



## **Cultural Influences in Mental Health Help-seeking among Malaysian Family Caregivers**

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### **ABSTRACT**

Previous research has found that ethnicity and culture play a significant role in the stress and coping process for family caregivers. There has been limited amount of research focusing on Malaysian families' mental health concerns, yet some emerging evidence suggests that the caregiver's experience of living with the mentally ill showed some differences associated with the caregiver's place of dwelling and ethnic background. The purpose of this article is to describe the experience of the help-seeking process and cultural coping strategy utilised by Malaysian families in dealing with mental health issues. In this study, a purposive sample of 24 family caregivers was interviewed to explore the caregivers' help-seeking process and their coping strategies in reducing caregiving stress. Transcribed data were analysed using the qualitative framework-analysis technique. The findings of this study indicated that family caregivers still believe in supernatural and mystical factors when describing their relatives' mental illness. They used coping mechanisms based on religious and cultural beliefs as a vital strategy for managing the cultural issues associated with mental illness due to the limited mental health resources that are available in their community. All these findings provide future research directions to better understand the interaction between culture and mental health, as well as mental health care policies to address potential family and community social problems in the help-seeking process to cope with the stress of caregiving.

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### **INTRODUCTION**

Family caregiving in mental illness is a complex phenomenon of how families

provide care for a mentally ill relative throughout their life span. Many researchers have tried to unravel the dilemma of caring for family members with mental illness (Azhar, 2001; Harvey *et. al.*, 2001; Lefley, 1996; Lopez *et. al.*, 2004; Miller, 1997; Mohamad *et. al.*, 2011; Szmukler *et. al.*, 1996; Webb *et. al.*, 1998). The term 'caregiving' itself is ubiquitous, but people generally take the meaning for granted. There is no exact definition of the term and the boundaries of what is included in the term are subjective. Nonetheless, Biegel *et. al.* (1991) have defined family caregiving as "the provision of assistance and support by one family member to another as a regular and usual part of family interaction, and is in fact a normative and pervasive activity" (p.16). Families who provide care for their mentally ill relatives are influenced by various factors such as political, social, cultural contexts, related policies and services (Johnson, 2000; Milstein *et. al.*, 1994; Nitsche *et. al.*, 2010; Roick *et. al.*, 2006; Solomon & Draine, 1995).

Throughout the world, families are the major caregivers for people with mental illness (Desjarlais *et. al.*, 1997). The picture varies cross-culturally and with respect to both cultural and racial groups. Lefley (2002) suggested that the idea of family caregiving could be divided into two global cultural systems, 'individualism' or 'collectivism'. Kim *et. al.* (1996) stated that individualism gives primacy to individual rights and boundaries, conceptualizing each person as a separate entity from the group, whereas the socio-centric or collectivism

perspective focuses on family, group membership and social role obligations. Lefley (2002) suggested that these two systems have effects on families' roles in caregiving, perspectives on disability, and relationships with members who are mentally ill. The distinction between these systems may be particularly important in law, because they involve disparate worldviews regarding the rights and responsibilities of individuals compared to those of the family and social order. In a comparison of the perceived interpersonal obligations of an individualistic versus collectivist culture, Western society has an interpersonal moral code that stresses personal freedom of choice and individual responsibility, whereas Eastern society has a duty-based interpersonal moral code that emphasizes mandatory responsibilities towards others (Miller & Bersoff, 1998). These views are based on one's position compared to the other person in the social and familial matrix.

In the oriental culture, family is regarded as the most important cohesive unit in society. For example, traditionally, Chinese families always look after their mentally ill members instead of sending their sick family members to a mental hospital (Chang & Horrocks, 2006). These perceptions have been influenced by their belief and culture in the community. Yip (2005) discussed the Chinese family caregiver's inclination to assume the responsibility in caring for their family members with mental illness. Some of the Chinese families feel shame to disclose family members' mental illnesses to others

(Lee *et. al.*, 2005). Furthermore, Lau (1993) argued that Chinese families were unwilling to seek outside help in caring for family members with disabilities as it may result in shameful disgrace to the whole family. They may feel inadequate in asking for external help including professional intervention (Yip, 2005). Chinese family caregivers are deeply influenced by 'familism' which means that Chinese individuals are accustomed to place family honour, family continuation, family prosperity, and stability above individual interests (Yang, 1995). Nevertheless, mentally ill family members can be or should be protected continuously by their families.

In addition, religious belief plays a significant role in caring for a family member with mental illness. Guarnaccia and Parra (1996) noted that a strong religious belief in the healing power of God is a factor affecting family caregivers' perceptions about curing their mentally ill relatives and that these beliefs are more strongly expressed by minority families. Similarly, Pirani *et. al.* (2007) explored the role of a Muslim shrine as a traditional multi-faceted resource in Pakistan and found that the Pakistani people perceived and used religious venues as major sources of help when dealing with physical, social, and mental-health problems. In addition, religion can also have an effect on family-relative relationships. For example, Haque (2005) stated that Islam is a way of life and not just a religion in the narrow sense of the term in prescribing behaviours in all areas of life including the family care giving role.

Flannelly and Inouye (2001) suggested that religion and spirituality may be positively linked with life satisfaction and quality of life. However, these ideas are predominantly based on Christian populations. Pirani *et al.* (2007) noted that individuals and families seek religious healing to improve their mental, physical, emotional, and spiritual health, thus, religious coping is utilized to deal with mental distress.

Based on their research, Aneshensel *et. al.* (1995) portrayed the caregiver's career in three stages: role acquisition, role enactment, and role disengagement. Within each of these stages the building blocks of the stress process theory, for example, primary and secondary stressors, stress proliferation, and stress containment (moderators of stress) are the result of caregiving roles. Godres (2005) noted that the family caregiver's role to people with mental illness is unpleasant and uncomfortable. This was further supported by Wasow (1995) who conducted in-depth interviews with twenty parents, children, siblings, grandparents, and extended relatives of family members with mental illness. His study explored the ways in which mental illness affects all the members of the family, not just the caregiver. Wasow (1995) suggested that families and practitioners need to learn from each other to understand the ripple effects of mental illness on all family members, not just the primary caregiver. The abnormal and dependent behaviours of the mentally ill relative could cause emotional and economic distress to his or her family (Magana *et. al.*, 2007).

On the other hand, Twigg and Atkin (1994) do not consider that the role of family caregivers to their family members with mental illness is necessarily unpleasant, but rather that it is the responsibility and sharing of one's life with another person. Thus, the nature of this type of care includes providing a home, coping with financial or public authorities, managing crises or hospitalisation periodically, and preventing the family member from falling into lethargy and self-neglect (Twigg & Atkin, 1994). For example, Endrawes *et. al.* (2007) found that Egyptian families tend to keep caring for their mentally ill relatives even though they experience feelings of powerlessness, lack of support, isolation, embarrassment, and stigma. They also found that Egyptians have a high sense of duty and obligation to maintain family ties and keep the family together despite the difficulties imposed by the illness of their relatives. Haque (2004) noted that 'caring for a sick family' is God's will and they believe that they will gain a reward either in this world or the afterlife for the good deeds that they do. This of course, reflects the collectivist nature of the Muslim society in general.

In line with the study above, which views caring as a rewarding experience, Chen and Greenberg (2004) conducted a study to examine family members' caregiving gains as a result of caring for their relatives with schizophrenic spectrum disorders, and the influence of formal and informal social support on these positive experiences. They found that formal support from mental health professionals through information

sharing and collaborative interactions, and informal support and contribution from other relatives, and support group participation have significant, positive associations with family members' experiences of caregiving gains. Although the satisfaction of caring is a cognitive and subjective process that may not be easily apparent to others, satisfaction may function as a coping resource, quality control measure, or "risk" indicator (Nolan *et. al.*, 1996). Therefore, it proves that the experience of caregiving is not necessarily negative. Therefore, this study is to understand the experience of the help-seeking process and cultural coping strategy utilised by Malaysian families in dealing with mental health issues.

## **MATERIALS AND METHODS**

A qualitative, descriptive research method as suggested by Flick (2006) was undertaken to analyse the family caregiver's experiences with the use of community mental health services. Participants were recruited from two community clinics in Perak and Kedah. A formal ethical approval and administrative clearance was obtained from the National Medical Research Register, Ministry of Health of Malaysia. A written informed consent was obtained from each participant. Subsequently, the participants were given a choice to select the interview site based on their convenience whether in their homes or in the community clinics. The interview took approximately 45 minutes and it was audio-taped.

### *Sample*

Twenty-four family caregivers volunteered to participate in the study. Two thirds were Malays, with six Chinese and two Indians. Most of the Malays live in the rural area and all but one of the Chinese live in the urban area. All Indians live in the urban area. The caregivers were recruited equally from both the urban and rural areas. More female (14) than male (10) caregivers were interviewed. Most were parents with two thirds being mothers. An equal number of husbands and wives were recruited in this study. There were five siblings, two brothers and three sisters of schizophrenic patients. Most of the caregivers were aged 50 years old and above. Only one of the caregivers was younger, below 40 years old who is a wife to a mentally ill husband. These participants have been providing care for their mentally ill family member for a period of one year to more than 20 years. The average of caring duration was 12 years.

### *Data Collection*

This study used a semi-structured interview because it allows a less rigid format of data collection with open-ended questions to elicit more qualitative information. The researcher conducted semi-structured interviews with the main caregivers. The main caregiver was defined as the family member who spends most of their time with the relative and it must be proven by the relative as being one without whom the relative would not be able to maintain their position of living in the community. The semi-structured interview enabled exploration of the mental health

help-seeking process from the caregivers' perspectives with respect to their caring roles toward people with mental illness in their home settings. Data collection stopped when it reached the point of data saturation, in which no new information about their experiences emerged.

### *Data Analysis*

Each interview was transcribed. The researcher reviewed the transcripts while listening to tapes and conducted the transcription to make sure that the interview content was complete. A second reading of the transcripts was then completed to obtain a general impression of the caregivers' experiences of services used, particularly to the benefits and barriers experienced by the caregivers. The data analysis was conducted using N-Vivo to assist in organizing the emerging free nodes. Later, all emerging nodes were clustered under the tree nodes. The framework analysis suggested by Ritchie *et al.* (2003) was applied. There were five stages of framework analysis:

1. Familiarisation with data (becoming thoroughly immersed in the material collected)
2. Indexing data (labelling key issues that emerge across a set of data)
3. Devising a series of thematic charts (allowing the full pattern across a set of data to be explored and reviewed)
4. Mapping and interpreting data (looking for associations, providing explanations, highlighting key characteristics and ideas)

## 5. Developing a thematic framework (identifying key issues from data)

The same framework was used to map the themes and sub-themes into different groups such as urban versus rural and Malay versus non-Malay to see the similarities and differences between the caregivers' answers. Later, the main theme of caregiving experiences was further examined using all the frameworks to identify categories and patterns in caregivers' responses. Verbatim quotes from study respondents were selected to illustrate the identified themes and categories. The frequency of themes emerged was also recorded to see which issue or idea was commonly discussed by caregivers.

## RESULTS AND DISCUSSION

One major category of help-seeking process and three categories of cultural beliefs about coping were identified from the data analysis which included: (1) family caregiver's help-seeking process, (2) help seeking based on ethnic beliefs, (3) help seeking based on cultural beliefs and (4) traditional healing. Descriptions of these categories with supporting data are given below.

### *Family Caregiver's Help-seeking Process*

In order to understand the life experiences of family caregiving to a person with mental illness, it is important to understand the caregiver's appraisal concerning the problems relating to the help seeking process and how they are coping with their stress. Their experiences of living with

mental illness showed some differences associated with the caregiver's area of residence and ethnic background in their help-seeking process and coping strategies. To understand how appraisal and coping processes ultimately affect adaptation outcomes, we must first understand how these processes affect the experiences of stressful encounters in an individual's life. Specifically, the primary appraisal can be affected by the past experiences of the stressful encounter with its adaptive outcomes. Not surprisingly, if the family caregivers provided a historical perspective about their experiences of caring as a response to their help-seeking process, this information is treated as individual factors because it varies between each caregiver. The historical perspectives of caregivers can explain how their current understanding about mental illness were shaped based on their knowledge and beliefs as well as what they had learnt in the past. Possibly, caregivers who used the mental health services might agree or disagree with the treatment of their mentally ill relatives. Those who agreed will choose to send their relative to undergo a formal mental health assessment and treatment from a mental health service agency but those who did not agree will seek alternative treatment or traditional healing. Family caregivers in this study experimented treatment using traditional ways. The Malay caregivers especially perceived traditional healing as complementary. Most of the caregivers looked for alternatives or new treatments while searching for the best treatment. When



they were satisfied with the treatment they continued with it, although some pursued other treatments for better outcomes, until they reached their own level of satisfaction for help-seeking.

#### *Help-seeking Based on Ethnic Beliefs*

The complexity of the caregivers' help-seeking experiences for a person with severe mental illness might be valued by understanding their ethnic beliefs. In Malaysia, mental illness such as schizophrenia is interpreted differently by the public compared to the people who have been diagnosed with schizophrenia. Furthermore, their families might not receive equal justice compared to other medical diseases. Community members are likely to believe that mental illness is a lifetime disease and cannot be treated. Furthermore, undergoing mental health treatment and medications are viewed by many people as a start to severe personality changes and drug dependency which then form more worries among families and community. Misunderstandings of people with mental illness are often dangerous, harmful, violent and worsens the situation not only to those suffering but also their families (Sorketti *et al.*, 2012). It is even worse when the mental health service users and families have been stigmatised because of mental illness. Thus, for every individual suffering severe mental illness there is a family and social support system that will be affected. Not only does the family have to deal with an illness that cannot be entirely cured, they also have to shoulder the stigma and perception attached

to it. Social isolation may result from the fear and stigma, ~~thus~~, consequently curbing the family's ability to obtain social support.

Some people still believe in supernatural and mystical factors associated with mental illness. To them, mental illness is the result of individual internal factors which become apparent in a particular belief such as the illness is a "curse from God" or the punishment of the past sins (karma), loss of mind strength, incitement of "Jin", the imbalance of "chi" and the incitement of the evil spirits (manifestations of evil spirits). Such beliefs are observed across ethnicity (Haque, 2001, 2005; Tan, 2007; Yeap, 2008). These superstitious beliefs are not exclusive as some caregivers in this study also believe in these things, which influence their thinking when describing their relatives' mental illness. For instance, some of the older caregivers believed that their relatives had been victimised by evil doers who had used black magic on them. The black magic was said to cause the victim to become insane.

Caregivers also described a bad *dukun* or *bomoh* (a local traditional shaman) who had cast a spell on their family members. They claimed that the *dukun* was paid by someone who was jealous and unhappy with their families. Some of the caregivers often associated the relative's altered behaviour to black magic. For instance, an older caregiver admitted that his relative started behaving oddly after coming back from a night class and that the person might be possessed by an evil spirit. Consequently, there was also the issue of taboo described by the caregiver

about his relative's mental illness. For instance, a Malay husband explained that his wife's illness was perceived as a taboo when she broke the rules of "Saka". Saka is a superstitious belief in Malay society about genies or fairies that act as guardians of their owners. In Malay customs, the rule of the *saka* is to protect its owner, usually a woman, from her enemies. His statement is illustrated below:

*She became ill after she walked under the clothes' line. It's speculated that she has saka and one of the taboos for that person is to walk under the clothesline. I think that is what my in-laws believe about her illness.*

Another Chinese caregiver perceived that her sister had been possessed by the spirit of dead people because of her ignorance of the 'do's' and 'don'ts' dictated by her great grandparents:

*For me she is like this because of her ignorance of what my great grandparents reminded us about. I believe that if she did not follow the bad influence of her friends, she wouldn't be possessed by the bad spirit. If she had stayed away from those bad influences, she would be fine. Now it's too late, my great grandparents are upset with her.*

There was an Indian caregiver who described the *karma* associated with the

relative's mental illness. She believed that her relative led an unrighteous life because he was very arrogant and did not care about other people in the past. Her statement is illustrated below:

*He used to treat us badly as a family. He was such an arrogant child and never cared about us. He never helped his brothers, never sent money to us. After he was dumped by his girlfriend and left alone after all his friends got married, he started to have depression. I believe it all happened because God punished him for his bad behaviour as a human being.*

#### *Help-seeking Based on Cultural Beliefs*

Caregivers in this present study used help-seeking process based on religious and cultural beliefs. A cultural belief is a coping mechanism and it is an important strategy for managing the cultural issues associated with mental illness.

#### *Religious Coping*

Many of the caregivers stressed the importance of religious coping in managing their caregiving experiences of a person diagnosed with schizophrenia. Caregivers sought religious support to cope with their stressful life. For instance, one Malay caregiver has a strong belief concerning spiritual healing, especially when dealing with mental illness. A mother who believes in spiritual coping stated that her daughter's



spirit will be restored to fight the mental illness when using specific tools that contain spiritual power:

*I used to bring her to the ustaz (the religious figure in Muslim society) to get air-penawar (so called 'holy water' for Muslims). It's important to raise her spirit. Besides, I also took the water for my grandchildren to improve their memory and to help them excel in their studies.*

Another mother commented that the *air-penawar* was used to boost her relative's confidence but that it was only temporary and serves as a complement to conventional medicine. It was believed that the *air-penawar* supposedly contains spiritual powers to control her relative's difficult behaviour. Some caregivers used spiritual healing to treat their relative because of its availability as a resource in their community, especially when they were unable to access other forms of community services. A caregiver who is a Malay father recounted that he used to recite *doa* (prayers) and worship *Allah* (the standard Arabic word for God that is mostly used by Muslims) on a daily basis for his relative's recovery. Most of the Muslim caregivers believe that *Allah* will help them throughout their life, for both the good and bad. For instance,

*I never fail to pray and worship Allah. I believe that by glorifying Allah continuously my doa (prayers) will be granted. Only with His*

*[refers to Allah] permission will they recover.*

This study found that the coping strategy pertaining to religious beliefs used by respondents was similar to earlier findings by Pirani *et. al.* (2007). Individuals and families seek religious healing to improve their mental, physical, emotional and spiritual health. In other words, religious coping is utilized to deal with mental distress.

In addition, some Chinese caregivers recounted that they used religious coping to deal with their relative's illness and their own problems. Some of the Chinese caregivers who were Buddhists assumed that their relatives were living with mental illness due to the impurity of their soul. Therefore, they brought their relatives to the temple and worshipped Buddha for recovery. Another Chinese caregiver who was a Christian noted that he regards the church as a good place for him to provide therapy for his relative through socialising with other members of the church. This is because, Christianity emphasizes on the relationship; relationship within the trinity of God, family relationships, and relationships with others (Maniam, 2001). A Chinese Christian said:

*I take her to church every weekend so that she can talk to other people. I believe that by following the church activities, she will mix around with other young people and she can practice to be a good*

*leader. This is because I notice that she likes to be a leader. I think this is a good form of therapy for her.*

Consequently, from an Indian perspective, an Indian caregiver who was a Hindu, recounted that spiritual healing in the Hindu temple can enhance her relative's good health:

*I used to go to India to treat him. We went to the famous Hindu temple in Gujarat. When we went there, we did a Pooja [a Hindu prayer to God] and followed all the rituals conducted by the Swami [is primarily a Hindu honorific title for either male or female priestess]. I believed that the healing process would be more effective in such an environment. However, before we finished the three poojas he already ran away from the temple. Then the treatment became unsuccessful.*

One of the Chinese caregivers who was a sister of a mentally ill person testified that she used religious support for her own self. She said that she felt released and relaxed after the precept and meditation practices at the Buddhist temple. Most of the caregivers used religious coping to manage their relative's illness and their own problems. Each ethnic group has their own way of religious coping, which depends on their religious beliefs. Caregivers who have religious beliefs seem to be more positive with their caregiving experiences. This is because religion might genuinely promote

positive psychology in human beings. People who used the religious coping method might have a boundary to control themselves, especially when facing tough and stressful situations. Previous literatures have stated that the religious coping style might promote better health because religious believers managed to control their behaviour when responding to any influential situations such as a life threatening event. Furthermore, religious and spiritual coping influence psychological distress and promote good health (Pargament *et. al.*, 2004). Therefore, caregivers who applied religious coping strategies might transform their stress in positive ways, which might reduce or buffer the psychological distress of caregiving.

#### *Traditional Healing*

In the community setting, caregivers demonstrated that they seek traditional healers for treating their relative. They believed that traditional healing is not limited to utilising therapeutic, physical means or prescribing a dose of medicine or herbs. However, it is a holistic approach that caters for the spiritual and psychological needs of their relative, together with other modes of treatment. Commonly, a traditional healing system is regarded as alternative medicine. A traditional healer in Malaysia is called a *bomoh*, *dukun*, or *pawang* who practises alternative medicine incorporating the therapeutic usage of herbs, metals and animal parts. It has been noted that the traditional healers, especially the elders who are called *tok*, are treated with great respect, particularly in rural societies.

The traditional help seeking process is a kind of 'trial and error' to find an effective way to treat the relative's mental illness. During this process, caregivers usually depend on the intermediate community resources that are available. Some of the caregivers tried other alternative treatments as recommended by people in their support networks. For instance, another Malay caregiver also confessed that she has had the experience of using a bomoh because initially she thought that her mental illness was caused by the possession of an evil spirit. Her action in seeking alternative treatment was highly influenced by friends. It is also noted that some of the caregivers were not fully satisfied with the traditional treatment that they had sought. They recalled their experience of traditional healing as *bomoh-shopping* (shopping around for traditional healer) as their coping strategy to search for better traditional healers. Therefore, some of the caregivers might use both treatments, in which the alternative medicine is regarded as complementary to the modern medicine. However, those who found that the traditional treatments failed would rely on the mental health services for treating their relatives. For example:

*Yes, previously I used to take them to the bomoh. I tried so many bomohs, it's kind of bomoh-shopping. Any recommended bomoh I tried... and none of them were effective. For me it was a waste of money, especially when I realised that it is not a spirit possession, but something else like*

*genetic disease. It was then that I decided to take them to the doctor and started to use the prescribed medication. Only after that did I find some improvement with them.*

Another caregiver also testified that the traditional healing was not effective and just a waste of money and energy in the attempt to find better treatment. This situation caused him to choose mental health services to cure his brother. At the same time, a caregiver reported that she faced difficulty in pursuing medical treatment for her daughter's mental illness because her husband was more inclined to use traditional treatment. Thus, this discrepancy had caused stress and conflict within the family. It is noted that some of the caregivers used traditional healing because of the influence of other family members who believe in traditional treatments, especially to treat illnesses (e.g., schizophrenia) which has highly been associated with superstition. For example, one Malay caregiver who is a husband to a mentally ill wife claimed that his family-in-laws wanted to treat his wife using traditional healing because they thought this mental illness was *Saka* and he accepted it without question as long as it did not harm his wife.

In addition, one Indian caregiver described that she practices alternative *Ayurvedic* medicine to treat her sister's illness while staying at home. Some of the caregivers recounted that the traditional healers use different treatments to cure their

relatives' mental illness. They mentioned that the *bomoh* used authentic sources as a form of spiritual therapy. For example:

*I used to bring the tok bomoh to my house to treat her. I saw the tok bomoh use lemon extract and local boreholes [boreholes are scarce, as rain and river water are the main sources of water supply in Malaysia] in the treatment. Then, the tok bomoh recited Quranic verses over her and cast magic spells into the water too.*

Similarly, another caregiver also reported that the *bomoh* cast a magic spell on a stone and performed a massage therapy for treating his son's mental illness. One example about the *bomoh*'s treatment given by a Malay caregiver who lives in the rural area described the *bomoh* who used a catfish to treat the relative's illness but the effect of the treatment was only temporary. Most of the caregivers who used the traditional treatments are Malay and the majority live in the rural areas. This might be because of their cultural beliefs and the limited resources available in their community for treating mental illness. Generally, caregivers who live in the urban areas are more exposed to other mental health services that provide them with more choices to treat their mentally ill relative.

Some of the Malay caregivers in this study showed that they are optimistic about the traditional treatments because of their positive attitude to keep searching for the best healers and even use them

to complement mental health services. However, some of the caregivers disagree with the traditional treatments and only believe in the treatment provided by mental health services. Nevertheless, caregivers have their own right to choose what treatment suits their preferences in treating their relative. Usually they will try various treatments before deciding on the most reliable treatment. This is an important experience in ways of coping based on their cultural beliefs. Caregivers made judgements concerning their support systems that might be convenient and reliable in their environment. In other words, the cultural beliefs shaped their coping strategy and influenced their secondary appraisals to reduce their psychological distress. Therefore, this type of coping strategy can mediate the stress of caregiving. All these strategies are treated as mediating factors to mediate the caregiver's appraisals as a means to reduce their psychological distress. Cultural coping strategies are important factors in caregivers' reappraisal about their experiences of caregiving in Malaysia.

## CONCLUSION

In conclusion, this paper is divided into two parts. First, is the explanation of the help seeking process among caregivers when they first began to face stressful life situations. Second, caregivers from different ethnic groups have their own ways of help-seeking and coping strategies. Most of the caregivers in this study used cultural coping, which can promote a positive

experience of caregiving because, in some way, it reduced their distress. At the same time, cultural coping is related to religious beliefs or religious healing. Cultural help-seeking was found to be more acceptable, in fact produced faster recovery than mental health treatment for caregivers in this study. Even though their relatives were treated in the mental health care system, their help-seeking process is a sociocultural approach which takes into account the social system of both families' and caregivers' values and beliefs. These values and beliefs are synonymous to cultural and religious influences. It can be concluded that the caregivers have their own way of seeing things and reacting to their stressors. All the caregiver's needs have to be calculated and targeted in their own right.

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