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## EFFECTS OF MENTAL ILLNESS STIGMA ON SOCIAL IDENTITY AND SOCIAL ISOLATION AMONG FAMILY CAREGIVERS OF PSYCHIATRIC PATIENTS

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### ABSTRACT

**Objective:** The present study aimed to study effects of mental illness stigma on social identity and social isolation among family caregivers of psychiatric patients. Mediating role of affiliate stigma between social isolation and social identity was assessed.

**Method:** Cross sectional research design was carried out in which 203 male and female family caregivers of psychiatric patients were approached for data collection after their consent was taken. 22 item Affiliate stigma scale, 12 item Lubben Social Network Scale-Revised measuring social isolation and 7 item Social Identity Scale were used in the study. (Winnie & Cheung, 2008; DeVellis, 1991; Sreiner & Norman, 1995; Cheek & Tropp, 2002) were administered.

**Results:** Affiliate stigma mediates the effect of social identity and social isolation among family caregivers of psychiatric patients. All the three components of stigma, that is, affection, cognition and behavior mediates the effect of disturbed social identity and social isolation from family and friends.

**Conclusion:** The results of present study help to understand potential barriers to psychological treatment due to stigma attached to mental illness and its cure. It also provided insight to difficulties faced by caregivers due to their association with the mentally ill person. Moreover, counselors may also benefit from this research knowing the difficulties faced by caregivers and their role in the treatment process thus, helping caregivers too and designing interventions accordingly. If caretakers to family ill are properly and thoroughly informed and educated about the illness, than they can be much more successful in the caretaking role.

**Keywords:** affiliate stigma, social identity, social isolation, family caregivers

### INTRODUCTION

Many people experiencing psychological problems never pursue treatment. The most often cited reason for not taking treatment for mental health problems and other related services is the stigma attached to them in the society (Corrigan, 2004). Stigma decreases the likelihood that an individual will seek psychiatric treatment for his / her psychological problems even if the condition is severe. From last few decades rapid changes have occurred in the services relating to psychological problems in Pakistan. The situation is still not very

commendable due to lack of professionals' related to mental health and the availability of related facilities. Professionals related to psychological problems are present mostly in urban areas and there is lack of availability of mental health professionals in rural areas (Afridi, 2009).

Proper epidemiological data regarding mental illnesses in Pakistan for proper mental health plan and its implication is lacking. According to World Health Organization (WHO), 1% of the population suffers from severe and 10% of population suffers from mild mental disorders in developing

countries like Pakistan. According to the Global Burden of Disease (GBD) psychological problems constitute 10.5% of GBD, which may increase up to 15% in 2020. Mental illnesses contribute about 29% of the total disabilities present in the world while problems related to behavior contribute an additional 34% to the GBD (Farina, 1982).

The importance of the problems related to mental health can well be estimated from the facts based on scientific studies by WHO that socioeconomic condition of any country can be disturbed by mental illnesses as two fifths (40%) of total disabilities at global level are psychiatric disorders effecting human functionality.

Stigma about having a mental illness has a long history. The Latin word for it was *instigare* and in ancient Greece, the word *stizein* a physical mark or tattoo was cut or burned into the skin of criminals, slaves, or traitors and this marking lead to an action as to discriminate them as blemished or morally polluted persons. These psychiatric patients were to be avoided or shunned, particularly in public places. Today, stigma refers to discrimination in some undesirable way. It is a sign of shame, disgrace, or disapproval, rejected by others or by even the entire community (Lopez-Ibor, 2002).

Goffman argues that stigma “refers to an attribute that is deeply discrediting”. A person’s stigma makes him different and puts him/her in a less desirable kind available (Goffman, 1963).

The general view of identity refers to the conceptualization and manifestation of one’s personality as well as social characteristics (Leary, Barling, Arias, Rosenbaum, Malone, & Tyree, 1986). It has played an important role in the field of humanities and social sciences for the past decades (Stryker, Owens, & White, 2007). Traditional theories of identity development during 1950s were founded on the view that identity formation is a linear process; which proceed through a predictable set of stages.

Social Identity theory and self-categorization theory describe that we identify with groups in

order to create a social identity, defined by any physical or social characteristic, role, or feature that distinguishes a group of people (Tajfel & Turner, 2004; Tajfel, 1982; Turner, 1979). A person’s identity may include his or her race, ethnicity, age group, occupation, place of origin, body shape and size, etc. Social identity provides a basis of self-concept and self-esteem, as well as a sense of association and connection with other people (Hogg & Terry, 2000).

There are many types of social identity which reflect different ways in which individuals connect to other groups and social classifications. Deaux (1996) pointed five distinct types of social identification: ethnic and religious identities, political identities, vocations and avocations, personal relationships, and stigmatized groups. Each of these forms of social identity has some different features that make it slightly different from the other type.

Social isolation has numerous definitions available in the literature. Day (1992) explained it as “the absence of fulfilling relationships and a decreased level of involvement in social life”.

Social isolation is disconnectedness from the society, accompanied by a lack of social relationships and reduced level of social involvement in different activities, and perceived isolation is explained to be marked by loneliness and a perceived lack of social support group (Cornwell & Waite, 2009).

Social isolation refers to a absence of complete or near-complete social contact with other individuals. Social isolation may manifest in two types. Objective social isolation is described by absence of contact with other people. It is indicated by situational factors, like a reduced or restricted social support network, occasional social communication, and lack of involvement in social activities and social groups (Caplan, 1979; Gierveld & Hagestad, 2006; Lin, Ye, & Ensel, 1999). Subjective social isolation, on the other hand, is characterized by perceiving reduction in

one's social resources, such as companionship and social support network

Mental Health is inseparably linked with the perception of society and culture; culture plays a significant role in how people conceptualize mental health, normality and healing (Kirmayer, 1989). One important socio-cultural factor in the treatment of the mentally ill individual is their family or the person providing care. Patel (2008) in caring for the mentally ill said, "The core resource is humans". One of the main reasons of avoiding help for mental issues by patients or their caregivers is due to the stigma attached to psychological problems and its treatment in the society (Liegghio & Sdao-Jarvie, 2012).

Studies have shown that 43% to 92% of caregivers of people with mental illness report feeling stigmatized (Struening, Perlick, Link, Hellman, Herman, & Sirey, 2001). Thus affecting the treatment process negatively. The recognition of the needs, in terms of support and services for individuals having mental illness, becomes the role of their caregivers; so it is very important to understand caregivers experiences; especially possible barriers to their care-giving experiences

People with mental illness and their families are well aware of the stereotypes about mental illness held by public and spread by media, in feature films and advertising. The dominance of negative images about mental illness is not only perceived as a cause of stigma and discrimination, but rather experienced as directly discriminating and hurtful; it is the integral part of the stigmatization process.

The aim of this study is to bring together and showcase recent research that examines the relationship between social identity, affiliate stigma, and social isolation among family caregivers of patients having mental illness.

## **MATERIAL AND METHOD**

The participants of this study were 203 family caregivers of psychiatric patients who were providing care from more than six months. Firstly, permission was sought from the psychiatrists of

hospitals and private clinics. Participants were approached in wards and OPDs of hospitals. They were briefed about the objectives of the study. Considering the sensitivity of the topic and reluctance of the participants, verbal as well as written consent was taken from those participants who were willing to participate in the study. After informed consent, the participants were given Urdu translated versions of Affiliate Stigma Scale, Lubben Social Network Scale-R and Social Identity Scale to complete in one sitting.

The mediation effects of affiliate stigma for explaining the relationship between social identity and social isolation among family caregivers of psychiatric patients were explored.

## **INSTRUMENTS**

### **Affiliate Stigma Scale**

Affiliate Stigma Scale was developed by Mak and Cheung (2008) to measure caregivers' internalization of stigma. It consists of 22 items. The scale items measured the cognitive, affective and behavioral components of affiliate stigma. Participants have to rate the extent to which they endorse each item on a 4-point Likert scale from (1) strongly disagree to (4) strongly agree. The mean score of the 22 items was used, with a higher score indicating a higher level of affiliate stigma. The affiliate stigma scale achieved excellent internal consistency for mentally ill, that is, Cronbach alpha = 0.94.

### **Lubben Social Network Scale-Revised (LSNS-R)**

The Lubben Social Network Scale-Revised (LSNS-R) developed by Lubben is a brief instrument developed in 1988 and revised in 2002. The LSNS-R assesses social isolation by measuring perceived social support received by family and friends. It infers social isolation from a low score on perceived social support. It ranges from one to six; one indicating minimal social support and six indicating substantial social support. Higher scores indicate greater level of social support and low risk for isolation while

lower scores indicate lower level of social support and high risk for social isolation. Cronbach alpha coefficient was chosen to examine the internal consistency of LSNS-R which was reported to be ranging from .70 to .90 (DeVellis, 1991; Sreiner & Norman, 1995).

### **Social identity Scale**

The Aspects of Identity Questionnaire was developed by Cheek & Briggs (1981). The AIQ-IV is a 45-item objective inventory that measures the importance of four identity orientations in individuals' self-concepts: (a) personal identity, (b) relational identity, (c) social identity and (d) collective identity. Items responses ranges from 1 ("not important to my sense of who I am") to 5 ("extremely important to my sense of who I am").

Alpha reliabilities ranged from .80–.82 for the Social Identity scale (Cheek & Tropp, 1997).

## **RESULTS**

Results indicated that there might be a partial mediating role of affective component of affiliate stigma between social identity and family social isolation. The table shows that social identity explains 3% variance in getting socially isolated from family; however, mediating effect of affective component of affiliate stigma to social identity explains 6% additional variance in family social isolation. In order to confirm the mediatory role of affective component of affiliate stigma among social identity and family social isolation, Sobel t-test was performed using a web-based statistical tool of Preacher and Leonardelli (2005). The value of sobel t-test (2.30,  $p < .05$ ) indicates the significant mediating effect of affective component of affiliate stigma between social identity and family social isolation.

Mediating role of affective component of affiliate stigma between social identity and friend social isolation was found but in order to confirm the mediatory role of affective component of affiliate stigma among the variables, Sobel t-test was performed using a web-based statistical tool of

Preacher and Leonardelli (2005). The value of sobel t-test (2.81,  $p < .05$ ) indicates significant mediating effect of affection (affiliate stigma) among social identity and friend social isolation.

There might be a partial mediating role of cognition (affiliate stigma) among social identity and family social isolation. Table shows that social identity explains 3% of variance in family social isolation; however, the mediating effect of cognition (affiliate stigma) to social identity explains 8% additional variance in family (social isolation). In order to confirm the mediating role of cognition (affiliate stigma) among the variable, Sobel t-test was performed using a web-based statistical tool of Preacher and Leonardelli (2005). The value of sobel t-test (2.23,  $p < .05$ ) indicates the significant mediating effect of cognition (affiliate stigma) between social identity and family social isolation.

There might be a partial mediating role of cognition (affiliate stigma) among social identity and friend social isolation. In order to confirm the mediating role of cognition (affiliate stigma) among the variable, Sobel t-test was performed using a web-based statistical tool of Preacher and Leonardelli (2005). The value of sobel t-test (2.99,  $p < .05$ ) indicates significant mediating effect of cognition (affiliate stigma) between social identity and friend social isolation.

Full mediating role of behavior (affiliate stigma) between social identity and family social isolation was found. The table shows behavior (affiliate stigma) as a mediator to social identity explains 7% variance in family social isolation.

Results indicated that there might be partial mediating role of behavior (affiliate stigma) between social identity and friend social isolation. Table shows that social identity explains 5% of variance in friend social isolation; however, the mediating effect of behavior (affiliate stigma) to social identity explains 12% additional variance in friend social isolation. In order to confirm the mediating role of behavior (affiliate stigma) among the variable, Sobel t-test was performed

using a web-based statistical tool of Preacher and Leonardelli (2005). The value of sobel t-test (2.78,  $p < .05$ ) indicates the significant mediating effect of

behavior (affiliate stigma) between social identity and friend social isolation.

**Table 1: Mediating effect of affection (affiliate stigma) between social identity and family social isolation (N=203)**

Predictors	Family social isolation			
	Model 1 B	Model 2		
		B	95% CI	
(Constant)	11.83	18.91	UL	LL
Gender	-2.52	-2.21	-3.95	-.48
Education	.574	.34	-.50	1.19
Age	2.68	2.68	.39	4.98
Marital status	1.62	1.35	-.79	3.49
Social identity	.15**	.13	-.01	.27
affection		-.34**	-.55	-.12
R <sup>2</sup>	.09	.02		
F	5.05***	5.99***		
$\Delta R^2$	.02	.04		
$\Delta F$		9.65		

\*\* $p < 0.01$ ; \*\*\* $p < 0.001$

**Table 2: Mediating effect of affection (affiliate stigma) between social identity and friend social isolation (N=203)**

Predictors	Friend social isolation			
	Model 1 B	Model 2		
		B	95% CI	
(Constant)	14.68	25.05	LL	UL
Gender	-2.99	-2.54	-4.28	-.80
Education	1.46	1.12	.28	1.96
Age	-.41	-.41	2.71	1.89
Marital status	1.79	1.39	-.75	3.53
Social identity	.17**	.13	-.008	.27
affection		-.49***	-.71	-.28
R <sup>2</sup>	.18	.26		
F	8.54***	11.27***		

$\Delta R^2$	.02	.08
$\Delta F$		20.65

\*\*p<0.01; \*\*\*p<0.001

**Table 3: Mediating effect of cognition (affiliate stigma) between social identity and family social isolation (N=203)**

Predictors	Family social isolation			
	Model 1 B	B	Model 2	
			95% CI	
			UL	LL
(Constant)	11.83	18.41	10.36	26.45
Gender	-2.52	-1.91	-3.64	-.18
Education	.574	.29	-.54	1.13
Age	2.68	3.03	.76	5.31
Marital status	1.62	1.61	-.49	3.71
Social identity	.15**	.12	-.01	.26
Cognition		-.41***	-.63	-.20
R <sup>2</sup>	.09	.02		
F	5.05***	6.07***		
$\Delta R^2$	.02	.06		
$\Delta F$		14.81		

\*\*p<0.01; \*\*\*p<0.001

**Table 4: Mediating effect of cognition (affiliate stigma) between social identity and friend social isolation**

Predictors	Friend social isolation			
	Model 1 B	B	Model 2	
			95% CI	
			LL	UL
(Constant)	14.68	25.29	17.50	33.09
Gender	-2.99	-1.99	-3.68	-.32
Education	1.46	1.00	.19	1.81
Age	-.41	.16	-2.05	2.36
Marital status	1.79	1.77	-.27	3.80
Social identity	.17**	.12	-.02	.25
cognition		-.67***	-.87	-.46

R <sup>2</sup>	.18	.32
F	8.54***	15.43***
ΔR <sup>2</sup>	.02	.14
ΔF		41.14

(N=203)

\*\*p&lt;0.01; \*\*\*p&lt;0.001

**Table 5: Mediating effect of behavior (affiliate stigma) between social identity and family social isolation (N=203)**

Predictors	Family social isolation			
	Model 1 B	B	Model 2	
			95% CI	
			UL	LL
(Constant)	11.83	20.37	11.52	29.21
Gender	-2.52	-2.06	-3.79	-.32
Education	.574	.43	-.40	1.26
Age	2.68	2.65	.37	4.94
Marital status	1.62	1.19	-.94	3.33
Social identity	.15**	.12	-.02	.26
behavior		-.37***	-.58	-.16
R <sup>2</sup>	.11	.17		
F	5.04***	6.40***		
ΔR <sup>2</sup>	.02	.05		
ΔF		11.80		

\*\*p&lt;0.01; \*\*\*p&lt;0.001

**Table 6: Mediating effect of behavior (affiliate stigma) between social identity and friend social isolation (N=203)**

Predictors	Friend social isolation			
	Model 1 B	B	Model 2	
			95% CI	
			LL	UL
(Constant)	14.68	25.41	16.46	34.37
Gender	-2.99	-2.41	-4.16	-.65
Education	1.46	1.28	.43	2.12
Age	-.41	-.44	-2.76	1.87
Marital status	1.79	1.26	-.90	3.42
Social identity	.17**	.12	-.02	.26

Behavior		-0.46***	-0.68	-0.25
R <sup>2</sup>	.18	.25		
F	8.54***	10.78***		
ΔR <sup>2</sup>	.02	.07		
ΔF		18.21		

\*\*p<0.01; \*\*\*p<0.001

## DISCUSSION

Caregivers are an important asset in treatment because they provide basic needs of the patients like food, clothes, etc. They can monitor compliance when it comes to medications and follow-up appointments. They are also essential in offering emotional, social and psychological support.

Present study was to explore the mediation effects of affiliate stigma for explaining the relationship between social identity and social isolation among family caregivers of psychiatric patients. It was hypothesized that components of affiliate stigma mediate the relationship between social identity and social isolation which was supported by results of present study. The result of present study is consistent with previous studies.

The results of present study highlighted that there are barriers to psychological treatment due to stigma attached to mental illness and its cure. Moreover, counselors may also benefit from this research knowing the difficulties faced by caregivers and their role in the treatment process thus, helping caregivers too and designing interventions accordingly. If caretakers to family ill are properly and thoroughly informed and educated about the illness, than they can be much more successful in the caretaking role.

## CONCLUSION

In short, it has been seen that the more caregivers internalize stigma at affective, cognitive and behavioral level; the more they experience disturbed social identity and become socially isolated from friends and family. Affiliate stigma

was seen to mediate the relationship between social identity and social isolation.

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