A Phenomenological Study on Caretaking Families of Schizophrenic Individuals: Does the Family Feel Burdened?

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Abstract. Caretaking families of schizophrenic individuals experience various psychological conditions involving the attention of mind, emotion, behaviour and social. These are experiences that each family undergoes both objectively and subjectively. The current study aims to comprehend the experiences of caretaking families of schizophrenic individuals. Descriptive Phenomenology Analysis (DPA) is chosen to analyse those experiences. Theme findings are roles and responsibility, emotional reaction, social activities, communication pattern, religiosity, and appraisal or expectation. Some research results show that the family's experience while caring for the schizophrenic individual is related to family burden. This burden is mainly a psychological family burden, such as emotional reaction in feeling angry and upset. On the other side, caretaking families also demonstrate patience acceptance, which happens to be part of the family's emotional regulation. Having a certain emotion regulation process helps lessen the family burden. Family values influence the emotion regulation process. Therefore, further study on family values other than religiosity is required to study the family's cultural values. Cultural context plays a role in expressing positive emotion in the emotion regulation process. Thus, further research on emotion regulation related to the family burden of caretaking families of schizophrenic individuals shall pay more attention to cultural context.

Keywords: family · caregiver · schizophrenia · experience · burden · emotion

1 Introduction

Schizophrenia is a type of psychotic disorder indicated by having a reaction or psychotic symptoms that interfere with individuals' cognitive, affective, and behavioural processes, making them socially inconsistent (Isaacs, 2005). Uhlhass and Mishara (2006) stated that a disturbing cognitive process implied by hallucinating is a typical symptom of schizophrenia. Ibrahim (2005) and Maramis (2009) explained that schizophrenic individuals mostly had disturbances in the cognitive process, such as false thought or perception, and disturbances in affective process. Schizophrenia is a disorder preying on the cognitive process (irrational), resulting in the inability to feel and inconsistent behaviour.

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In 2000, around 1% of the world population had been reported to have schizophrenia, while in Indonesia, the number of people having schizophrenia was around 1% to 2% of the nationwide population (American Psychiatric Association, 2000). In a report from WHO (2012), schizophrenia affects around seven per thousand of the world population, especially in 15–35 years old, with around 0.2%–0.8% of people having schizophrenia. In 2013, the prevalence of severe mental disorders like schizophrenia in Indonesia had reached 1.7 per 1000 people, meaning over 400.000 people were struggling with severe mental disorders across all Indonesian provinces (Riskesdas, 2013).

The factors causing schizophrenia can be categorized into internal and external factors. Internal factors are individual predispositions, e.g., knowledge and pressure/ stress, while external factors are support systems such as family (Nevid, Rathus, & Greene, 2005). After being diagnosed and referred to certain kinds of therapy, few conditions influence the recovery of the schizophrenic individual. One of those is their family. Family plays an essential role in the life of schizophrenic individuals, especially in their recovery. Family supports living a normal life (Tomb, 2004). In schizophrenic individuals, recovery is appraised from decreasing symptoms and family conditions (Janardhana et al., 2018). The family is supposed to function well to provide proper care for schizophrenic individuals in recovery.

On the contrary, the family portrays an unpleasant situation when living with the schizophrenic individual. Huang et al. (2021) described four situations that the family experienced while living with the schizophrenic individual: 1) a heavy responsibility, 2) a requirement to function well, 3) having many challenges, and 4) living under pressure. This pressure made the caretaking family feel burdened. Family as caregiver or companion has physical, psychological, emotional, and social experiences, including financial problems due to taking care of a sick family member, be it physically or mentally ill (Zarit, Reever, & Back-Peterson, 1980).

Agus (2011) stated that relapse in the schizophrenic individual is caused by the psychosocial factor, such as family. Family might influence schizophrenic individuals not to take their medication as prescribed, which results in a relapse. Konadi, Nauli, and Erwin (2017); Pratama, Syahrial, and Ishak (2015) affirmed that a relapse happened due to disobedience in taking medication. A relapse in the schizophrenic individual is caused by decreasing empowerment function, supported by disobedience toward treatments, which could involve family perception, acceptance, appraisal, and stigma related to schizophrenic individuals (Tiara et al., 2020). Another assumption also existed in families, saying that schizophrenic family members are better cared for in the hospital instead of at home, making families less cooperative toward caretaking and medication at home, resulting in a relapse (Rosdiana, 2018).

At present, there are still few families limiting the activities of their schizophrenic family members. To schizophrenic individuals, limited or even no activities stimulate adverse prognosis, which can also cause a relapse (Chan, 2011). According to Konadi, Nauli, and Erwin (2017), a relapse did not happen due to the absence of intention in schizophrenic individuals, but instead because of the family giving them the freedom not to have any activities at home.

Some families still conceal the presence of their schizophrenic family members from social surroundings. The study conducted by Suryani, Komariah, and Karlin (2014)

confirmed this and reported that 4 out of 6 family members admitted feeling confused, disliked, and ashamed being part of a family with schizophrenic family members. These feelings made them unable to provide proper care for a schizophrenic family member and later relapse. Few conditions in caretaking families of schizophrenic individuals are producing a burden for the family themselves (Huang et al., 2021).

Whether cognitive, emotional, behaviour or social conditions, various conditions follow families while caring for schizophrenic individuals. Consequently, it is necessary to further study family experiences in taking care of schizophrenic individuals. These experiences may be in the form of events that happened to the family, involving mental activities on how they think, feel, and behave while taking care of the schizophrenic family member. These experiences are exclusive to each family could be both objective and subjective. For that reason, the current research aims to recognize experiences from each family in a descriptive way.

2 Method

A descriptive phenomenological approach from qualitative methods was chosen for the current study. A qualitative descriptive phenomenological study was conducted to explore family experiences in caring for individuals with schizophrenia from a first-person perspective, in this case, the family itself. The descriptive in this study was obtained by probing as much and as deep information as possible regarding the experiences of caretaking families of schizophrenic individuals, using verbal data. This phenomenology approach sought to comprehend the subjective life experiences of individuals going through certain events or phenomena (La Kahija, 2017).

Participants were selected using purposive sampling technique, with the following criteria (1) families taking care of schizophrenic individuals directly, (2) being 18 years old or above, (3) living in the same house with schizophrenic individuals. A semi-structured interview via online video conference was applied to collect data. Interview guidance consisted of questions asking about families' experiences in taking care of schizophrenic individuals. What are the reactions, roles, ways of being hot, influences and impacts on treating schizophrenia.

Data analyses were conducted descriptively (Descriptive Phenomenological Analysis) with the steps developed by Giorgi, Husserl, and Maurice Merleau-Ponty (La Kahija, 2017). Those are 1) reading through interview transcripts repeatedly to obtain meaning units as apprehensions, 2) taking transcripts that have contained meaning units, to describe each meaning unit as close as possible to the original statements, 3) constructing psychological description, 4) creating structural description to find meaning underneath the transcripts, 5) explicating themes from the structural description, 6) synthesizing themes, and 7) discovering essences of those themes.

3 Ethical Clearance

The current study has been acknowledged to fulfil standard research ethic principles by the Research Ethics Committee of the Faculty of Psychology, Gadjah Mada University, Yogyakarta (No. 6822/UN1/FPSi.1.3/SD/PT.01.04/2021 dated November 18, 2021).

A. *Results*

Characteristic of Partisi pants (Table 1).
Research Findings.

1) *Participant L*
a) *Emotional Reaction*

Participant L felt various reactions living with her mother, who had schizophrenia. As she assisted her mother daily, Participant L admitted feeling upset and angry, yet trying to accept the situation with patience. There were several behaviours of a schizophrenic individual that she found to be against her opinion or judgement, which caused her to feel upset and angry. Besides, there was also a feeling of remorse due to her mother's condition being worse.

Yes, I feel angry, and yes, I feel upset. However, all I can do is be patient accept things as they are. Like what happened the other day; it was a part of the symptoms. (Subject L, Post 2). It felt like everything I did was wrong, but what can I do? Just go with the flow. Sometimes I lose my composure, but I try to stay calm (Subject L, Post. 2). Why is my mother behaving this way? She changes drastically, is angry continually, and I am wrong all the time. I try to accept, though it feels unhealthy to me. Oh, this makes me cry. (Subject L, Post. 2).

b) *Social Activities*

Participant L is a socially active individual. Consequently, she gets the support and knowledge (related to taking care of schizophrenic individuals) needed and a positive response from her surroundings (a help when her mother had a relapse and needed to stay in the hospital). Participant L regularly attends social activities in the neighborhood, such

Table 1. CHARACTERISTIC OF PARTISIPANTS

Category	**Participant 1**	**Participants 2**
Name	L	P
Age	37 years old	58 years old
Sex	Female	Female
Education	S1	SMA
Material Status	Single	Married
Means of meeting	Meeting *online* via *google-meeting* and *WhatsApp video call*	Meeting *online* via *google-meeting* and *WhatsApp video call*

as joining the health community for mentally ill people, religious gatherings, exercise sessions, and therapy activities for caregivers.

Since she knew us too, the lady from that shop told me that I should take whatever mother said. If mother got angry, I should let her accept it because that is just how her condition was (Subject L, Post 2).

c) *Roles*

Participant L did what she could to help the recovery of the schizophrenic individual, and this had become a role she performed daily. For instance, she always took her mother to a therapy program provided in the village and a routine check-up to the hospital, provided her mother's daily needs, and occasionally took her mother to some entertainment.

I took mother to TAK this whole day (Subject L, Post 2.) Mother cannot do things herself; I must assist her always. She no longer remembers the seasoning when she cooks, so I take over. She does the laundry wrong. The same goes for the dishes. So I do all the laundry, dishes and cleaning. I also prepare her clothes, food, medication, take her to check-ups and grab the medication later (Subject L, Post 2).

d) *Responsibility and Service*

Participant L took care of the schizophrenic individual as a responsibility toward her parents. She felt it was her responsibility since she lived with the schizophrenic individual, yet she positively received financial support from other family members. Participant L willingly put aside her wish to marry and instead focused on her mother's company. Taking care of her mother came first as it is a form of service toward her parents, which also resonated with Javanese cultural values.

I tried to accept and be grateful that I still have both my parents. I still have my mother and the chance to serve her (Subject L, Post 2). My older siblings asked me to take care of our mother. Occasionally they sent me some money for my mother (Subject L, Post 2). Yes, I tried my best to serve my parents, the however mother is. Father is older too, so yes… Mrs Rsaid, just serve your best and accept. Moreover, yes, God sent me the strength to do so. (Subject L, Post 2).

e) *Communication Pattern*

Participant L and the schizophrenic individual maintain warm communication, as seen in their habits to share jokes and walk around the neighbourhood to cheer her mother. In addition, participant L tried to stay by the side of the schizophrenic individual at all times.

Sometimes, I think it is okay to joke around with her, and she will laugh at it (Subject L, Post 2).Hehe, yes, Ma'am (laughing). I need to always be there for my mother (Subject L, post. 2).

f) Religiosity

Participant L kept herself close to God by praying in every situation she went through. She felt that this made her feel grateful to be able to serve her parents.

People around me have their wishes come true without having to say it. However, I prayed to Allah for my wishes, and they came true. The same went for my wishes for

my mother. They come true as well. Even though I did not say, I only prayed (Subject L, Post 2). Yes, by getting myself closer to Allah (Subject L, Post 2).

g) *Self-appraisal*

Participant L admitted feeling unconfident about the condition she and her family went through and sometimes feeling unable to face the rest of the family.

How am I supposed to appraise myself? Hehe, I cannot do that. People can. However, here I am, just being myself (Subject L, Post 2). Yes, I tried my best to put my mother first to prevent any conflict with her (Subject L, Post 2).

2) *Participant P*

a) *Emotional Reaction*

Participant P confessed feeling burdened by the past behaviour of a schizophrenic individual, which still triggered severe symptoms. However, she felt better already since the schizophrenic individual now could perform daily activities. Otherwise, participant P could remain patient in accompanying the schizophrenic individual, regardless of her behaviour. Patience, acceptance, and letting go were reactions shown by the family as understanding and tolerance upon the condition of the schizophrenic individual.

Yes, I cried. Why, but it is all done, and I try to be patient (Subject P, Post 2). One day I saw her angry and smashed everything, the plates were broken all over.. The neighbours knew, but I was okay. I accepted those with patience. I did nothing else. I let it go. Let the plates break. We could buy some more later. However, D was unaware of what she was doing, all the rageand smashing things. (Subject P, post 2).

b) *Social Activities*

Participant P is also a socially active individual, involved in a religious gathering, and joining a healthy community for children and mentally ill people. Participant P received support from her social surroundings in information on the caretaking of schizophrenic individuals from the neighbours. Moreover, her social surrounding treated the schizophrenic individual well.

The health committee here, Alhamdulillah, provided many activities for the mentally ill. I really felt the change, the impact. Now D is totally different (Subject P, post 2). Other people knew our condition. They all supported me. Including the health committee members, they supported D's recovery. Just the usual interactions, nothing more (Subject P, post 2). I am, too, actively involved in their activities. The health committee activities, I join them so I can know more about D's condition (Subject P, post 2).

c) *Roles*

Participant P made various efforts to aid the recovery of the schizophrenic individual. For instance, I always assisted the schizophrenic individual to therapy sessions, provided daily needs, and continually sought information on the caretaking and medication of schizophrenic individuals.

I tried my best to be there for her, always. Alhamdulillah, now she is really changed. She is recovered now, Ma'am? I did everything I did for D. I went to check-ups everywhere with her. I did what I could for her recovery (Subject P, post 2). Yes, everything, she is with me in her daily activities. I prepared all those. All I did was for her recovery (Subject

P, post 2). Yes, I took her to the doctor to get the medication and anywhere else. I went with her to any of her activities (subject P, post 2). Well, I tried to stay patient and did what I could for D's recovery. Ever since she got sick until now, I have stayed by her side. I used to think about my own condition, but now D came first. Anything for D (subject P, post 2).

d) *Responsibility*

Participant P set aside her interest and chose to focus on the recovery of the schizophrenic individual. Despite feeling burdened in the process, she felt better now since the schizophrenic individual could perform daily activities.

However, she still felt burdened when it came to the future of the schizophrenic individual, such as marriage, work, and how the future conditions of the schizophrenic individual would be.

Well, I did not think about myself. I tried to be patient, to be grateful. All I did was for D's recovery. Moreover, alhamdulillah, now it is all better. Patience and constant praying, focus on her recovery (subject P, post 2) I wanted to be there for her, always. Alhamdulillah now she is really changed. She is recovered now, Ma'am? Everything I did was for D. I accompanied her to check- up sessions everywhere. Anything for her recovery (Subject P, post 2). Yes, everything, every day, her activities, all with me. I prepared everything for her. All I did was for her to recover (Subject P, post 2).

e) *Communication Pattern*

Participant P tried her best to stay patient, accompanying the schizophrenic individual, even when she was angry.

To me, she is recovered. Furthermore, I go with her everywhere, making me feel closer to her (Subject P, Post 2). Yes, I try to be kind and supportive. All I did was for D, for her recovery (Subject P, Post 2).

f) *Religiosity*

Participant P constantly prayed to God for the recovery of the schizophrenic individual. As for the current condition, participant P felt grateful because the schizophrenic individual got better gradually.

Alhamdulillah now she is totally changed. She went everywhere with me, told me everything. I stayed patient, always prayed, and my prayers were answered alhamdulillah. She changed. So grateful (Subject P, post 2). Well, I said nothing, remained silent. Be patient, be patient. I prayed and prayed for her to recover and normally live (Subject P, post 2). I thought this was what God had chosen for her. I kept praying for her to recover. At first, I was like, why should it be like this? However, it is okay now. Let it go (Subject P, post 2).

g) *Physical Reaction*

Taking care of a schizophrenic individual had impacted participant P physically. She rarely got the chance to take care of her physical health, causing her some weight loss.

I used to think about D's condition all the time until it made me lose my appetite. I lost weight, and my body got worst thinking about D (Subject P, post 2). Yes, I was only skin and bones once (Subject P, Post 2).

h) *Future Expectation*

Participant P admitted having expectations for the schizophrenic individual to be able to live a normal life in the future.

Yes, now the number 1 hope is D's future. How the future would be for her, and alhamdulillah, she could speak English, even still worked as a teacher. I was grateful for that. I did not demand anything, any work. Everything was good. Suitable for her activities in the future. I hope it will stay this way and improve her future. (Subject P, post 2). Yes, I have more hopes for D. For her bright future, working; any work is good. Alhamdulillah now can work gradually. Everything is focused on how her condition in the future would be. (Subject P, post 2). Yes, I expect all good things for D (Subject P, post 2).

4 Discussion

The experience of caretaking schizophrenic individuals is closely related to reactions to understand produce emotions and attitudes toward schizophrenic individuals and social surroundings. As Zarit, Reever, & Back-Peterson (1980) defined, the family burden is physical, psychological, emotional, social experiences, and financial problems that the family goes through because of their responsibility in taking care of the mentally ill or physically ill family member. Families in this study experienced both physical and psychological burdens. Moreover, psychological experiences were in the form of family responses on a schizophrenic individual associated with the thinking process, emotion or feelings, social aspects, and religiosity.

1) *Psychological Experiences*

Families did everything they could as a responsibility to take care of the schizophrenic individual. For schizophrenic individuals, their families provide daily needs, maintain healthy communication, accompany them to therapy sessions, and help them join other activities supporting recovery. Demands, obligations, and responsibility in carrying the role and function as caretaking family of the schizophrenic individual may generate a burden (Huang et al., 2021). Family burdens generate several psychological conditions involving their mind, feelings, and behaviours.

In the thinking aspect, psychological experiences were the changing point of view and understanding. Families understand what to do to support the recovery of the schizophrenic individual. With the burdens present, families could not determine the conditions and proper care for schizophrenic individuals (Huang et al., 2021). On the contrary, families did not feel any burden in the understanding aspect. They understood and realized that what they did was for the recovery of the schizophrenic individual. They even had a positive outlook and expectations that the schizophrenic individual might be able to live a normal life.

Psychological experiences **in the emotional reactions aspect** included both positive and negative emotions. Negative emotions were feeling upset, angry, and burdened by

the presence of the schizophrenic individual. Feeling burdened normally caused intense emotional expression which later on contributed to the relapse of the schizophrenic individual (Scazufca & Kuipers, 1996; 1998; Thara et al., 1998). Families with intense emotional expression in the form of harsh behaviour and criticizing schizophrenic individuals influenced relapses in 9 months, and 57% of the schizophrenic individual had to be hospitalized (Leff & Vaughn, 1985). Widianti, Karmansyah, and Yani (2020) added from their research the intense emotional expressions were Emotional Over Involvement (EOI) (such as overreacting families due to feeling guilty and being overprotective toward the schizophrenic individual) and Critical Comment (CC) (for example, avoiding when the schizophrenic individual had a relapse). Inthe current study, emotional expressions shown were feeling upset and angry, plus burdened by the future of the schizophrenic individual.

Positive emotions include patience, sincere acceptance, persistence, and gratitude. Emotional reactions shown by the caretaking families had been a particular dynamic, as a part of regulating negative emotions into more positive ones. Emotion regulation contains a cognitive process (thinking process and point of view) that leads to the expression of positive emotion. Gross (2014) described emotion regulation as specific ways adapted by individuals to manage emotions, including influencing, feeling, and expressing one's emotion. This expression refers to how individuals intensify or lessen both positive and negative emotions.

Emotion regulation is a skill indicating emotional intelligence (Goleman, 2015). Therefore, the first step in emotion regulation is related to how individuals perceive the situation before them. Emotion regulation monitors emotion, evaluates emotion, and expresses emotion (Gross, 2006; Gross & Thompson, 2006). 1) How the caretaking families did not perceive the behaviour of a schizophrenic individual during a relapse as a problem, or ignore it as a form of letting go, understanding the behaviour during relapse (smashing things) as parts of schizophrenic symptoms, and think more positively that there is a hope leading to the recovery of the schizophrenic individual, also putting aside personal interest to focus on the needs of the schizophrenic individual. These mentioned above belong to monitoring emotion as the first step of emotion regulation. Monitoring emotion is a skill to acknowledge and understand the process within the self, such as thoughts, feelings, and motives of actions (Gross, 2006). In caretaking families, acknowledgement and understanding of schizophrenic individuals' conditions were present, which directed the family to accept.

Evaluating emotion is a skill to handle negative emotions like anger, sadness, disappointment, so the individual will not get overwhelmed (Gross, 2006). It has become a suppression when the families. Accept sincerely and do not express unwanted negative emotions. Suppression is a process of suppressing unwanted feelings by controlling and not expressing them (Gross & John, 2003). Evaluating emotion is conducted by assessing oneself to avoid being triggered by negative emotions.

Modifying emotion is a skill to alter certain emotions into motivation (Gross, 2006). Modification helped caretake families persevere in facing the condition of schizophrenic individuals. Families altere danger and disappointment into acceptance and sincerity. 4) Expressing emotion, the last step of emotion regulation, is an effort to manifest emotion in various models and strategies (Gross, 2006). Hude (2006) mentioned coping

as a model in emotion regulation, like accepting and living life fully, including gratitude, patience, forgiveness, and adjustment to others. The caretaking families had shown patience, sincere acceptance, gratitude as emotional expressions and self-adjustment to the schizophrenic individual. Emotion regulation did help lessen the burden of caretaking families of the schizophrenic individual. Models and coping strategies in emotion regulation had become factors influencing family burden (Rafiyah & Sutharangsee, 2011).

Socially, the caretaking families remained active and involved in social activities in the neighbourhood, for example, joining the health committee for children and mentally ill people (Kader posyandu & Kader Jiwa). These activities allowed the caretaking families to receive support from their social surroundings. Those supports came in the form of information related to schizophrenic individuals, instrumental support (by providing help to take the schizophrenic individual to a hospital), and emotional support (by showing attention and encouragement). Wai and Chan (2011) explained that in Asian countries where social values are dominant, showing empathy is considered a life principle. This value causes a citizen to have roles and responsibilities, to maintain a balanced relationship with others.

The caretaking families had relatively dominant religiosity, which led them to be grateful for the condition of schizophrenic individuals. The families relentlessly prayed for the recovery of schizophrenic individuals. This helped them stay patient and accepting sincerely. They even had a positive outlook regarding the future of schizophrenic individuals, that they would be able to work and live a normal life.Religiosity is closely related to a family's religious experiences. Religious experiences involve religious awareness, which indicates a belief resulting from specific actions (Jalaluddin, 2005). Gratitude and sincere acceptance lead to patience and belief that there are hope and possibilities for the schizophrenic individual to recover.

2) *Physical Experience*

Physical experience refers to caretaking families shifting their focus to the schizophrenic family member and putting aside their personal needs. This impacted the family both in their physical needs and personal interest. For instance, putting off the wish to marry to provide care for the schizophrenic individual. Physically, the family loses their appetite and, later on, their weight because of thinking about the health of the schizophrenic individual. Family burdens are experiences that the caretaking family go through physically, psychologically, emotionally, and socially and financial problems (Zarit, Reever, & Back-Peterson, 1980).

3) *Factors of Family Burden*

Factors influencing family burden are 1) responsibility that becomes a demand, 2) involvement in social activities, where families get social support and more understanding about caretaking of schizophrenic individuals, 3) family belief, like religiosity, and 4) emotion regulation. The research that Rafiyah & Sutharangsee (2011) conducted confirmed the factors related to family burden were categorized into; 1) caregiver factors, which include age, sex, education, income, health status, daily working hours, knowledge on schizophrenia, culture, coping strategies; 2) patient factors, which include age, clinical symptoms, and disability in daily life, and 3) environment factors, which include

mental health service and social support. Responsibility in carrying out roles and functions of caretaking the family creates a burden, impacting family attributes, such as not giving proper support and medication, feeling stressed, exhausted, isolated, and worried about the future (Huang et al., 2021).

4) *Impacts on the Family*

Rafiyah and Sutharangsee (2011) defined burden as a negative impact of taking care of the mentally ill individual. The burden may be both objective and subjective. The objective burden includes what the family go through in their daily activities, while the subjective burden refers to what family experience are related to physical health, emotions, social life, and financial status (Rafiyah & Sutharangsee, 2011). The objective burden can be seen in the decreasing daily activities, while the subjective burden can be seen in their emotional reactions, like upset and anger.

5 Conclusion and Recommendations

The themes found in the experiences of caretaking families of schizophrenic individuals were roles and responsibility, emotional reactions, social activities, communication patterns, religiosity, and appraisal or expectation. These experiences while providing care for the schizophrenic individual were related to family burden. 1) Families felt burdened psychologically, as seen in their emotional reactions, which we are feeling angry and upset. 2) Factors influencing family burden were responsibility and involvement in social activities, where social support, religiosity, and emotion regulation were obtained. 3) The caretaking families had shown patience, gratitude, and acceptance, which were parts of the emotion regulation process, and later reduced family burden. As one of the factors impacting family burden, the emotion regulation process is associated with family values. Consequently, further study on family values other than religiosity is necessary. One example of the values is cultural values. Thus, further studies on emotion regulation related to cultural values are expected to be carried out in the future.

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