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Research Article

Caregivers' Experience with Children with Mental Health Needs: A Qualitative Study

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Abstract

Background: A child with a mental health problem complicates the ability to manage several issues that can be addressed through planning involving the entire family.

Objectives: The present study sought to explore the needs and gaps that caregivers face in developing and designing evidence-based services.

Methods: This qualitative study used conventional content analysis through semi-structured face-to-face interviews. The Granheim and Landman method was used to analyze the data. Nine caregivers and six healthcare professionals (HCPs) were interviewed via semi-structured interviews (SSIs) in Iran in 2022.

Results: Psychological and emotional problems, family conflicts, social exclusion, and a lack of information about mental illnesses were identified. An integrated care model based on family-centered mental health, parenting, and family therapy services compatible with Iranian culture, the economy, and society is crucial for creating a national care strategy. This strategy should be based on the experience of the best countries while simultaneously considering the needs of Iranian families. Specific priorities include education and support services, counseling, learning and development opportunities, and financing.

Conclusions: The physical, emotional, psychological, and practical demands placed on caregivers mean that they need professional support, better knowledge about mental health, and good support systems. Transformed caregiving practices and caregiver support plans are essential in transforming children's lives, supporting families, and strengthening mental health care. All of these efforts are crucial to creating the necessary conditions for care provision in the Iranian context.

Keywords: Child, Caregivers, Experience, Needs, Mental Disorders

1. Background

Mental disorders are syndromes or behavioral/psychological patterns that have clinical significance and result in distress or impairment in affected individuals (1). It is estimated that one in every eight people worldwide is living with a mental health disorder (2). The increasing prevalence of mental disorders has heightened the demand for assistance and support for those affected. While healthcare providers play a crucial role in providing medical interventions, a substantial portion of the responsibility for supporting individuals with mental health conditions falls on family caregivers (3). Parents of children with developmental and mental disorders often face numerous challenges (4, 5). Prolonged diseases with pathological features, particularly in children with mental disorders, exert a significant effect on families (6). Chronic illnesses, particularly mental disorders in children, pose substantial challenges for families.

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Numerous national and international studies have demonstrated a connection between anxiety and social, demographic, and psychosocial factors in these families. However, many studies have reported a lack of support for family caregivers and insufficient attention to their needs (7). Studies have shown that no special attention has been given to the welfare of caregivers of those with mental health disorders in some aspects (8).

In chronic mental illnesses, outcome measures are often oriented toward the patient and their symptomatology because of chronic healthcare contact. However, this may lead to the failure of the healthcare system to recognize and/or attend to the needs of caregivers and family members (9). Healthcare providers frequently encounter families with members who have psychiatric disorders and are in a good position to assess these needs, prioritize them, and develop effective interventions to meet them (10). Given the myriad needs of these caregivers, nurses are capable of addressing and resolving such needs through identification, prioritization, meticulous planning, and the application of nursing interventions. While some policy focus has been given to caregivers, little attention has been given to individual caregivers' needs and well-being within the family situation (11). The lack of effective communication and follow-up care, as well as insufficient support for the relatives of patients with mental disorders, is one of the most urgent problems for families with a sick family member during hospitalization and after their discharge (12). Satisfying these needs is a collective responsibility of all health and treatment team members.

While previous research has explored parents' experiences in various regions, there is a notable dearth of literature specifically examining the unique needs of parents in Iran. Iranian parents often face distinct challenges in meeting their children's needs due to cultural, social, and economic factors that shape their caregiving experiences. Cultural expectations in Iran place a strong emphasis on family responsibility, particularly on parents as primary caregivers, which can increase the emotional and financial burden on families of children with mental disorders. Additionally, societal stigma surrounding mental illness may discourage families from seeking professional help, leading to delays in diagnosis and treatment. Unlike in some Western societies where institutional and community-based support systems are more readily available, Iranian families often rely on extended family networks for support. However, these networks may lack the necessary knowledge and resources to provide adequate care. Moreover, economic challenges, including inflation and healthcare access limitations, further hinder families' ability to seek specialized mental health services. Addressing these cultural and structural barriers is essential for developing effective support systems tailored to the needs of Iranian families (13, 14).

Parents of children with mental disorders must create an environment where they, as families, embrace sustainable ecosystems of care. This mandate requires a new model of care addressing both the child and the caregiver. Applying this model specifically to Iranian culture and the financial and social aspects of illness and treatment may reveal concerns such as stigma, access, and lack of communication with the care provider. Importantly, having a national strategy for caregiver support should involve global policies and the requirements of Iranian families. The support strategy should aim to decrease social prejudice, increase expertise, and offer funds, along with insights from social partnerships and learning from supplementary community approaches. In this way, the alternative research strategy connected with cultural diversity becomes not only a change in caregivers' and families' lives for better generations but also a positive change in the framework for future generations.

2. Objectives

Since it is necessary to identify and redefine the needs of families of children with mental disorders in their natural environment in every society, this research aims to understand the fundamental and first-hand experiences of parents with children with mental disorders and the caregivers involved in providing care based on the available evidence. This research aims to create more effective care.

3. Methods

The study was established and launched in December 2022. A qualitative descriptive approach was employed, using conventional content analysis and semi-structured, face-to-face interviews with both the families and their care provider teams. This method was considered suitable for the research objective, as the main purpose of qualitative descriptive research is to offer a thorough, inductive summary of particular events encountered by a group of individuals, expressed through clearly detailed themes. We used MAXQDA software version 2020 to organize the qualitative data and EndNote software version 9.3.3 to organize the extracted data during the review process. Data analysis in the qualitative phase was conducted via conventional content analysis and an inductive approach, as outlined by Granheim and Landman (15).

3.1. Research Setting

The studied community consists of families of children aged 6 to 12 years with mental disorders, healthcare providers who work with these children and their families, and individuals who have had direct contact with them and are familiar with their needs. Participants were recruited from various settings, including their homes, hospitals, policy and decision-making organizations, outpatient clinics, and follow-up visits for children with a medical history.

3.2. Inclusion Criteria for Participants (Families of Children with Mental Disorders)

The study includes primary caregivers of children aged 6 to 12 years who have a medical diagnosis of a mental disorder, provided that the disorder is not caused by intellectual disabilities. The participants had to have a medical record documenting the child's mental disorders. Additionally, the service providers included in the study had at least 2 years of work experience in health and treatment centers, as well as in centers that provide services to families of children with mental disorders. Various factors, including the parent's age, the type and duration of the child's illness, the parent's education level, and the family's economic and cultural conditions, were considered in participant selection to ensure diversity. These factors were carefully considered to capture a broad range of perspectives and experiences.

The exclusion criteria were as follows: Reluctance to continue cooperation at any stage or reluctance to continue cooperation due to complications arising from the child's illness or treatment.

3.3. Sampling Method and Sample Size

The initial participant selection was based on their willingness to participate and purposive sampling, ensuring that the participants had substantial caregiving experience for a child with a mental disorder and the ability to provide rich, detailed insights into the challenges faced by caregivers. The selection was based on predefined inclusion criteria. Saturation was determined by continuously analyzing the data after each interview. When no new themes, perspectives, or significant insights emerged after the 15th interview, the data collection was considered complete (16). To ensure saturation, the research team conducted member checking and reviewed the data to confirm the redundancy of the themes. To ensure maximum diversity, maximum variation sampling was employed. Participants were recruited based on various sociodemographic factors, such as age, socioeconomic status, geographic location, and type of mental disorder in the child (Tables 1 and 2).

3.4. Data Collection Tool and Method

Data collection was carried out through in-depth and semi-structured interviews (SSIs). After the participants were selected, they were asked to sign a written consent form. The interviews were conducted privately and face-to-face at hospitals in Iran. The interviews were recorded only with the participants' consent, and the interviewer also took notes during the sessions. The duration of each interview was adjusted based on the participant's energy to avoid causing any discomfort, with an average length of 50 - 60 minutes. In this study, semi-structured interview questions were developed through an extensive literature review (16) to ensure alignment with existing research on caregivers' needs. The initial set of questions was subjected to face validity assessment by a panel of faculty members with expertise in psychiatry, mental health nursing, and qualitative research.

3.4.1. Sample Questions for Interviewing Parents

- Please talk about your experience in caring for a child with mental illness.

- What needs do you feel are necessary to take care of these children?

- What problems have you faced in taking care of your child?

3.4.2. Sample Questions for Interviewing Healthcare Providers

- What is your experience of the needs of families of children with mental disorders?

Table 1. Health Care Professionals' Characteristics

Health Care Providers Identifier	Age (y)	Gender	Work History (y)	Service Location	Educational Level	Place of Communication with Family
H1	28	Female	3	Department of pediatric psychiatry	Master's degree in psychiatric nursing	Psychiatric nurse
H2	34	Female	4	Head nurse of the department of children's psychiatry	Bachelor of nursing	Psychiatric nurse
H3	48	Female	22	Ministry of Health	Master of clinical psychology	Head nurse of the department of mental health
H4	36	Female	3	Occupational therapist	Master	Rehabilitation of mental patients
H5	46	Female	18	Clinical psychology	PhD	Rehabilitation of mental patients
H6	39	Male	32	Pediatric psychiatrist specialist	Doctoral	Head of department of pediatric psychiatry

Table 2. Family Caregiver Characteristics

Caregiver Identifier	Age (y)	Gender	Marital Status	Occupational Status	Educational Level	Type of Disease	Duration of Disease (y)	Household Income	Family History of Mental Disorders	Diagnosis Period (y)	Location
C1	41	Female	Married	Housewife	Master	ODD	4	Less than expenses	Positive	2	City
C2	38	Female	Married	Teacher	Master	ADHD	3	Normal	Negative	3	City
C3	34	Female	Married	Housewife	Diploma	ADHD	2	Normal	Positive	1	City
C4	39	Female	Married	Housewife	Bachelor	Depression	7	Above expenses	Negative	4	City
C5	40	Male	Married	Employee	Master	ODD	3	Less than expenses	Positive	3	City
C6	33	Female	Married	Housewife	Bachelor	BID	5	Normal	Positive	3	City
C7	33	Female	Divorced	Housewife	Diploma	ADHD	3	Less than expenses	Positive	2	Suburb
C8	36	Female	Divorced	Housewife	Diploma	ODD	6	Less than expenses	Positive	4	Suburb
C9	37	Female	Married	Housewife	Advanced diploma	OCD	2	Normal	Negative	1	City

- What services are most needed and paid attention to by the families of children with mental disorders?

- What things attract your attention when dealing with the families of these children?

Open-ended questions were asked throughout the interviews to explore the details of the participants' responses more deeply. If the participants strayed from the main topic, the interviewer guided them back. Probing questions were used strategically to gain more insight into the phenomenon under study.

3.5. Ethics Approval and Consent to Participate

The present study was approved by the Ethics Committee of Isfahan University of Medical Sciences, Isfahan, Iran (IR.MUI.NUREMA.REC.1401.181). Before the interviews, participants were thoroughly informed about the research purpose, the researcher's duties, the possible risks and benefits of their participation, and their right to withdraw from the study at any time without any consequences. They were also informed about the team members who would access their interview transcripts. Each participant fully comprehended the nature of the study and consented to participate. Participants remained anonymous during the data analysis stage and were assigned a code: "Caregiver = (C)" and "Healthcare Professionals (HCPs) = (H)", followed by a unique ID number. A member of the research team, a PhD student majoring in psychology with formal training in qualitative research methods such as data collection and analysis, conducted the interviews. The senior research team oversaw the project's design and conceptual framework.

3.6. Data Analysis

Qualitative data gathered from the interviews were recorded and transcribed word-for-word, ensuring

Table 3. Overview of Themes and Subtheme

Themes	Subthemes (Frequency)
Emotional and psychological support for the family	Emotional problems and negative feelings in parents; mental exhaustion in parents; unrest in the family; concern about the child's condition
Reconstruction of family relationships and interactions	Disruption in family relationships; disruption in family social interactions; compatibility problems and lack of coping skills
Improving family awareness and performance	Low health literacy level of the family regarding the child's illness; improper parenting style; disturbance in family roles and functioning; inability to meet economic needs; inability to manage the health status of family members

anonymity for names and locations. The researcher conducted a thematic analysis of the transcribed data. Two researchers independently coded the data, and through continuous checks and comparisons, they reached a final agreement on the coding. Upon examination of the transcripts, the researcher employed an inductive approach to thematic analysis to identify primary codes within the data through line-by-line coding. The coding process was driven by the data, wherein themes were derived through open coding as the data were systematically analyzed (17, 18). Each relevant piece of data underwent coding to reveal various patterns. Two analysts subsequently independently coded each transcript, and the codes were then collectively reviewed, compared, and refined to establish a consensus. Following the completion of coding, the codes were structured in a manner that facilitated the identification of overarching themes. To ensure quality and accuracy by obtaining multiple points of view, three university faculty members with PhD degrees and experience in conducting qualitative research who were familiar with the subject participated in the data analysis. Each research team member identified significant words, phrases, or paragraphs. These meaningful units were coded to represent the raw data's content. Whenever possible, participants' own words were used for labeling to minimize researcher bias. Categories were formed by grouping similar codes and repeatedly analyzing them to identify relationships and themes. Each theme was named to capture the "essence" of its content. From the beginning and throughout the process, researchers sought meaning in the data and considered alternative explanations by comparing their findings to the literature. Reliability was assessed following the guidelines of Lincoln et al. (19). An audit trail documented all the methodological and analytical decisions. To avoid researcher bias and ensure that themes accurately represent participants' experiences of living with a child with mental health needs, all themes were selected by consensus among all four members of the research team.

3.7. Rigor

To ensure the rigor of the study, credibility, validity, reliability, confirmability, and transferability were established as key benchmarks. Credibility was addressed through the use of the member-checking technique, where participants were allowed to review and confirm the data and codes. Reliability was ensured by providing preliminary codes, examples of quotes, themes, and items extracted from the interview transcripts for each category to an external observer, who verified their consistency. Confirmability was achieved through a process in which the research team and several university faculty members reviewed multiple interview texts along with the extracted codes and categories to assess the accuracy and consistency of the data coding process. Finally, transferability was strengthened by presenting the participants' statements as objectively as possible, allowing readers to assess the applicability of the findings to other contexts.

4. Results

The analysis of the data generated 66 different labels, which the researchers then assigned to three main themes: (1) Emotional and psychological support for the family, (2) reconstruction of family relationships and interactions, and (3) improving family awareness and performance. Table 3 describes the themes along with the associated subthemes.

4.1. Theme 1: Emotional and Psychological Support for the Family

Four major themes emerged from the study explaining the psychological and emotional challenges experienced by parents while caring for a child with a mental disorder. Four subthemes bolster this primary theme:

4.1.1. Emotional Problems and Negative Feelings in Parents

Emotional problems and negative feelings in parents were identified by most participants when asked about their needs in caring for their children. During the interviews, many mothers shed tears when describing their negative emotions and expressed emotional reactions, negative feelings, and daily struggles related to child care. "I committed a minor error, wherein I allowed the physical distance separating us to grow. He utilized his educational pursuits as a justification, evident through his dedication to studying. Despite my academic performance being commendable, I erred by assuming his absence from our collective activities. Consequently, a mistake was made on my part" (C4).

4.1.2. Mental Exhaustion in Parents

The respondents said they experienced feelings of hopelessness, despair, and isolation after the child's illness. A mother explained that when she learned about her child's definitive diagnosis, she felt very sad and found many psychological and physical problems. "You see, emotionally, psychologically, behaviorally, everything I have is damaged, that is the biggest problem I have with my daughter is in terms of nerves and mental health" (C8).

4.1.3. Family Breakdown

The majority of caregivers in this study reported frustration and inherent suffering resulting from their child's destructive behaviors that created many disruptions in the family. For example, one of the caregivers who had a 12-year-old daughter diagnosed with mood and behavioral disorders and was undergoing treatment stated, "When he gets angry, he hits me and himself. These behaviors hurt both of us. Well, these behaviors are harmful. If we are educated morally and behaviorally, these incidents will not happen, in my opinion, it will help our family a lot to make their environment a little calmer psychologically" (C8).

4.1.4. Concern About the Child's Condition

Caregivers reported constant concern about the long-term impact of their child's illness on the child's future education. For all the caregivers, the difficulty in child academic work was a cause for anxiety for all the mothers irrespective of the age of the child. Lack of knowledge regarding the child's progress at school and, therefore, the likelihood of employment, housing, and adaptation to adulthood generates high levels of anxiety. Such was the nature of possible fears expressed by one of these caregivers about academic difficulties in the middle of the first-grade school year. "The biggest problem that I am worried about is her academic performance in the first year when she went to school, she could not read and write like other children, so her academic performance was lower than the others" (C9).

4.2. Theme 2: Reconstruction of Family Relationships and Interactions

This theme examines how a child's mental condition affects the family structure. It emphasizes the need to target change in family relations and dynamics as the demands of caregiving transform the ways in which the family relates.

4.2.1. Disruption in Family Relationships

The central theme shown by the mothers' experiences was that mental disorders changed the relationships and interactions of family life because the whole ecology of the family had to adapt to a new reality. This means that the affected child needs special treatment from the parents and long-term care. All caregivers in this study found that their relationship with their spouse changed after their child's diagnosis. Most of the mothers in this sample felt that they had neglected their husbands' needs, which led to conflict and tension between the parents and ultimately changes in the relationships within the family. In this regard, one of the participants, who was going through a divorce, stated, "You see I am about to separate from my wife, but usually, in this family that I am in contact with now, fathers also need to have this training and learn how to treat their wives, their children, and their children. The rest of their family" (C8).

4.2.2. Disruption in Family Social Interactions

Mothers described in primarily negative terms how having a child with a mental disorder affected their social relationships. This behavior was regularly mentioned as a consequence of spending less time with families and social circles, and in some cases completely ignoring them to decrease the generated tensions. In one case, the mother of a child who had been experiencing symptoms of her child's illness for three years but had not consulted a psychiatrist due to her family's cultural beliefs shared her experience, saying, "Because of the problems that my child is having now, we had to cancel all our parties, and this is causing problems for us in a way, but we had no choice" (C3).

4.2.3. Compatibility Problems and Lack of Coping Skills

Sometimes parents consider themselves responsible for the child's behavior. They believe that when a child acts unusually, parents are unable to respond with the appropriate skills. It is also one of the most critical points that the families expressed regarding these children; they expressed some challenges related to not having proper adaptation methods and practical coping skills. One of the participants stated, "I like to control myself, but it is very difficult for me, it is very difficult for me, can you believe I'm stuck behind a barrier" (C7).

4.3. Theme 3: Improving Family Awareness and Performance

The third theme focuses on the need to enhance the degree of awareness among family members, including the child, regarding the mental disorder and its impact. Improving the overall knowledge of the family about mental health is crucial to enable the family to provide an adequate response to the child.

4.3.1. Low Health Literacy Level of the Family Regarding the Child's Illness

The unknown and complex nature of mental illnesses has added to parents' fear, anxiety, and worry. They are often confused about how to care for and support the healing process while maintaining a normal family life. These families expressed a lack of knowledge and the need to increase awareness about the nature of the disease from the people providing care. One participant stated, "I anticipate that the physician of my child will provide reasoning for the prescription. It is expected that he will clarify the duration required for the child to show slight improvement. Understanding the extent of my involvement in this decision is crucial. The question arises whether one should hold optimism for the child's recovery or if there is an element of despair to consider. It is important to be informed about the potential side effects of the medications prescribed for the child. For instance, the scenario may resemble being a subject in an experiment where the doctor instructs to take certain medications with the promise to evaluate the outcome after a month. Subsequent visits may lead to the introduction of a new set of medications. At times, it may seem repetitive with the same drugs being offered, leading to frustration and questioning the efficacy of the treatment approach. This lack of variation may result in skepticism toward the justification of the treatment plan" (C2).

4.3.2. Dysfunctional Parenting

Scientific literature has provided concrete evidence linking parenting practices and proneness to psychopathology (20). In families where children have mental disorders, elements of improper child-rearing practices, such as permissive or authoritative parenting, may increase the risk of psychological disorders, including depression, substance abuse, and aggressive behavior. "In my perspective, the paramount consideration is the necessity for parental unity in the upbringing of a child, particularly in the formative years. This unity stands as a crucial element in fostering the development of a child. For instance, while I tend to exhibit a more stringent approach characterized by discipline and adherence to rules, my spouse consistently advocates for a more lenient stance, advising minimal interference in the child's actions" (C3).

4.3.3. Disturbance in Family Roles and Functioning

Family processes are involved in the development of mental disorders and determine the process of recovery and future development. Maladaptive patterns of functioning in families are likely to affect different aspects of mental health and welfare of family members. Caretakers of children with mental disorders often experience disruptions of their roles and routines and various aspects of family functioning. "In the initial stages, I sought the expertise of a psychologist to guide me on addressing inappropriate behaviors exhibited by the child. The psychologist advised implementing a system of reinforcement, such as rewarding the child for positive actions with a star or a gift. Initially, the child responded well to this approach but gradually lost interest. When informed that lack of compliance would result in no rewards, the child displayed indifference, expressing uncertainty about the appropriate course of action" (C9).

4.3.4. Inability to Meet Economic Needs

The parents identified economic difficulties as the primary reason for their incapacity to fulfill specific essential requirements of the mentally unwell child. Some of them had no means of doing any productive work and depended exclusively on their husbands. Furthermore, several interview participants described the inability to pay bills, care for the child, spend time on the child's play, and consider his preferences due to lack of financial support from the spouse. "Upon escorting him to the kindergarten, he engaged in crafting activities with enthusiasm, followed by a keen interest in resuming his karate and gymnastics classes. He displays a fondness for attending such activities. While I desire to accompany him, my financial resources are lacking, as my sole source of income is derived from my spouse. In instances where he declines, I am unable to proceed independently. Thus, I aim to generate income to facilitate my independent participation" (C7).

4.3.5. Inability to Manage the Health Status of Family Members

Another challenge faced by this family was that most of the caregivers of these children had no idea, and even those who had some idea did not have insight. Along this line, one of the professionals concerning policymaking about these families stated, "The current issue at hand revolves around the lack of insight into the disease by both the patient and their family, posing significant challenges across various aspects of our work. The escalating frequency of hospitalizations is a pressing concern, accompanied by numerous obstacles in the realm of medical interventions. Owing to a deficit in knowledge, these families prematurely terminate treatment due to personal contentment, indicating a pervasive issue with treatment continuity. It is evident that the monitoring procedures across all medical facilities in Iran exhibit considerable shortcomings" (H1).

5. Discussion

The participants' concerns in this study highlighted various psychological, social, and financial burdens that children with mental disorders impose on their caregivers. These findings support previous studies and stress the essential role of emotional stress for caregivers. A similar pattern was observed in Ambikile and Outwater's study in Tanzania, which documented the high emotional burden of caregivers and their need for psychological support (21). Additionally, studies from some countries also confirm that caregivers of children with mental disorders frequently experience stress, anxiety, and social isolation due to caregiving responsibilities (22). Although the problems of stress for caregivers and lack of support resources exist in various settings, specific features of culture may define the character of caregiving. Stigma, along with a lack of professional support and socioeconomic factors, could act as sources of influence on caregivers in Iran. A comparison of these results with those obtained from other nations with different cultural and economic aspects, such as Pakistan, may reveal some common problems and cultural differences felt in different nations, including those in Western or African states. This can be further used to highlight the gap by calling for the development of context-appropriate interventions that should still incorporate a global perspective of caregiving in mental health.

One key finding of this study was the limited professional support available to caregivers, which exacerbates their stress. Many participants reported feeling overwhelmed due to a lack of guidance from healthcare providers, leading them to rely on trial-and-error methods to care for their children. These findings directly support the need for structured caregiver education programs, which have been successfully implemented in Scandinavian countries to improve caregivers' confidence and competence (23). In Iran, establishing specialized training sessions for parents, based on their expressed need for mental health literacy and practical caregiving skills, could help bridge this gap.

Additionally, the study found that caregivers often struggled with stigma and societal misconceptions surrounding mental illness. This aligns with research indicating that stigma is a major barrier to seeking help (24). In response to this challenge, caregivers in this study emphasized the need for community-based awareness programs to educate the public and reduce stigma. Such programs have been effective in improving societal attitudes toward mental illness (25).

Furthermore, financial difficulties were a prominent challenge reported by caregivers, with many struggling to afford mental health services, medication, and specialized care. This finding reinforces previous studies from low- and middle-income countries, where economic barriers limit access to mental health care (26). Participants in this study specifically called for financial assistance, a recommendation that directly aligns with global best practices, such as government-subsidized caregiver support programs in some countries (27).

Caregivers also described using various coping mechanisms, including religious practices, consulting healthcare providers, joining support groups, and using educational materials. These findings indicate a clear need for formalized peer support networks to enhance resilience and reduce caregiver isolation. Similar initiatives in some studies have provided structured support groups that significantly improve caregiver well-being (28). Implementing such programs in Iran, tailored to cultural and religious contexts, would address an expressed need identified in this study.

The study highlights the need for government institutions to enhance the quality of life of caregivers. There is a desperate need for policies addressing issues like stigma, increasing access to community support services, and financial support. Another approach is to analyze successful international practices and develop an Iranian program that fits the cultural context and fills the mentioned gaps. More such measures would enable caregivers and assist families in better supporting mentally ill children.

5.1. Conclusions

Caregivers of children with mental illnesses in certain nations encounter numerous obstacles stemming from inadequate mental health infrastructure. These caregivers assume various responsibilities in delivering care for individuals with mental illnesses; consequently, the caregiving responsibility imposes a substantial burden. They endure suffering and require the assistance of mental health experts. It is crucial to recognize the requirements of family caregivers, the stress it induces, and offer suitable interventions to alleviate their burden. The utilization of professional training in delivering healthcare services to families highlights the essential involvement of nurses. Their focus should extend beyond children with mental disorders to encompass their caregivers, who encounter various challenges and diverse issues. These caregivers undergo distinct experiences. In conclusion, the results of this research emphasize the importance of creating nursing intervention initiatives aimed at reducing stress levels and increasing productivity among caregivers of children with mental disorders. This can be achieved by understanding the needs of the family and providing adequate social assistance to improve their capacity.

5.2. Limitations

One primary limitation of this study is the lack of involvement of other family members, such as siblings or extended family, in data collection. Since families function as interconnected systems, the experiences of other family members could provide additional insights into the broader impact of caring for a child with a mental disorder. Future research should consider including siblings, grandparents, or other caregivers to gain a more comprehensive understanding of family dynamics and support mechanisms. Additionally, this study did not focus on a specific category of mental disorders. Given the diverse nature of mental health conditions, the needs and challenges faced by caregivers may vary significantly depending on the specific disorder. While our study aimed to identify common themes across different conditions, future research should focus on individual disorders to provide tailored insights and targeted support strategies for caregivers. Finally, the qualitative nature of this study means that findings may not be generalizable to all caregivers of children with mental disorders. Future studies could use mixed-method or longitudinal approaches to examine long-term caregiving experiences and validate findings on a larger, more diverse sample.

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Footnotes

Authors' Contribution: S. Z. participated in the design. She contributed to the interpretation of data and the writing and editing of the manuscript. Additionally, she coordinated meetings with stakeholders, recorded meeting reports, and identified potential participants. M. K. participated in project development and design. She supervised data collection, acquisition analysis, interpretation of study results, and writing of the manuscript. She was responsible for all aspects of the ethics committee of Isfahan University of Medical Sciences and Research. M. A. and M. H. participated in the design of the study and will meet during the study to monitor behavior and progress. The authors read and approved the final manuscript.

Conflict of Interests Statement: The authors declare no conflict of interest.

Data Availability: The dataset presented in the study is available on request from the corresponding author during submission or after publication. The data are not publicly available due to this privacy.

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