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

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) que buscan ayuda por sus problemas emocionales. 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; Sandin, 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 problems...
problemas y aprenden, como la falta de concentración, bloqueo mental, errores, inestabilidad de los sentimientos; y c) en una etapa del comportamiento de la personalidad, podemos observar reducción de la productividad, fatiga, incremento del consumo de tabaco y alcohol, problemas de alimentación, trastornos de la alimentación y evasión, evasión, conflictos y conflictos sociales.

Desde un punto de vista diagnóstico, en relación con el DSM-IV-TR (American Psychiatric Association, 2002), ajuste reactivo (ansiedad, depresión o mixto), que se produce en respuesta a un estímulo psicosocial reconocible, es la categoría diagnóstica que se asocia más frecuentemente con el trastorno crónico (Pérez-Sales, 2008). Este trastorno es altamente prevalente y puede presentarse entre 5 y 21% de los pacientes hospitalizados y en 7.1% de los internos (Botella, Baños, & Guillén, 2008; Carta, Ballestier, Murru, & Hardoy, 2009).

Vivir con una familia que tiene un problema severo o con un problema que se mantiene con el proceso de inmigración involucra un estrés crónico de gran intensidad, que afecta varias áreas de una persona. Las familias han pasado a ser la comunidad de apoyo para personas afectadas por trastornos psiquiátricos severos. Los problemas de pareja, desacuerdos y tensión entre los miembros de la familia, marginalización social y falta de apoyo son comunes entre las familias que tienen un miembro con problemas de salud mental. Por tanto, padres, hermanos y pareja de las personas severamente afectadas y/o las inmigrantes que no tienen un miembro con problemas severos o crónicos de salud mental pueden experimentar el riesgo de desarrollar la salud mental con problemas de salud mental a un mayor riesgo y niveles más altos de trastornos emocionales (American Academy of Child and Adolescent Psychiatry, 2002; Barrowclough & Tarrier, 1992; Rodríguez, Padilla, Caballero, & Rodríguez, 2002; Sánchez del Hoyo & Sanz, 2004).

En efecto, cuidar de una persona con problemas de salud mental implica la presencia de una variedad de situaciones estresantes (Stefani, Seidman, Pano, Acrich, & Bail, 2003), tales como una dependencia progresiva, comportamientos disruptivos presentados por el paciente, la restricción de la libertad, la pérdida de estilos de vida y el enfrentamiento de nuevas tareas relacionadas con el ciclo de la vida. Específicamente, los estilos de estrés para cuidadores son diversos: la falta de entendimiento de la behavior y la denegación de problemas de existencia para este person, discusiones y dificultades en relaciones, no entendiendo cómo actuar en el día a día y las consecuencias financieras y legales. Hay dificultades con el sistema de salud en el proceso de diagnóstico y tratamiento del trastorno (London School of Economics, 2012; Treanor, Lobban, & Barrowclough, 2011).

Según Bayés, Arranz, Barbero y Barreto (1997), en al menos 80% de los casos es la familia quien toma cuidado de la persona con problemas de salud mental en la familia. Seis de cada diez cuidadores que toman cuidado del paciente con problemas de salud mental en la familia.
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 (pos) 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**

SSPS 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 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 (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>
<thead>
<tr>
<th>Table 1. Sociodemographic characteristics of the samples</th>
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<tr>
<td><strong>Variables</strong></td>
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<td><strong>Imigrants</strong></td>
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<td><strong>Relatives of mentally ill people</strong></td>
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<td><strong>Chi ((d.f.)) / V</strong></td>
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<td>SEX</td>
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<tr>
<td>Men</td>
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<td>Women</td>
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<td>CIVIL STATUS</td>
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<td>Divorced</td>
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<tr>
<td>Widower</td>
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<td>EDUCATION LEVEL</td>
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<td>First level</td>
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<tr>
<td>Secondary level</td>
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<tr>
<td>Universitary level</td>
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<tr>
<td>WORK</td>
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<td>Working</td>
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<td>Unemployment</td>
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<td>Studying/other</td>
</tr>
<tr>
<td>INCOME</td>
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<tr>
<td>Less than 1000(€)</td>
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<tr>
<td>More than 1000(€)</td>
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</tbody>
</table>

* \(p < .05\); ** \(p < .01\); *** \(p < .001\).
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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

<table>
<thead>
<tr>
<th>Variables</th>
<th>Immigrants $(n = 58)$</th>
<th>Relatives of mentally ill people $(n = 50)$</th>
<th>Comparisons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>Pc</td>
</tr>
<tr>
<td>SCL-90-R</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Somatization</td>
<td>1.68</td>
<td>0.87</td>
<td>90</td>
</tr>
<tr>
<td>Obsession</td>
<td>1.84</td>
<td>0.75</td>
<td>95</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>1.93</td>
<td>0.75</td>
<td>97</td>
</tr>
<tr>
<td>Depression</td>
<td>2.48</td>
<td>0.66</td>
<td>97</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.84</td>
<td>0.86</td>
<td>95</td>
</tr>
<tr>
<td>Hostility</td>
<td>13.4</td>
<td>1</td>
<td>90</td>
</tr>
<tr>
<td>Phobic Anxiety</td>
<td>0.98</td>
<td>0.87</td>
<td>90</td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td>1.76</td>
<td>0.78</td>
<td>95</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>1.25</td>
<td>0.63</td>
<td>97</td>
</tr>
<tr>
<td>GSI</td>
<td>1.75</td>
<td>0.58</td>
<td>97</td>
</tr>
<tr>
<td>PST</td>
<td>60.6</td>
<td>15.16</td>
<td>97</td>
</tr>
<tr>
<td>PSDI</td>
<td>2.50</td>
<td>0.57</td>
<td>90</td>
</tr>
<tr>
<td>SELF-STEEM</td>
<td>(10-40)</td>
<td></td>
<td>27.16</td>
</tr>
<tr>
<td>TARGET-BEHAVIORS</td>
<td>(5-50)</td>
<td></td>
<td>40.86</td>
</tr>
</tbody>
</table>

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

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

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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, & García, 1991; Echeburúa, Salaberría, Corral, Cenea, & Beraategui, 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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