





Review Article

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Supportive interventions for family caregivers of adults with mental illness: An integrative review

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ABSTRACT

Background: People of all ages, genders, social classes, income levels, and geographical regions can be affected by mental illness. Families of individuals diagnosed with mental illnesses face significant burdens, particularly due to their role as family caregivers.

Aim: This integrative review aims to characterize the interventions that support family caregivers to reduce their burden of caregiving.

Methodology: Whittemore and Knaff's methodology guided this integrative literature review. CINAHL, MEDLINE, and PsycINFO were searched for articles published between 2014 and 2023. Eighteen articles were identified as eligible studies to identify supportive interventions. These articles were then critically appraised and relevant data analyzed and synthesized to formulate the results.

Findings: The included studies reported interventions focused on family caregivers of relatives with mental illnesses. The two main themes of these studies are (a) interventions to offset the burden of caregiving and (b) outcomes related to these interventions. These interventions include psychoeducation, adaptive cognitive-behavioral strategies, peer support, and religious support.

Conclusion: Caring for a mentally ill family member is an extremely stressful situation for family caregivers. Supportive interventions found in this integrative review could help these family caregivers overcome their burdens.

Keywords: Family caregivers, mental illness, burden of care, supportive interventions

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1. INTRODUCTION

Mental illness is a global issue consisting of a wide range of conditions that affect a person's mood, behavior, and ability to think [1]. Globally, over one billion people suffer from mental illnesses, and over 75% in low-income countries fail to receive treatment [2]. In 2020, approximately 1,312 individuals were admitted for psychiatric hospital treatment in Qatar (M. Chaabane, Hamad Medical Corporation, Doha, Qatar, personal oral communication, December 1, 2021). People of all ages, genders, social classes, income levels, and geographical areas can be affected by mental illnesses [2]. Mental illnesses are often accompanied by difficulty functioning in social, professional, and family settings [3]. Furthermore, a mental illness can cause long-term emotional distress for the affected person and their family members [4].

Families of individuals diagnosed with mental illnesses face significant challenges and stress [5,6], primarily due to their role as family caregivers [7]. The care provided by family caregivers includes assistance with daily activities, identifying early signs of relapse, taking family members to appointments, and providing treatment and emotional support at home [5]. Family caregivers face different burdens such as financial strain, social discrimination, social stigma, and physical and emotional stress [8]. Continuous stress on caregivers can affect their physical and mental well-being [9,10] as well as their social life and other responsibilities [7]. These caregivers put the needs of the person they are caring for above their own and therefore lose touch with themselves [11]. A caregiver could be a child or adolescent whose parents suffer from a serious mental illness that may have an impact on the child's health, development, school attendance, and their social life [12].

Caregivers of a mentally ill family member are at risk of emotional and physical abuse [7,13]. According to Kızılırmak and Küçük [14], 67.42% of family caregivers are at risk of abuse. Furthermore, 47.3% of family caregivers are at a high risk of developing a mental illness such as depression or anxiety [14]. There is a strong association between caregiver burden and the development of psychotic symptoms [15]. Moreover, the burden of caring a relative with mental illness affects the entire family unit, not just the primary caregiver [16]. The stigma that society inflicts on people with mental illness often affects the family [17]. These caregivers suffer in silence due to stigma and lack of supportive interventions [18].

Despite the stigma and challenges of caregiving, family members have emerged as one of the most valuable sources of support for their loved ones [19]. These caregivers are normally untrained, inexperienced, and lack the training needed to maintain their own well-being under stressful conditions [20,21]. Therefore, family caregivers should be provided with supportive interventions when caring for family members with mental illnesses [22]. This integrative review aims to identify interventions that can support family caregivers and reduce their burden. The results of the integrative review are expected to assist in the development of supportive interventions for family caregivers of relatives with mental illness in Qatar.

1.1. Mental illness in Qatar

Due to the increase in mental illnesses in developing countries such as Qatar, attention to mental illnesses and related services

are expanding [23]. The study by Bener et al. [24] was conducted in Qatar to assess the prevalence and burden of common mental illnesses in primary healthcare centers, which showed that major depression disorders accounted for 18.31% of mental illnesses, followed by anxiety disorders (17.3%), mood disorders (16.95%), and personality disorders (14.1%) [24]. Nearly one-quarter of all Qatari adults who accessed primary healthcare suffered from some form of mental illness. In 2015, it was found that 37.8% of the Qatari population between 35 and 49 years of age had mental illnesses [24].

In 1971, the first specialized mental health clinics to treat mental illnesses were opened in Qatar [23]. Over the past 40 years, a wide range of services have been created, including inpatient, outpatient, community, and specialized mental health services in Qatar [23]. In 2013, the first Qatar National Mental Health Strategy (QNMHS) was launched, establishing the vision for a mental health system in the country [25]. The QNMHS was updated between 2019 and 2022 to further transform the mental health system in Qatar [25]. In recent years, the quality of healthcare in Qatar has improved dramatically, as outlined in Qatar's National Health Strategy 2018–2022 [26]. The primary vision of Qatar 2030 is to improve the health of Qatar's population by developing a world-class healthcare system that meets the needs of the present and future generations [25]. The national health strategy focuses on ensuring good mental health and well-being of the people of Qatar. Moreover, it focuses on providing integrated mental health services that include access to the right care at the right time and in the right place [25]. In addition to the promotion and prevention of the mental health, the strategy has five objectives: comprehensive and integrated mental health services, strengthening leadership and governance, and improving information systems, research, and evidence-based practice [26]. As the State of Qatar has experienced rapid growth and development over the past several decades, the country has been redefining its strategies and policies to build a world-class healthcare system [27]. Mental health is emerging as a priority area for improvement [27]. Furthermore, bed capacity across the psychiatry department has been increased from 69 to 123 (M. Chaabane, Hamad Medical Corporation, Doha, Qatar, personal oral communication, December 1, 2021).

1.2. Culture and mental illnesses

Individual perceptions about mental illness vary depending on culture and religion [28]. A culture's beliefs and values can affect mental illness in several ways, for example by causing symptoms and by changing beliefs and explanations of illnesses [28]. For example, in Qatar, 50.2% of university students believe that people with mental illness are mentally retarded, and that mental illness is a punishment from God [29]. This shows that cultural beliefs and values play a crucial role in determining individual perceptions about mental illness [28]. Due to cultural differences, what is acceptable in one society may not be acceptable in another [29]. Arabs share deeply engrained values, beliefs, and traditions that differ significantly from those of Westerners [28]. For example, in Arab culture, adolescents younger than 18 years old take care of their ill parents and live in the same home [18]. In most Arab countries, mental health resources are scarce, and the stigma associated with mental illness makes it an even more difficult situation [18]. Haque et al. [30] stated that before the development of hospitals in Qatar,

medical care was largely provided by traditional healers using herbal remedies and religious healers. Moreover, people suffering from psychosis were often forced to be physically restrained or confined at home [30]. Hospitalization of a female relative is considered more stigmatizing in many cultures than that of a male relative [29].

Culture plays an important role, perhaps more so than in any other healthcare discipline in psychiatry [28]. Although diseases may be the same, their manifestations can vary according to the culture in which they occur [29]. To reduce the burden of mental illness, accessibility to mental health services is vital [18]. One of the most common reasons people do not seek mental healthcare is the stigma related to mental illness, which leads to detrimental health consequences and unnecessary suffering for individuals and their families [18]. Zolezzi et al. [29] added that there is significant stigmatization of people with mental illness in the Middle East. Additionally, Qatar's National Mental Health Strategy notes that stigma and lack of understanding of mental illness widens the gap between the provision of treatment and public acceptance of mental illness [26].

Caring for a family member who has been diagnosed with mental illness is an extremely challenging task that involves various burdens on caregivers [22]. Therefore, an integrative review was conducted to identify the interventions that support the coping of caregivers to reduce their burden of caregiving. It is expected that the results of the integrative review will support the development of supportive interventions for family caregivers of relatives with mental illness in Qatar.

2. METHODOLOGY

An integrative review was chosen to identify supportive interventions to help family caregivers cope with the demands of caregiving. The integrative review method of Whittemore and Knafl [31] was adopted because it is a rigorous method that allows for the inclusion of evidence from research conducted using different methodologies. This rigor ensures the quality of information necessary for a comprehensive analysis while adding to the nursing knowledge base. Whittemore and Knafl's [31] method includes five steps: problem identification, literature search, data evaluation, data analysis, and synthesis of findings.

2.1. Problem identification

Family caregivers of individuals with mental illness face many types of burdens when caring for a relative with mental illnesses, which negatively affects their quality of life. Supportive interventions would help the caregivers of mentally ill individuals to cope with these burdens. This integrative review aims to identify supportive interventions that could be used to mitigate the burden on family caregivers.

2.2. Literature search

Three databases were systematically searched for relevant literature: CINAHL, MEDLINE, and PsycINFO. The search included the following keywords: *caregivers, family care, spouse, family caregivers, informal caregivers' mental illness, burden, and support interventions*. The search was limited to primary peer-reviewed research articles published in English between 2014 and 2023. This search resulted in 937 possible articles.

2.3. Data evaluation

The 937 articles were further evaluated for inclusion in this review. Five duplicate articles were removed. After reviewing the titles and abstracts of the remaining 932 articles according to the inclusion and exclusion criteria, 884 articles were excluded. Articles related to family caregivers of individuals with mental illness were included, while articles related to other caregivers, such as nurses, were removed. After a full-text review of the remaining 48 articles, 19 articles were found to be relevant for inclusion in this review (Figure 1).

The quality of these 19 articles was assessed using the Mixed Methods Appraisal Tool (MMAT) version 2018. The MMAT evaluates the methodological quality of qualitative, quantitative descriptive, quantitative randomized controlled trials, non-randomized controlled trials, and mixed methods research [32]. The MMAT only provides information on the study quality being reviewed rather than providing an overall score. The 19 articles in this review were assessed by two reviewers and deemed to be of adequate quality as described in the MMAT.

2.4. Data analysis

Whittemore and Knafl [31] asserted that data from primary sources should be comprehensively categorized and summarized to integrate decisions related to the research problem. A matrix table was created to organize and compile the information from the 19 studies included in this review. This table included elements of the research question and/or hypothesis, study setting, study design, sample size and characteristics, outcomes and measures, results, strengths and limitations, and comments. The organization of this table and the analysis process facilitated the comparison and exploration of key themes.

3. RESULTS

One qualitative and 18 quantitative research studies were included in this integrative review. These studies were conducted in different contexts in Asia and Europe. All studies investigated the use of supportive interventions provided to caregivers of individuals with mental illnesses to reduce the burden of caregiving. The studies in this integrative review addressed two main themes: interventions to offset the burden of caregiving and outcomes related to these interventions.

3.1. Interventions to offset the burden of caregiving

The interventions found in this review were designed to help caregivers cope with and offset the burden of caregiving. These interventions included specific topics to support the needs of family caregivers, such as dealing with violence and suicide, managing dysfunctional behaviors associated with bipolar disorders [33], and reducing the burden of caregiving for schizophrenic patients [33,34]. Different conceptual models or approaches to guiding the interventions were reported in the literature, including the cognitive-behavioral model of family intervention [35], the multi-family model [27], and the stress coping process model [34]. The approaches or structures used to inform the interventions reported in the literature include family-directed cognitive adaptation [36], compassion cultivation training [37], the family connections approach [38], and other mental health support programs specifically developed for family caregivers, such as family education programs [39]. These interventions

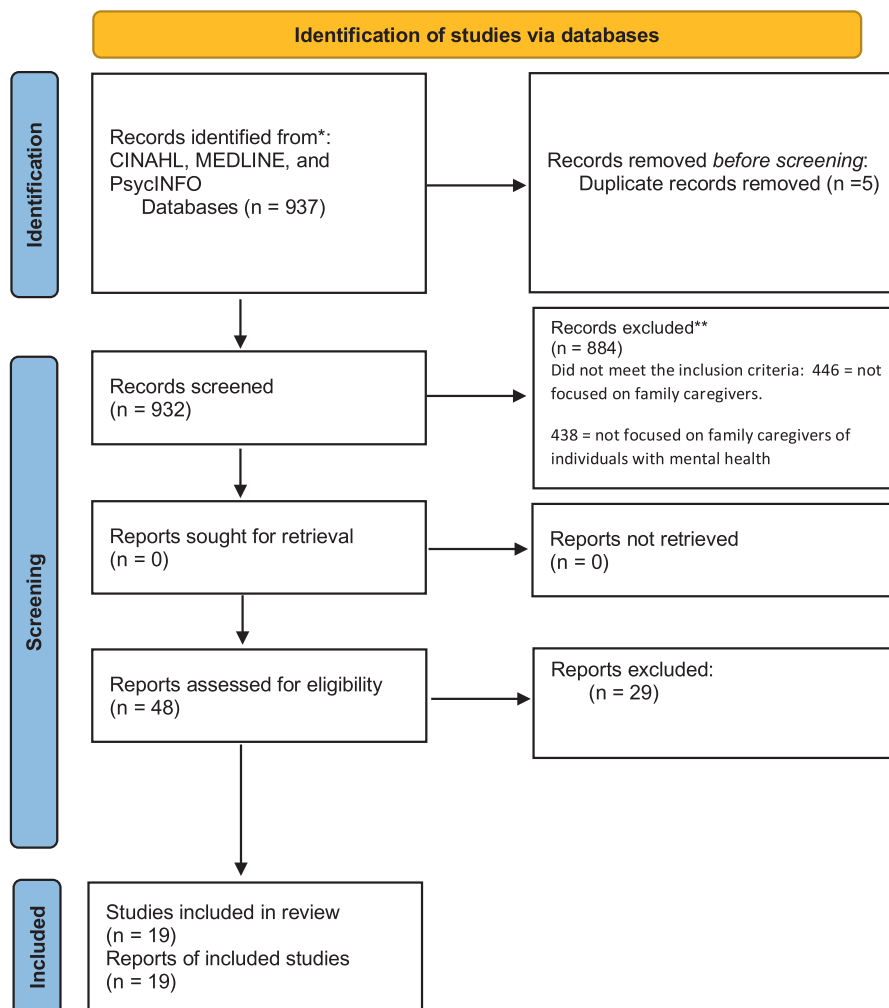


Figure 1. Flowchart of the literature search.

included psychoeducational therapy, adaptive cognitive-behavioral strategies, and peer and religious support. Interventions to offset the burden of caregiving can be divided into two sub-themes: interventions provided to a group of families and interventions provided to a single family.

3.1.1. Interventions provided to a group of families

Interventions provided to a group of families of individuals with mental illness in this review were developed by healthcare providers specifically to help family caregivers deal with the problems they face while caring for their relatives [27,33,40]. These interventions aimed to support family caregivers in caring for their relatives with mental illnesses as well as their own well-being. Needs assessments were conducted for family caregivers at baseline, either through face-to-face interviews [38], via phone calls [27], or using surveys [40]. Follow-up assessments to assess the impact of the interventions were performed after completion of the intervention protocol [18,27–43]. Facilitators of the interventions were either psychologists [27,35], registered nurses [27,33,44], or psychiatrists [36,45]. The role of the facilitator was to lead activities and guide the sessions. These sessions were conducted in different settings, such as outpatient clinics [27,35,37] or inpatient units [18, 27–35,37,40–42]. Caregivers attended a series of sessions lasting from 60 minutes [33] to 120 minutes [38] for two [46] to six months [36]. These sessions provided information on mental health and illness [27,45,47], problem-solving skills [35,38,3,4], physical health

training [42,47,49], and self-confidence skills [34,42,44]. Active learning techniques such as collaborative work and problem-solving skills, were used to actively engage family caregivers and provide them with opportunities to practice the skills [35–37,39]. Strategies such as psychoeducation, adaptive cognitive behavior, and peer support were used as part of family group interventions.

Psychoeducation. Psychoeducation provides fundamental knowledge about an illness: its causes, treatments, and prognosis. Psychoeducation is a common mental health practice that promotes personal and interpersonal growth [33,34,37,42–44]. A psychologist [42] or a psychiatric nurse [42,44,50] conducted the psychoeducation sessions in the reviewed studies. The number of sessions varied between 2 [38] and 15 [44]. These sessions lasted from 60 minutes [33] to 120 minutes [38]. They were offered on a weekly [34,38] or biweekly basis [35]. These sessions included group discussions about different topics such as dealing with a mentally ill relative, diagnoses, treatments [42,34], and learning coping skills [44,50]. The aims of the psychoeducational treatments found in this review were to improve caregivers’ personal mastery to make them feel more in control of the caregiving process, to motivate them to take charge of their circumstances [34,38,44], or to help prevent depressive symptoms in spousal caregivers [33,44]. Moreover, Lee et al. [33] found that patients who were followed up for a year in family-focused psychoeducational therapy could postpone and reduce the frequency of relapses and depressive symptoms.

Adaptive cognitive behavior. Learning cognitive-behavioral strategy is an important aspect of mental health, which helps family caregivers identify and address issues that may result from various life stressors [36]. In this integrative review, eight studies addressed the use of cognitive-behavioral strategies [41,42,35,36,38,40,48,51]. Cognitive-behavioral strategy sessions provided in these studies lasted from 10 [35] to 16 sessions [36]. These sessions were led by psychologists [42], psychiatrists [36], or psychiatric nurses [35,38,3,4]. These sessions lasted from one hour [35] to three hours [42]. The sessions were provided at weekly [42] or biweekly intervals [35]. The sessions were conducted in psychiatric hospitals [35,36,38,40,41,42,48,51], including acute inpatient clinics [41,42], outpatient clinics [35,36,3,4], and rehabilitation facilities [48,51]. Assessment of family caregivers was performed before and after the intervention through an interview [38], a phone call [35], surveys [36,42,3,4], or online surveys [48]. In the study by Friedman-Yakoobian et al. [36], the sessions encouraged people to adopt cognitive adaptation techniques to reduce the functional impact of cognitive challenges. The interventions in the study by Jensen et al. [35] taught family caregivers adaptive strategies to help them function better and reduce the stress on family members. Moreover, interventions in the study by Kazemian et al. [42] strengthened the family's coping resources [42]. Family caregivers who receive adaptive cognitive-behavioral strategies demonstrate better time management skills [35,42], better self-care [38,41,48], and significant improvement in adaptive living skills [35,36,42].

Peer support. Peer support is another important intervention that helps family caregivers cope with the burden of caregiving. Studies in this review provided peer support through support groups, which helped family caregivers develop more efficient strategies for solving everyday problems related to their concerns and enhance new social networks [39,45]. Peer support was provided in interventions such as meditation [33], physical exercises [39,45], self-assistance [33], socialization [33], emotional regulation [45], and yoga [33,46]. The peer support sessions were facilitated by a psychiatric nurse [39,46,50] or allied health worker [46] through face-to-face interviews [39,45,50] or online meetings [46]. In the study by Stjernswärd and Hansson [46], family caregivers found online peer support to be flexible, convenient, and ideal for sharing experiences and creating a social community. Peer support sessions in this integrative review lasted from 60 minutes [46] to three hours [45]. One [46] to 12 sessions were provided weekly [45] to biweekly [41]. Baseline assessment and follow-up evaluations were conducted for family caregivers to assess outcomes. The literature has shown that adequate social support would help caregivers improve their caring skills and acquire coping strategies from others [46,50].

3.1.2. Single-family interventions

Interventions to offset the burden of caregiving are also provided to caregivers from a single family. These interventions are generally short term and focus on specific goals for the family's needs [33,39,41]. Topics in the reviewed studies included plans for the future, employment prospects [45], medication monitoring [46,49], behavioral management [46,49], and strengthening communication [46,49]. These sessions were primarily face-to-face [33,39,3,4] and were offered either during home visits [39] or at clinics [33,41,45]. Healthcare providers conducted these interventions in a

single session [41,45] or multiple sessions [33,39,46,49,50]. The duration of these family interventions was one [41] to six sessions [33]. These interventions aimed to improve communication skills [41,49], improve and strengthen relationships [41,49], identify problem areas in the family [39,50], and provide skills to cope with challenging situations and knowledge about the disease [41,49]. Psychoeducation and religious support were common strategies in individual family interventions.

Psychoeducation. Psychoeducation for a single family improves the disease comprehension and management skills of family members [33,44,49]. Single families in this review received psychoeducation from psychologists [37,43,44], psychiatric nurses [44,49], or psychiatrists [33,37,44]. In the study by Khalaila and Cohen [44], sessions focused on the needs of family caregivers by discussing the illness, treatment plan, and management of the illness in one or more sessions. The duration of psychoeducational sessions varied between one [33] and two hours in the reviewed articles [44]. Caregivers from a single family attended the sessions alone or with their relative diagnosed with a mental illness. Psychoeducation reduces the burden of caregiving by reducing stress, reducing family expression of anger and guilt, supporting anticipation and resolution of issues [37,43,49], fostering greater family unity and communication, and highlighting the benefits of caregiving, such as personal development [33,37,42–44,49,50].

Religious support. In this integrative review, two studies discussed the impact of religious support on the burden of caregiving. Mental illness may be viewed as a spiritual issue, leading some caregivers to turn to prayer, holy books and other inspirational works, mediation, or other religious coping strategies instead of receiving other mental health interventions [41,47]. This could inspire them to face caregiving tasks with hope. In the study by Hsiao et al. [41], family caregivers used emotion-focused family coping strategies and religious healers in the rehabilitation center to cope with their burdens. Religious support provides some caregivers with the tools they need to find meaning and purpose in challenging and stressful situations. Caregivers who use religious coping strategies report providing more help and supervision in daily life [41,47].

3.2. Outcomes of the interventions

Most of the studies in this review reported significantly greater improvement in at least one target outcome for caregivers participating in the interventions, compared to those who did not receive the interventions [33,36–40,42,43–46]. Positive outcomes include a reduced burden of care [31,36,38,41,44,48,50], reduced stress [33,35,37–39,41,42,44], reduced anxiety [36,39,3,4], reduced depression [36–39,43,46,47] improved quality of life [34,45–47], enhanced communication [40,43,3,4], improved problem-solving skills and coping mechanisms [45–47,50], and enhanced mental health knowledge [42,44,45]. Additionally, family caregivers' understanding of cognitive problems improved, reducing feelings of irritation or self-blame [39,45] and improving the ability to cope with the burden of caregiving [36,44,50].

4. DISCUSSION

Family caregivers play an essential role in the daily care of mentally ill people. Caregivers of patients with mental illness in Qatar require access to supportive interventions due to the burden

of caregiving. The literature included in this integrative review identified numerous interventions for family groups or single-family units that support family caregivers to reduce their burden of caregiving.

4.1. Interventions to support family caregivers of relatives with mental illness

Family group interventions were found to be commonly used and effective in supporting the needs of family caregivers. This finding is supported by the broader literature. Sharing knowledge and talking with others in a group gives family caregivers confidence and support in coping with their burdens [52]. This review and other literature have identified numerous benefits of family group interventions, such as improving family dynamics and relationships and providing family members with strength and coping tools. Several studies, not included in this review as they were conducted in departments outside of mental health, including pain management, cancer patients, and elder patients with comorbidities, have reported that family caregivers in group interventions can identify and communicate with others who share their feelings, thoughts, and problems, thereby feeling a sense of belonging, being understood, and being accepted by others [53, 54]. In addition, in group interventions, family caregivers develop interpersonal skills by understanding the impact they have on their relatives and by receiving feedback from other families who have experienced the same situation. However, family group interventions also have disadvantages. For example, the focus of healthcare providers is divided among the entire group when working in a group setting. Other literature has also found that there is less individual focus and the therapist has fewer opportunities to provide specific feedback in these sessions [55]. Furthermore, while all group therapy places a strong focus on confidentiality and respect for the individual's privacy, there is no guarantee that everyone in a group will keep the information to themselves [55].

This review found several advantages of individual therapy that are supported by the literature. Koffel et al. [56] found that family caregivers have the full attention of healthcare providers during sessions, allowing family caregivers to speak privately, have more interaction, and develop a healthier relationship with the healthcare provider. Similarly, Polusny et al. [57] found that family caregivers' privacy and confidentiality are maintained. However, this review and other literature have found that individual therapy has disadvantages. Polusny et al. [57] found that caregivers do not have the opportunity to talk to and receive feedback from other caregivers in these sessions. Furthermore, the caregiver's thoughts and emotions could be intensified as they and the healthcare provider are the sole participants in the session, which may be overwhelming for the caregiver [57]. These interventions could include psychoeducational therapy, adaptive coping skills, and/or peer or religious support groups.

4.1.1. Psychoeducation

The goal of psychoeducation in the studies included in this review and other literature [58] is to help people better understand mental health disorders and prepare them for living with these disorders. During psychoeducational therapy, healthcare providers view the patient's family as a resource and prioritize education, communication, and problem-solving skills [52]. Additionally, psychoeducation aims to increase cooperation

between patients, families, and healthcare professionals through communication and emotional involvement, and practical assistance [52,59]. Studies have shown that psychoeducation reduces the number of days a patient spends in hospital as well as rehospitalization rates [60]. Participation in psychoeducational therapy improves quality of life because this therapy plays a vital role in destigmatizing mental illness [59]. Psychoeducational therapy has also been found to improve family caregivers' perceptions of their ability to play a more active role, such as interacting with healthcare providers while reducing the burden of caregiving and improving family caregivers' quality of life [58,60]. Family caregivers of dementia patients have shown improved self-care and enhanced communication skills after psychoeducation intervention [58].

4.1.2. Adaptive cognitive-behavioral strategies

This review identified adaptive cognitive and behavioral strategies that are intended to help family caregivers cope with stressful situations or the associated emotional distress. The use of coping mechanisms is a popular technique for dealing with demands and potentially threatening situations [61]. Similar to social resources, adaptive coping mitigates the negative consequences of life stressors and can also increase the likelihood that stressors will not occur [62]. Moreover, coping strategies are essential in reducing caregivers' emotional and physical strain [63]. Effective coping techniques can be used to reduce personal load, which can enhance the physical and mental health of caregivers [62,64]. Coping strategies can affect physical health indirectly through psychological reactions [64]. Studies have shown that family caregivers using such coping strategies exhibit reduced stress, anxiety, and depression symptoms when dealing with relatives with dementia, encouraging and supporting the caregivers to continue providing care [1,61,63]. As a result, the outcomes of these strategies show positive effects on caregivers and patients [1,63].

4.1.3. Peer support

In this review and other literature, peer support has been found to be a positive intervention for family caregivers. The World Health Organization [2] emphasizes the importance of accessible and cost-effective support for caregivers. Peer support has been shown to reduce the use of inpatient services, improve communication with healthcare providers and involvement in care, and enhance feelings of empowerment and hope [65]. Peer support has also been found to reduce the stigma of mental illness and play an important role in providing overall social support [65]. This review and other studies [66] have shown that peer support has positive impact on family caregivers, including renewed hope, greater strength, and lower burden of caregiving.

4.1.4. Religious support

Religious support is the support that people receive from others because of their religious beliefs and involvement in religious activities [67]. This review and other literature [67,68] have found that spirituality and religion may provide a sense of security and social structure that can be effective coping mechanisms in difficult times. During such times, family caregivers may seek more religious support to cope and ease their suffering [68,69]. Studies have shown that religious and spiritual activities have a positive impact on a variety of mental and physical health variables [68].

Studies have suggested that religious and spiritual activities are associated with better stress management and lower rates of depression [67,68], suicide, anxiety [67,68], and substance abuse [70]. Moreover, religious social support can help caregivers cope with stress by encouraging healthy coping strategies and building a sense of meaning and purpose in life [69].

4.2. Challenges associated with implementing these interventions

Several studies have explored the challenges of using these interventions, such as lack of staff motivation in providing separate interventions for family caregivers [71]. Moreover, barriers could be related to organizational factors such as lack of space, shortage of staff, lack of specialist training and knowledge and skills to provide these interventions, and workload pressure [72]. Although Arab cultures across the Middle East are unique, stigma towards mental health still has an enormous impact on perceptions of seeking help [72]. In addition, some of the interventions applicable in other cultures may not fit the Qatari culture due to sensitivity.

4.3. Strengths and limitations

This integrative review has several strengths and limitations. Whittemore and Knaff's framework provided a robust methodology. Moreover, this integrative review included primary quantitative and qualitative studies from diverse cultural and healthcare contexts, resulting in a range of interventions that successfully support family caregivers of individuals with mental illness. However, no relevant literature from Qatar or other

neighboring countries was available for inclusion. Therefore, the findings of this work may not be directly applicable to the context of Qatar. In addition, this integrative review only included articles written in English, which could have excluded important literature written in other languages.

5. CONCLUSION

Support for family caregivers needs to be enhanced to improve their ability to cope with these burdens and stressors. This support is needed to enable family caregivers to continue in their role as long as possible without compromising their physical or mental well-being. Supportive interventions such as psychoeducation, adaptive coping strategies, peer support, and religious support could be implemented in Qatar to help and support family caregivers to cope with their burdens. Due to cultural conventions, individual interventions may work best for family caregivers in the Qatar context. Administering such interventions would require the involvement of a multidisciplinary healthcare team. Additionally, research aimed at characterizing the burden of caretaking for individuals with mental illnesses is needed in Qatar. This integrative review may inform such research as it has identified supportive interventions that are already used in other contexts and can be applied in the context of Qatar.

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

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