion without coercion.

In identifying potential participants, the researcher contacted mental health professionals who were directly connected to communities of caregivers of persons with schizophrenia. With assistance from community caregivers, health program officers at Patuk 1 Public Health Center (*Puskesmas Patuk 1*) in Gunung Kidul and Samigaluh Public Health Center (*Puskesmas Samigaluh*) in Kulon Progo, the researcher obtained contact information for 11 potential participants. After contacting them, the researcher explained the research procedures via WhatsApp messages and phone calls. If a potential participant agreed, the researcher conducted a home visit with the program officer (the health intervention planner and implementer at the community health center or subdistrict level, usually a medical staff member) or arranged a meeting at a mutually agreed-upon location suitable for the interview. Of the 11 potential participants, eight responded, and five agreed to take part in the research from beginning to end.

The total number of participants involved in this study was five. Although this number is relatively small, it aligns with the characteristics of descriptive qualitative research, which prioritizes the depth of experiential exploration over sample size or population representativeness (Willig, 2021). A small sample size is considered adequate when the information obtained is rich and relevant to the research focus. Furthermore, husbands who care for wives with schizophrenia represent a hard-to-reach population, making snowball sampling an appropriate technique to identify participants fitting the study's objectives (Creswell & Poth, 2023).

All participants were male spousal caregivers in middle adulthood, with an average age of 48.6 years. The youngest spousal caregiver was 41 years old, and the oldest was 60 years old. On average, participants had provided care to their wives for 11.2 years, with caregiving durations ranging from 5 to 22 years. A brief profile of the research participants is presented below: See Table 1

Table 1

Participant Demographic Information

Pseudonym	Age	Education	Occupation	Caregiving Duration	Number of Children
Andi	41 years	Vocational High School (SMK)	Parking attendant	13 years	3
Bayu	43 years	Vocational High School (SMK)	Facilities and infrastructure staff at Islamic junior high school (MTs)	11 years	4
Cakra	45 years	Vocational High School (SMK)	Online motorcycle taxi driver	6 years	–
Danur	50 years	Vocational High School (SMK)	Private-sector employee	16 years	2
Endra	53 years	Junior High School (SMP)	Construction laborer	22 years	3

Procedure

Because this study involved vulnerable participants, written informed consent was obtained prior to the start of each interview. All interviews were conducted face-to-face. Driscoll (2011) notes that conducting interviews traditionally-that is, offline-offers advantages for researchers, such as the ability to ask follow-up questions and observe nonverbal communication, thereby enriching the information gathered compared to online interviews. All interviews were conducted in adherence to COVID-19 health protocols. The researcher had received three doses of the COVID-19 vaccine before the in-person interviews. The interview process took place from May 5 to July 10, 2022. Participants received compensation in the form of eating utensils and basic necessities (*Sembilan Bahan Pokok*).

Each participant (Table 1) was interviewed two or three times. The first meeting focused on building rapport and collecting demographic information. The second meeting consisted of the main interview, and the third meeting was used for clarification. The total interview duration per participant ranged from 70–180 minutes, allowing for in-depth exploration in accordance with the characteristics of descriptive qualitative research (Colorafi & Evans, 2016; Creswell & Poth, 2023). Interviews were audio-recorded using a mobile phone, with each session lasting 35–60 minutes.

For participants whose wives were present during the interview, the researcher ensured that the data collection process did not have a negative impact. To support this, the researcher conducted observations using the Clinical Global Impression–Schizophrenia Scale (CGI-SCH) to assess positive and negative symptoms of schizophrenia. The researcher also followed up through WhatsApp to ensure that participants' wives remained in a stable condition. Pseudonyms were used in all reporting to maintain confidentiality and prevent social or psychological risks to participants.

Instruments

Data were collected through semi-structured interviews and observation. Several open-ended questions were adapted from (Wingham et al., 2015), who examined self-management among caregivers of patients with heart failure. These questions were modified to suit the context of caregiving for individuals with schizophrenia. The interview guide consisted of seven core questions for each participant.

Examples of interview questions:
"Could you describe your experiences as a caregiver for a wife with schizophrenia?"
"What situations do you consider most challenging, and how do you cope with them?"
"What sources of support help you to remain resilient in the long term?"
"How do you manage emotional stress or fatigue while caring for your wife?"
"In your view, what enables you to continue fulfilling the caregiving role up to this point?"

These additional questions were designed to explore specific aspects of resilience, including coping, social support, emotional adaptation, and personal resources.

Data Analysis

This study used thematic analysis to provide a comprehensive description of the entire data set as described by Braun and Clarke (2006). Thematic analysis can also be used to provide a more detailed inductive explanation of specific themes. This form of analysis can help contextualize how individuals give meaning to their experiences and realities. The interviewer was a master's candidate in clinical psychology, and the supervisor was a psychologist with a doctorate in psychology and experience in family psychology. Most participants were not previously known to the researchers.

In developing themes, there are three phases: initialization, construction, and finalization (Vaismoradi et al., 2016). The initialization process began when the researchers carefully read the interview transcripts and highlighted meaningful units and recurring content, such as repeated events or thoughts, inconsistent expressions, and distinctive ideas. Then, the raw data were coded according to the research questions. The researchers also made reflective notes to record the analytical process for ease of further data interpretation.

In phase 2, or the construction stage, the researchers selected and compiled similar and different pieces of content from the transcripts. Keywords and sentences were labeled according to their thematic meaning. In phase 3, the researchers improved the accuracy of previous coding by critically reviewing themes and coding procedures and carefully conducting an in-depth literature review. Then, they provided a more in-depth description by detailing the connections between themes and sub-themes to enhance data saturation. This stage of analysis included the development of questions about meaning. The questions revealed key concepts that the researchers thought might emerge from the data analysis. At this stage, the researchers began to develop emergent themes. In making conceptual comments, the researcher noted initial concepts regarding the participants' overall understanding of the role of being a spousal caregiver for a wife with schizophrenia. After completing the initial notes on each participant's response, the researcher sought themes that emerged among all participants by examining different parts of the transcript and simultaneously recalling what had been learned during the analysis to date.

In the final stage, the researchers developed a storyline in the form of theme tables and charts and reviewed the entire process, which helped identify gaps in data analysis. The themes reflected the participants' original words and thoughts, as well as the researchers' interpretations. Each theme was supported by descriptive comments, linguistic comments, and conceptual comments from participants.

To improve thematic consistency and validity, the researchers consulted with Dr. La Kahija, M.Si., an expert in interpretative phenomenological analysis (IPA), Prof. Dr. Tina Afiatin, M.Si., an expert in qualitative psychology, and two doctoral students in psychology who are experienced in qualitative research using the IPA approach. Although the research was descriptive and qualitative in nature, these consultations helped ensure that the interpretation of themes was unbiased and in accordance with the principles of IPA analysis.

The validation used in this study was member checking. Member checking is employed to validate, verify, and assess the trustworthiness of qualitative findings (Doyle, 2007). In subtle realist research, social phenomena exist only insofar as they are known through individuals' representations of them (Blaikie, 2007). Member checking was conducted by providing interview transcripts and the constructed analytical framework of the study, then reviewing them together with the participants (Birt et al., 2016).

The researcher also conducted data triangulation. Triangulation is a technique for examining the credibility of data by requiring something external to the data itself for verification or comparison purposes (Moloeng, 2014). Sugiyono (2012) categorizes triangulation into three types: (a) source triangulation, (b) technique triangulation, and (c) time triangulation. The researcher employed technique triangulation and time triangulation. Technique triangulation was carried out by cross-checking data with the same sources using different methods, such as interviews, observations, documentation, and demographic questionnaires. Time triangulation was conducted by checking interviews, observations, or other methods at different times and under varying conditions.

Results

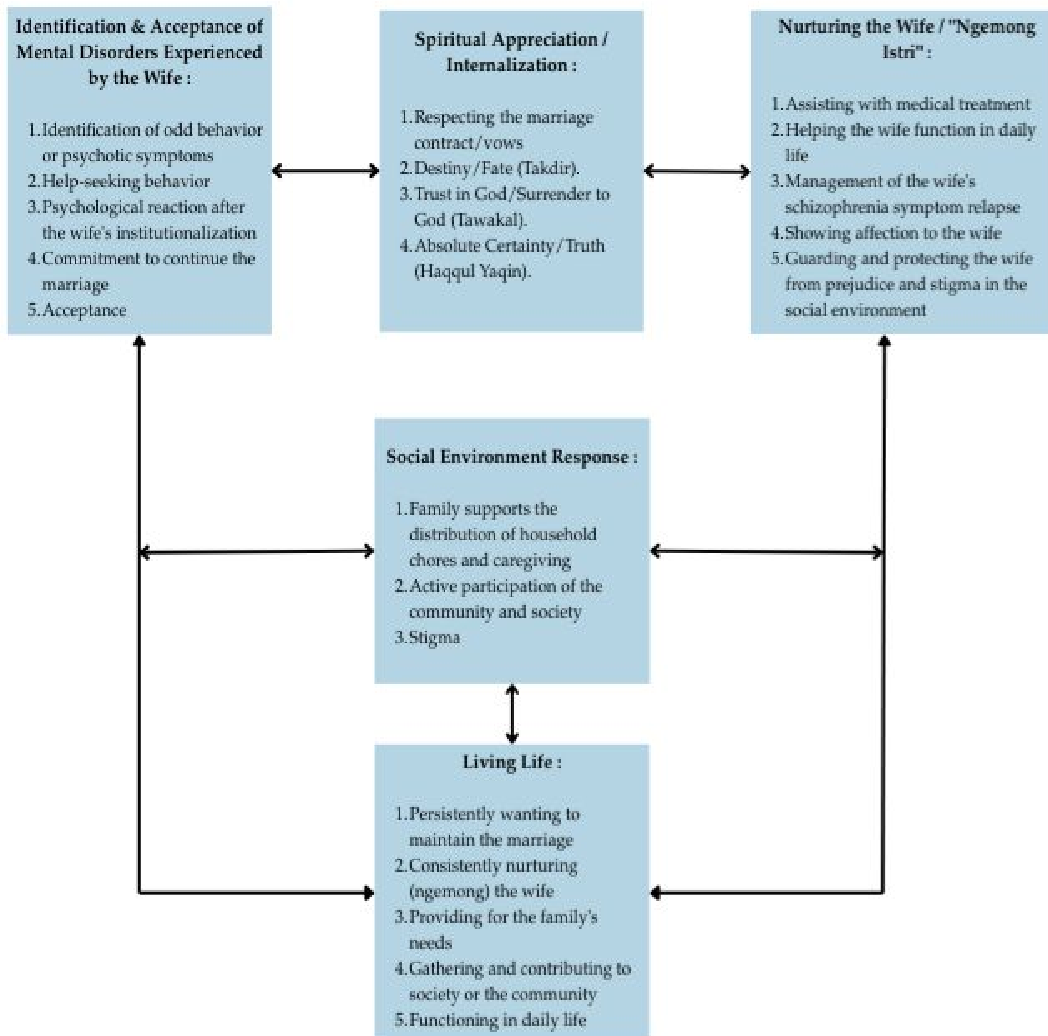
The analysis identified five main themes: 1) identification and acceptance of the disorder experienced by the wife, 2) spiritual discipline, 3) *ngemong*, 4) responses from the environment, and 5) living life. These five themes form an interconnected psychological dynamic. Acceptance of the wife's disorder is the initial foundation that enables caregivers to develop spiritual discipline as a source of internal strength. Spiritual discipline, in turn, influences the practice of *ngemong*, which is a form of active attention paid to one's partner. The response from the environment acts as an external factor that can strengthen or weaken this process. Finally, the integrated experience of the previous four themes leads to the fifth theme, namely, living life with coping strategies and new meaning. Thus, these five themes form a flow that describes a dynamic, contextual, and layered process of resilience.

Identification and Acceptance of the Wife's Mental Disorder

Spousal caregivers go through several processes to identify and accept the psychiatric disorder experienced by their wives. Four participants did not learn about their wives' schizophrenia until after marriage, while one participant knew, before marriage, that his wife had previously been

Figure 1

Resilience Dynamics of Male Spousal Caregivers



hospitalized in a psychiatric institution. The four participants who discovered their wives' schizophrenia diagnosis explained that they were surprised by the behavioral changes that their wives exhibited. Two participants said that these behavioral changes occurred after their wives had given birth.

"It was at the end of 2008. After giving birth, it kept happening. She would go *jalan-jalan* (wandering away from home on foot while crying and carrying our newborn baby). So it kept happening after childbirth… the doctor said it was baby blues, but this felt like it was beyond the 'dose' of baby blues. She even attempted suicide (a few days after the wandering episodes)." – R1.W1.14–16

"Yes, it was after she gave birth. Our second child. *Owah* (a Javanese expression referring to severe psychological change or mental disturbance)." – R5.W2.58.

Participant Endra (R5) used the word "*owah*" to describe his wife's behavioral condition, characterized by frequently talking to herself and becoming easily irritable. After identifying these behaviors, the participant explained that it took some time before they decided to seek help for his wife's condition. Almost all participants initially sought non-medical assistance. Two participants took their wives to a *pesantren*-an Islamic boarding school where *santri* live and study religious teachings—for religious-based therapy, while one participant brought his spouse to an *orang pintar*, a person perceived as possessing special spiritual abilities, to remove the voices heard by Cakra's (R3) wife.

After realizing that no progress had been achieved following several rituals and spiritual treatments, participants began to consider medical treatment. Three participants brought their wives to mental health institutions after the symptoms became persistent and increasingly severe (duration of untreated psychosis). Over time, all participants came to understand the importance of medical treatment and began routinely accompanying their wives to receive psychiatric care and medication.

During the process of seeking help and finding appropriate treatment, spousal caregivers experienced a range of negative emotions. These negative effects included confusion, sadness, panic, disappointment, guilt, the urge to leave their wives, and worry, before they gradually entered the stage of developing the intention to accept their wives' condition.

"At the beginning… wow, why is it like this? Wow, I thought… should I just leave? But then I thought again—no, that would make me a coward."
– R1.W1.182–184

"Actually, for me personally, it started from that… we were together… to build a household… which means there was already a commitment there…"
– R2.W1.35–37

"Commitment" was one of the words directly used by participants to refer to the marital bond between the spousal caregiver and his wife. When they understood that their wives had been diagnosed with schizophrenia, commitment became one of the central elements motivating participants to go through the process of accepting and adjusting to the new situation. The narratives indicate that the relationship between husband and wife was a strong bond, which significantly influenced the caregiver's acceptance. In addition to this marital bond, the presence of children was considered important for maintaining the marriage. The broader sense of family connectedness within the marriage was likewise deemed essential.

"She once had to *mondok* (stay at a religious boarding facility), even having to leave our baby. It felt incredibly heavy. But slowly, as time went on, I learned to accept it. I realized that it was part of my life—a test I have to go through."
– R1.W1.176–179

"What matters most is to accept everything first, whatever the condition is. Once we are able to accept it, then we can start thinking about solutions—whether that means seeking treatment or giving the best care possible".

"Because we have known each other for a long time, I really understand her character. So yes, we go through it with acceptance, even if it means arguing first, hehehe." – R3.1.W1.392–393

For two participants, acceptance of their wives' conditions was influenced by their faith and belief in the marital commitment. In contrast, one participant accepted his wife's condition because he had known her for a long time and had built a longstanding relationship with her.

Spiritual Internalization

Here, spiritual internalization refers to participants' process of internalizing Islamic concepts in understanding matters related to marital commitment, accepting their wives' conditions, and navigating life in general. Participant R1 believed he was responsible to God for the promise he had made to accompany his wife after the marriage contract (*akad nikah*). Moreover, R1 perceived his wife's condition as a life test from Allah.

"From the beginning of our marriage, I had promised to accompany my wife, while also bearing responsibility before Allah."

– R1.W1.445–447

"With strong conviction (*haqqul yaqin*), I believe that if Allah gives a test, it means we are capable of going through it."

– R1.W1.187–188

"Within patience, there is always wisdom. Sometimes suffering brings unexpected blessings."

– R4.W1.B.388–390

"I always rely on Allah (*tawakkal*). I try to be patient according to the capacity of my heart, because overthinking can make everything worse."

– R5.1.W2.B.433–435

In addition to perceiving their wives' conditions as predetermined, several participants used Islamic concepts to make sense of life events, particularly those related to their wives' conditions and accompanying circumstances. Concepts such as *tawakkal* and *sabar* reflect the husbands' resilience strategies in facing challenges. *Tawakkal* means surrendering oneself, freeing oneself from all dependencies except Allah, and entrusting all decisions to Him. *Sabar*, according to Islam, refers to remaining on Allah's path, or the righteous path, during difficult conditions. By internalizing these concepts, participants maintained calmness, mental strength, and behavioral consistency in supporting their spouses. Thus, these spiritual strategies were integral to their resilience process.

"Ngemong" the Wife

This theme reflects cultural and gendered perceptions among Javanese men. *Ngemong* is a Javanese term derived from the root word *momong*, which means to care for, nurture, and protect.

"I tend to prefer yielding. If both of us are stubborn, there will be no solution. So I try to be patient and understand the situation. When my wife is sensitive, I try to avoid hurting her feelings. Because she is easily upset, I make small efforts to calm her, like *ngemong* (caring for, understanding, and soothing)."

– R1.W1.501–508

"Actually, we both try, but I do more *ngemong*. If my wife says no, I just follow her. For example, at work, if she says it's not necessary, I stay at home to accompany her. Sometimes I yield, sometimes I

ngemong (care for, understand, and soothe)—that's how it goes."
– R3.1.W1.359–363

Based on additional information from the participants, the perceived meaning of *ngemong* is the desire to care for and understand their wives. Behavioral manifestations of *ngemong* include: assisting their wives in taking medication, accompanying them to regular psychiatric and medical appointments, helping with personal care, protecting their wives' feelings, being cautious to avoid actions that might trigger their wives, and acting as a mediator in social interactions and communication between their wives and others in the surrounding environment.

Social Responses

While caring for and accompanying their wives, spousal caregivers continue to interact with various parties. These social interactions influence their resilience processes, serving as both protective and risk factors. Participants recognized that some individuals provided assistance, but they also experienced social responses that created pressure or stigma for both themselves and their wives.

1. Family Support The division of responsibilities in marriage is typically balanced. However, the wife's condition necessitated a shift in roles, with family members providing assistance to the caregiver. Three participants (R1, R2, R5) reported receiving help with caregiving, childcare, and household tasks. For example, R1 entrusted his children to his wife's family while he was at work or when monitoring his wife's condition, whereas R2 received assistance from his children in managing household chores during episodes of relapse. This family support functioned as a protective factor by reducing the caregiver's physical and emotional burden, thereby strengthening their ability to adapt and maintain well-being.

2. Community Support Participants also benefited from community support, which included information on relapse management, medication adherence, and social networking with other caregivers. These community resources enhanced resilience by providing emotional support, social resources, and increased knowledge that improved coping abilities. Through community involvement, caregivers felt less isolated, which enhanced their sense of control and reduced stress—both of which serve as protective mechanisms in the resilience process.

3. Community Responsiveness The wider community offered assistance during emergencies, such as when the wife experienced agitation or exhibited aggressive behavior. Community responsiveness served as a protective factor by offering safety and practical support to the caregiver. Examples from participants include:

   "In 2017, staff from the village and subdistrict offices came, including the Subdistrict Head and Village Head. Officers from *Gonda* (a local area) also arrived promptly. They brought assistance, and some even provided milk for the baby. Neighbors also helped by watching over and taking care of the baby." – R1.W1.258–264

   "When my wife once ran away, some university students helped escort her back home." – R4.W2.178

This community care reinforced caregivers' sense of safety and reduced psychological burden, functioning as a protective factor that supported the continuation of their caregiving role.

4. Stigma Three participants (R2, R4, R5) reported experiencing stigma directed toward both their wives and themselves as caregivers. Expressions such as "*ngomong-ngomong*" (people talking), "*tekanan*" (pressure), and "*mikirnya*" (mental burden) were used to describe the psychological strain resulting from negative social interactions, which serve as risk factors in the resilience process. Examples include:

   "The most difficult part actually came from the social environment. When people outside started talking, we felt offended. It became a mental burden, even to the point of triggering a relapse." – R5.1.W2.B.347–350

   "People's assumptions vary widely. From there, I learned how to face others' judgments, including the emotional pressure that arises from the surrounding environment." – R2.W1.41–45

   This stigma functions as a risk factor by increasing psychological pressure, triggering feelings of shame, and potentially worsening the wife's condition. Consequently, it hinders the adaptation process and reduces the caregiver's coping effectiveness.

Living Life

Four out of five participants described accompanying their wives through a mindset of acceptance and simplicity, which helped maintain their psychological well-being and functioned as a protective resilience strategy. Participants focused on sustaining daily life and fulfilling other roles, such as working, upholding the marital commitment, and meeting family needs. These roles strengthened their identity, sense of responsibility, and coping capacity. However, when not balanced with adaptive strategies, these same roles could generate psychological strain, making them both protective factors and potential risks within the resilience process.

Examples shared by participants include:
"I just live it, accept everything as it is, go with the flow." – R1.W1.B.470, 477
"Understand the condition, accept it, and carry on sincerely." – R3.W1.B.320
"Just live it; don't overthink it." – R5.W2.B.584–585
"Whatever can be done, just do it." – R5.W2.B.366–367

Additional information from the participants revealed that they understood the importance of functioning effectively in daily life. They expressed a desire to stay healthy because they recognized that if both parents were to fall ill, it would negatively impact the family's well-being. Furthermore, participants viewed work as something that must be carried out in order to meet the family's needs. Beyond fulfilling family-related roles, two participants (R1 and R2) played active roles in their communities.

"I am active at the Community Health Center (*Puskesmas*) as a mental health care, and I am part of the *Jawil Jondhil* Team (referring to a rapid-response volunteer team for emergency calls) as a member of the red team. In emergency situations, I am responsible for assisting, including transporting patients." –

R1.W1.381–384

"Coincidentally, I also serve as the neighborhood head (RT). In that position, people tend to be more respectful, so they are more careful with their words." – R2.W1.806–808

This shows that participants live not only for their families but also to gain personal satisfaction and establish social interactions outside the family environment. This is one of the qualities of resilient individuals who adapt not only to roles within the family but also to active roles as members of society.

Living life is a form of understanding that enables participants to accept their wives' conditions, continue to fulfill their roles, function in life, and actively interact with their social environment. It is also a form of understanding that life is a dynamic process—one that is not constant and that can be worked on. There are always challenges and problems in daily life that can be managed and overcome.

Discussion

Through descriptive thematic analysis, this study identified five themes shaping the resilience process of male spousal caregivers: 1) identification and acceptance of the mental disorder experienced by the wife, 2) spiritual appreciation, 3) caring for the wife, 4) responses from the social environment, and 5) living life. These five themes are interrelated and form the psychological dynamics of resilience: Acceptance of the wife's mental disorder is the basis for spiritual appreciation, which supports the practice of caring as a form of active attention paid to the partner. Interaction with the social environment provides protective support while also presenting the risk of pressure or stigma, which moderates the experience of resilience. Furthermore, focusing on sustaining life and fulfilling various roles helps caregivers strengthen their identity, responsibility, and coping abilities. Thus, the process of resilience is reflected not only in each theme but also through the dynamic relationships between themes that enable spousal caregivers to navigate challenges adaptively.

These findings complement previous literature and present a new perspective on the lives of Javanese male spousal caregivers in Yogyakarta, particularly in relation to how they build and maintain resilience through a combination of acceptance, spiritual appreciation, active attention, social support, and daily life roles. Participants' awareness of their new roles arose when their wives started exhibiting strange behaviors that were characteristic of psychotic episodes. The first psychotic episode of schizophrenia can cause deep distress in partners (Jungbauer et al., 2004). This is consistent with the findings of this study. Participants expressed a range of emotions, such as sadness, confusion, and mixed feelings, as well as behaviors such as crying. Emotional responses can be a reaction to the caregiver's subjective burden, as described by (Jungbauer et al., 2004). This subjective burden can also negatively affect the caregiver's well-being.

When the diagnosis is confirmed, the role of caregiver begins. This role starts with a variety of frightening and challenging questions, such as what are the risks, what treatment costs will the patient incur, and will the disorder become more complex, among others (National Academies of Sciences, Engineering, and Medicine, 2016). This was the case with several participants. Concerns were expressed about the continuity of marriage, parenting, and family, especially by participants who already had

children.

All participants had low to middle SES. Many studies have examined the association between poverty and poor mental health. Kuruvilla and Jacob (2007) explain that poverty and mental disorders are linked in complex ways and that factors contributing to poor mental health include feelings of insecurity, low levels of education, inadequate housing, and malnutrition. Culture, educational level, and mental health literacy are some of the factors that influence decision-making related to help-seeking behavior (Almanasef, 2021).

Help-seeking behavior is an active effort to find resources that can solve problems (Nurdiyanto, 2021). Help-seeking generally refers to the use of support and assistance from: 1) the formal sector, which Barker et al. (2005) classify into several forms of health services or social institutions carried out professionally (psychiatrists, psychologists, counselors, doctors, social workers) and 2) informal support sources (family, friends, parents) and semi-formal sources (school, workplace). Participants sought help from the informal sector before turning to the formal sector. In the context of this study's findings, the informal sector comprises Islamic boarding schools and other alternative therapy centers. Debrah et al. (2018) found that alternative and complementary medicine is ineffective and affects patient compliance with conventional treatment.

Cultural differences also influence variations in help-seeking behavior related to mental health issues (Nurdiyanto, 2021). Differences in health-related beliefs also shape help-seeking behavior in addressing psychological problems (Gilchrist & Sullivan, 2006). Javanese people generally use traditional, religious, or alternative approaches and therapies to resolve psychological crises (Subandi, 2008). This is consistent with the findings of this study, in which all participants were Javanese individuals.

According to Levine and Barry (2003), caregivers carry out several tasks: 1) accompanying and caring for someone with a chronic or acute illness, 2) managing medication or talking to doctors and other medical personnel on behalf of family members who are ill, 3) assisting with the daily functioning of the care recipient, and 4) managing household tasks, meals, and living expenses for someone who cannot do so independently. This is consistent with the themes that emerged in this study. Participants understood that their task was to help their wives function and to accompany them to treatment. In addition, participants manage household tasks and childcare, usually with support from the wife's family of origin. Verbakel et al. (2016) state that instrumental support (assistance with the care process), emotional support (understanding and a sense of security), and financial support (care funds) can ease the caregiver's tasks. This also emerged in the participants' experiences. The tasks most frequently distributed between spousal caregivers and families were parenting tasks and the division of ODS care time. Families helped take care of the participants' wives and children when the participants had to work.

The most common trait among male caregivers is bringing and practicing a unique set of masculine behaviors in the care they provide (Mott et al., 2019). Swinkels et al. (2018) found that male caregivers tend to use a task-oriented approach in caregiving situations. These tasks can demonstrate their learned technical skills and their ability to control certain situations (Anjos et al., 2012). This

is consistent with previous research findings that participants exhibited behaviors to control certain situations, particularly in the context of relapse management and protecting their wives from public stigma. Robinson et al. (2014) state that men tend to view the role of caregiver as being that of a protector and provider.

Among participants, a theme that emerged was *ngemong*, a Javanese word meaning to protect and care for. According to Subandi (2008), *ngemong* refers to a family's attitude of resignation and acceptance of the reality of having a family member with a mental disorder, but not passive acceptance. Instead, they accept reality while continuing to try. The basic principle of *ngemong* is to understand a person's behavior and attitude and to position that person as a child. Subandi (2008) adds that the three main characteristics of *ngemong* are: 1) showing a tolerant attitude and not criticizing, 2) not being demanding, and 3) fulfilling the needs of the care recipient. This aligns with the research results. However, based on the participants' perceptions, *ngemong* is an attitude whose behavioral manifestations include identifying symptoms of relapse, helping the wife function in daily life, assisting with the wife's treatment, and protecting the wife from public prejudice and stigma.

The participants' definition of *ngemong* aligns with the findings of the descriptive phenomenological study by Mizuno et al. (2011) on male spousal caregivers in a caregiver community in Japan. According to Mizuno et al. (2011), the roles of male spousal caregivers include supporting their wives' care needs, assisting with daily functioning, helping wives maintain recovery and stability, facilitating mother–child relationships within the family, and protecting wives from social prejudice. In addition to working, male spousal caregivers must manage their time, energy, and mental resources to carry out household tasks, care for their children, and visit their wives during periods of institutionalization—responsibilities that affect their work performance and contribute to caregiver fatigue.

Male spousal caregivers who learn to recognize their wives' symptoms demonstrate considerate behaviors, such as refraining from pressuring their wives to perform household tasks, especially during periods of positive or negative symptoms of schizophrenia. They also seek alternative solutions to manage these conditions. According to Minarni and Sudagijono (2015), relapse management by family members as informal caregivers involves supporting medication adherence by preparing the medication daily, providing explanations and encouragement to motivate the patient to take the medication, and showing compassion toward individuals with schizophrenia. These descriptions are consistent with the findings of this study. Moreover, informal caregivers are typically the first responders when a relapse occurs.

All participants gradually developed an understanding of their situation concerning their wives' mental health conditions. They accepted these circumstances out of commitment to their wives and to the marital bond they shared. The marital relationship—rather than gender-based expectations—was found to be a more influential motivator for men to undertake caregiving and supportive roles for their wives (Comas-d'Argemir & Soronellas, 2018). An interesting aspect of male spousal caregivers is their persistent sense of responsibility toward caring for their wives, which, in several cases, surpassed their sense of responsibility for caring for their children.

The *akad nikah* (marriage contract) is found to imply a moral obligation to care for one's wife, even in challenging situations such as when she experiences a mental disorder (Comas-d'Argemir & Soronellas, 2018). This aligns with the findings of this study. The commitment described by participants refers to a promise to support their wives, not abandon them, and to a willingness to accompany and care for them. This commitment extends beyond the marital relationship between the spousal caregiver and the wife to encompass familial or kinship values (Swinkels et al., 2018).

The participants' sense of commitment can be interpreted through Sternberg's theory of love. Sternberg (1986) explains that the type of love formed by the union of commitment and intimacy is called companionate love. This form of love emerges when physical attraction between partners gradually diminishes and transforms into a long-term committed relationship. Commitment or sense of responsibility refers to the decision to care for someone and maintain the relationship over time, while intimacy refers to feelings of closeness, connectedness, and attachment within the loving relationship.

Kate et al. (2013) found that the caregiver role, often associated with negative consequences, is also accompanied by positive experiences, including companionship, finding or creating meaning in life through caregiving, and increased life satisfaction derived from living a meaningful, purposeful life as a caregiver. This is consistent with the findings of this study. Male spousal caregivers reported feelings of attachment, affection, and positive emotions toward their wives. They perceived their wives' presence and the process of accompanying them as sources of happiness and meaning.

Sternberg (1986) also notes that commitment tends to be higher among couples with children. This aligns with the findings of this study, in which some participants refrained from leaving their wives because they had children together. Salehi-tali et al. (2017) found that a sense of responsibility toward the patient reinforces husbands' caregiving behaviors toward their wives. Marital commitment and a sense of responsibility provide comfort to male spousal caregivers. They feel that they play a significant role for their wives, which enhances acceptance and positive perceptions of both their wives and their caregiving roles. Furthermore, Lambert and Dollahite (2007) explain, from a Jungian perspective, that marital commitment is often influenced by conscious factors, religious fears, and reverence for God at the unconscious level.

Herrera et al. (2009) explain that intrinsic religiosity refers to individuals who integrate God into their lives and maintain beliefs that can shape their perceptions of burdens. This resonates with the beliefs of several participants in this study. Most participants believed that God had predetermined the circumstances of their wives' conditions. Participants also employed the concept of *tawakal*, which means surrendering to divine will regarding conditions beyond human control, such as the mental disorder that their wives experienced.

Caring for family members with schizophrenia often leads to feelings of alienation from society, and isolated individuals frequently perceive a lack of access to necessary support and services. Community or support groups are considered effective in reducing loneliness and empowering caregivers to share stories, experiences, and information (Mizuno et al., 2011). Community support programs have also been shown to help spousal caregivers develop independent strategies for managing distress, with positive outcomes for caregiver well-being (Windle et al., 2012). These elements were

reflected in the findings of the present study.

In the caregiving resilience model, Windle et al. (2012) identify resources as a key indicator of an individual's capacity to develop resilience. This aligns with the findings of the present study. Spiritual engagement and the principle of *ngemong* function as individual psychological resources. Community resources include social support, active community participation, and public concern during incidents resulting from the manifestation of positive and negative symptoms of the wife's schizophrenia. According to the framework proposed by Garcia-Dia et al. (2013), support from family, community, and society constitutes protective factors. However, Windle et al. (2012) conceptual framework does not adequately capture the importance of family support. This study found that participants regarded family support as a significant source of help in distributing caregiving tasks.

Participants perceived less favorable responses from their social environment, including stigma and insufficient social support from their families. Goffman (1963) explains that stigma toward individuals with mental disorders has two main components: public stigma (the general reaction of society toward individuals with mental illness) and individual stigma (one's own prejudice toward the disorder, often internalized). In this study, the stigma was primarily public, reflecting general societal reactions. Within Windle's framework, this represents the absence of resources at the community and societal level. In Garcia-Dia's conceptual framework, stigma and inadequate social support are considered risk factors that impede the process of achieving resilience.

Social support plays an important role in the positive aspects of caregiving (Kate et al., 2013). Many men derive support for resilience from religion and family (Chung et al., 2014). Moreover, Donnellan et al. (2014) assert that high-quality social support is a key source of resilience. Social support functions as a protective factor by fostering a sense of being understood, reducing isolation, and strengthening positive coping. Therefore, it is concerning that participants perceived themselves as lacking adequate social support. Insufficient social support constitutes a risk factor that hinders resilience by leading caregivers to internalize caregiving burdens, feel neglected, and feel misunderstood. This situation is exacerbated by the gender stereotype that men must be strong, making them reluctant to seek help (Lopez-Anuarbe & Kohli, 2019). The psychological impact includes increased internal pressure and reduced adaptive capacity, which can adversely affect well-being and caregiving effectiveness.

Resilience among caregivers can be understood as a process of adapting, negotiating, and managing stressors and trauma (Windle et al., 2012). Individual assets and resources facilitate coping with difficulties and "bouncing back" from challenges (Windle, 2011).

In the context of this study, resilience represents the researchers' interpretation of the lived experiences of husbands caring for wives with schizophrenia. Participants described how they manage daily tasks, confront unexpected situations arising from their wives' schizophrenia symptoms, and adapt spiritual values to navigate life. Spiritual values, such as the Islamic concepts of *tawakal* (trust in God's plan), *sabar* (patience), and *yakin* (certainty in divine destiny), function as internal resources that facilitate adaptive capacity. Thus, the meaning of resilience for husbands in this study is reflected in coping strategies, spiritual interpretations, and the ability to continue fulfilling life roles despite significant stress and challenges.

Rathier et al. (2015) explain that the strength of religious belief is an important predictor of well-being. The findings of this study support this observation, showing that faith-based coping contributes to how caregivers manage stress while caring for a spouse with schizophrenia.

According to Erikson, middle adulthood involves the stage of "generativity versus stagnation" (Santrock, 2013). Generativity refers to giving back to the world and, in various ways, guiding or leaving a legacy for future generations. For many individuals, generativity involves raising children and passing on values to the next generation. However, Erikson as cited in Santrock (2013) notes that this stage is not limited to child-rearing; generativity can also involve contributing to future generations as a teacher, mentor, or leader.

Erikson further explains that generativity can occur through creativity or productivity, potentially leaving artistic, literary, or even business legacies. This aligns with the findings of this study. Two participants not only performed family and occupational roles but also contributed to the community as mental health cadres and neighborhood leaders (*Ketua RT*). In addition, these two participants prioritized the health and safety of their wives, as evidenced by infrequent relapses (only two institutionalizations) over a period exceeding five years.

All study participants engaged in psychosocial developmental tasks: managing daily responsibilities, maintaining their marriages, caring for children, performing domestic tasks while their wives were hospitalized, and fulfilling the role of spousal caregiver. Nevertheless, the quality of caregiving varied among participants and reflected unique individual experiences.

The primary factor in resilience outcomes is not super-functioning or thriving; rather, it is the maintenance of normal development or functioning (e.g., mental or physical health) or the development of functioning "better than expected," given exposure to the stressor in question (Windle et al., 2012). This aligns with the findings of the present study. Participants perceived a theme of living life, in which life was seen not as a fixed or static state but instead as flexible, acceptable, and manageable. Participants maintained development and normal functioning, such as sustaining their marriages, performing parenting duties, working to meet family needs, and actively participating in social life within their communities and society at large.

The study did not fully explore the aspect of parenting by spousal caregivers, as the focus was on the caregiving relationship with their wives. Nevertheless, the dynamics between spousal caregivers and children warrant further investigation. All participants expressed concerns about the hereditary nature of schizophrenia and experienced uncertainty in conveying information about their wives' conditions. Sometimes, this resulted in incomplete disclosure to their children. Future research should examine the importance of mental health literacy and information sharing within families, particularly for children whose parents have been diagnosed with schizophrenia.

This study examined the meaning of resilience among spousal caregivers. However, some studies have found that unhealthy spousal behaviors and dysfunctional marital dynamics can act as triggers or barriers to recovery for individuals with schizophrenia. In some cases, this may involve violence or neglect directed at either the individual with schizophrenia or the caregiving partner during episodes of symptomatic relapse (Howard et al., 2018; Putra et al., 2020; Seeman, 2013; Thara et al., 2003). Among

the participants, R3 reported a history of violence in both dating and marital relationships. Therefore, the spousal caregiver relationship with the individual with schizophrenia warrants further in-depth study, given the complexity of these relationships and the importance of healthy relational dynamics for the recovery process.

Limitations

All participants in this study were members of communities for caregivers of individuals with severe mental illness (ODGJ) in Yogyakarta. Therefore, the findings may not represent the experiences of spousal caregivers who are not affiliated with such communities. Furthermore, all participants were Muslim and of Javanese ethnicity, resulting in a highly homogeneous sample. Consequently, the findings cannot be generalized to caregivers in broader or more diverse populations.

Conclusion

Based on the findings and discussion, resilience among male spousal caregivers whose wives are diagnosed with schizophrenia can be understood through the caregivers' attitudes and behaviors in daily life, including recognizing and accepting their wives' mental disorder, internalizing spiritual values, providing *ngemong* care, and managing social environmental responses. This resilience is reflected in the caregiver's ability to maintain continuity of life, perform daily functions, and carry out social roles while fulfilling his responsibilities as a spousal caregiver. Therefore, resilience represents the researcher's interpretation of caregiver adaptation strategies and coping processes, rather than a subjective view directly elicited from participants.

The process of developing resilience among male spousal caregivers can be observed in their attitudes and behaviors, beginning with identifying and accepting the wife's mental disorder, internalizing spiritual values, practicing *ngemong* as a form of affection and support, managing social responses, and navigating daily life. A distinctive feature of this study is the practice of *ngemong* as a guiding principle to demonstrate attention and care toward the wife, as well as the empowering role of community support in developing adaptation strategies and coping mechanisms, thereby strengthening the resilience process.

Implications

The findings highlight the importance of recognizing the experiences, challenges, and needs of male spousal caregivers in caring for a partner with schizophrenia. For healthcare professionals and clinicians, understanding cultural values, the practice of *ngemong*, and the social and spiritual needs of caregivers can serve as a foundation for developing more relevant and effective psychoeducation programs and supportive services. At the community level, this study underscores the critical role of communities as resources that provide social support, information, and networks among caregivers, thereby empowering them to develop coping strategies, enhance their psychological well-being, and strengthen resilience. Additionally, these findings offer insights for the development of inclusive social

policies and services-including access to mental health services, information, and adequate community support-for families whose members are experiencing psychiatric disorders.

Recommendations

Future research may consider a mixed-methods approach to collect both quantitative and qualitative data simultaneously, for example, through scales or questionnaires to identify resilience assets and resources. Furthermore, subsequent studies are encouraged to explore the experiences of spousal caregivers in child-rearing and to map the needs of vulnerable families, such as those with members who have psychiatric disorders, to develop more comprehensive and contextually relevant intervention strategies.

Declaration

Acknowledgments

The authors would like to express their sincere gratitude to everyone who contributed to this research. In particular, the authors extend their deepest appreciation to the participants, who generously shared their personal experiences. Their openness and trust were invaluable in shaping this study and advancing understanding in this field.

Funding

This research received no financial support from any funding agency, institution, or organization.

Authors' Contributions

IY conceived and designed the study, conducted the research, analyzed the data, and drafted the manuscript. TA provided guidance on research formulation, methodology, and analysis, and reviewed and revised the manuscript. Both authors read and approved the final version of the manuscript.

Conflict of Interest

The authors declare no financial or professional conflicts of interest related to this research. However, a small number of interview participants were personal acquaintances of AH. To mitigate potential bias, standardized interview protocols and independent data analysis procedures were applied.

Declaration of Generative AI in Scientific Writing

In the preparation of this manuscript, artificial intelligence (AI) was used in a limited capacity to improve sentence structure, paraphrase certain sections of text, and assist in generating ideas for opening sentences. All content, analysis, interpretations, and conclusions are the sole work of the researcher. AI was not used to generate data, analyze research findings, or draw scientific conclusions.

Orcid ID

Tina Afiatin https://orcid.org/0000-0002-7684-3042

References

Almanasef, M. (2021). Mental health literacy and help-seeking behaviours among undergraduate pharmacy students in Abha, Saudi Arabia. *Risk Management and Healthcare Policy*, *14*, 1281–1286. https://doi.org/10.2147/rmhp.s289211

American Psychiatric Association. (2022). What is schizophrenia? [Retrieved August 12, 2022, from psychiatry.org]. https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia

Anjos, A. P., Ward-Griffin, C., & Leipert, B. (2012). Discourse / discours - understanding gendered expectations and exemptions experienced by male double-duty caregivers: a qualitative secondary analysis. *Canadian Journal of Nursing Research Archive*, *44*(3), 104–123. https://cjnr.archive.mcgill.ca/article/view/2365

Barker, S. B., Knisely, J. S., McCain, N. L., & Best, A. M. (2005). Measuring stress and immune response in healthcare professionals following interaction with a therapy dog: A pilot study. *Psychological Reports*, *96*(3), 713–729. https://doi.org/10.2466/pr0.96.3.713-729

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Blaikie, N. (2007). *Approaches to social enquiry*. Polity Press.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, *59*(1), 20–28. https://doi.org/10.1037/0003-066X.59.1.20

Boritz, T. Z., Sheikhan, N. Y., Hawke, L. D., McMain, S. F., & Henderson, J. (2021). Evaluating the effectiveness of the Family Connections program for caregivers of youth with mental health challenges, part I: A quantitative analysis. *Health Expectations*, *24*(2), 578–588. https://doi.org/10.1111/hex.13205

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Caqueo-Urízar, A., Gutiérrez-Maldonado, J., & Miranda-Castillo, C. (2009). Quality of life in caregivers of patients with schizophrenia: A literature review. *Health and Quality of Life Outcomes*, *7*(1). https://doi.org/10.1186/1477-7525-7-84

Chung, B., Meldrum, M., Jones, F., Brown, A., & Jones, L. (2014). Perceived sources of stress and resilience in men in an African American community. *Progress in Community Health Partnerships: Research, Education, and Action*, *8*(3), 312–322.

Colorafi, K. J., & Evans, B. (2016). Qualitative descriptive methods in health science research. *HERD: Health Environments Research & Design Journal*, *9*(4), 16–25. https://doi.org/10.1177/1937586715614171

Comas-d'Argemir, D., & Soronellas, M. (2018). Men as carers in long-term caring: Doing gender and doing kinship. *Journal of Family Issues*, *40*(3), 315–339. https://doi.org/10.1177/0192513x18813185

Creswell, J. W., & Poth, C. N. (2023). *Qualitative inquiry and research design: Choosing among five approaches* (5th ed.). SAGE Publications.

Debrah, A. B., Buabeng, K. O., Donnir, G., & Akwo Kretchy, I. (2018). A caregiver perspective of complementary and alternative medicine use among patients with schizophrenia and bipolar disorders. *International Journal of Mental Health*, *47*(4), 298–310. https://doi.org/10.1080/00207411.2018.1546097

Donnellan, W. J., Bennett, K. M., & Soulsby, L. K. (2014). What are the factors that facilitate or hinder resilience in older spousal dementia carers? A qualitative study. *Aging & Mental Health*, *19*(10), 932–939. https://doi.org/10.1080/13607863.2014.977771

Doyle, S. (2007). Member checking with older women: A framework for negotiating meaning. *Health Care for Women International*, *28*(10), 888–908. https://doi.org/10.1080/07399330701615325

Driscoll, D. L. (2011). *Introduction to primary research: Observations, surveys, and interviews*. Library of Congress Cataloging-in-Publication Data.

Fan, Y., Fan, A., Yang, Z., & Fan, D. (2025). Global burden of mental disorders in 204 countries and territories, 1990–2021: results from the global burden of disease study 2021. *BMC Psychiatry*, *25*(1). https://doi.org/10.1186/s12888-025-06932-y

Fernandes, J. B., Fernandes, S. B., Almeida, A. S. G., & Cunningham, R. C. (2021). Barriers to family resilience in caregivers of people who have schizophrenia. *Journal of Nursing Scholarship*, *53*(4), 393–399. https://doi.org/10.1111/jnu.12651

Fidyalmi, T. D. (2020). *Spousal acceptance as primary caregiver of a person with schizophrenia* [Undergraduate thesis]. Faculty of Psychology, Universitas Gadjah Mada.

Garcia-Dia, M. J., DiNapoli, J. M., Garcia-Ona, L., Jakubowski, R., & O'Flaherty, D. (2013). Concept analysis: Resilience. *Archives of Psychiatric Nursing*, *27*(6), 264–270. https://doi.org/10.1016/j.apnu.2013.07.003

Gilchrist, H., & Sullivan, G. (2006). The role of gender and sexual relations for young people in identity construction and youth suicide. *Culture, Health & Sexuality*, *8*(3), 195–209. https://doi.org/10.1080/13691050600699831

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Simon; Schuster.

Gupta, S., Isherwood, G., Jones, K., & Van Impe, K. (2015). Assessing health status in informal schizophrenia caregivers compared with health status in non-caregivers and caregivers of other conditions. *BMC Psychiatry*, *15*(1). https://doi.org/10.1186/s12888-015-0547-1

Herrera, A. P., Lee, J. W., Nanyonjo, R. D., Laufman, L. E., & Torres-Vigil, I. (2009). Religious coping and caregiver well-being in Mexican-American families. *Aging & Mental Health*, *13*(1), 84–91. https://doi.org/10.1080/13607860802154507

Howard, R., Cort, E., Bradley, R., Harper, E., Kelly, L., Bentham, P., Ritchie, C., Reeves, S., Fawzi, W., Livingston, G., Sommerlad, A., Oomman, S., Nazir, E., Nilforooshan, R., Barber, R., Fox, C., Macharouthu, A. V., Ramachandra, P., Pattan, V., . . . Gray, R. (2018). Antipsychotic treatment of very late-onset schizophrenia-like psychosis (ATLAS): a randomised, controlled, double-blind trial. *The Lancet Psychiatry*, *5*(7), 553–563. https://doi.org/10.1016/s2215-0366(18)30141-x

Jungbauer, J., Wittmund, B., Dietrich, S., & Angermeyer, M. C. (2004). The disregarded caregivers: Subjective burden in spouses of schizophrenia patients. *Schizophrenia Bulletin*, *30*(3), 665–675. https://doi.org/10.1093/oxfordjournals.schbul.a007114

Kate, N., Grover, S., Kulhara, P., & Nehra, R. (2013). Relationship of caregiver burden with coping strategies, social support, psychological morbidity, and quality of life in the caregivers of schizophrenia. *Asian Journal of Psychiatry*, *6*(5), 380–388. https://doi.org/10.1016/j.ajp.2013.03.014

Kocabaş, D., Karaçar, Y., & Barçın, N. E. (2025). The effect of psychological resilience and self-efficacy on caregiver burden: A cross-sectional study among caregivers of people with Alzheimer's disease. *Nursing Open*, *12*(8), e70288. https://doi.org/10.1002/nop2.70288

Kuruvilla, A., & Jacob, K. (2007). Poverty, social stress & mental health. *Indian Journal of Medical Research*, *126*(4), 273–278. https://ijmr.org.in/poverty-social-stress-mental-health/

Lambert, N. M., & Dollahite, D. C. (2007). The threefold cord: Marital commitment in religious couples. *Journal of Family Issues*, *29*(5), 592–614. https://doi.org/10.1177/0192513x07308395

Levine, S. A., & Barry, P. P. (2003). *Home care. In Geriatric medicine (pp. 121-131)*. Springer.

Lopez-Anuarbe, M., & Kohli, P. (2019). Understanding male caregivers' emotional, financial, and physical burden in the United States. *Healthcare*, *7*(2), 72. https://doi.org/10.3390/healthcare7020072

Martyr, A., Rusted, J. M., Quinn, C., Gamble, L. D., Collins, R., Morris, R. G., & Clare, L. (2023). Resilience in caregivers of people with mild-to-moderate dementia: Findings from the IDEAL cohort. *BMC Geriatrics*, *23*(1), 512. https://doi.org/10.1186/s12877-023-04549-y

Minarni, L., & Sudagijono, J. S. (2015). Dukungan keluarga terhadap perilaku minum obat pada pasien skizofrenia yang sedang rawat jalan [Family support for medication taking behavior in outpatient schizophrenia patients]. *EXPERIENTIA : Jurnal Psikologi Indonesia*, *3*(2), 13–22. https://journal.ukwms.ac.id/index.php/EXPERIENTIA/article/view/904

Mizuno, E., Iwasaki, M., & Sakai, I. (2011). Subjective experiences of husbands of spouses with schizophrenia: An analysis of the husbands' descriptions of their experiences. *Archives of Psychiatric Nursing*, *25*(5), 366–375. https://doi.org/10.1016/j.apnu.2011.03.001

Moloeng, L. J. (2014). *Metodologi penelitian kualitatif*. PT Remaja Rosdakarya.

Mott, J., Schmidt, B., & MacWilliams, B. (2019). Male caregivers: Shifting roles among family caregivers. *Clinical Journal of Oncology Nursing*, *23*(1), E17–E24. https://doi.org/10.1188/19.CJON.E17-E24

National Academies of Sciences, Engineering, and Medicine. (2016, November). *Families caring for an aging America* (R. Schulz & J. Eden, Eds.). National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK396409/

Nurdiyanto, F. A. (2021). I'm not alone: A phenomenological study of psychological help sources in suicide crisis. *Gadjah Mada Journal of Psychology (GamaJoP)*, *7*(2), 245–259. https://doi.org/10.22146/gamajop.67687

Palacio G, C., Krikorian, A., Gómez-Romero, M. J., & Limonero, J. T. (2020). Resilience in caregivers: A systematic review. *American Journal of Hospice and Palliative Medicine*, *37*(8), 648–658. https://doi.org/10.1177/1049909119893977

Putra, A. Y. M., Sari, Y. P., & Demur, D. R. D. N. (2020). Kualitas hidup caregiver skizofrenia: A cross sectional study. *Jurnal Kesehatan Perintis*, *7*(1), 91–97. https://doi.org/10.33653/jkp.v7i1.423

Rathier, L. A., Davis, J. D., Papandonatos, G. D., Grover, C., & Tremont, G. (2015). Religious coping in caregivers of family members with dementia. *Journal of Applied Gerontology*, *34*(8), 977–1000. https://doi.org/10.1177/0733464813510602

Robertson, I., & Cooper, C. L. (2013). Resilience. *Stress and Health*, *29*(3), 175–176. https://doi.org/10.1002/smi.2512

Robinson, C. A., Bottorff, J. L., Pesut, B., Oliffe, J. L., & Tomlinson, J. (2014). The male face of caregiving: A scoping review of men caring for a person with dementia. *American Journal of Men's Health*, *8*(5), 409–426. https://doi.org/10.1177/1557988313519671

Rutten, B. P. F., Hammels, C., Geschwind, N., Menne-Lothmann, C., Pishva, E., Schruers, K., van den Hove, D., Kenis, G., van Os, J., & Wichers, M. (2013). Resilience in mental health: linking psychological and neurobiological perspectives. *Acta Psychiatrica Scandinavica*, *128*(1), 3–20. https://doi.org/10.1111/acps.12095

Sahu, S., Mujawar, S., Garg, D., Chaudhury, S., & Saldanha, D. (2020). Quality of life and marital adjustment in spouses of schizophrenia patients. *Industrial Psychiatry Journal*, *29*(2), 323–328. https://doi.org/10.4103/ipj.ipj_176_20

Salehi-tali, S., Ahmadi, F., Zarea, K., & Fereidooni-Moghadam, M. (2017). Commitment to care: the most important coping strategies among family caregivers of patients undergoing haemodialysis. *Scandinavian Journal of Caring Sciences*, *32*(1), 82–91. https://doi.org/10.1111/scs.12432

Santrock, J. W. (2013). *A topical approach to life-span development*. McGraw-Hill Companies.

Schoon, I. (2006). *Risk and resilience: Adaptations in changing times*. Cambridge University Press. https://doi.org/10.1017/CBO9780511490132

Seeman, M. V. (2013). Bad, burdened or ill? Characterizing the spouses of women with schizophrenia. *International Journal of Social Psychiatry*, *59*(8), 805–810. https://doi.org/10.1177/0020764012456818

Stanley, S., & Balakrishnan, S. (2023). Informal caregivers of people with a diagnosis of schizophrenia: Determinants and predictors of resilience. *Journal of Mental Health*, *32*(1), 198–205. https://doi.org/10.1080/09638237.2021.1952945

Sternberg, R. J. (1986). A triangular theory of love. *Psychological Review*, *93*(2), 119–135. https://doi.org/10.1037/0033-295x.93.2.119

Subandi. (2008). Ngemong: Dimensi keluarga pasien psikotik di Jawa [Ngemong: Family dimensions of psychotic patients in Java]. *Jurnal Psikologi Universitas Gadjah Mada*, 62–79. https://jurnal.ugm.ac.id/jpsi/article/view/7099

Sugiyono. (2012). *Metode penelitian kuantitatif, kualitatif, dan R&D*. Alfabeta.

Sun, H., Zheng, Z., Hengudomsub, P., & Wacharasin, C. (2025). Resilience among wife and husband caregivers of patients with newly diagnosed advanced cancer: A cross-sectional study. *Health Science Reports*, *8*(11), e71431. https://doi.org/10.1002/hsr2.71431

Swinkels, J. C., Broese van Groenou, M. I., de Boer, A., & Tilburg, T. G. v. (2018). Male and female partner-caregivers' burden: Does it get worse over time? *The Gerontologist*, *59*(6), 1103–1111. https://doi.org/10.1093/geront/gny132

Thara, R., Kamath, S., & Kumar, S. (2003). Women with schizophrenia and broken marriages - Doubly disadvantaged? Part I: Patient perspective. *International Journal of Social Psychiatry*, *49*(3), 225–232. https://doi.org/10.1177/00207640030493008

Vaismoradi, M., Jones, J., Turunen, H., & Snelgrove, S. (2016). Theme development in qualitative content analysis and thematic analysis. *Journal of Nursing Education and Practice*, *6*(5), 100–110. https://doi.org/10.5430/jnep.v6n5p100

Verbakel, E., Metzelthin, S. F., & Kempen, G. I. J. M. (2016). Caregiving to older adults: Determinants of informal caregivers' subjective well-being and formal and informal support as alleviating conditions. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *73*(6), 1099–1111. https://doi.org/10.1093/geronb/gbw047

Willig, C. (2021). *Introducing qualitative research in Psychology (4th ed.)* Open University Press.

Windle, G. (2011). What is resilience? A review and concept analysis. *Reviews in Clinical Gerontology*, *21*(2), 152–169. https://doi.org/10.1017/S0959259810000420

Windle, G., Bennett, K. M., & Ungar, M. (2012). Caring relationships: How to promote resilience in challenging times. In M. Ungar (Ed.), *The social ecology of resilience: A handbook of theory and practice* (pp. 219–232). Springer.

Wingham, J., Frost, J., Britten, N., Jolly, K., Greaves, C., Abraham, C., Dalal, H., & research investigators, R.-H. (2015). Needs of caregivers in heart failure management: A qualitative study. *Chronic Illness*, *11*(4), 304–319. https://doi.org/10.1177/1742395315574765

World Health Organization. (2022). Schizophrenia [Retrieved January 10, 2022]. https://www.who.int/news-room/fact-sheets/detail/schizophrenia

Zauszniewski, J. A., Bekhet, A. K., & Suresky, M. J. (2009). Effects on resilience of women family caregivers of adults with serious mental illness: The role of positive cognitions. *Archives of Psychiatric Nursing*, *23*(6), 412–422. https://doi.org/10.1016/j.apnu.2008.12.004