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Relations Among Internalized Stigmatization, Depressive Symptom Frequency and Family Loading in First-degree Caregivers of the Patients Treated in the Psychiatry Clinic of a State Hospital

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INTRODUCTION

Internalized stigma is given as individuals' acquiescence of negative moral judgments displayed by society for themselves and consequent retraction behavior of these individuals from society owing to negative feelings of insignificance and shame (Corrigan, 1998; Corrigan, Roe, & Tsang, 2011). Internalized stigma could be considered as a subjective status that arises as a result of living in a society having common beliefs and prejudice without concrete stigmatization experiences (Corrigan & Rao, 2012).

For many societies, stigmatization and discrimination exist in many cases, for number but the most affected are individuals with mental disorders (Taşkın, 2007). Stigmatization of chronic psychiatric disorders not only affects the patient negatively, but patients' relatives as well; and results in stigmatization of patients and their families by their society (Kocabaşoğlu & Aliustaoğlu, 2003). It is reported that afterwards of the initial attack experienced by psychiatric patients, >60% of them return home continue living with their relatives (Addington, Bouchard, Goldberg, et al., 2005; Ukpong, 2012). It is reported that the prominent supporters and primary caregivers of psychiatric patients in Turkey is their families and that majority of patients are living with their family (Duman & Bademli, 2013; Tel, Doğan, Özkan, et al., 2010). Families could experience feelings such as future anxiety, hopelessness, disappointment, embarrassment and feeling as the cause of the disease when they have a member with psychiatric disorder (Rosenfield, 1997). Based on such reasons, families could stigmatize themselves owing to tendency to concealing the member with disorder and\or getting away from social relationships (Larson & Corrigan, 2008). In regard to self-stigmatization behavior of family, not only existence of family members with psychiatric disorder, but also negative social view towards individuals with psychiatric disorder is significantly effective. Families usually experience the sense of devaluation together with their patient members (Struening, Perlick, Link, et al., 2001). Distress in affection caused by stigmatization and exposure of patient in the family to others could be resulted in both patients and their families to feel self-depreciation (Lee, Lee, Chiu, et al., 2005). Whereas family members could feel stigmatization from others because of their patient member, they could display stigmatizing behavior against their patients (Wahl & Harman, 1989). When families exhibit adverse affection and opinions such as "I wish she/he was not born; I wish she/he was dead; I wish we did not met' caused by perception of stigmatization (Ostman & Kjellin, 2002) towards family members with psychiatric disorder; and this further increases patients' perception of stigmatization unintentionally. For a patient member of a family, stigmatization sensed from own family could result in more devastation with respect to the one felt from outside (Lee et al., 2005). Moreover, it is known that stigmatization is effective on family, inter-personal relationships and roles inside the family as well. The essential reason of this is that chronic psychiatric patients are viewed as weird and scary by society and that society has incomplete information concerning the disorder and different perceptions (Bloch, Hafner, Harari, et al., 1994; Tel & Ördek, 2006).

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Individuals with psychiatric disorder usually receive caring service from their families who are held first-degree responsible for them. Providing caring service to individuals with psychiatric disorders is a difficult task and introduce heavy burden to caregivers (Gülseren, 2002). Concept of caring burden refers both negative objective and subjective consequences caused by providing caring service on caregivers such as psycho-social problems, physical health problems, economic problems, deterioration in family relationships and sense of losing control (Ak, Yavuz, Lapsekili, et al., 2012; Magliano, Fadden, Economou, et al., 2000). Caregivers undertake fundamental roles regarding adjustment of patient to treatment, ensuring maintenance of care and provision of social support (Perlick, Miklowitz, Link, et al., 2007). Therefore, well-being of caregivers is directly effective on them and indirectly on patients (Çoban, Özkan, Medik, et al., 2013).

It was reported in studies describing mental health status that individuals with psychiatric disorder could cause caregivers to experience psycho-somatic, anxious and depressive symptoms (Perlick et al., 2007). Patients' relatives who are experiencing difficulty with expressing their affections related with stress or hindrance could display more depression symptoms (Arguvanlı & Taşcı, 2013; Kasuya, Polgar-Bailey, & Takeuchi, 2000). Increasing severity of disease symptoms of patients or occurrence of more remarkable symptoms result in mental health problems in families and elevate their depression and stigmatization affections (Rosenfield, 1997). In the fight against stigmatization, internalized stigmatization was determined as more convenient target to have access and to work on (Corrigan & Watson, 2002).

Although there have been number of studies on social stigmatization related with psychiatric disorder, number of studies concerning self-stigmatization attitudes of families are rather limited (Yıldız, Özten, Işık, et al., 2012). Accordingly, the present study was conducted to determine the relationship among internalized stigmatization, depressive symptom frequency and loading on family in families of individuals with psychiatric disorder.

METHOD

Study design

This descriptive, cross-sectional and correlational study was conducted with family members of the patients with psychiatric disorders. The aim of the study was to determine the relationship between internalized stigmatization, depressive symptom frequency and family loading on family members of the patients with psychiatric disorders.

Sample of study

Study universe was consisted of family members of the patients with psychiatric disorders who appealed to Psychiatric Clinic of the Burdur State Hospital in the period of 20 June–14 July 2016. The sample of this study was consisted of first degree relatives, who agreed to participate in research, of individuals who applied to inpatient or outpatient treatment to Psychiatric Department of Burdur State Hospital. Sixteen individuals who did not accept to participate in the study and 29 individuals who did not meet the inclusion criteria were not included in the study. A feedback of 89.8% was provided in the study. The inclusion criteria were as follows; regarding the DSM-4 diagnosis criterions, it was necessary to have a volunteer family members in patients diagnosed with psychiatric disorder; to be aged between 18 and 65; not work at a psychiatric clinic; and not to be diagnosed with any psychiatric disorder. In the study, only one patient relative was met for each patient (daughter, son, spouse, brother, sister, mother or father).

Measurements

In collection of study data, an information form for personal family and disease information of family members of patients, Beck Depression Scale (BDS), Perceived Family Loading Scale (PFLS) and Internalized Stigma in Mental Illnesses Scale (ISMI) were employed.

Information form

There are totally 18 questions in this form prepared by the researchers based on the current literature, which include socio-demographical and disease characteristics of patients' relatives.

Beck Depression Scale (BDS)

This scale was developed by Beck (1961) to determine depression levels of individuals and consisted of 21 items. Scores that could be obtained from the scale could range between 0 and 63. Whereas range of 0–9 score refers minimal depression, range of 10–16 refers mild depression, range of 17–29 refers medium depression and range of 30–63 refers severe depression. Turkish validity and reliability studies of the scale were conducted (Hisli, 1988).

Perceived Family Loading Scale (PFLS)

This scale which investigates loading of a family member in the last one month was developed by Levene, Lancee, and Seeman (1996). Whereas it is consisted of 24 items in Likert type; it is structured in self-declaration form. Through a general evaluation, current behaviors of patient (objective component) and their relevant disruption levels on relatives (subjective component) are determined. If the relevant behavior probed by the corresponding item does not exist with the relevant patient, zero (0) score is assigned. If probed behavior existing with the patient, disruptive effect of the relevant behavior on the family is assessed with respect to four-point Likert scale: none (1), little (2), rather (3) and a lot (4); and each item is scores in the range of 0–4. Total score is obtained through addition of these individual scores for each item. As the total score increases, perceived family loading increases. Turkish validity and reliability studies of the scale were conducted (Arslantaş, Adana, Dereboy, et al., 2011).

Internalized Stigmatization in Mental Illnesses (ISMI)

As it evaluates internal stigma, it is structured in self-declaration form. The scale is comprised of five sub-scales: “alienation” (items: 1, 5, 8, 16, 17 and 21), “approval of judgment patterns” (items: 26, 10, 18, 19, 23 and 29), “perceived discrimination” (items: 3, 15, 22, 25 and 28), “social withdraw” (items: 4, 9, 11, 12, 13 and 20) and “resistance against stigmatization” (items: 7, 14, 24, 26 and 27). Items in the scale were structured in 4-point Likert type as follows: “certainly disagree” (1 point), “disagree” (2 points), “agree” (3 points) and “certainly agree” (4 points). Items of the sub-scale concerning resistance against stigmatization (7, 14, 24, 26 and 27) are calculated according to reverse proportion. Total ISMI score calculated through addition of scores obtained from five sub-scales range between 4 and 91; and there is no cutoff score for the scale. Higher scores indicate higher severity rates of persons' internalized stigmatization in negative way. Turkish validity and reliability studies of the scale were conducted (Ersoy & Varan, 2007). Upon the approval of the Ersoy who conducted Turkish validity and reliability study of the ISMI Scale, unlike the individual expressions used by Zisman-Ilani, Levy-Frank, Hasson-Ohayon, et al. (2013), “my daughter” and “my son” or “my child” expressions were utilized. For instance, instead of ‘having psychiatric disease ruined my life’, the expression of ‘psychiatric disease of my daughter/son/spouse/brother/sister/mother/father ruined my life’ was preferred (Zisman-Ilani et al., 2013).

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