

Understanding cultural perceptions of family support for mental health in patients with comorbid TB: A thematic analysis using Braun and Clarke's framework in Kendari, Southeast Sulawesi

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Abstract

Background

Qualitative health research often uses thematic analysis as a procedural coding method with little emphasis on reflexivity, analytical decision-making, and theme linkages. Family support is often considered a significant finding in chronic illness research, but its use as an analytical framework for studying local perceptions of illness, caregiving practices, and family mental health support for tuberculosis patients with culturally organized comorbidities is understudied. This study solves this methodological gap by demonstrating how reflective thematic analysis (RTA) can provide culturally relevant explanations.

Methods

This study used Braun and Clarke's reflexive thematic analysis to analyse semi-structured interviews with family caregivers and key informants in Kendari, Southeast Sulawesi, Indonesia. The analytical process was explicitly reflexive and interpretative, with themes being actively constructed through an iterative engagement with the data. Analytical decisions, theme development and relationships between themes were made transparent. Cultural context was treated as integral to interpretation, rather than as a background description.

Results

Three interrelated themes were identified through analysis. Firstly, cultural constructions of tuberculosis and comorbidities demonstrate how disease is understood through a symptom-based, culturally embedded framework that marginalises explicit mental health discourse. Secondly, family support in the form of everyday emotional and moral practices shows how care is provided through presence, motivation and practical assistance. This implicitly supports mental health without being explicitly acknowledged. Thirdly, barriers to explicit mental health support were conceptualised as analytical consequences of these constructions and practices.

Conclusion

This methodological paper, illustrated through an empirical case study, contributes to qualitative methodology by demonstrating the explanatory potential of reflective thematic analysis in examining naturalistic practices in family mental healthcare and support for tuberculosis (TB) patients with comorbidities. The findings emphasise the importance of analytical reflexivity, theme integration, and contextual sensitivity when using thematic analysis in health research.

Introductions

This study aims to understand how family members perceive mental health support for TB patients with comorbidities in Kendari City, Southeast Sulawesi. Kendari is a multicultural city center often referred to

as "**Lulo City**," where unity is celebrated through the concept of "*Mepokoaso*," a Tolaki term reflecting the spirit of togetherness. The city is home to various ethnic groups, including Tolaki, Muna, Buton, and Bugis, all of whom contribute to the rich culture that shapes the community's social fabric. This diversity significantly influences how health issues, including TB and its comorbidities, as well as mental health issues, are understood and addressed.

In this context, family members' cultural backgrounds significantly influence their understanding and approach to health challenges, including their perceptions of the disease, care practices, and the role of mental health in the treatment of TB with comorbidities. Local terminology and traditional healing practices are often fused with medical concepts, influencing how diseases such as tuberculosis and its comorbidities present. This cultural lens influences how families provide support, navigate the health system, and interpret mental health struggles related to TB with comorbidities (Kumar Panda et al., 2024).

Despite the increasing number of studies on the medical aspects of tuberculosis and related comorbidities, there remains a substantial lack of information regarding family perspectives on mental health support for TB patients with comorbidities, particularly in a multicultural setting like Kendari. Previous research has largely focused on the clinical and biological dimensions of tuberculosis therapy and related comorbidities, neglecting the impact of cultural perspectives on the mental health care provided by family members (Chen et al., 2021). Furthermore, there is little research examining the interaction between traditional and medical methodologies in the management of tuberculosis patients with comorbidities (Jarde et al., 2022). This study aims to address this gap by examining how cultural beliefs influence family perceptions of tuberculosis-related mental health problems and the types of support they provide. This study will describe the integration of mental health care into the treatment of tuberculosis with comorbidities in a culturally appropriate manner by examining family support and cultural attitudes.

Researchers frequently employ qualitative analysis to examine community perceptions in public health studies. Qualitative research allows researchers to significantly contribute to the exploration of community comprehension and to facilitate communities' understanding of the challenges they encounter (Ozuem et al., 2021). In-depth interviews and personal narratives are employed to investigate the diverse ways in which communities comprehend issues. This shows how important qualitative research is for guiding public health behaviors, helping health professionals and policymakers make decisions, and helping them plan community interventions (Natasha Mack, 2011).

In-depth interviews and personal narratives are used to explore cultural aspects. These demonstrate the impact of cultural values on health-related behaviours, decision-making processes, and community dynamics in public health studies (Carrion et al., 2022). Understanding the context helps health professionals and policymakers create effective, community-specific treatments (Gnanapragasam, 2021). Qualitative research using in-depth interviews, participant observation, and document analysis

can reveal community behaviours, beliefs, and values that influence health decisions and public health interventions (Davis et al., 2019).

A theme research will clarify this. In qualitative research, thematic studies are crucial (Vandecasteele et al., 2024). Several experts and authors of qualitative research have revealed that thematic studies play a significant role in shaping researchers' ability to describe societal perceptions of an issue. These studies facilitate the identification and classification of perceptions, providing a clearer understanding of changes in public perception until the fundamental issues of a research object are revealed (Ozuem et al., 2021).

Thematic analysis (TA) is one of the most widely used methods for analyzing qualitative data (Alkhaled et al., 2022). It offers a structured yet flexible approach to identifying, analyzing, and reporting patterns or themes within a dataset (Roberts et al., 2019). Since its inception, the six-phase framework developed by Braun and Clarke has been widely adopted across disciplines, including health research, education, and the social sciences (Ahmed, 2025). This method emphasizes researcher reflexivity and the importance of theoretical transparency to ensure rigor and credibility in qualitative research (Ant et al., 2022). TA is not bound to any specific theoretical framework, making it a versatile tool suitable for both inductive and deductive approaches to data analysis (Ozuem et al., 2021).

Despite its strengths, confusion remains surrounding its application, particularly with respect to reflexive thematic analysis, where researcher subjectivity is embraced rather than minimized (Warne et al., 2022). Furthermore, inconsistencies in TA reporting have been noted in various fields, highlighting the need for clearer methodological guidance (Putri et al., 2021). Additionally, researchers may present themes as "emerging" from the data without acknowledging their role in constructing them, which risks obscuring the interpretative process.

Unlike more structured methods, such as framework analysis or grounded theory, thematic analysis lacks formal procedures for sampling, comparison, and saturation, which can challenge its reproducibility and analytic depth (Ozuem et al., 2021). Novice researchers often confuse TA with simple coding, missing its conceptual depth, which can be achieved when reflexivity, transparency, and theoretical alignment are prioritized (Ahmed, 2025). Thus, to ensure credible and meaningful findings, thematic analysis must be conducted systematically, with careful documentation of interpretive decisions and engagement with the data beyond surface-level description. Thematic studies are very important for finding out about changes in society and common themes. This can assist researchers learn about how people in the community see the research topic and the problems that come with it (Bowman et al., 2023); (Polat, 2025).

This study was conducted in Kendari City, in Southeast Sulawesi, Indonesia. Known as the 'City of Lulo', unity and the concept of *Mepokoaso* are central to the city's social fabric. Although the Tolaki ethnic group is dominant, the presence of other ethnicities, including Muna, Buton, Bugis and Javanese, contributes to the city's cultural diversity. It's important to know how different cultural groups in Kendari see sickness. This entails analyzing language, vocabulary, and idioms, along with the incorporation of

traditional concepts into medical discourse (Skeen et al., 2022). This study utilized a thematic analysis approach to examine family members' opinions of mental health assistance for patients with concomitant tuberculosis (TB). The emphasis is on the impact of culture ideas on family relations and support in the care of tuberculosis patients, particularly the interaction between these cultural perceptions and medical conceptions and practices.

Methodology

Research Design

This study employed a qualitative research design using thematic analysis (TA) to explore family members' perceptions of mental health support for TB patients with comorbidities in Kendari City, Southeast Sulawesi. Thematic analysis was selected for its adaptability and capacity to discern, examine, and present patterns (themes) within qualitative data, rendering it particularly effective for comprehending intricate social phenomena and cultural impacts on health behaviors. Thematic analysis allowed the exploration of both inductive and deductive themes derived from participants' experiences and perceptions (Ahmed, 2024).

The study was guided by Braun and Clarke's six-phase framework for thematic analysis, which emphasizes the importance of researcher reflexivity, transparency in data handling, and theoretical rigor throughout the research process. This approach is particularly relevant in the context of culturally sensitive research, where researchers' positionality and cultural awareness are integral to interpreting data meaningfully (Ant et al., 2022).

Setting and Participants

The research was conducted in Kendari City, the capital of Southeast Sulawesi, Indonesia. Kendari is a multicultural city where various ethnic groups, including Tolaki, Muna, Buton, and Bugis, each with their own cultural understandings of health and illness. The local concept of *Mepokoaso*, reflecting unity and collective support, is central to the social fabric of the city and influences how family members provide support for patients, including those with TB and mental health challenges.

The study participants were family members of patients diagnosed with TB and comorbidities, including diabetes. The inclusion criteria required participants to be immediate family members (parents, spouses, children) of individuals undergoing treatment for TB with comorbidities. Key informants also participated in the study, including TB healthcare workers, program officers, and academics, to provide additional perspectives on the cultural and healthcare context surrounding TB treatment, comorbidity management and mental health support.

Sampling Strategy

A purposive sampling method was used to select participants who were most knowledgeable about the research topic and could provide in-depth insights into family support for TB patients with comorbidities. Family members from the four major ethnic groups in Kendari—Tolaki, Muna, Bugis, and Buton—were selected to ensure that the perspectives of the primary cultural groups in the city were represented. A total of 15 participants were selected, including primary informants (family members) and key informants (healthcare professionals, Psychologist, and academics).

Data Collection

Data were collected through semi-structured interviews, which allowed participants to express their thoughts and experiences freely while ensuring that the key topics related to mental health support for TB patients were covered. The interview guide included questions about cultural beliefs about TB and its comorbidities, the role of family in supporting patients, family perceptions of mental health, and challenges faced by families in managing both physical and mental health needs.

Interviews were conducted in Indonesian and lasted between 30 and 60 minutes. All interviews were audio-recorded with participants' consent and transcribed verbatim. The transcription process also captured non-verbal cues (such as pauses or tone of voice), which added depth to the analysis by reflecting emotional contexts and underlying meanings in participants' responses.

Data Analysis

Data were analyzed using Braun and Clarke's thematic analysis framework (2006), which involved the following steps (Ahmed, 2025):

1. Familiarization with the data: The first phase involved reading and re-reading the transcripts to become familiar with the content and gain initial insights into the themes that might emerge.
2. Generating initial codes: In this phase, key concepts and words related to family support and mental health perceptions were identified and coded. Codes included terms such as family support, emotional resilience, cultural beliefs, and mental health awareness.
3. Searching for themes: The codes were grouped into broader themes based on patterns in the data.
4. Reviewing themes: The identified themes were reviewed to ensure they were meaningful and relevant to the research questions. The themes were revised and refined to ensure that they accurately captured the data's essence.
5. Defining and naming themes: Clear definitions for each theme were established, ensuring that each theme accurately reflected the data and addressed the research questions.
6. Writing the report: Finally, the findings were written up, with themes supported by direct quotes from participants to illustrate the lived experiences and perceptions of family members.

1. Braun and Clarke's thematic analysis framework

Ensuring Trustworthiness

To ensure the trustworthiness of this study, we applied the four key criteria outlined by Guba and Lincoln (1986): credibility, transferability, dependability, and confirmability. These strategies help to establish the rigor and validity of qualitative research findings by addressing issues of bias, consistency, and the applicability of the results (Lincoln & Guba, 1986).

Credibility

Credibility refers to the confidence in the truth of the findings and their interpretation. To enhance the credibility of the research, several strategies were employed:

1. **Prolonged Engagement:** The study took place across three months, from June to September 2024, which gave the researchers more time to talk to the participants. This longer time frame gave the researchers a chance to create trust with the community, see how families change over time, and learn more about the participants' real-life experiences. Long-term participation helped make sure that the data collected was rich and showed how the participants really felt.
2. **Peer Debriefing:** Peer debriefing was used during the research process to check and improve the interpretations of the findings. Regular conversations with coworkers, such as research assistants and specialists in the subject, made it possible to double-check results, which helped to reduce researcher bias. This technique helped find any misunderstandings and made the analysis stronger by making sure that several points of view were taken into account.
3. **Member Checking:** To make sure the interpretations were correct and legitimate, member checking was performed. After the first analysis, the results were shared with the people who took part so they could give comments and make sure that the interpretations of their answers were correct. This feedback loop helped the researchers improve the themes and make sure that the participants' views were appropriately reflected in the results. Participants were asked to go over their answers and clear up any differences, which made the results more trustworthy.
4. **Negative Case Analysis:** Negative case analysis was used to make the credibility even stronger. This meant looking for evidence or points of view that were opposite to the ones that were starting to come together and may challenge them. For instance, those who were unsure about the link between TB and mental health were given special attention. The research offered a more nuanced comprehension of the topic by incorporating these alternate viewpoints, so ensuring a diverse range of opinions in the analysis.

Transferability

Transferability is the degree to which the study's results can be utilized in different situations or groups. To facilitate the transferability of this study, comprehensive and detailed descriptions of the research setting and participant characteristics were supplied. This let readers figure out if the results could be useful in other places or communities that are comparable. The study's thorough description of Kendari City's cultural diversity, the various ethnic groups there, and the particular healthcare and familial

dynamics guarantees that the findings may be evaluated for applicability in other regions with analogous socio-cultural and healthcare contexts.

Dependability

Dependability concerns the consistency of the research process and the stability of data over time. To ensure dependability, the researchers maintained detailed records of the entire research process, from data collection through to the final analysis. Regular team meetings were held to discuss the research approach, share observations, and refine the methodology. This allowed the research team to address any shifts or changes in the study design or focus during the course of data collection. The consistency of the research process was maintained by ensuring that all researchers followed the same procedures for conducting interviews, analyzing data, and interpreting themes. The involvement of multiple researchers in data analysis also ensured that the findings were stable and reliable.

Confirmability

Confirmability refers to the objectivity of the findings, ensuring that the results are based on the participants' perspectives rather than the researchers' biases or preconceptions. To enhance confirmability, the researchers employed several strategies:

1. **Audit Trail:** There was an audit trail all the way through the research process. This included detailed notes on decisions made during data collection and analysis, as well as a log of discussions and revisions. This openness in the research process makes sure that the results can be tracked back to the raw data, which makes it evident how the data and the conclusions are related.
2. **Triangulation:** To mitigate researcher bias, triangulation was utilized through the incorporation of diverse data sources, including family members, healthcare providers, and academics. Utilizing many informants from diverse viewpoints facilitated a more holistic understanding of the issue, hence augmenting the confirmability of the findings.
3. **Reflexivity:** The researchers maintained an ongoing process of reflexivity throughout the study. This involved reflecting on how their own cultural backgrounds and experiences may influence their interpretation of the data. The research team regularly discussed how their perspectives could impact the analysis, and these discussions were documented to provide transparency in how interpretations were made.

By employing these strategies, the study ensured that the findings were credible, transferable, dependable, and confirmable, thereby enhancing the overall trustworthiness of the research process.

2. Trustworthiness criteria in Qualitative inquiry by Guba and Lincoln

Data Analysis

We used a theme analysis approach to look at the data. The researchers delineated principal themes and sub-themes, examining repeating motifs across the interviews to elucidate the research findings with

clarity and depth. To keep things private, participant quotes were labeled with anonymous codes (P1–P15) and basic job descriptions. All of the recorded data were typed out word for word and then entered by hand into interview tables for data cleansing. We classified the interview transcripts according to categories that had been set in advance. Researchers utilized interview matrices in Microsoft Excel to conduct the coding process. The interview table had information including the participants' characteristics and answers, data reduction, and a summary of each theme (Vandecasteele et al., 2024). The categories were double-checked by two research assistants using the interview matrix to ensure the validity of data interpretation. Qualitative data were presented using direct quotes from respondents, narratives, and thematic review tables (Natasha Mack, 2011).

Analytic Procedure

Data analysis followed a step-by-step thematic analysis process, adapted to foreground conceptual acculturation rather than static theme identification.

Table 1
Informant characteristic

Number	Participant Code	Age Range (Years)	Participant Category / Status
1	P1	40–49	Family caregiver of TB patient
2	P2	40–49	Family caregiver of TB patient
3	P3	30–39	Family caregiver of TB patient
4	P4	20–29	Family caregiver of TB patient
5	P5	50–59	Family caregiver of TB patient
6	P6	40–49	Family caregiver of TB patient
7	P7	40–49	Family caregiver of TB patient
8	P8	50–59	Family caregiver of TB patient
9	P9	40–49	TB program officer (primary care level)
10	P10	40–49	TB program officer (primary care level)
11	P11	30–39	TB program supervisor
12	P12	30–39	Mental health professional
13	13	40–49	Public health academic
14	P14	50–59	Social science academic
15	P15	40–49	Public health academic

Results

Theme 1: Cultural Interpretations of Tuberculosis and Comorbidities

We defined the first theme as Cultural Constructions of Tuberculosis and Comorbidities by looking at the stories told by participants. This theme shows how family members from different ethnic groups understand tuberculosis (TB) and its comorbid conditions through the language they use, their understanding of symptoms, the way they adapt local terms to medical terms, and their everyday health practices. Instead of showing a lack of biological knowledge, these creations show how local cultural meanings and practical care objectives actively impact how people view the condition.

Family members consistently utilized local terminology—such as Hoda (Muna), Kobu (Buton), Hosa (Tolaki), and Posso (Bugis)—to articulate tuberculosis across the dataset. These phrases were mostly based on physical signs that could be seen, such a cough that won't go away, weight loss, trouble breathing, and a fever. Throughout the investigation, we viewed this pattern as a culturally anchored, symptom-based framework, where disease detection is strongly related to apparent bodily changes rather than abstract diagnostic categories.

One participant explained:

We call it Hoda or Kobu because of the coughing and breathing difficulties. That's what people understand here. When it comes to mental health, we don't really emphasise it.

Analytically, this description illustrates how TB is constructed as a physical condition requiring bodily treatment, while psychological suffering is barely mentioned. It is important to note that this absence of explicit mental health language does not indicate a lack of concern, but rather reflects the limited cultural understanding available to articulate psychological experiences.

Several participants described comorbidities, particularly diabetes, using similar pragmatic terms and often referring to it as *“penyakit gula”* or *“kencing manis.”* In these narratives, diabetes mellitus refer to the body's overabundance of glucose and carbohydrates, which is described as 'sweet sugar'. However, comorbidity is understood as the coexistence of multiple bodily problems requiring parallel treatment rather than as interconnected biopsychosocial conditions.

During the coding process, we collected references to diabetes management, herbal remedies and dietary adjustments alongside descriptions of TB treatment. This led us to interpret comorbidity as a layered illness experience rather than a unified diagnostic category.

As one family caregiver noted:

“I don't understand the term comorbidity, but I understand that TB with comorbidities places an additional burden on the patient.” (P2)

This interview excerpt shows that the informant recognises that TB patients undergo two treatments. However, the medical term 'comorbidity' was not clearly understood.

"TB is treated at the health centre, and so is diabetes. Sometimes we also use herbal leaves to regulate blood sugar levels, but I don't know if mental health issues are part of the disease." (P8).

This excerpt illustrates how mental health issues are often positioned outside the core illness narrative, even when participants acknowledge emotional exhaustion or stress. In our analysis, we do not view this as denial, but rather as a culturally patterned boundary between what is considered a medical problem and what is seen as a normal emotional response to a long-term illness.

Theme 2: Family Support as a Daily Emotional and Moral Practice

After examining the participants' narratives, we discerned the second theme as 'Family Support as Everyday Emotional and Moral Practice,' which conveys the idea that assistance for patients with comorbid tuberculosis (TB) is primarily achieved through habitual, relational, spontaneous, and ethically informed practices. The dataset does not characterize family support as a specialized or technical form of care; instead, it is depicted as an extension of kinship obligations, solidarity, and collective resilience during the protracted duration of the illness.

Participants similarly characterized support as involving presence, active listening, patience, and accompaniment during diagnosis, treatment, and follow-up care. People didn't often call these things mental health help. Instead, they were seen as natural and unquestioned duties that were part of ordinary family life. We regarded this pattern as an implicit form of mental healthcare, wherein emotional well-being is sustained through relationship intimacy and moral obligation rather than clinical or psychological terminology.

One participant explained:

"Caring for a sick family member is like that. We have to be patient. We just listen to what they say and offer encouragement." (P3).

From an analytical perspective, this description illustrates how emotional care becomes normalised in everyday caregiving practices. Rather than through explicit acknowledgement or mention of psychological suffering, support is provided through patience, attention, and emotional availability. Emotional support is therefore embedded in moral expectations about what it means to be a responsible family member rather than being viewed as separate from mental healthcare.

Motivation emerged as a central component of family support, particularly in the context of long-term TB treatment. Family members described how they encouraged patients to adhere to treatment, reassured them that they would recover, and reminded them of their responsibilities to the family. When we coded these narratives, we found that references to motivation were clustered with expressions of shared

expectations, obligations and burdens. This led us to interpret motivation as a moral practice aimed at maintaining resilience rather than as a deliberate psychological strategy.

One participant explained:

"Family definitely provides motivation. If we don't support them, who else will?" (P1)

This excerpt highlights the essential and inherent nature of emotional labour in family relationships. Support is not considered optional or conditional, but rather an expectation of kinship and a moral obligation.

As well as providing emotional support, family members also offer practical assistance, such as scheduling medication, accompanying patients to healthcare facilities, preparing appropriate meals, and monitoring physical changes during treatment. While participants often described these activities as practical assistance, our analysis interpreted them as a form of emotional support. This provides patients with a sense of security, predictability and shared responsibility during the lengthy and uncertain treatment process.

One participant explained:

"We make sure that everything is ready for them, including medicine, food and access to the health centre. If they see that we are serious, they feel more at ease." (P2)

This suggests that emotional reassurance is often communicated through actions rather than words. Caregiving practices serve as symbolic affirmations of commitment, reinforcing patients' sense of being valued and supported.

At the same time, however, participants often drew a distinction between the emotional support provided by families and what they understood to be legitimate mental healthcare. While families were actively involved in caring for patients' emotional well-being, mental health issues were generally considered the responsibility of health professionals rather than family members.

"We provide support and encouragement, but we don't understand mental health issues. Is it related to TB or diabetes? If it is, we think it's the health workers' job." (P6).

We verified the information provided by the key informant. He explained,

"In Indonesian society, cooperation and mutual assistance are generally the norm. Within the smallest circles, such as families, people help each other, especially when a family member experiences a disaster, such as illness." (P14)

This highlights the important role of the family in providing mental support. Conversely, several health workers at community health centres confirmed that mental health services are not currently integrated into TB programmes, including those for TB with comorbidities.

"As programmers, we play the role of providing physical support."(P10)

"In Kendari City itself, mental health services for patients are not yet integrated. Support services are available for drug-resistant TB, but not for drug-sensitive TB. Even then, they are provided by programme managers or community health workers."(P11)

This reflects the complexity of mental health issues for TB patients with comorbidities at policy and community levels.

By explicitly identifying family support as evidence of adequate mental healthcare, we conceptualise it as a culture-based approach that prioritises emotional resilience, moral responsibility and relational presence. This approach is consistent with the principles of reflective thematic analysis, which recognises that themes are actively constructed through interpretive engagement with the data rather than being discovered as objective features.

The theme of family support as an everyday emotional and moral practice serves as both a substantive finding and a methodological illustration of how reflective thematic analysis can shed light on family care within a cultural context. Specifically, it demonstrates how analytical attention to routine practices can reveal forms of mental health support that are provided but not explicitly mentioned. This contributes to methodological discussions about analysing care, emotional support and family moral obligations, and improves our qualitative understanding of families.

Theme 3: Obstacles to Mental Health Assistance

After examining participant experiences throughout the dataset, we framed the third theme as 'Barriers to Mental Health Support' instead of treating it as a separate entity. This theme encompasses the establishment of obstacles to mental health support arising from the cultural construction of sickness (Theme 1) and the moral organization of care within quotidian family practices (Theme 2). From a reflective analytical viewpoint, these constraints are perceived not as a deficiency of care, but as outcomes of inherent practices that emphasise physical recovery, resilience, morality, and familial obligations.

During interviews, the psychological suffering linked to extended TB therapy was frequently normalised as an anticipated aspect of the illness and its management. People often talked about feeling worried, tired, unhappy, or emotionally drained, but they rarely thought these were mental health problems that needed special treatment. We viewed this pattern during the study as the normalisation of emotional distress, wherein such suffering was integrated into the routine caregiving role rather than being acknowledged as a separate health concern (mental health).

One participant explained:

"Sometimes they feel sad or get tired of taking medication, but that's normal. Anyone would feel that way if they had been unwell for a long time." (P11).

From an analytical perspective, this description illustrates how emotional distress is perceived as normal and manageable, thus reducing the need for explicit mental health support. Instead, it is interpreted as a problem requiring intervention. Similarly, mental distress in patients is viewed as something to be endured with patience and family support.

Another barrier arises through the delegation of mental health responsibilities to health professionals. Although families actively provide emotional support and practical care, mental health is often considered a specialised field beyond the scope of the family's responsibilities. Participants generally described a threshold-based approach to mental health, where professional support is deemed necessary only when behaviour becomes disruptive or appears abnormal.

As one caregiver stated:

"If someone is very stressed or acting strangely, they might need to see a doctor. But usually, we just support them at home." (P13).

"Do we equate mental health issues with being crazy? Can TB patients be mentally ill?" (P8)

From an analytical perspective, this reflects the fact that mental health is conceptualised as an exceptional condition rather than an integral part of chronic disease management. Emotional difficulties that do not exceed a perceived threshold are considered to be within the remit of family care and moral resilience, thus limiting opportunities for early or preventative mental health support.

Limited mental health literacy further reinforces these patterns. Participants frequently expressed uncertainty about how to recognise psychological problems or how to respond other than by providing encouragement, patience and presence. Rather than interpreting this uncertainty as a lack of knowledge, we analysed it as a consequence of limited interpretive resources, whereby the available cultural and biomedical frameworks offer little language with which to articulate everyday psychological suffering.

One person said,

"We don't really know the signs of mental illness." We think it's okay as long as they can still eat and communicate (P9).

"We think it's okay for people who are getting long-term treatment to complain." You have to go to a mental health institution for treatment if you have a mental health problem, right?" (P5)

The stigma that society places on mental health also affects how families deal with tough times. Several individuals characterised mental health issues as a delicate or stigmatising subject that ought to be confined to the family. Even though this stigma doesn't stop families from getting help, it does make it harder for them to talk about their problems and get help from outside sources.

"People will talk if you say someone has a mental health issue." (P9).

"They have to go to a mental hospital; people will assume they have a mental illness." (P3)

Adopting a reflective analytical approach, this study illustrates how barriers to explicit mental health support are ingrained in culturally significant care practices, wisdom and moral responsibility. By conceptualising these barriers as analytical consequences rather than deficiencies of the individual or their family, the analysis highlights how well-intentioned support practices can maintain emotional well-being while simultaneously limiting the visibility and articulation of mental health needs.

We confirmed the results of our interview with a mental health professional (psychologist), who was one of our key informants. He explained that illnesses usually follow a distinct pattern, moving from the physical to the psychological and vice versa. Both require serious attention at every level. The family plays a key role as the patient's immediate environment and is capable of recognising the early symptoms of mental health problems. This is particularly important if the family has received prior education and is in regular communication with mental health professionals at community health service centres.

"Families are in a crucial position to support mental health and have the capital to do so. However, they need to be more educated about mental health issues. This is not just a moral obligation; they can also be at the forefront of raising awareness with the help of professionals." (P14)

Overall, Theme 3 corroborates the findings by showing how cultural constructions of illness (Theme 1) and moral practices of family support (Theme 2) converge to restrict the recognition and treatment of mental health issues in the context of TB comorbidity. This framework emphasises the importance of reflective thematic analysis in revealing existing forms of care, as well as highlighting how certain needs can be obscured by culturally based and indigenous modes of care.

Discussions

This study enhances qualitative health research methodologies by illustrating the application of reflexive thematic analysis (RTA) to investigate culturally ingrained caregiving practices and their inadvertent analytical repercussions in chronic illness scenarios. Instead of viewing thematic analysis as a mere descriptive method for classifying events, this study demonstrates how themes may be deliberately formulated to elucidate the structuring of meaning, care, and limitation in quotidian family life (Campbell et al., 2021).

A primary methodological contribution of this study is its clear focus on reflective thematic analysis as an interpretive, rather than procedural, analytical framework (Sun et al., 2025). According to Braun and Clarke's methodology, themes were not considered as mere patterns that "emerged" from the data; rather, they were viewed as interpretive constructs constructed by continuous interaction with participants' narratives, theoretical awareness, and reflexive decision-making (Braun & Clarke, 2024). This methodology facilitated the analysis to transcend superficial categorization and engage in a more

profound investigation of the influence of cultural meanings on health-related practices (Crowe et al., 2015).

By emphasizing analytic decisions—like viewing family support as a moral practice instead of a functional intervention—the study illustrates how reflexive thematic analysis enables researchers to examine not only participants' statements but also the processes through which meanings are generated, normalized, and sustained within particular sociocultural contexts (Skeen et al., 2022). This stance directly addresses recent methodological discussions concerning the inappropriate use of thematic analysis as merely a technical coding task (Ahmed, 2024).

Another methodological addition is the clear expression of the analytical connections among themes. This study illustrates the application of reflexive thematic analysis in the creation of an integrated analytic narrative that delineates the transition from cultural meaning-making (Theme 1) to moral enactments of care (Theme 2), and ultimately to limited articulations of mental health needs (Theme 3). This analytical integration demonstrates that thematic analysis may be employed to investigate processes and outcomes, rather than solely experiences. The study addresses demands within qualitative methods for enhanced transparency about the interrelations of themes and the generation of analytic insights across the dataset. By framing impediments to mental health help as analytical outcomes rather than personal shortcomings, the study circumvents simplistic interpretations and underscores the explanatory capacity of reflexive theme analysis (Dellafore et al., 2025).

Methodologically, the study enhances discourse around the capacity of qualitative analysis to elucidate types of care and support that are performed yet not clearly expressed (Noronha et al., 2021). Reflexive thematic analysis revealed that everyday activities, including presence, patience, motivation, and practical caregiving, were analyzed as implicit forms of mental health assistance. This illustrates RTA's ability to reveal meanings that might remain hidden when analysis depends exclusively on explicit language or biomedical classifications (Cena et al., 2024).

This methodology is especially pertinent for studies undertaken in cultural settings where psychological experiences are not commonly medicalized or articulated. Reflexive thematic analysis provides a methodological approach for investigating emotional and mental health problems by focusing on participants' actions rather than solely their terminologies, so avoiding the imposition of external diagnostic frameworks (Coomes, 2024).

Another methodological novelty is the study's reflective stance regarding participants' narratives. Instead of viewing low mental health literacy or dependence on professional care as shortcomings, the analysis intentionally characterized these trends as culturally consistent and ethically justified practices (Willig, 2008). This reflective position highlights the significance of analytical responsibility in qualitative health research, especially when examining community perspectives in a local context (Lim, 2025).

Situating reflective thematic analysis within this regional and cultural framework enables the analysis to circumvent a deficit-oriented interpretation of family practices, instead acknowledging them as organic,

ethically grounded responses influenced by local values, social relationships, and the lived experiences of managing chronic illness (Braun, 2024). The study illustrates that by clearly recognizing the influences on analytic interpretations, reflexive thematic analysis can assist researchers in circumventing deficit-based narratives, thereby generating explanations that are both contextually grounded and theoretically informed. This adds to bigger issues about how to undertake qualitative analysis that are about ethics and representation.

Collectively, these findings illustrate the usefulness of reflective theme analysis when examining the complex relationships between culture, caregiving and mental health in chronic illness research. Methodologically, this study highlights the importance of viewing themes as interpretive constructs rather than merely descriptive classifications. It emphasises the need for transparent and deliberate analytical decisions, the exploration of relationships between themes to provide readers with insights, and the acknowledgement of actions as contexts in which meaning is created. These methodological insights extend beyond the specific context of tuberculosis and can improve qualitative health research more generally, particularly studies focusing on caregiving behaviours, emotional labour, and culturally appropriate forms of support (Roelandt et al., 2020).

Strength and Limitations

This study exhibits numerous methodological strengths pertinent to qualitative health research and the utilization of reflective thematic analysis. First, the study uses a clear interpretive reflective thematic analysis (RTA) method, which makes it easy to see how decisions were made during the research process. By emphasizing the active construction of themes as emerging patterns, this approach adheres to contemporary methodological standards and circumvents the procedural simplification of thematic analysis. Second, Systematic contemplation and openness make analytical rigor stronger. Analytical conclusions, like the conceptualization of family support as a moral practice and the structuring of impediments to mental health care as analytical consequences, are clearly expressed and substantiated with illustrative data citations.

Limitations of the Methodology

Initially, this research is predominantly based on self-reports from family members and key informants. These narratives provide profound insights into the formulation of meanings and caring practices; nevertheless, they may be influenced by societal desirability or normative expectations pertaining to familial responsibilities and caregiving. Although thoughtful involvement with these processes enhances the analysis, it constitutes an intrinsic constraint of interview-based qualitative research.

While the core research team predominantly handled the analysis, reflexive thematic analysis does not pursue inter-coder reliability in a positivist sense. Although the use of peer debriefing and reflexive discussion helped to increase the depth of analysis, other interpretations could still be valid. Instead of seeing this as a flaw, the study recognizes that reflexive qualitative analysis is inherently characterized by interpretive variety.

Declarations

Ethic Approval

This study was approved by the Research Ethics Committee of the Faculty of Public Health, Hasanuddin University, under the approval number 1319/UN4.14.1/TP.01.02/2024. All participants were informed about the purpose of the study, the voluntary nature of participation, and their right to withdraw at any time without consequence. Written informed consent was obtained from all participants prior to data collection. To ensure confidentiality, participants were assigned pseudonyms (e.g., P1–P15) and their personal information was not disclosed in any research outputs.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the study, authorship, and/or publication of this article.

Author Contributions

Conceptualization, JG., SP., and MS.; methodology, JG., SP and M.S.; validation, SP and MS.; formal analysis, JG.; investigation, W., SR. and MT.; data curation, JG. And MS.; writing—original draft preparation, JG.; supervision, SP., MS., W., SR. and MT. All authors have read and agreed to the published version of the manuscript.

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Author Contribution

Conceptualization, JG., SP., and MS.; methodology, JG., SP and M.S.; validation, SP and MS.; formal analysis, JG.; investigation, W., SR. and MT.; data curation, JG. And MS.; writing—original draft preparation, JG.; supervision, SP., MS., W., SR. and MT. All authors have read and agreed to the published version of the manuscript.

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Figures

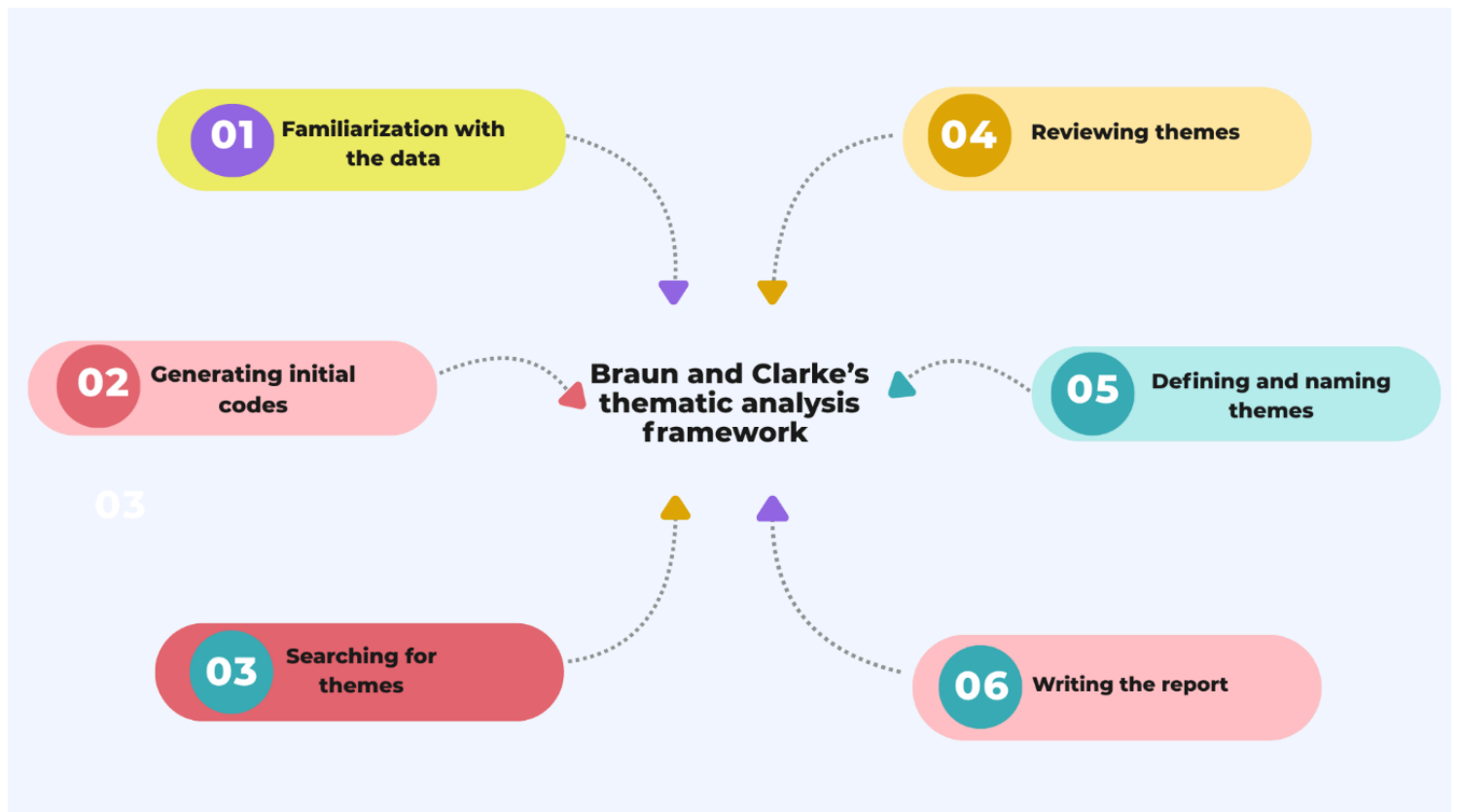


Figure 1

1. Braun and Clarke's thematic analysis framework

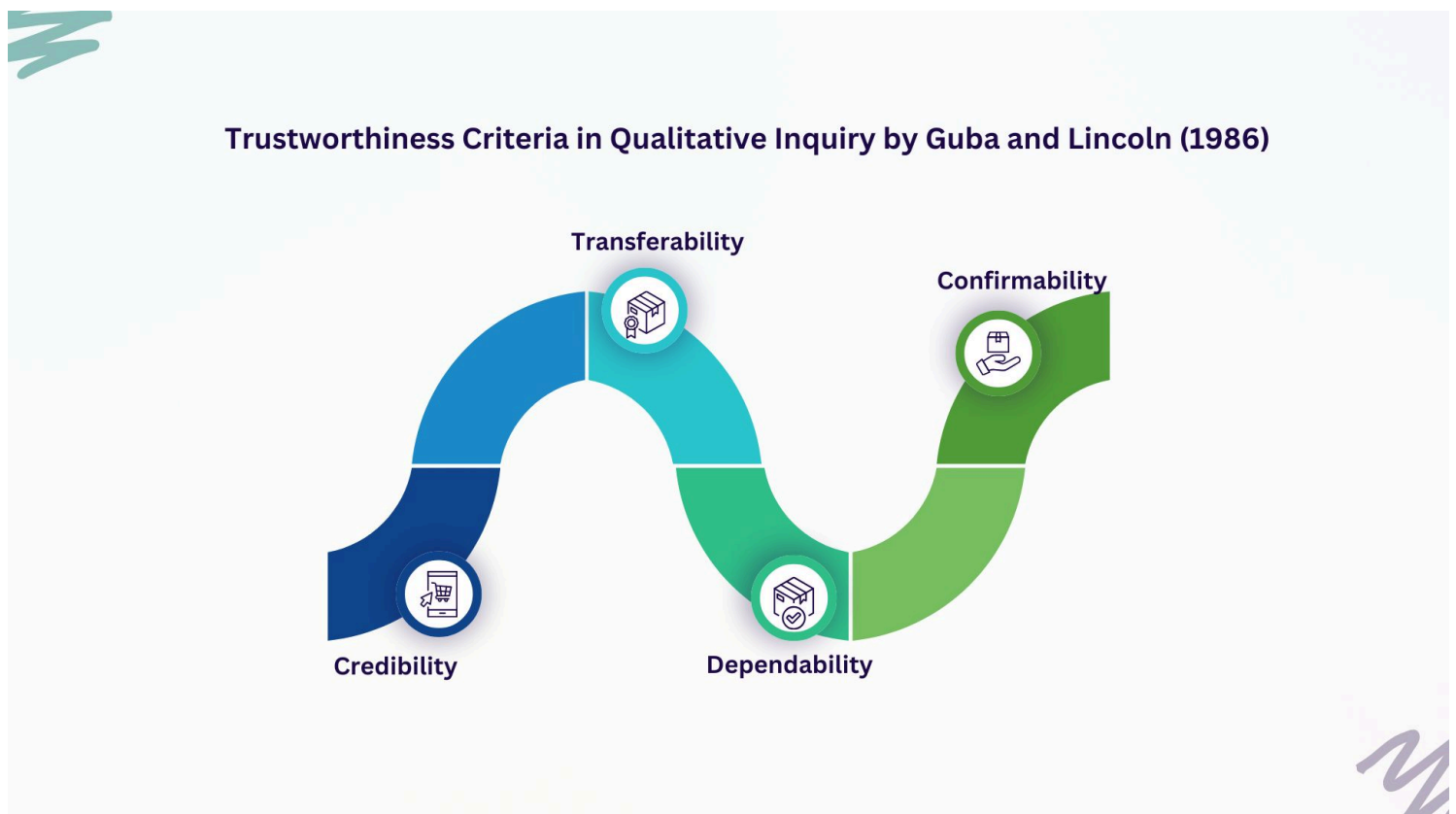


Figure 2

2. Trustworthiness criteria in Qualitative inquiry by Guba and Lincoln

