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Lived Experiences of Family Caregivers of Schizophrenic Patients Followed at the National University Hospital Center of Psychiatry in Cotonou: An Interpretive Hermeneutic Phenomenological Qualitative Study

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Abstract

Introduction: The deinstitutionalization of care for patients suffering from chronic illnesses such as schizophrenia has led to a paradigm shift from a pathological model of the family to a competency-based model, which has significant consequences for the lives of informal caregivers. **Aim:** To understand the lived experiences of informal caregivers of schizophrenic patients treated at the National University Hospital Center of Psychiatry in Cotonou (CNHUPC) in Benin. **Method:** A qualitative, interpretive phenomenological approach was

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adopted. The integrative framework used consisted of the hermeneutic phenomenology of Van Manen and Adams, and the transactional model of stress and coping by Lazarus and Folkman. Data collected through semi-structured interviews with participants selected using a non-probability, convenience sampling method were analyzed using descriptive statistics and according to the hermeneutic phenomenological analysis approach advocated by Van Manen. **Results:** Ten caregivers were included in the study, seven of whom were women (mean age: 38.9 ± 11 years). The caregivers experienced intense emotional distress marked by suffering, fear, guilt, and resignation. They also faced social stigma and isolation, which caused invisible wounds. Physically, caring for schizophrenic patients resulted in chronic fatigue, sleep disturbances, pain, and sometimes aggression. Their professional lives were frequently affected, with interruptions or reductions in work activities. To cope with these daily challenges, the caregivers adopted coping strategies centered on spirituality and faith, as well as acceptance and hope**. Discussion and Conclusion:** Interventions likely to reduce the emotional and psychological burden associated with their role, and strengthening their capacity through specific training on stress management and self-protection strategies, should be promoted.

Keywords

Lived Experiences, Family Caregivers, Schizophrenic Patients, Psychiatry, Benin

1. Introduction

Schizophrenia is a serious mental illness that manifests clinically through acute episodes associated with debilitating symptoms such as hallucinations, delusional ideas, thought disorders, and alterations in social behavior [1] [2]. These symptoms often require long-term management, which involves pharmacological treatments and psychotherapeutic follow-ups. Indeed, the evolution of psychiatry in recent decades worldwide has been marked by the deinstitutionalization of patients suffering from chronic conditions like schizophrenia, thereby facilitating their return to the community [3]. As a result, in Western countries, for example, 50% to 80% of individuals with schizophrenia return to their families after hospitalization and rely on the ongoing aid and support provided by them [4]. The reduction in hospital beds, along with the shift of psychiatric care from hospitals to community settings for stabilized patients post-hospitalization, has significantly altered the perspective on families and close caregivers [5]. Thus, the notion that family members and the family environment were the origin of their loved one's mental illness has gradually begun to change, and today, the family has become an indispensable partner in psychiatric care [5]. The family home then becomes an extension of the health institution, which must be adapted to accommodate the patient's long-term care [6], inducing a paradigm shift from a pathological model of the family to a competence-based model [7].

This paradigm shift is not without consequences for the lives of close caregivers. Indeed, schizophrenia is a chronic psychiatric illness that has repercussions extending beyond the individual framework of the patient, also affecting their family and social environment directly or indirectly. It generates a high cost for the patient due to their personal suffering and for the close caregiver because of the transfer of hospital care to the family, as well as repeated hospitalizations in cases of decompensation and the importance of long-term psycho-socio-economic support [8]. Schizophrenia thus constitutes one of the most serious psychiatric conditions, ranked first in terms of hospitalization duration, the significance of its disruptions to family life, and the extent of costs on personal and social levels [9].

In the support they provide to individuals in need, informal caregivers are led to invest themselves extensively on emotional, cognitive, social, and material levels, which can gradually lead to overload [10]. The responsibilities of informal caregivers can be particularly overwhelming, resulting in considerable stress and psychological distress. Studies [10] [11] have shown that caring for a person suffering from mental illness can have detrimental consequences on the caregiver's life. The caregiver may experience chronic stress, anxiety, depression, and even despair. In addition to this psychological suffering, the repercussions can also manifest as physical health problems, family disruptions, reduced social and leisure activities, financial difficulties, and a general decline in their quality of life. The experiences of informal caregivers of schizophrenic patients are therefore a crucial area of research that deserves particular attention.

In Benin, as part of the deinstitutionalization of psychiatric centers, the National University Hospital Center of Psychiatry in Cotonou (CNHUPC) has faced numerous restrictions regarding the organization of its mental health services, including the reintegration into the community of patients whose health condition has stabilized. The CNHUPC therefore relies on families for the continued support and social reintegration of individuals living with mental health problems, particularly schizophrenia. These family caregivers, often untrained, thus play an essential role as intermediaries in the daily care of the patient.

Understanding the challenges faced by these caregivers is crucial for developing effective support policies, hence the importance of this study, which aims to explore the experiences of caregivers of schizophrenic patients followed at the CNHUPC in Benin. Specifically, it will address:

- To identify the significant situations or events that mark the journey of family caregivers in their role of supporting patients with schizophrenia;
- To describe the psychological, physical and socio-professional experiences of family caregivers related to their role in supporting patients with schizophrenia;
- To identify the coping strategies developed by family caregivers to deal with the daily challenges related to their role in supporting patients with schizo-

phrenia.

2. Method

2.1. Research Proposal and Integrative Reference Framework for the Study

An interpretive hermeneutic phenomenological qualitative research design was adopted. The integrative reference framework used consisted of two elements: the hermeneutic phenomenology of Van Manen and Adams [12] [13] and the transactional approach to stress and coping by Lazarus and Folkman [14] [15].

Indeed, the hermeneutic phenomenology of Van Manen and Adams [12] [13] focuses on the meaningful experiences of human beings and is situated within an ontological and epistemological stance that enables the exploration, through narration and reflection, of the existential dimensions of the lived experience of the family caregivers of the investigated schizophrenic patients, namely: corporeality (the subjective experience of the body), temporality (the subjective experience of time), spatiality (the relationship to places and the environment), relationality (links with others), and sometimes materiality (everyday objects or elements that take on meaning in the experience). It involves a process of co-construction of meaning in which the discourse of the family caregivers of schizophrenic patients is not simply analyzed, but interpreted in dialogue with the researcher, thereby highlighting the deep structures of their lived experiences [12] [13].

As for Lazarus and Folkman's transactional approach to stress and coping [14] [15], it allows for an analysis of how caregivers perceive and manage stressful situations experienced in the process of caring for schizophrenic patients. Indeed, according to these authors [14] [15], stress results from a cognitive appraisal of the situation and occurs when an individual believes that the demands of the environment exceed their coping resources. They [14] [15] define coping as "the constantly changing cognitive and behavioral efforts used to manage specific internal and/or external demands that are appraised (by the person) as taxing or exceeding their resources." According to Lazarus and Folkman [14] and Lazarus and Launier [16], coping has two main functions: 1) modifying the problem that is the source of the stress and, 2) regulating the emotional responses associated with that problem.

We can therefore distinguish between:

- Coping strategies based on emotion regulation are used to reduce distress and negative emotions caused by the stressful event (avoidance; minimization; distancing; selective attention; positive comparisons; assigning positive value to negative events; spiritual values; faith; confiding in others; investing in activities other than caregiving tasks; withdrawal and detachment; self-blame; expressing emotions [anger, anxiety]; reassurance; etc.);
- Problem-focused coping strategies, which aim to address the stressful event with the objective of reducing the source of stress (e.g., social support, spirituality, family reorganization, or conversely, withdrawal, isolation, reorientation;

seeking help; searching for resources or tools; distancing oneself from the situation; ignoring or accepting it; collusion or complicity; etc.). Indeed, problem-focused coping strategies act directly on the environment itself to mitigate the difficulties resulting from the interaction between the person and their environment: the individual identifies the nature of the problem, analyzes the causes, and seeks to develop an action plan to resolve or alleviate the stressful situation.

2.2. Target Population and Sampling Method

The study included family caregivers of schizophrenic patients followed at the CNHUPC. The inclusion criteria were as follows: 1) being a family caregiver who provides regular support to a schizophrenic patient in managing their care for at least six months; 2) being able to answer questions during the semi-structured individual interview; and 3) having no personal history of psychiatric disorders. Non-probability sampling of the accidental type was the method used due to its characteristics, which are perfectly suited to the target population of the study and the chosen research design. Also called convenience or haphazard sampling, this type of sampling requires the accessibility (or availability) of subjects at a specific location and at a specific time. Thus, the family caregivers surveyed were recruited when they accompanied their schizophrenic patients to consultations at the CNHUPC for therapeutic follow-up or during home visits for follow-up of their schizophrenic patients conducted by the researcher. The sample size was determined based on the principle of theoretical or empirical data saturation [17], which corresponds to the point in qualitative research where new interviews become redundant and do not provide any additional data or knowledge. Indeed, sampling, data collection (recording and transcription of respondents' discourse), and content analysis were carried out iteratively or concurrently. The point of empirical data saturation was reached when no new information was gleaned from the discourse of the eleventh respondent onward, in relation to the variables or main phenomena under study.

2.3. Data Collection Tools and Main Variables or Phenomena under Study

A semi-structured interview guide, including main questions and follow-up questions, was used to allow caregivers to better express their experiences related to their involvement with patients with schizophrenia. The data collection instrument was constructed based on the emerging themes from the study's integrative conceptual framework [12]-[15] and took into account the study's objectives. This allowed for the identification of significant situations or events marking the journey of caregivers in their role of supporting patients with schizophrenia (specific object 1 of the study), the description of the psychological, physical, and socio-professional experiences of caregivers related to their support of patients with schizophrenia (specific object 2 of the study), and the identification of coping strategies developed by caregivers to deal with the daily challenges related to their role in supporting patients with schizophrenia (specific object 3 of the study). The interviews were recorded using a digital voice recorder with an integrated VAR/VOR microphone. In accordance with ethical standards for scientific research, data collection was authorized by memorandum No. 345-2025/MS/CNHUP-C/DAF/SP dated August 8, 2025, issued by the Director of the CNHUPC. The main variables or phenomena under study for each specific objective are listed in **Table 1**.

Table 1. Main variables or phenomena under study according to the specific research objects.

N°	Specific objects	Variables or phenomena under study and their modalities
01	To identify the situations or events that mark the journey of family caregivers in their commitment to patients with schizophrenia.	**Significant events or situations** (according to the narrative reported by those interviewed)
02	To describe the psychological, physical and socio-professional experiences of family caregivers related to their role in supporting patients with schizophrenia	**Psychological experiences:** sadness; anger; stress; anxiety; feelings of loneliness; depression; insomnia; etc. **Physical experiences:** pain; headaches; aggression; neglect of one's own health; etc. **Socio-professional experiences:** cessation or reduction of professional activity; absenteeism from work; loss of professional opportunities; etc.
03	To identify the coping strategies developed by family caregivers to deal with the daily challenges related to their role in supporting patients with schizophrenia.	**Problem-focused coping strategies:** social support, spirituality, family reorganization or, conversely, withdrawal, isolation, reorientation; seeking help; searching for resources or tools; distancing oneself from the situation; ignoring or accepting it; connivance or complicity; active reassurance, a constructive attitude, etc. **Coping strategies based on emotion regulation:** avoidance; minimization; distancing; selective attention; positive comparisons; giving a positive value to negative events; spiritual values; faith; confiding in others; investing in activities other than caregiving tasks; withdrawal and detachment; self-blame; expressing emotions [anger, anxiety]; emotional reassurance; ignoring the problem; resignation; (passive) acceptance; disorganization; coercion; connivance; complicity; etc.

The main variables or phenomena under study, according to each specific objective, are listed in **Table 1**.

As with any classic scientific research, certain socio-demographic and professional data were also collected to better understand the informal caregivers surveyed: age; gender; marital status; ethnicity; level of education; employment status; the caregiver's relationship to the patient with schizophrenia; and the duration of their role as caregiver for patients with schizophrenia. Finally, each caregiver for patient with schizophrenia included in the study signed a free and informed consent form before the semi-structured individual interview. Furthermore, the collected data was processed with strict confidentiality in accordance with the provisions of Law No. 2009-09 on the Protection of Personal Data in the Republic of Benin, passed by the National Assembly on April 27, 2009. In addition, freedom of expression was guaranteed to all participants.

2.4. Methods for Analyzing the Collected Data

The quantitative data, primarily derived from the study of sociodemographic and professional variables, were analyzed using descriptive statistics by calculating their absolute frequencies. The recorded individual interviews were transcribed, and a content analysis of the discourses was conducted according to the hermeneutic phenomenological analysis methodological approach advocated by Van Manen [18] [19], which combines descriptive and interpretive characteristics. This is an analysis approach [19] that unfolds in four steps described by Streubert and Carpenter [20] as follows: 1) return to the nature of the lived experience by seeking to capture meanings; 2) engage in existentialist investigation by exploring the phenomenon, that is, generating data, tracing etymological sources, seeking idiomatic phrases, obtaining participant descriptions, etc.; 3) engage in phenomenological reflection, including thematic analysis, the unveiling of descriptive thematic aspects, the separation of thematic statements, the composition of linguistic transformations, and the gathering of descriptions from artistic sources; and 4) engage in phenomenological writing and rewriting.

Indeed, according to Patton [21], phenomenological analysis aims to grasp and clarify the meaning, structure, and essence of a phenomenon. Within the framework of this research, the main phenomena under study were the lived experiences of family caregivers of schizophrenic patients and the coping strategies they developed to manage the daily challenges related to their roles. Regarding hermeneutic phenomenological analysis, it is a particular type of phenomenological interpretation that seeks to unveil the hidden meanings in the participants' descriptions of the phenomenon [20], that is, the meanings of lived experience in its everydayness, which led to the narrative and explanatory writing of the results by indicating the meaning given by the family caregivers of schizophrenic patients to their lived experiences and feelings, what they understand from them, and how they interpret them. Each theme is accompanied by excerpts from discourses (verbatim quotes) explicitly attributed to participants designated by their identifier.

3. Results

Ten family caregivers of patients with schizophrenia were included in the study.

3.1. Socio-Demographic and Professional Characteristics of the Surveyed Informal Caregivers

The socio-demographic and professional characteristics of the informal caregivers of the schizophrenic patients surveyed are shown in **Table 2**.

Table 2. Distribution of informal caregivers of schizophrenic patients surveyed according to their socio-demographic and professional characteristics (N = 10).

N˚	Variables	Terms and conditions	Absolute frequency
01	**Age (in years)**	<20	1
		[20 - 40]	6
		>40	3
		Total	**10**
02	**Gender**	Male	3
		Female	7
		Total	**10**
03	**Marital status**	Married	5
		Single	3
		Widowed	1
		Divorced	1
		Total	**10**
04	**Ethnicity**	Fon	6
		Goun	2
		Adja	1
		Yoruba	1
		Total	**10**
05	**Education level**	Not enrolled in school	0
		Higher education	1
		Secondary education	5
		Primary education	4
		Total	**10**
06	**Employment status**	Employee	3
		Self-employed	7
		Total	**10**
07	**Relationship of the caregiver to the care recipient**	Immediate family	9
		Other family member	0
		No family relationship	1
		Total	**10**

The average age of the respondents was 38.9 ± 11 years, ranging from 19 to 57 years. The sample was predominantly female (N = 7), resulting in a male-to-female ratio of 0.43. Half of the respondents (5/10) were married, and six of them were of the Fon ethnic group. All of the surveyed caregivers were educated, with half having a secondary level of education (5/10). The majority of respondents (7/10) were self-employed, and almost all (9/10) were close family members of the patient (father, mother, brother, or sister).

Furthermore, all the respondents lived with the patient for whom they provided daily care.

3.2. Experience in Fulfilling the Role of Caregiver for Schizophrenic Patients

Table 3 shows the distribution of surveyed family caregivers according to the duration of their involvement in caring for patients with schizophrenia as a family caregiver.

Table 3. Distribution of respondents according to the duration of their role as caregivers for schizophrenic patients (N = 10).

N°	Duration of the Role of Caregiver for Schizophrenic Patients	Number of Family Caregivers
01	6 months	1
02	12 months	1
03	24 months	**4**
04	36 months	1
05	48 months	2
06	60 months	1

The analysis of the data in **Table 3** shows that the majority of respondents (4 out of 10) have been acting as caregivers for schizophrenic patients for 24 months. Furthermore, the average duration of caregiving for schizophrenic patients among the respondents was 30.6 months, and the modal duration was 24 months (N = 4).

3.3. Significant Events, Experiences, and Coping Strategies Reported by Informal Caregivers of Schizophrenic Patients Surveyed

Five main themes and sub-themes emerged from the analysis of the statements of the interviewed caregivers and are presented in **Table 4** below.

Table 4. Main themes and sub-themes emerging from the qualitative analysis of the narratives of the interviewed family caregivers.

N°	Themes	Sub-Themes
01	**Significant events**	Stigmatization and social isolation The painful experiences of relapses

Continued

		Managing the manifestations of the illness by the caregiver
02	**Physical experiences related to commitment**	The deterioration of the caregiver’s health
		The physical experience in the face of the patient’s aggression
		Physical injuries and the pain experienced
03	**Psychological experiences**	Negative emotions felt
04	**Socio-professional experiences**	Stopping or reducing professional activity
		Loss of employment opportunities
05	**Coping strategies**	Spirituality and faith
		Acceptance and hope

3.3.1. Key Events

In order to make sense of what they were experiencing and their experiences, the informal caregivers surveyed paid close attention to past events that had shaped their journey. This approach allowed them to express their subjective experience of their role as caregivers.

○ **Stigmatization and social isolation**

A recurring theme in the narratives of the interviewed caregivers was the stigmatization they experienced, which was painfully felt as a daily wound. This manifested in disapproving glances and a gradual withdrawal from social relationships: “*You see, I can no longer go out with my friends. They can’t even come to my house anymore because one day, my older brother attacked them* […]; *for them, we are a cursed family* […]” (Caregiver 4; 19 years old; Male). This stigmatization is not limited to the sick person, but also extends to the entire family, including the caregiver themselves: “*I wonder if another man will ever want me* […]; *when someone hears that I’m with my child in Jacquot* […], *they stop communicating with me*” (Caregiver 7, 33 years old, Female). Other caregivers modified their behavior to protect the patient (avoiding public places, anticipating reactions), but also to avoid being personally stigmatized: “*You see, when we left here (Jacquot) to go home, I didn’t go out much anymore because I didn’t want anyone to talk to me about my mother’s health* […]. *At first, it was difficult for me* […]. *But now, I can say that I’m doing better* […]” (Caregiver 9; 40 years old; Female).

○ **The painful experiences of relapses**

The moments that most affected the interviewed caregivers were their patients’ relapses. These relapses appeared in the narratives of our interviewees as temporal ruptures where the story begins again. Moments of anxiety, guilt, and fatigue were reported: “*Doctor, you see, every time I think it’s finally over, this illness comes back. And um* […] *it’s as if everything is falling apart again. I’m constantly on high alert. Before we came back here for this, I wasn’t at home. I was traveling* *when I got the call that my child had stripped naked in the neighborhood and they had restrained him to take him to Jacquot. I had to drop everything I was doing to come here. I traveled all night* […], *I arrived here at 3 in the morning like that. Do you see that?* […]" (Caregiver 7, 33 years old, Female); "*When it starts again, it's not a happy time. I don't like coming to this hospital because I know what I'm going to see* […]" (Caregiver 10, 30 years old, Female).

The participants mentioned that when the patient's health improved over a given period, it fostered hope for recovery and gave them the necessary energy to remain invested in the relationship. Finally, one of the situations that most significantly impacted one of our participants was a suicide attempt: "*My older brother wanted to commit suicide. What seemed strange to me was that on that day, he wasn't showing any signs of distress. He was taking his medication properly. Everything seemed fine. Our parents weren't even home. He had gone out to pay for something at the neighbor's house. That's when the neighbor came over and asked what my older brother wanted to do with the rat poison. That's when we realized something was wrong. I was scared that day because it was the first time something like that had happened. He was going to kill himself* […] *and we went to the hospital. He stayed there for two weeks before they discharged him*" (Caregiver 8, 45 years old, Female).

- **Managing the symptoms of the disease by the caregiver**

The manifestations of schizophrenia, such as behavioral eccentricities, irritability, or negativism, were sources of distress for caregivers, who felt exhausted or frustrated by certain behaviors: "*When the illness manifests itself strongly, he might start shouting, breaking things in the house; and making everyone leave, even if it's nighttime. What can I do? I have to stay calm* […] *and ensure his safety and mine too. Despite our efforts, we sometimes can't manage to relieve him* […]. *And we have to call the ambulance to take him to the hospital*" (Caregiver 2, 35 years old, Male); "*His last relapse, when he got naked in front of people, that's heartbreaking, as I said* […]. *And also the way he talks. We told the doctor, and he said it's the effects of the medication. Otherwise, it's not pleasant to see a loved one going through all of this. But he takes his medication properly. I make sure of that*" (Caregiver 4, 53 years old, Female).

3.3.2. Physical Experiences Reported by Caregivers of Schizophrenic Patients Were Surveyed

- **Deterioration of the caregiver's health condition**

The caregivers interviewed describe persistent fatigue, unsatisfactory sleep, and sometimes, the onset of somatic illnesses linked to chronic stress, where the body becomes the refuge for a burden that is difficult to bear: "*Since I've been taking care of my sick child, I sleep very little, always afraid of a seizure at night* […] *honestly, my body is tired. I think that's why I get sick easily. If you took my blood pressure now, it would be high*" (Caregiver 5, 39 years old, Female); "*I have aches and pains everywhere. You see what I've been going through here since our hospitalization. I have to hold him when he gets too agitated. My back hurts* […], *I* *have headaches* […]" (Caregiver 10, 30 years old, Female).

- **Physical injuries and the pain experienced when faced with the patient's aggression.**

Family caregivers live in a state of hypervigilance, anticipating possible crises where verbal or physical aggression constitutes an intense physical ordeal for them. This aggression places the caregiver's body in a state of heightened alertness: "*I live with the fear of being attacked, especially after what happened in the north where a mentally ill patient killed his doctor while he was sleeping.*" (Caregiver 2, 35 years old, Male). Some caregivers have suffered blows, shoves, or have had to physically restrain the patient during a crisis, which leaves real physical marks. These caregivers bear visible (bruises, pain) or invisible (tremors, muscle tension) scars.

"*Once, he hit me, and I was in pain for days. Sometimes, I'm even afraid to live with my brother.*" (Caregiver 3, 38 years old, Female).

3.3.3. Psychological Experiences Reported by Family Caregivers of Schizophrenic Patients Were Surveyed

Through the striking situations evoked, the family caregivers revealed significant elements of their psychological lived experiences, particularly the negative affects they felt. Indeed, the experience of the family caregiver role for schizophrenic patients is accompanied by an intense emotional burden. The interviews reveal a coexistence of painful emotions that reflect the difficulty of living daily with the suffering of the other and the progressive loss of personal landmarks. This is all the more so as it involves a chronic pathology. First, the mere fact of witnessing the suffering of a loved one caused, among the family caregivers, sadness, worry, and anxiety: "*Seeing him like that hurts me. Someone who was very intelligent in school and whose illness has spoiled everything. Sometimes I think it's a loss for our family. He's no longer the same person. I can't find my brother from before. It's as if I've lost him, but he's still there*" (Family Caregiver 1, 19 years old, Male). Feelings of helplessness, guilt, and psychic fatigue were evoked by family caregivers in their commitment: "*Sometimes, I don't know what to do anymore. I feel like everything I do is useless* […] *it's as if the illness is deciding for him; I tell myself I should be more patient, but I'm at the end of my rope; I sleep only halfway, always listening if he gets up, if he talks to himself, if he's sleeping* […] *it's exhausting*" (Family Caregiver 3, 38 years old, Female). The difficulties related to distance also constitute a factor of exhaustion in the family caregiver role. In this sense, they are sometimes obliged to resort to traditional care: "*We live far from the hospital. We stay in Sakété in the plateau. Every time he relapses, we have to find a way to get transportation, and that tires me out enormously. Sometimes, we prefer to go see the neighborhood healer, just so he can get a little relief*" (Family Caregiver 9, 40 years old, Female).

3.3.4. Socio-Professional Experiences Reported by the Caregivers of Schizophrenic Patients Surveyed

- **Stopping or reducing professional activity**

Stopping or reducing professional activity is frequently perceived as a constraint imposed by the illness of a loved one. Some family caregivers describe this experience as a forced sacrifice of their personal fulfillment and professional aspirations. This interruption of work often generates feelings of social isolation and marginalization: "*I had to stop working because someone needed to be at home to look after him. At first, I thought it would be temporary, but years went by and I was never able to go back*" (Family caregiver 1, 19 years old; Male); "*My job was very important to me, but every time he had a seizure, I would get an emergency call. I left my job primarily to take care of my son*" (Family caregiver 3, 38 years old, Female).

- **The loss of job opportunities**

For the family caregivers surveyed, caring for an individual with schizophrenia often limits their availability to pursue professional opportunities: "*I've had several job offers, but each time I thought to myself: how will I manage if the illness relapses? As a result, when the job is far from home, I can only reluctantly refuse* […]. *While others are moving forward, I remain stuck in the same place because I have to look after him* […]." (Family caregiver 4, 53 years old, Female).

3.3.5. Adaptation or Coping Strategies Developed by the Surveyed Family Caregivers

In the experiences of family caregivers, confronting illness or disability represents a profoundly disruptive experience that demands a significant reorganization of their lives. The caregivers surveyed thus developed various coping strategies reflecting their cognitive, emotional, and behavioral efforts to deal with the situation. Two sub-themes emerged as particularly important in the caregivers' journeys and their strategies for coping with daily challenges: 1) spirituality and faith, and 2) acceptance and hope.

- **Emotion-regulating coping strategies: spirituality and faith**

For many caregivers, spirituality and faith represent essential resources in managing stress and finding meaning. Turning to prayer, belief in a higher power, or the idea of divine destiny serves as a coping mechanism in the face of psychological distress. Thus, some caregivers expressed their need to cling to God to avoid succumbing to despair: "*Sometimes I tell myself that if God allowed this, it's because He knows why. He doesn't abandon us, even if it's difficult*" (Caregiver 5; 39 years old; Female); "*I pray a lot. That's what helps me get through it. When I can't take it anymore, I confide in God*" (Caregiver 8, 45 years old; Female).

- Problem-focused coping strategies: acceptance and hope

Acceptance emerges as another essential strategy in the journey of the family caregivers surveyed. It does not reflect resignation on their part, but rather a gradual adjustment to the reality of the illness. This approach allows them to free themselves, at least partially, from the feeling of injustice and to regain a form of psychological balance: "*At first, it was difficult for me. But at some point, I understood that I couldn't change everything* […] *so I learned to live with it. I just believe that things will get better one day* […]. *We don't have a choice, we have to* *keep going. It's family* […]" (Family caregiver 3; 38 years old; Female).

4. Discussion

4.1. Socio-Demographic and Professional Characteristics of the Surveyed Informal Caregivers

The mean age of the study participants (38.9 years ± 11 years) is close to that observed in the study by Laborde *et al.* [22], where more than half of the family caregivers were aged 40 to 65 years. The female sex dominates the sample (7/10), which corroborates the results of the study by Traoré *et al.* [9], where more than half of the participants were women (66.22%), and that of Otti *et al.* [23] (93.33%). This female overrepresentation confirms the idea of Zilhman [24], according to which women were at the forefront of gathering activities, contributing to feeding but also to caring. Indeed, women traditionally assume a central role in family and social responsibilities, which exposes them more to the situations or burdens evaluated in this study. They are also more numerous in engaging in support, care, or accompaniment activities, which could explain their predominance in the study sample. According to Sallaint [25], the care provided by women communicates a different language than traditional medical language with regard to health and illness. This language is one that rejects the aseptic, measured, distant body-object, where the soul and affect are, ultimately, merely sources of error for establishing a diagnosis. The language of the body carried by care is a language that conveys the realities of life in motion: intimacy, fear of suffering, uncertainty, fragility, lack of control, transgression of norms, etc. These realities of life in motion are some of those experienced by the family caregivers of schizophrenic patients included in this study.

The results of the study also showed that the majority (9/10) of the family caregivers of the investigated schizophrenic patients were close family members (father/mother/brother/sister). These results corroborate those of the study by Traoré *et al.* [9], in which 87.13% of the family caregivers were members of the patient's nuclear family. All of this seems to reveal the concept of the "privileged caregiver" developed by Pueugueu [26], referring to the nuclear family (father, mother, brothers, and sisters) of the African patient, who finds equilibrium only in relation to the other, their family, and their community. Mimche and Feudjio [27] also reported that in the African sociocultural context, health problems are first experienced in a relational and familial context. Pueugueu [26] further argues that, for example, in a hospitalization situation, separation from the family could be a factor in slowing the recovery rate, reinforcing, or even generating a psychiatric disorder. According to Sow [28], the African individual residing in Africa is a being of relation, which means that caregivers (in the context of this study, the family caregivers of schizophrenic patients) are culturally recognized as essential in the care system, often taking on the role of substitutes for nurses and nursing aides in the daily care of patients, and they reside in the very space of care during the duration of the hospitalization [26]. In summary, in the specific African sociocultural context, responsibilities regarding illness, care, and the vulnerability of a family member are generally shared among direct relatives. Parents and children then feel morally obligated to ensure protection, assistance, and support for their loved ones. Staying by the patient's side is not merely an affective choice but a valued social norm in Africa and sometimes demanded by the entourage. Failing to assume this role would be perceived as a breach of family values, or even an act of neglect. In their status as family caregivers of schizophrenic patients, the roles they play corroborate those reported by Pueugueu [26]: family caregivers manage the patients' schedules, meaning they wake them up; prepare their baths; prepare their breakfast; remind them of medication times; and go to pharmacies to purchase medications prescribed by doctors. They act as mediators between the healthcare staff and the patients, manage prescriptions, report certain patient difficulties, and sometimes even go so far as to ease tensions between caregivers and patients. For the patients, they are generally the first responders in terms of helping relationships.

4.2. Key Events

The significant events reported by the surveyed caregivers attest to a particularly intense and difficult experience where social stigma and the relapses of the ill individual play a central role. This double burden, both social and medical, proves to be a major source of stress and suffering for caregivers. Re-examining the words of one respondent: "*I didn't go out of the house much anymore because I didn't want anyone to talk to me about my mother's health*" (Caregiver 9, 40 years old, Female), it seems that stigma functions as a socio-cultural mechanism that reifies difference and reactivates norms of normality. Indeed, this stigmatization, which manifests itself through social isolation, is not only the consequence of external withdrawal; it is also internalized, that is, experienced as shame or a fear of being held responsible. These experiences modify the way the caregiver inhabits the social world: the caregiver is therefore no longer merely a witness to their loved one's illness, but becomes a bearer of stigma themselves. Biegel *et al.* [29], in their work, also reported the same phenomenon of stigmatization that generates painful social isolation, affecting not only the ill person but also the entire family, and particularly the primary caregivers. Tan *et al.* [30], in their study, even reported that 33.3% of caregivers stated that they had experienced distressing stigmatization.

Accounts of relapses, often described in this study as temporal disruptions that disrupt the daily lives of family caregivers, also reflect the fragility of their future plans, as illustrated by this excerpt from an interview: "*Every time I think it's finally over, the illness comes back. And um* […]" (Caregiver 7, 33 years old, Female). These relapses represent a heavy symbolic burden for the caregiver, demonstrating the impermanence of recovery or the clinical instability of the patient with schizophrenia, and highlighting the fragility of the caregiver's future prospects. The future is perceived as uncertain, planning becomes difficult, and life focuses on the immediate management of the current episode. This reality is similar to that described by Roussel [31] in a study where family caregivers reported that periods of crisis or relapse are extremely distressing for them, as they witness a family member becoming completely disorganized and suffering. Living in the same household as the ill person also represented a difficult situation for these family caregivers, who described relapse episodes as carrying a heavy symbolic burden, generating anxiety, guilt, and fatigue. The author [31] also reports stigmatization as a significant issue for family caregivers who find it difficult to have social interactions in the presence of the ill person because, for them, it means exposing themselves to the possibility that everyone will realize that something is wrong with a family member. Suicide attempts, for their part, also constitute moments of anxiety and helplessness for family caregivers. They often represent a relational trauma and shatter daily normality, accompanied by fear, guilt, and stigmatization.

4.3. Physical Experiences of Caregivers of Schizophrenic Patients

Through the analysis of the narratives of the individuals interviewed, it becomes clear that supporting a person suffering from a mental illness, particularly schizophrenia, involves daring to take the risk of putting oneself in the place of the ill individual (being highly empathetic) and confronting their suffering. This is not without consequences for the physical health of the caregiver. The physical experience of caregivers is marked by chronic fatigue, sleep disturbances, pain, and sometimes physical injuries related to the patient's aggression, as evidenced by this account: "*I sleep very little*, *always afraid of a crisis at night* […]" (Caregiver 10; 30 years old; Female). This physical deterioration reflects a gradual wear and tear linked to the stress and hypervigilance necessary to manage crises. These data confirm the results of the study by Thunyadee *et al.* [32], which reported that caring for people with schizophrenia has a significant negative impact on the physical health of caregivers. Moreover, in that study [32], 19.5% of family caregivers of people with schizophrenia exhibited significant depressive symptoms, and 65.5% perceived themselves as being in poor physical health. These experiences demonstrate a progressive physical exhaustion that reflects the weight of the emotional burden and stress of caregiving. The caregiver's bodily experience, from this perspective, is not only a biological reaction but also the sign of an existential experience where the body becomes the embodiment of shared suffering.

4.4. Psychological Experiences of Caregivers of Schizophrenic Patients

Psychologically, the experience of caregivers is marked by intense negative emotions such as sadness, anxiety, anger, and guilt, exacerbated by social stigma and the fear of relapse. The emotional burden is heavy and leads to feelings of powerlessness and sometimes isolation. All of this corroborates the findings of the study by Traoré *et al.* [9], in which sadness (88.89%); discouragement (86.67%); stress (77.78%); worry (91.11%); frequent awakenings (48.89%); tension (46.67%); difficulty falling asleep (37.78%); and irritability (33.33%) were the main psychological experiences reported by family caregivers. The role of caregiver is therefore a major source of chronic stress. These negative emotions not only reflect emotional distress but also reveal the lived meaning of the caregiving experience, that of an inner struggle between love, guilt, and resignation. The caregiver seeks to maintain existential coherence despite the disorganization imposed by the illness.

4.5. Socio-Professional Experiences of Caregivers of Schizophrenic Patients

The role of family caregivers profoundly influences their professional lives. The study participants often experience imbalance between their professional lives and their responsibilities as family caregivers. This continuous commitment to schizophrenic patients leads them to modify, reduce, or even suspend their professional activities. This lived experience reflects a sense of personal sacrifice, sometimes accompanied by frustration related to the loss of autonomy and economic independence. The account of one participant illustrates this situation well: "*My job was close to my heart, but every time he had a crisis, they called me urgently*" (Family Caregiver 3; 38 years old; Female). These facts reflect a tension between the moral duty to help and the desire to exist professionally. This also reveals an identity suffering where the family caregiver struggles to reconcile their social role and family role. This difficulty in balancing professional life and caregiver responsibilities leads to social isolation and loss of employment opportunities, thereby provoking feelings of frustration and social decline, as stated by one of the study's participants: "*While others advance, I stay at the same point*" (Family Caregiver 4, 53 years old, Female). Objectively, this demonstrates a loss of future projection among family caregivers and a progressive disengagement from the professional sphere, perceived not as a choice but as a direct consequence of their role. This situation generates guilt mixed with resignation, marking psychological and socio-economic exhaustion for the family caregiver and the family in general. This analysis corroborates the results of the study by Tan *et al.* [30], which demonstrated that the caregiver role generates repercussions at the socio-professional and economic levels. In the aforementioned study [30], 26.7% of the surveyed family caregivers reported concentration difficulties in performing their daily activities and saw their routine lives disrupted, sometimes to the point of having to change their professional plans. Chronic illness thus strongly impacts the socio-economic participation of family caregivers, limiting their future prospects and accentuating their vulnerability, as also confirmed by the study of Traoré *et al.* [9], which reported work stoppages among 26.67% of the surveyed family caregivers.

4.6. Coping Strategies Adopted by Family Caregivers of Patients with Schizophrenia

The participants in this study more frequently adopted spirituality and faith as coping strategies in response to their experiences as caregivers of patients with schizophrenia. This corroborates the coping strategies identified in Roussel's study [31], such as: reorientation, seeking help, distancing oneself from difficulties, faith and spiritual values, investing in activities other than the caregiver role, withdrawal, and detachment. Indeed, spirituality and faith play an essential role by offering a psychological refuge and giving meaning to the suffering experienced, as illustrated by the statement of one of the caregivers interviewed in this study: "*When I can't take it anymore*, *I confide in God*" (Caregiver 8; 45 years old; Female). These words show that faith acts here as an emotional coping strategy, offering a form of existential reassurance. Spirituality then becomes a way of accepting the incomprehensible, transforming pain into hope, and maintaining a sense of inner continuity. From this perspective, religious belief is not simply a refuge, but a symbolic reconstruction of the meaning of the experience. Spirituality helps caregivers integrate suffering into a broader vision of life where misfortune is not devoid of meaning. This corroborates the results of the study by Traoré *et al*. [9], in which faith and spiritual values were mentioned as part of the strategies aimed at self-protection. Furthermore, the gradual acceptance of the illness also allows for a readjustment of the experience and a precarious psychological balance, which falls within the same analytical framework used by Roussel [31] in her study.

5. Limitations of the Study

Although the small sample size (N = 10) could constitute a methodological limitation that might hinder the generalization of the results, it is entirely acceptable given the chosen research design, which falls under a qualitative approach and, in particular, an interpretive hermeneutic phenomenological study. Since the objective was to deeply understand the meaning of the family caregivers' experiences rather than to seek statistical representativeness, the study's results retain all their scientific validity. However, social desirability bias during the interviews cannot be completely ruled out, as some participants may have adjusted their responses to conform to what they thought was socially acceptable or expected by the study.

6. Recommendations

In light of the results obtained, it is clear that the burden associated with the family caregiver role remains particularly significant. It is therefore desirable to strengthen their adaptive capacities so that they can better cope with the stressors inherent to their role. To this end, it would be relevant to implement support actions aimed at equipping family caregivers, particularly through specific training on stress management and self-protection strategies. These interventions would contribute to reducing the emotional and psychological burden associated with daily assistance. Furthermore, healthcare staff hold a key position in identifying and referring family caregivers to available resources. Since many family caregivers are not necessarily aware of the programs and services available to them, whether within the CNHUPC or in the country (Benin) in general, it is therefore desirable to enhance the skills of healthcare staff in orienting and supporting family caregivers so that they can effectively direct them toward existing aid programs. In this regard, the establishment of psychoeducational programs targeted at family caregivers appears indispensable. As an example, given that spirituality and faith have proven to be essential coping mechanisms, integrating spiritual support adapted to the cultural context of caregivers into these psychoeducational programs could be beneficial. These programs would improve their knowledge of the illness, develop their adaptive skills, and promote better psychosocial balance. Additionally, it would be desirable to train both specialized and non-specialized professionals in the use of clinical tools such as the S-CGQoL (Schizophrenia Caregiver Quality of Life Questionnaire) [33] to enable a common assessment of family caregivers' lived experiences. The issue of stigmatization was widely raised by several family caregivers encountered. To address it, it is desirable to conduct awareness-raising actions aimed at combating stigmatization and promoting mental health within the population. To this end, the periodic organization of educational discussion sessions within the CNHUPC could constitute an effective strategy for informing, supporting, and valuing family caregivers.

7. Conclusions

Family caregivers constitute an indispensable link in the care pathway and the maintenance of the patient within the community. The general objective of the study was to explore the lived experiences of family caregivers of schizophrenic patients followed at the CNHUPC. The results revealed that family caregivers of schizophrenic patients undergo a particularly trying experience marked by a sense of psychological, physical, and socio-professional burden. Through these results, the onset of schizophrenia in a family member constitutes a traumatic event for the family due to the brutal upheavals it imposes. First and foremost, family caregivers experience an intense emotional ordeal marked by suffering, fear, guilt, and resignation. The social stigmatization and isolation they endure are so many invisible wounds that weaken their social ties and sense of belonging. The perception of being judged or sidelined affects not only the ill individuals but also their entourage, thereby reinforcing the feeling of exclusion.

Furthermore, family caregivers vividly recount the physical impact of their role, namely: chronic fatigue, sleep disturbances, pain, and even physical assaults. Constant hypervigilance is exhausting and contributes to a progressive weakening of their health status. Cohabitation with a person suffering from schizophrenia often entails a significant burden in terms of time, energy, and responsibilities. This situation has provoked, among the majority of family caregivers, physical and mental fatigue, as well as isolation.

It is therefore essential to integrate the physical well-being of family caregivers into support programs, as their health is a vital component of the continuity of care for patients.

On the socio-professional level, a significant alteration in the professional lives of family caregivers was noted, frequently involving the cessation or reduction of in income-generating activities. This situation generates a sense of sacrifice and sometimes social isolation, thereby impacting their professional integration and economic future. The loss or refusal of employment opportunities reflects a sometimes painful adaptation to a situation imposed by the illness, and this experience weighs considerably on family dynamics. Tensions, misunderstandings and a lack of support can weaken relationships within the household. The role of family caregivers thus appears both essential and complex. Finally, the study highlighted a certain adaptive capacity among the caregivers through coping strategies centered on spirituality and faith, and on acceptance and hope. These mechanisms, even if imperfect, allow for the preservation of a form of psychic and social balance in a demanding context. They also open avenues for the development of specific support measures aimed at strengthening these resources.

Conflicts of Interest

The authors declare no conflicts of interest.

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