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THE RELATIONSHIP BETWEEN SELF STIGMA AND FAMILY BURDEN OF PEOPLE WITH MENTAL DISORDERS

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Mental disorders affect not only the patients but also the families who are the primary caregivers. Families often experience a heavy burden, especially due to self-stigma or negative views internalized from society. Self-stigma can worsen the psychological condition of families and increase the burden of caring for people with mental disorders. The purpose of the research is to determine the relationship between self-stigma and the burden on families of people with mental disorders at the Clinic in Bandung City. The research method uses quantitative analytical correlation with a cross-sectional approach. The research population consists of all 1,165 patients with mental disorders, with a sample of 93 people taken using the accidental sampling technique. Data collection used primary data with questionners from Internalized Stigma of Mental Illness Scale (ISMI) and The Burden Assessement Schdeule (BAS). Data analysis used univariate and bivariate analysis. The results of the univariate analysis showed that (49.5%) of the families of people with mental disorders had moderate self-stigma, and (58.1%) had a heavy burden. The results of the statistical test obtained a p-value (0.001) < α 0.05, which means there is a relationship between self-stigma and the burden on the families of people with mental disorders at the Nur Ilahi Mental Health Clinic in Bandung City. The conclusion indicates that self-stigma experienced by families of people with mental disorders is significantly related to their high burden in caring for family members with mental disorders.

Keywords: family burden; people with mental disorders; self-stigma

INTRODUCTION

Mental health is not merely defined as the absence of mental illness, but also includes a positive state of well-being. Mental disorders are complex problems characterized by changes in thought, emotion, and behavior, leading to impaired functioning. According to WHO (2021), more than 300 million people worldwide suffer from mental disorders, including depression, bipolar disorder, dementia, and schizophrenia. In Indonesia, the prevalence of mental disorders is relatively high, with around 20% of the population experiencing such conditions, accounting for more than 9 million cases in 2023. West Java has the highest prevalence of depression, and in Bandung City, tens of thousands of visits for mental health issues are recorded.

Mental disorders have wide-ranging impacts, both on individuals and families. Individuals may experience a decline in quality of life, discrimination, and difficulties in social interaction, while families face emotional, physical, and financial burdens. Family burden includes objective burdens (daily care), subjective burdens (stress, shame), and iatrogenic burdens (barriers in accessing treatment). Research shows that most families struggle to recognize problems, make decisions, and access health services, further increasing the burden. One of the major factors that exacerbates family burden is stigma, particularly self-stigma or internalized stigma. Social stigma, which views mental illness as a disgrace, often leads families to feel isolated, ashamed, and lacking in self-confidence. This self-stigma significantly affects family well-being, causing social isolation, reducing quality of life, and creating barriers to seeking help. Previous studies confirm that self-stigma is strongly linked to discrimination, stereotypes, and psychological harm experienced by families of people with mental disorders.

A preliminary study at the Nur Ilahi Mental Health Clinic, Bandung (2024) revealed high cases of depression, schizophrenia, and bipolar disorder. Interviews with families of patients indicated feelings of fatigue, hopelessness, economic pressure, and shame caused by social exclusion and negative perceptions. Based on these findings, the researcher was motivated to investigate the relationship between self-stigma and family burden in caring for people with mental disorders at this clinic

METHOD

This study employed a quantitative analytical correlational design with a cross-sectional approach, aimed at measuring the relationship between risk factors by collecting data at one point in time (Heriyanto, 2022). The purpose of this study was to examine the relationship between self-stigma and the family burden of patients with mental disorders. The independent variable was self-stigma, while the dependent variable was family burden. Data were obtained using primary questionnaires, and the sampling method used was accidental sampling. The instrument used in this research is Internalized Stigma of Mental Illness Scale (ISMI) and The Burden Assessement Schdeule (BAS). The validity test results on the family burden instrument, namely the BAS instrument, showed that the statements in the questionnaire are considered valid because they meet the validity requirement with a calculated r = 0.382, which is greater than the table r = 0.361, and a Cronbach's alpha reliability value of 0.915. The validity test results on the community stigma instrument showed test values ranging from 0.80-0.92 for all subscales and 0.81-0.91 without the stigma subscale. This study used statistical tests whereby univariate analysis utilized frequency distribution and bivariate analysis used Spearman rank analysis.

RESULTS

The univariate analysis revealed that 49.5% of families experienced moderate self-stigma, while 58.1% experienced a heavy family burden. The bivariate analysis using statistical tests showed a p-value of 0.001 (<0.05), indicating a significant relationship between self-stigma and family burden among caregivers of people with mental disorders at the Nur Ilahi Mental Health Clinic in Bandung City.

Table 1.
Frequency Distribution of Family Self-Stigma of People with Mental Disorders

Self stigma	f	%
Tinggi	30	32.3
Sedang	46	49.5
Rendah	17	18.2

Table 1, it shows that 49.5% of the families of people with mental disorders (PWMD) experience a moderate level of self-stigma**.**

Table 2.
Overview of Family Burden of People with Mental Disorders

Family Burden	f	%
Hard	54	58.1
Average	35	37.6
Mild	4	4.3

Table 2, it shows that 58.1% of families of people with mental disorders experience a heavy burden

Table 3.
The Relationship between Self-Stigma and Family Burden of People with Mental Disorders

Self Stigma	Family burden						Total		*p* value
	Hard		Average		Mild				
	f	%	f	%	f	%	f	%	
High	24	80.0	6	20.0	0	0	30	100	
Moderate	24	52.2	19	41.3	3	6.5	46	100	0.001
low	6	35.3	10	58.8	1	5.9	17	100	

Table 3, it shows that most families of people with mental disorders (52.2%) experience a moderate level of self-stigma with a heavy family burden. The statistical test results obtained a p-value of 0.001 (< α 0.05), which means that Ha is accepted. This indicates that there is a relationship between self-stigma and the family burden of people with mental disorders at Nur Ilahi Mental Health Clinic, Bandung City

DISCUSSION

Description of Self-Stigma Among Families of People with Mental Disorders

The study found that 30 respondents (32.2%) experienced high self-stigma, 46 respondents (49.5%) experienced moderate self-stigma, and 17 respondents (18.2%) experienced low self-stigma. Self-stigma among families caring for individuals with mental disorders reflects the internalization of societal stigma toward mental illness and its impact on the family (Danukusumah et al., 2022). The dominant finding was that self-stigma was mostly in the moderate category, which indicates that the majority of families had begun to internalize some of the stereotypes and negative prejudices that prevail in society. At this level, families generally felt ashamed or uncomfortable discussing the condition of their family members in the community, reduced their participation in certain social activities, and felt hesitant in carrying out their role as caregivers, although they still fulfilled caregiving responsibilities (Corrigan et al., 2016).

Further analysis showed that within the moderate self-stigma group, the highest scores were found in the stereotype dimension, particularly in item number 4 ("avoiding building relationships with people without mental illness to prevent rejection") and item number 18 ("withdrawing from social situations to protect family and friends from shame"), where the majority of respondents agreed. According to Corrigan et al. (2016), self-stigma can trigger social withdrawal due to the internalization of negative societal stereotypes. Julien et al. (2021) also supported these findings, showing that families with moderate to high self-stigma tended to experience social anxiety, shame, and avoidance of community involvement. Such conditions may worsen social isolation, reduce quality of life, and negatively affect the quality of care provided for family members with mental disorders (Julien et al., 2021).

The study also revealed that 32.3% of respondents experienced high self-stigma, with the highest score found in the labeling dimension, particularly item number 24 ("various views about people with mental disorders apply to my family"), where most respondents strongly agreed. According to Corrigan et al. (2016), the labeling process can cause families to absorb negative stigma, resulting in feelings of shame, helplessness, and withdrawal from social environments. This reduces the social and emotional support that families provide to patients and may further exacerbate social isolation (Corrigan et al., 2016). These findings are consistent with Morris et al. (2019), who found that high self-stigma often results from labeling, social rejection, and the belief that society rejects their presence, which can lead to psychological harm. Yanos et al. (2020) further emphasized that high self-stigma is associated with reduced self-esteem, pessimism, social withdrawal, and decreased motivation among families to participate in patient care and decision-making.

Based on age characteristics, the majority of respondents with high self-stigma (36.7%) were aged 26–35 years, while low self-stigma (17.6%) was most common among those aged 46–55 years. This is consistent with Corrigan et al. (2016, in Nasriati, 2020), who stated that younger or productive-age individuals (<50 years) tend to experience higher self-stigma because they are more sensitive to social judgment, are in the process of identity formation, and face multiple demands in family, work, and social roles. Yanos et al. (2020) also showed that individuals in productive age groups are at greater risk of self-stigma due to high social expectations and demands, which, when disrupted by stigma, may lead to disappointment, low self-worth, and decreased self-esteem.

In terms of education, 65.2% of respondents with moderate self-stigma had low educational attainment (elementary or junior high school). According to Link and Phelan (2001, in Nasriati, 2020), individuals with higher education generally possess greater knowledge of mental illness and stigma, enabling them to manage negative societal perceptions more effectively. Conversely, those with lower education are more vulnerable to self-stigma because limited knowledge makes them more likely to believe negative views. Julien et al. (2021) also found a significant relationship between education and self-stigma, indicating that lower education is associated with a higher likelihood of experiencing self-stigma.

Regarding employment status, 63.3% of those with high self-stigma were employed. According to the social role theory (Biddle, 1986, in Nasriati, 2020), role conflict occurs when individuals must fulfill different demands simultaneously, which increases psychological stress. In this context, social stigma toward mental disorders may cause respondents to feel ashamed or concerned about their professional image. Julien et al. (2021) also reported that individuals who are employed but also care for family members with mental disorders tend to experience greater social pressure, as they must maintain their reputation at work while coping with societal stereotypes.

High self-stigma was also observed among 93.3% of respondents who had been caregiving for less than five years. Friedman (2018) stated that family adaptation to chronic conditions requires time, and in the early stages, the emotional burden tends to be heavier because families are still learning about the illness, seeking information, and adjusting to new routines. Maisulvi et al. (2023) also found that families who provided care for one to five years were more likely to experience greater burden and had not yet developed optimal emotional readiness, making them more susceptible to internalizing negative societal views.

Self-stigma is a highly vulnerable condition among families, and the higher the level of self-stigma, the greater the impact on their ability to function as the main support system for people with mental disorders. Therefore, interventions aimed at reducing self-stigma among families are essential. Health professionals should enhance families' coping skills by training both families and patients in managing emotions, stress, and social pressures caused by stigma; teaching assertive communication skills to confront discrimination; and helping families remain psychologically resilient in caregiving. The ultimate goal is to create a safe, stable, and stigma-free environment for families, thereby supporting the optimal recovery of people with mental disorders.

Description of Family Burden among Families of People with Mental Disorders

The results of Table 4.2 show that the majority of respondents experienced a relatively high level of family burden, with 54 respondents (58.1%) reporting a heavy burden, 35 respondents (37.6%) reporting a moderate burden, and only 4 respondents (4.3%) reporting a light burden. Family burden is defined as the level of distress or pressure experienced by family members as a result of the health condition or behavior of another family member (Friedman, 2018). This burden includes objective burdens, such as the need to care for the patient, arrange medical appointments, and cover additional financial expenses, as well as subjective burdens, including psychological stress such as anxiety, fear, shame, or emotional exhaustion (Pardede, 2022).

The findings indicate that families experienced heavy burdens, especially in the subjective burden dimension. The highest response was on item number 9, "Do you feel stressed and anxious because of the patient's condition?", to which most respondents answered "very much." According to Bahari et al. (2018), heavy subjective burdens negatively impact family psychological well-being and the quality of patient care, often causing prolonged stress, worry, and increased pressure due to social stigma. Maisulvi et al. (2023) supported this finding, reporting that 65% of families with heavy burdens described caregiving as a traumatic experience filled with sadness, anger, and a sense of being trapped due to changes in the family member.

In terms of objective burden, the highest response was to item number 2: "the patient's illness hinders maintaining good relationships with family members or others," with most respondents answering "sometimes" and "very much." This indicates that having a family member with a mental disorder affects the quality of social relationships, both within the family and with the wider community. Bahari et al. (2018) stated that objective burden includes social aspects, such as disrupted interpersonal relationships and family social activities, which may lead to feelings of shame or discomfort in interactions. Similarly, Patricia et al. (2020) found that 33.3% of families experienced heavy burdens in the objective aspect, particularly in relation to disrupted social relationships, where families tended to avoid gatherings or felt uncomfortable due to negative public perceptions.

Family burden can be influenced by several factors, including education, duration of illness, and economic status. Based on economic characteristics, 62.8% of families with heavy burdens were unemployed. Sadock (2018) emphasized that economic factors are among the most important in assessing family burden, as mental health care requires significant time and financial resources. Alfiandi et al. (2018) supported this, finding that most families had a monthly income between 1–2 million rupiah. The absence of stable employment or sufficient income increases both financial strain and psychological burden, as families must manage the patient's care needs amid economic limitations.

The findings also showed that 53.7% of respondents with heavy burdens had low educational attainment (elementary or junior high school). According to Link and Phelan (2001, in Nasriati, 2020), individuals with higher education generally possess better knowledge and coping skills, enabling them to face stigma and stress more adaptively. Conversely, low education limits understanding and makes families more vulnerable to psychological and social pressures. Julien et al. (2021) also found a significant relationship between low education levels and higher family burden, as a lack of knowledge and caregiving skills increases feelings of being overwhelmed, stress, and perceptions of burden, both subjectively and objectively.

In terms of caregiving duration, 90.7% of respondents had been caring for less than five years. Friedman (2018) noted that family adaptation to the role of caring for a member with a chronic illness takes time, and psychological, physical, and social burdens are usually higher in the early stages. During this period, families are still learning about the patient's condition, seeking information, and adjusting to new roles and routines. Maisulvi et al. (2023) also reported that families caregiving for one to five years tend to experience greater burdens, as their physical, emotional, and social readiness is not yet optimal.

The family burden experienced has a significant impact on the patient's condition, as the family serves as the main support system in the treatment and recovery process. When families face heavy burdens, their ability to provide optimal care decreases, and the risk of patient relapse increases. Therefore, efforts such as education, strengthening social support, and empowering families are essential concrete steps to reduce family burden. Health facilities, healthcare professionals, and relevant stakeholders are expected to provide continuous guidance, information, and emotional support to the families of people with mental disorders, in order to improve family quality of life and accelerate patient recovery.

The Relationship Between Self-Stigma and Family Burden among Families of People with Mental Disorders

The study found that 58.7% of families of people with mental disorders (PwMD) experienced a moderate level of self-stigma along with a moderate family burden. Statistical analysis showed a *p*-value of 0.001 < α 0.05, indicating that the alternative hypothesis (Ha) was accepted, meaning that there is a significant relationship between self-stigma and family burden among families of

PwMD at Nur Ilahi Mental Health Clinic, Bandung. These findings are consistent with Maisulvi et al. (2023), who also reported a significant relationship between the burden experienced by families and the stigma associated with schizophrenia in Kumun Debai District, Sungai Penuh City, with a *p*-value of 0.001.

The results further showed that 80.0% of respondents with high self-stigma experienced a heavy family burden. The higher the self-stigma, the greater the burden experienced by the family. According to Corrigan et al. (2016), families with high self-stigma not only experience shame and guilt but also avoid social environments, withdraw from support systems, and feel reluctant to seek help. This exacerbates their stress and directly increases the psychological and emotional burden they face. Chang et al. (2020) also found that families with high self-stigma are more likely to experience greater social anxiety, difficulties in accessing external support, and a decline in quality of life. Consequently, they become more vulnerable to burnout, emotional exhaustion, and internal conflicts, all of which contribute to a heavier family burden.

Interestingly, the study also revealed that 35.5% of respondents with low self-stigma still experienced a heavy family burden. This finding does not fully align with Corrigan et al.'s (2016) theory, which suggests that individuals with low self-stigma should experience lighter burdens, as lower self-stigma is generally associated with better self-acceptance, more positive coping abilities, and stronger social support, thereby reducing family psychological burden. However, this result can be explained by considering other factors beyond self-stigma that influence family burden, such as economic status, family knowledge levels, caregiving skills, or insufficient social support. Alfiandi et al. (2018) similarly noted that family burden can remain high when families face financial difficulties or lack emotional support from extended family, friends, communities, religious groups, or other social networks.

The findings suggest that high self-stigma among families is a significant factor contributing to an increased caregiving burden. Self-stigma negatively affects self-perception, lowers self-confidence, worsens psychological well-being, and hinders the pursuit of help or social support. Therefore, family-based interventions are essential, including counseling, mental health education, and ongoing training in coping and stress management. Social support from communities, environments, and healthcare facilities is also critical to create a supportive atmosphere. With appropriate interventions and adequate support, family burden can be reduced, quality of life can be improved, and the recovery and social reintegration process of people with mental disorders can be optimized.

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