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CHRONIC STRESS IN IMMIGRANTS AND RELATIVES OF PEOPLE WITH MENTAL ILLNESS: A COMPARATIVE STUDY¹

ESTRÉS CRÓNICO EN INMIGRANTES Y FAMILIARES DE PERSONAS CON TRASTORNO MENTAL: UN ESTUDIO COMPARATIVO

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Resumen: La inmigración y la convivencia con una persona que padece un trastorno mental severo son situaciones estresantes que provocan altos niveles de malestar. El propósito de este estudio es comparar el estrés crónico en inmigrantes y en familiares de enfermos mentales. La muestra está compuesta por 108 adultos mayores de edad (58 inmigrantes y 50 familiares de enfermos con trastorno mental) que buscan ayuda por su malestar emocional. Los resultados muestran que hay una sobrerrepresentación de mujeres en ambos grupos. Los inmigrantes son más jóvenes, tienen menor nivel de estudios y cuentan con mayores tasas de paro que los familiares de enfermos mentales. Ambas muestras presentan una sintomatología psicopatológica elevada y un nivel de autoestima bajo. Los tratamientos bien establecidos y efectivos para los familiares de enfermos mentales podrían ser de utilidad también para los inmigrantes, ya que éstos presentan niveles de sintomatología similares.

Palabras clave: expatriación, cuidadores, comparación, alteraciones emocionales, diferencias de género.

Abstract: Being immigrant or living with a person who experiences mental disorders can lead to high levels of emotional problems. The aim of this study is to compare chronic stress in immigrants and relatives. The sample comprised 108 adults (58 immigrants and 50 relatives) who were seeking help due to their emotional problems. In both groups there was an overrepresentation of women. The immigrants were younger; had a lower level of education and higher unemployment rates than the relatives. Both groups showed high levels of symptoms and low self-esteem. The fact that immigrants report similar symptoms to relatives might mean that some of the treatments for relatives, which are well established and effective, could be applied to immigrants.

Keywords: expatriation, caregivers, comparison, emotional disturbance, gender differences.

Stress is the physiological, emotional, cognitive and behavioral response that manifests itself when demands are made of a person, who overwhelms his or her capacity to cope. When the stressor is prolonged and chronic, it can physically, emotionally, cognitively and behaviorally exhaust the individual (Lazarus & Folkman, 1986).

The consequences of stress are manifested at different levels (Crespo & Labrador, 2003; Sandín, 2003): *a*) at an emotional/physiological 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

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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 tobacco and alcohol consumption, sleep and eating disorders, escape, avoidance and social isolation.

From a diagnostic point of view, according to the DSM-IV-TR (American Psychiatric Association, 2002), 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 (Pérez-Sales, 2008). This disorder is highly prevalent and can be present between 5 and 21% of outpatients and in 7.1% of hospital admissions (Botella, Baños, & Guillén, 2008; Carta, Balesrieri, Murru, & Hardoy, 2009).

Living with a family member who has a 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 (American Academy of Child and Adolescent Psychiatry, 2002; Barrowclough & Tarrier, 1992; Rodríguez, Padilla, Caballero, & Rodríguez, 2002; Sánchez del Hoyo & Sanz, 2004).

In fact, caring for a person with health problems involves addressing a range of stressful situations (Stefani, Seidman, Pano, Acrich, & Bail, 2003), 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 (London School of Economics, 2012; Treanor, Lobban, & Barrowclough, 2011).

According to Bayés, Arranz, Barbero and Barreto (1997), 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 Caregiver 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 (Breslau et al., 2011; Kinzie, 2006). So, the immigrant has to face chronic, multiple and highly stressful psychosocial stimuli (Steel et al., 2006) without a social support network and lacking a sense of control (Coffman & Norton, 2010; Delgado & Senín, 2011; Gimeno, Lafuente, & González, 2014). All these can give way to various symptoms of depression, anxiety, somatic symptoms and symptoms of confusion (Achotegui, 2008; Farley, Galves, Dickinson, & Díaz, 2005; Salaberría, Corral, Sánchez, & Larrea, 2008).

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 (Drake, O'Neal, & Wallach, 2008). Usually, these difficulties are experienced in isolation and with little social support, because of prejudice in the case of the immigrant population (Chandler, Charles, & Yung-mei, 2001) and the social stigma in the case of the families of people with mental health problems. According to Talarn, Navarro, Rossell and Rigat (2006), 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 individuals to experience an intense emotional reaction and/or hard and long periods of adaptation.

Given the scarcity of Spanish comparative and descriptive studies on these types of populations, the main aims 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 aim is to specify the type of target-behaviors that arise when immigrants or relatives of people with mental health problems seek therapeutic help. The interest of these aims is that those people belong to vulnerable populations who could benefit from preventive interventions to address adaptive problems and prevent the development of more severe disorders.

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 program 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 program was carried out in the School of Psychology at the University of the Basque Country. The inclusion criteria for admission to the study were the following: *a*) to be aged over 18 years, *b*) to be able to complete the questionnaires, and *c*) meet diagnostic criteria for an adjustment disorder. The specific criteria for admission of the sample of immigrants were being first generation, spending more than 3 months outside their countries of origin and having an economic motivation; and in the case of relatives, to have lived or to be living with the family member with mental health problems, and not have a severe mental disorder (schizophrenia, bipolar disorder) or addictive disorder.

The immigrant populations were mainly from Latin America (51) and Africa (7, 5 of whom were from Morocco, the other 2 came from Sub-Saharan Africa). Regarding relatives, they were 19 descendants, 16 parents, 9 sister/brothers and 6 couples. Their families have been affected by psychotic disorders (27 persons), bipolar disorders (10 persons), addictions (6 persons), chronic depression (3 persons), personality disorders (3 persons) and autism (1 person).

Design

The design of the study was cross-sectional.

Instruments

A structured interview was used to collect demographic information.

SCL-90-R Scale (Derogatis, 1975; Spanish version by González de Rivera, 2002). This instrument was used to evaluate the presence of general psychopathological 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 nine 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 symptoms intensity (PSDI). The internal consistency of the questionnaire ranges from .81 to .90 and the test-retest reliability from .78 to .90.

Self-Esteem Scale (Rosenberg, 1965; Spanish version by Echeburúa, 1995). 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 that 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 (R. A. Ward, 1977).

Target-Behaviors Scale (Echeburúa & Corral, 1987). 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 the quality of their lives. These are going to be the target-behaviors in the therapeutic process. 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. The test-retest reliability is .85.

Procedure

After obtaining permission from the Ethics Committee of the University, the existence of a free psychological support program 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 program, were assessed to see if they met the inclusion criteria. They were then offered information about the program and asked for their informed consent. Finally, the assessments were carried out over 2 sessions, (one hour each session), by a clinical psychologist.

The psychological support program described in this study was carried out in the School of Psychology of San Sebastian (Basque Country, Spain) from 2008 to 2012.

Data analysis

SPSS 20 was used for analyzing the data. The data were all normally distributed. 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, scores of the sample were compared to the normal population scales of the SCL-90-R.

RESULTS

Sociodemographic variables

Table 1 describes the main demographic characteristics of the two samples. Most individuals who came to the program for counseling were women (82%).

The immigrants' sample was of younger people (on average 33.57 years old *SD* = 9.2), had a lower level of educa-

tion 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 (40.97 months *SD* = 32.65), 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 24.48 years (*SD* = 7.84), they were middle-aged (on average 44.56 years old *SD* = 15.5), 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 moderate, except in the case of age ($t = 4.37$; $p < .001$; $d = 0.86$).

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

Table 2 describes the main features of psychopathology and self-esteem of the two samples. 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

Table 1. Sociodemographic characteristics of the samples

Variables	Immigrants		Relatives of mentally ill people		Chi (<i>d.f.</i>) / <i>V</i>
	<i>N</i>	%	<i>N</i>	%	
SEX					$\chi^2 (1) = 0.37 / 0.06$
Men	9	15.5	10	20	
Women	49	84.5	40	80	
CIVIL STATUS					$\chi^2 (3) = 5.60 / 0.23$
Single	18	31	13	26	
Married	25	43.1	31	62	
Divorced	9	15.5	5	10	
Widower	6	10.3	1	2	
EDUCATION LEVEL					$\chi^2 (2) = 17.78^{***} / 0.40$
First level	15	25.9	11	22	
Secondary level	32	55.2	11	22	
Universitary level	11	19	28	56	
WORK					$\chi^2 (2) = 8.01^* / 0.27$
Working	33	56.9	31	62	
Unemployment	24	41.4	12	24	
Studyng/other	1	1.7	7	14	
INCOME					$\chi^2 (1) = 20.17^{***} / 0.43$
Less than 1000€	51	87.9	24	48	
More than 1000€	7	12.1	26	52	

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

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 had significant emotional problems when compared with the general population.

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 program was perceived as high (mean: 40; range 5 to 50) and was similar in both samples.

Table 2. *Psychopathological variables, self-esteem and target-behaviors in both samples*

Variables	Immigrants (<i>n</i> = 58)			Relatives of mentally ill people (<i>n</i> = 50)			Comparisons <i>t</i> / <i>d</i>
	<i>M</i>	<i>SD</i>	Pc	<i>M</i>	<i>SD</i>	Pc	
SCL-90-R							
Somatization	1.68	0.87	90	1.41	0.73	85	1.72 / 0.34
Obsession	1.84	0.75	95	1.60	0.82	90	1.60 / 0.31
Interpersonal	1.93	0.75	97	1.47	0.89	95	2.89** / 0.56
Depression	2.48	0.66	97	1.95	0.77	95	3.85*** / 0.74
Anxiety	1.84	0.86	95	1.46	0.65	90	2.61** / 0.50
Hostility	13.4	1	90	0.92	0.65	85	2.60* / 0.50
Phobic Anxiety	0.98	0.87	90	0.76	0.65	85	1.45 / 0.28
Paranoid Ideation	1.76	0.78	95	1.09	0.73	85	4.56*** / 0.89
Psychoticism	1.25	0.63	97	0.68	0.56	90	4.92*** / 0.95
GSI	1.75	0.58	97	1.36	0.50	95	3.65*** / 0.72
PST	60.6	15.16	97	50.3	14.21	95	3.62*** / 0.70
PSDI	2.50	0.57	90	2.40	0.60	85	0.90 / 0.17
SELF-STEEM							
(10-40)	27.16	4.18		27.48	4.82		-0.36 / 0.07
TARGET-BEHAVIORS							
(5-50)	40.86	6.31		40.94	4.92		-0.07 / 0.10

Pc: SCL-90-R percentiles of general population.

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

From a qualitative point of view, some examples of target-behaviors frequently reported by immigrants for working in therapeutic process were: 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; and to reduce perfectionism. Some examples of target-behaviors reported by relatives of the mentally ill patients were: to manage anxiety and panic; to improve family communication and social skills; to reduce the level of self-demand; to manage excessive worry and to handle feelings of guilt.

DISCUSSION

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 (Crespo & López, 2008), which may explain the relatively high proportion of women in the sample of the relatives (Kuipers, Onwumere, & Bebbington, 2010). Regarding immigration, women are seeking more support because they are in a more vulnerable position than men, have poorer working and economic conditions, have also very often left their children in their countries of origin, and suffer from more stress than men (Aroian, Norris, González de Chávez, & García, 2008; Dalgard & Thapa, 2007; Hidalgo, Peralta, Robles, Vilar-López, & Pérez-García, 2009; Patiño & Kirchner, 2011). This finding is consistent with studies on the demand for care at Mental Health Centers by female patients with anxious-depressive symptomatology and adaptive disorders (Benton & Lynch, 2005; De las Cuevas, González de Rivera, Benítez, & Gracia, 1991; Echeburúa, Salaberría, Corral, Cenea, & Bera-sategui, 2006).

Clinically, chronic stress involved in the migration process or in living with people with mental health problems creates a significant emotional distress, as shown in other studies (Aznar & Berlanga, 2004; Weissman, Gomes, & López, 2004). 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 (Lobban, Barrowclough, & Jones, 2003; Valiente, Sandín, Chorot, Santed, & González de Rivera, 1996).

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 (Magaña & Hovey, 2003; Salinero-Fort et al., 2012). 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 (Bhugra, 2004; Collazos, Qureshi, Antonín, & Tomás-Sábado, 2008). 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 symptom 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 the feeling of guilt of the family members (Harter, 2000), as well as the social prejudice in the case of immigrants (Gee, Ryan, Laflamme, & Holt, 2006; C. Ward, 2008), may explain the negative self-image 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 are highlighted by both relatives of people with mental health problems and immigrants. Specifically, anxiety and concern management, and the reduction in self-demand, are common features that were identified in both samples.

This study contributes to a better understanding of people who are under chronic stress (Whaley & Davis, 2007). And this is essential, because untreated cases can evolve in time to become more severe disorders and consume more health care resources (Pincus, McQueen, & Elinson, 2005; Tizón, 1992) and for developed culturally adapted mental health interventions (Griner & Smith, 2006).

Some limitations of this study are 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 participants, with the aim of providing more specific and effective psychological treatments (Bernal, Jiménez-Chafey, & Domenech, 2009).

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