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CHRONIC STRESS IN IMMIGRANTS AND RELATIVES OF PEOPLE WITH MENTAL ILLNESS: A COMPARATIVE STUDY

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Corresponding Author:	Karmele Salaberria, Ph.D. Faculty of Psychology of University of Basque Country San Sebastian, Guipuzcoa SPAIN
Corresponding Author Secondary Information:	
Corresponding Author's Institution:	Faculty of Psychology of University of Basque Country
Corresponding Author's Secondary Institution:	
First Author:	Karmele Salaberria, Ph.D.
First Author Secondary Information:	
Order of Authors:	Karmele Salaberria, Ph.D.
	Rocio Polo-Lopez, Ph.D. Student
	Soledad Cruz, Lecturer
	Enrique Echeburua, Professor
	Katherine Berry, Lecturer
Order of Authors Secondary Information:	
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CHRONIC STRESS IN IMMIGRANTS AND RELATIVES OF PEOPLE WITH MENTAL ILLNESS: A COMPARATIVE STUDY

Karmele Salaberría[1]

Rocío Polo- López[1]

Soledad Cruz[1]

Enrique Echeburúa [1]

Katherine Berry[2]

School of Psychology, University of Basque Country[1]

School of Psychology and Sciences, Manchester University[2]

Please address correspondence to:

Karmele Salaberría

School of Psychology

mcarmen.salaberria@ehu.es

Avda. Tolosa, 70

San Sebastian 20018

Spain

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ABSTRACT

Being an immigrant or living with a person who experiences mental health problems can lead to high levels of emotional problems in individuals who cope with these situations. Purpose: The aim of this study is to compare chronic stress in immigrants and relatives of people with mental health problems. Method: The sample comprised 108 adults (58 immigrants and 50 relatives of people who have mental health problems) who were seeking help due to their emotional problems. Results: In both groups there was an overrepresentation of women. The immigrants were younger; had a lower level of education and had higher unemployement rates than the relatives of people who have mental health problems. Both groups show a high symptomatology and low self-esteem. Problems in interpersonal relationships and anxious-depressive symptomatology were more severe in immigrants. Conclusions: We discuss the future research implications arising from the study. The fact that immigrants report similar symptomatology to relatives might mean that some of the treatments for relatives which are well established and effective could be applied to immigrants.

KEY WORDS: immigrants, relatives of patients with mental disorders, chronic stress, adjustment disorder.

INTRODUCTION

Stress is the physiological, emotional, cognitive and behavioral response which manifests itself when demands are made of a person which overwhelms his or her capacity to cope. Thereby, stress is a triple system response in the face of a perceived threat, a change or a significant loss. When the stressor is prolonged and chronic, it can physically, emotionally, cognitively and behaviourally exhaust the individual [1].

The consequences of stress are manifested at different levels [2-3]: a) At an emotional level, anxiety, fear, irritability and depressive moods are exhibited; b) At a cognitive level, we can often detect decreased attention, memory and concentration impairment and reduction in the ability to solve problems and learn, such as forgetfulness, mental blocks, mistakes, constant worry and indecision; and c) At a behavioral level we can observe decreased productivity, fatigue, increased consumption of tobacco and alcohol, sleep and eating disorders, escape, avoidance and social isolation. Chronic stress can also lead to various types of health problems, such as cardiovascular, endocrinological, gastrointestinal, immune and respiratory diseases.

From a diagnostic point of view, according to the DSM-IV-TR [4], an Adjustment Disorder (anxious, depressive or mixed type) which is produced in response to a recognizable psychosocial stressor is the diagnostic category that is most frequently associated to the experience of chronic stress [5]. This disorder is highly prevalent and can be present between 5 and 21% of outpatients and in 7.1% of hospital admissions [6-7].

Living with a family member who has severe mental problem or coping with the migration process frequently involves a chronic stress of great intensity, which affects multiple areas of a person's life. Families have become the essential community support for people affected by severe psychiatric problems. Couples' problems, disagreements and tensions among family members, social marginalization and a lack of support are common among families with a member with mental health problems. Thus children, parents, brothers and partners of the people with severe and/or chronic mentally health problems are at increased risk of developing mental health problems themselves and show higher rates of emotional disorders [8-9-10-11-12-13].

In fact, caring for a person with health problems involves addressing a range of stressful situations [14], such as progressive dependence, disruptive behaviors presented by the patient, the restriction of freedom, loss of past lifestyles and tackling new tasks related to the demands of the life cycle. Specifically, sources of stress for caregivers are diverse: the lack of understanding of family behavior and denial of problem existence for this person, discussions and difficulties in relationships, not knowing how to act in the daily living and the financial and legal consequences. There are also difficulties with the health system in the process of diagnosis and treatment of the disease [15-16].

According to Bayes, Arranz, Barbero & Barreto [17], in at least 80% of cases it is the family who takes care of the person with mental health problems in the family home. Sixty five percent of the caregivers who take care of the patient will undergo substantial changes in their lives and a significant decline in their physical and psychological health. Up to 20% of these will develop a strong clinical profile known as "Burnout" or "Burn-out Carer Syndrome".

In terms of immigrant stress, the most common sources of stress are derived from getting to the destination country, obtaining residence, work permits, finding a job, coping with the fear of deportation, registration, having access to health care, earning enough money to survive and pay the debts, overcoming prejudices and/or achieving family reunification. So, the immigrant has to face chronic, multiple and highly stressful psychosocial stimuli without a social support

network and lacking a sense of control [18-19] . All this can give rise to various symptoms of depression, anxiety, somatic symptoms andsymptoms of confusion [20-21]..

In summary, both the immigrant population and the relatives of mental health patients have to cope with stressful situations of great intensity and duration, many of them novel and unpredictable, which generate great uncertainty and ambiguity [22]. Usually, these difficulties are experienced in isolation and with little social support, because of prejudice in the case of the immigrant population and the social stigma in the case of the families of people with mental health problems. According to Talarn, Navarro, Rossell & Rigat [23] who describe the experience of acute stress, chronic stress and trauma, both living with a family member with long-term mental health needs as well as living as an immigrant can be considered stressful situations that can lead the affected persons to experience an intense emotional reaction and/or a hard and long periods of adaptation.

Given the scarcity of studies on these types of populations, the main objectives of this study are to define the sociodemographic profile and determine the level of their symptoms and self-esteem of both samples, as well as comparing them. A secondary objective is to specify the type of target-behavious that arise when patients came approach mental health services for help. We know that relatives experience a high level of stress. We suspect that immigrants do to, so if we compare them to relatives and they are found to have higher levels of stress, we will know that they are a really disadvantaged group who need lots of resources, the fact that they report similar target problems to relatives might mean that some of the treatments for relatives which are well established and effective could be applied to immigrants.

METHOD

Participants

The study sample consisted of 108 adults (58 immigrants and 50 relatives of patients with mental disorder). In both cases, they were people who attended a psychological support programme which is designed to alleviate the symptomatology associated with the migration process in the first case and to alleviate stress associated with living with the family member in the second case. This programme was carried out in the School of Psychology at a University in the Basque Country. The inclusion criteria for admission to the study were the following: a) to be of age, b) to be able to complete the questionnaires, and c) to present an adjustment disorder. The specific criteria for admission were being first generation immigrants and having an economic motivation in the case of the sample of immigrants and to have lived or to be living with the family member with mental health problems, in the case of the relatives.

The immigrant populations were mainly from Latin America (51) and Africa (7, 5 of whom were from Morocco, the other 2 were from Africa). The characteristics of the sample are described in Table 1.

TABLE 1

Design

The design of the study was cross- sectional.

Assessment tools

SCL-90-R Scale [24-25]. This instrument was used to evaluate the presence of general psychopathology symptoms. The scale consists of 90 items with 5 possible answers on a Likert

scale, ranging from 0 (none) to 4 (very much). The scale assesses 9 symptom dimensions (somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism). It also provides three global indexes that reflect the severity of symptoms: the global severity index (GSI), the overall rate of positive symptoms (PST) and the index of the intensity of symptoms (PSDI). The internal consistency of the questionnaire ranges from .81 to .90 and the test-retest reliability from .78 to .90.

Self-Esteem Scale [26-27]. This self-report measure aims to assess the feeling of satisfaction that a person has about him/herself. This instrument consists of 10 general items which score from 1 to 4 on a Likert scale. The range of the questionnaire is from 10 to 40, the higher the score, the greater the self-esteem. The test-retest reliability is .85, the alpha coefficient of internal consistency is .92. The cut-off score in an adult population is 29 [28].

Target-Behaviors Scale [29]. This is a self-report measure, in which patients make up a list of five types of behavior that they want to improve and would represent a significant benefit to their daily lives. These five target-behaviors are valued according to their degree of difficulty from 1 to 10 each, with a range varying from 5 to 50.

PROCEDURE

After obtaining permission from the Ethics Committee of the University, the existence of a free psychological support programme for immigrants and families of the mentally ill people was spread through the media, aid organizations and institutions linked to both types of populations (Red Cross, Caritas, Association of Mentally Ill Patients, Alcoholics Anonymous, etc.). Those interested who got in touch with the programme were evalued to see if they met the inclusion criteria. They were then offered information about the programme and asked for their informed consent. Finally, the assesments were carried out over 2 sessions (one hour each session).

The programme described in this study was carried out in San Sebastián (Basque Country, Spain) from 2008 to 2012.

DATA ANALYSIS

SSPS 20 was used for analyzing the data. Descriptive analysis (means, standard deviations and frequencies) and group comparisons were performed using T tests for independent measures in quantitative variables and chi-squared tests for qualitative variables. The effect size was calculated using Cohen's D (quantitative variables) and Cramer's V (qualitative variables). In addition, we compared the results of the sample with the normal population scales of the SCL-90-R.

RESULTS

Sociodemographic variables

Table 2 describes the main demographic characteristics of the two samples (immigrants and families of people with mental health problems). Most individuals who come to the programme for counseling were women (82%), and both samples show this trend to a similar level.

Immigrants who seek psychological support were younger, had a lower level of education and had higher unemployment rates. They also had a lower income level and on average had been away from their country for 3.5 years, so they were still in the first phase of settlement. The relatives of the patients with mental health problems had been living with them for an average of 24 years, they were middle-aged (on average 44 years old), 62% of them were married and more than half of the sample group had University degrees and were economically better off.

Despite the differences being statistically significant, these differences were quite small, except in the case of age (d=0,86).

TABLE 2

Psychopathological variables, self-esteem and target- behaviors in both samples of participants

Table 3 describes the main features of psychopathology and self-esteem of the two samples (immigrants and relatives of the mentally ill). Both immigrants and the families of people with mental health problems had scores well above the 50th percentile of the general population in the Global Severity Index (GSI) of SCL-90-R. And at a level of specific dimensions, both relatives, with percentiles between 85 and 95, and immigrants, with scores corresponding to percentiles 95-97, were well above the average percentiles of the general population in all subscales. Therefore, both samples have significant emotional problems when compared with the general population.

TABLE 3

Comparing the two samples, the overall level of emotional distress and psychopathology were higher in the immigrant population than in the population of relatives. For example, the differences were statistically significant for the GSI ($t = 3.65$, $p < .001$) and with a medium effect size ($d = 0.72$). More specifically, the immigrant population had higher scores on the subscales related to interpersonal relationships (interpersonal sensitivity, paranoid ideation, psychoticism and hostility). Thus, immigrants showed more shame, inferiority feelings, hypersensitivity to the opinions of others, suspicion, fear of loss of autonomy, need for control, social alienation, anger, irritability, rage and resentment. The size of the differences was large in paranoid ideation ($t = 4.56$, $p < .001$, $d = 0.89$) and psychoticism ($t = 4.92$, $p < .001$, $d = 0.95$) subscales.

As for the anxious-depressive symptoms, scores were also higher in the immigrant population, but the size of the difference was medium (depression subscale, $d = 0.74$, and anxiety subscale, $d = 0.50$).

Furthermore, the level of self-esteem was below the cut off score in both samples, but scores did not differ statistically between the groups. Finally, the level of difficulty in target- behaviors that participants wished to work on the psychological support programme was perceived as high (mean: 40; range 5 to 50) and was similar in both samples.

Table 4 shows some examples of target-behaviors frequently reported by patients.

TABLE 4

DISCUSSION AND CONCLUSIONS

According to the results obtained in this study, the prevalence of women in the total sample is much higher (about 80%) than men. The caregiving role usually falls upon women. Regarding immigration, women are seeking more support because they are in a more vulnerable position than men, have poorer working and economic conditions and have also very often have left their children in their countries of origin [30-31-32]. This finding is consistent with studies on the demand for care at Mental Health Centers by patients with anxious-depressive symptomatology and adaptive disorders [33-34-35].

Clinically, chronic stress involved in the migration process or in living with relatives of people with mental health problems creates a significant emotional distress, as shown in other studies [36-37-38]. More specifically, the level of psychopathological distress is well above the 50th

percentile of the general population, reflecting the need to provide support for these populations. The situations that they face threaten their coping skills and produce high levels of distress [39-40-41].

When comparing the two samples, immigrants were younger, were less educated and were in a lower socioeconomic and poorer employment situation, which may give rise to a greater emotional instability, as shown in previous studies [19]. In terms of psychopathology , immigrants had a higher intensity of symptoms than family members,. This finding can be explained by the economical insecurity, the greater social isolation and uncertain legal situation that immigrants face. The psychosocial stress that the immigrant population has to face, along with the effort to adapt to a new culture, may explain the higher number of and type of symptoms experienced [42-43]. Furthermore, the period of time exposed to stressful stimuli is different between the two samples: the relatives have been exposed to the stressor for a longer period of time and they could therefore be more accustomed to the burden of the stressful situation involved.

However, the symptomatological profile is similar in both samples. In both groups there are two groups of symptoms: first, those related to interpersonal relationships (interpersonal sensitivity, psychoticism and paranoid ideation) with levels of distress somewhat higher among immigrants; and secondly, those related to the presence of recurrent and repetitive thoughts, (emotional tension, dysphoric mood, hopelessness and helplessness), which are related to anxiety-depressive symptoms.

Regarding the level of self-esteem, it was low in both groups, without differences between them. The stigma of mental illness and addiction [44] and the feeling of guilt of the family members and social prejudice of immigrants [45-46] may explain the negative self-images of in these groups of individuals.

Finally, the perception of low self-effectiveness in dealing with stressful situations, poor social support, economic hardship and fatigue resulting from protracted situations, as well as low self-esteem, make it difficult to cope with stressful situations. Thus, from the viewpoint of target-behaviors, there are common aspects that highlighted by both relatives of people with mental health problems and immigrants. Specifically, the management of anxiety and concerns, and the reduction in self-demand, are common features identified by both samples.

This study contributes to a better understanding of people who are under chronic stress. And this is essential, as untreated cases can evolve in time to become more severe disorders and consume more health care resources [47-48].

One limitation of this study is that the sample is not excessively large. Future studies could expand the sample size and establish various subgroups, specifying in the case of relatives the types of mental illness with which they have to live and in the case of immigrants the different backgrounds of the subjects.

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Table

Table I. Characteristics of the sample of families (N=50)

DEGREE OF KINSHIP	TYPE OF MENTAL ILLNESS
Descendants: 19 persons Parents: 16 persons o Mother: 11 o Father: 5 Sister/brother: 9 persons Couple: 6 persons	Psychotic disorder: 27 persons Bipolar disorder: 10 persons Addictions: 6 persons Chronic Depression: 3 persons Personality disorders: 3 persons Autism: 1 person

Table II. Sociodemographic characteristics of the samples

Variables	Immigrants	Relatives of mentally ill people	X^2 *(gl)/ t(gl)*
SEX			
Men	9 (15,5%)	10 (20%)	X^2 (1)=0,37
Women	49 (84,5%)	40 (80%)	
AGE	*M* 33,57 (*SD* 9,2)	*M* 44,56 (*SD* 15,5)	*t* (106)=-4,37***
CIVIL STATUS			
Single	18 (31%)	13 (26%)	
Married	25 (43,1%)	31 (62%)	X^2 (3)=5,60
Divorced	9 (15,5%)	5 (10%)	
Widower	6 (10,3%)	1 (2%)	
EDUCATION LEVEL			
First level	15 (25,9%)	11 (22%)	
Secondary level	32 (55,2%)	11 (22%)	X^2 (2)=17,78 ***
Universitary level	11 (19%)	28 (56%)	
WORK			
Working	33 (56,9%)	31 (62%)	
Unemployment	24 (41,4%)	12 (24%)	X^2 (2)=8,01 *
Studyng/other	1 (1,7%)	7 (14%)	
INCOME			
Less than 1000€	51 (87,9%)	24 (48%)	
More than 1000€	7 (12,1%)	26 (52%)	X^2 (1)=20,17***
MONTHS OUT OF THEIR COUNTRY	*M* 40,97 (*SD*32, 65)	----------	
YEARS LIVING WITH THE FAMILIAR MENTALLY ILL	----------	*M* 24,48 (*SD* 7,84)	

* p<.05; ** p<.01; ***p<.001

Table III. Psychopathological variables, self-esteem and target-behaviors in both samples

Variables	Immigrants (N=58)			Relatives of mentally ill people (N=50)			*t / d*
	M	*SD*	*Pc*	*M*	*SD*	*Pc*	
SCL-90-R							
Somatization	1,68	0,87	90	1,41	0,73	85	1,72
Obsession	1,84	0,75	95	1,60	0,82	90	1,60
Interpersonal sensitivity	1,93	0,75	97	1,47	0,89	95	2,89** (*d*=0,56)
Depression	2,48	0,66	97	1,95	0,77	95	3,85***(*d*=0,74)
Anxiety	1,84	0,86	95	1,46	0,65	90	2,61** (*d*=0,50)
Hostility	1,34	1	90	0,92	0,65	85	2,60* (*d*=0,50)
Phobic anxiety	0,98	0,87	90	0,76	0,65	85	1,45
Paranoid ideation	1,76	0,78	95	1,09	0,73	85	4,56*** (*d*=0,89)
Psychoticism	1,25	0,63	97	0,68	0,56	90	4,92*** (*d*=0,95)
GSI	1,75	0,58	97	1,36	0,50	95	3,65*** (*d*=0,72)
PST	60,6	15,16	97	50,3	14,21	95	3,62*** (*d*=0,70)
PSDI	2 ,50	0,57	90	2,40	0,60	85	0,90
Self-esteem (10-40)	27,16	4,18		27,48	4,82		-0,36
Target-behaviors scale (5-50)	40,86	6,31		40,94	4,92		-0,07

Pc: SCL-90-R percentils of general population

* p<.05; ** p<.01; ***p<.001

Table IV. Examples of target-behaviors

Target- behaviors reported by immigrants
• To be stronger, less afraid and face situations. • To worry less and to be able to focus on reality. • To be able to handle anxiety and nervousness, shyness and embarrassment. • To try to be less sad, to be in a better mood and feel less guilty. • To reduce perfectionism. • To improve relationships with partner, family and society. • To learn to say no, to defend your rights, to ask for something. • Not shouting and controlling anger and frustration. • To be able to study and have legal papers, that is, work permits and residence.
Target-behaviors reported by relatives of the mentally ill patients
• To manage anxiety and panic • To improve family communication • To improve social skills and assertiveness • To reduce the level of self-demand • To manage excessive worry • To relieve emotional distress • To handle feelings of guilt