Journal of Health Sport and Nursing
Vol 1, No. 1, (2025), 65-72
DOI: https://doi.org/10.26740/jhsn.v1i02.73761
eISSN 3125-1412

THE RELATIONSHIP BETWEEN FAMILY STIGMA AND FAMILY BURDEN IN CARING FOR PATIENTS WITH SEVERE MENTAL DISORDERS IN THE WORKING AREA OF MALINAU SEBERANG COMMUNITY HEALTH CENTER

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ABSTRACT

Background: People with mental disorders often face negative stigma, including that from their own families, who should serve as their primary source of support. This stigma can increase the emotional, physical, and financial burden on families and may hinder the care and recovery process of the patient. This study aims to analyze the relationship between family stigma and family burden in caring for People with Mental Disorders. Methods: The research design used was descriptive correlational. The sampling method used was total sampling, with 36 family members caring for People with Mental Disorders who met the inclusion criteria. Data were collected using questionnaires measuring family stigma and family burden, then analyzed using Fisher's Exact Test. Results: Among the 36 respondents caring for People with Mental Disorders, 13 respondents (36.1%) reported moderate family stigma with a moderate family burden. Meanwhile, 19 respondents (52.8%) reported severe family stigma with a moderate family burden. The analysis using Fisher's Exact Test yielded a p-value of 0.040 ($p < 0.05$), indicating a significant relationship between family stigma and family burden in caring for People with Mental Disorders patients. Conclusion: The stigma perceived or experienced by families plays a vital role in increasing the burden of caring for People with Mental Disorders. Therefore, educational efforts and psychosocial interventions are needed to reduce stigma and strengthen support for families, to ease the burden they experience in caring for People with Mental Disorders.

Keywords: Family, Stigma, Family Burden, People with Mental Disorders

Article information:
Received: 2025-06-25 | Revised: 2025-07-30 | Approved: 2025-11-14 | Published: 2025-12-30
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INTRODUCTION

People with mental disorders continue to face negative stigma, including from their own families who should serve as their primary support system (Botha, Tucker and Mwaba, 2025). This stigma influences the family's perspective and treatment toward the patient, thereby increasing the emotional, physical, social, and financial burden during the caregiving process. The burden becomes even heavier when families have limited knowledge and receive minimal support from their surroundings or healthcare providers (Nurazizah, Fitriani and Harisa, 2025). These conditions can hinder the recovery process of individuals with mental disorders (Marques and Battistella, 2025).

Globally, WHO (2024) reports that 970 million people experience mental disorders, yet 85% do not receive adequate care. In Indonesia, the trend of mental disorders is also increasing, including in North Kalimantan Province. Malinau Regency recorded 200

people with mental disorders (ODGJ) in 2024, and the Malinau Seberang Community Health Center noted an increase in cases from 35 in 2023 to 40 in 2024. This increase highlights the need to strengthen mental health services at the primary care level.

Community stigma further increases the family burden by causing feelings of shame, anxiety, isolation, and hesitation to seek support (Subu *et al.*, 2021; Almomen *et al.*, 2022). When stigma and burden intersect, families are at risk of experiencing prolonged stress, decreased quality of life, and burnout. Previous studies also show that the higher the family stigma, the greater the burden felt in caring for individuals with mental disorders (Fitryasari *et al.*, 2025; Sugiarsih, Fitri and Mardiana, 2025).

In the working area of the Malinau Seberang Community Health Center, strong stigma and limited access to mental health services create significant challenges for families caring for individuals with mental disorders. The health center provides programs such as home visits, medication adherence support, and mental health education; however, their effectiveness is highly influenced by the family's attitudes and level of acceptance (Sharif *et al.*, 2025).

Some families of individuals with mental disorders are known to experience high levels of stigma and burden, whether emotional, physical, or financial. However, some families adapt more effectively because they have long cared for the patient and have achieved a higher level of acceptance. These variations indicate that stigma and family burden levels are not uniform, underscoring the need for further study.

METHODS

Design study: This quantitative study employed a cross-sectional design and was conducted in July 2025 in the working area of Malinau Seberang Primary Health Center, East Kalimantan, Indonesia. The study population consisted of families caring for individuals with mental disorders. A total sampling technique was applied, in which all eligible families were recruited as study participants (n = 36).

Criteria for inclusion: Family members directly involved in caring for individuals with mental disorders aged 18 years or older, able to read and write in Indonesian, and willing to participate by providing written informed consent. Participants who did not complete the questionnaires were excluded from the analysis.

Search Strategy: Data were collected through the direct distribution of structured questionnaires to eligible respondents at the Malinau Seberang Primary Health Center. The instruments used in this study consisted of a family stigma questionnaire adapted from Chang *et al.*, (2019) and the Zarit Burden Interview (ZBI) adapted from Larantukan and Yudiarso, (2025). The family stigma questionnaire comprises 18 items, measured on a three-point Likert scale (0–2), whereas the ZBI comprises 22 items, measured on a five-point Likert scale (0–4).

Study Selection: All families who met the inclusion criteria during the data collection period were recruited as study participants. The selection process followed a total sampling approach to ensure that the entire accessible population was represented. Participants who returned incomplete questionnaires were excluded from the final analysis.

Data Extraction: Data extracted included respondents' demographic characteristics, family stigma scores, and family burden scores. The collected data was coded and entered a statistical software program for analysis. Stigma and family burden scores were

categorized into moderate to severe levels for analytical purposes. Data analysis consisted of univariate analysis to describe respondent characteristics and variable distributions, and bivariate analysis to examine the association between family stigma and family burden using the Fisher's test, with a significance level set at $p < 0.05$.

Ethical Considerations: This study received ethical approval from the Health Research Ethics Committee of ITKES Wiyata Husada Samarinda (Ethical Approval No. 63/ITKES-WHS/KEPK/EC/2025). Permission to conduct the study was obtained from Malinau Seberang Primary Health Center. Participation was voluntary, and the confidentiality and anonymity of all respondents were strictly maintained.

RESULTS

Based on Table 1, most families caring for individuals with mental disorders in the working area of the Malinau Seberang Community Health Centre experienced severe family stigma, namely 19 respondents (52.8%). Meanwhile, 17 respondents (47.2%) were classified as having moderate stigma.

Table 1 Distribution of Family Stigma Among Families Caring for Individuals with Mental Disorders (n = 36)

Variable Family Stigma	Frequency (n)	Percentage %
Moderate Stigma	17	47.2
Severe Stigma	19	52.8
Total	36	100

As presented in Table 2, most families caring for individuals with mental disorders in the working area of Malinau Seberang Primary Health Center experienced a moderate level of family burden, accounting for 26 respondents (72.2%). Meanwhile, 6 respondents (16.7%) reported low family burden, and 4 respondents (11.1%) reported high family burden.

Table 2 Frequency Distribution of Family Burden in Caring for Patients with Mental Disorders in the Working Area of the Malinau Seberang Community Health Centre (n = 36)

Variable Family Burden	Frequency (n)	Percentage %
Low Burden	6	16.7
Moderate Burden	26	72.2
High Burden	4	11.1
Total	36	100

As shown in Table 3, cross-tabulation analysis of 36 respondents indicated that families experiencing severe stigma predominantly reported a moderate level of family burden, with 19 respondents (52.8%). Among families with moderate stigma, 13 respondents (36.1%) experienced a moderate burden, whereas four respondents (11.1%) reported a high burden. Statistical analysis using Fisher's exact test revealed a significant association between family stigma and family burden ($p = 0.040$). This finding indicates that higher levels of stigma experienced by families are significantly related to the level of burden perceived in caring for individuals with mental disorders. Families

facing greater stigma tend to experience increased psychosocial strain during the caregiving process.

Table 3 Association Between Family Stigma and Family Burden in Caring for Individuals with Mental Disorders in the Working Area of Malinau Seberang Primary Health Center (n = 36)

Variable Family Burden	Frequency (n)	Percentage %
Low Burden	6	16.7
Moderate Burden	26	72.2
High Burden	4	11.1
Total	36	100

DISCUSSION

This study provides evidence that family stigma remains a prominent issue among families caring for individuals with mental disorders in the working area of Malinau Seberang Primary Health Center. Most families reported experiencing moderate to severe levels of stigma, indicating persistent negative perceptions, feelings of shame, fear, and social withdrawal related to mental illness. These findings suggest that mental disorders are still strongly associated with social disapproval and misunderstanding at the family and community levels (Holis, Rohman and Yaya, 2024; Fitryasari *et al.*, 2025; Nurazizah, Fitriani and Harisa, 2025).

The results are consistent with previous studies reporting that families of individuals with mental disorders frequently encounter social rejection, discrimination, and exclusion from their surrounding environment. Studies by Sugiarsih et al. (2025) and Brandt et al. (2022) reported that families often experience negative labeling, social avoidance, and community pressure, which collectively contribute to social isolation (Brandt *et al.*, 2022; Sugiarsih, Fitri and Mardiana, 2025). Such findings support the theoretical framework proposed by Corrigan and Watson, which explains that stigma becomes internalized when families accept negative societal stereotypes, leading to emotional distress and reduced social engagement (Subu *et al.*, 2021; Vogel and Wade, 2022).

In addition to stigma, this study found that families predominantly experienced a moderate level of caregiving burden (Qin *et al.*, 2025). This finding indicates that although families may have adapted to their caregiving roles, they continue to experience substantial emotional, social, and economic pressures (Yosrinanda and Utami, 2024; Fitryasari *et al.*, 2025) Zarit's caregiver burden theory emphasizes that family burden arises from both subjective experiences, such as emotional strain, and objective demands, including financial responsibilities and time commitment (Yosrinanda and Utami, 2024). The moderate burden observed in this study may reflect a balance between caregiving demands and the family's ability to adapt over time.

Previous research has demonstrated that caregiving burden tends to increase with longer duration of care, limited social support, and greater symptom severity. Studies by Suharsono, Faidah and Hanafi, (2023) highlighted that prolonged caregiving is associated with higher levels of stress and burden among family caregivers. In the present study, although many families had long-term caregiving experience, the burden did not

predominantly reach severe levels, suggesting that adaptive coping strategies and accumulated caregiving experience may help families manage ongoing stress (Bahari *et al.*, 2024; Holis, Rohman and Yaya, 2024).

A key finding of this study is the presence of a significant association between family stigma and family burden. Families experiencing higher levels of stigma tended to report greater caregiving burden, supporting the study hypothesis that stigma contributes to increased psychological and social strain among caregivers. This relationship may be explained by the concept of courtesy stigma, whereby families experience social devaluation due to their association with a relative who has a mental disorder, resulting in emotional distress, reduced social support, and increased caregiving challenges (Yosrinanda and Utami, 2024; Sugiarsih, Fitri and Mardiana, 2025).

These findings align with previous studies indicating that stigma amplifies caregiver burden by increasing psychological stress, social isolation, and feelings of helplessness (Kolb, Liu and Jackman, 2023; Bahari *et al.*, 2024). However, contrasting evidence has also been reported. Nurazizah, Fitriani and Harisa, (2025) found no association between family stigma and caregiver burden, attributing this to strong family support and long-term adaptation to the caregiving role. This discrepancy suggests that the impact of stigma on caregiver burden may vary depending on contextual factors such as social support, family resilience, and access to mental health services (Leta *et al.*, 2025).

The findings of this study have important implications for mental health nursing and community-based mental health services. Interventions aimed at reducing stigma through community education, family psychoeducation, and home-based mental health services may help alleviate caregiver burden. Strengthening family coping skills and enhancing social support systems are essential to improving the quality of life of both individuals with mental disorders and their families (Subu *et al.*, 2021; Suharsono, Faidah and Hanafi, 2023; Fitryasari *et al.*, 2025).

Despite its contributions, this study has several limitations. The cross-sectional design limits the ability to establish causal relationships between stigma and caregiver burden. The small sample size and the use of self-reported questionnaires may also affect the generalizability of the findings. Future research using longitudinal designs and larger, more diverse samples is recommended to further explore the dynamic relationship between family stigma and caregiver burden over time.

CONCLUSION

This study concludes that family stigma toward people with mental disorders in the working area of Malinau Seberang Primary Health Center remains high, while most families experience a moderate level of caregiving burden. The findings support the research hypothesis by demonstrating a significant relationship between family stigma and family burden, indicating that higher stigma is associated with greater burden in caregiving. These results emphasize the need for mental health interventions that focus on reducing family stigma and strengthening family support to alleviate caregiver burden. However, the cross-sectional design and limited sample size restrict causal interpretation and generalizability of the findings. Future studies are recommended to involve broader populations and to evaluate intervention strategies aimed at reducing stigma and family burden in mental health care.

ACKNOWLEDGMENTS

The authors would like to express their sincere gratitude to all parties who contributed to the preparation and completion of this study. Special thanks are extended to Mr Welly Bongga, A.Md.Kep, Head of Malinau Seberang Primary Health Centre, for granting permission and providing facilities for the research. Appreciation is also conveyed to the Undergraduate Nursing Programme, ITKES Wiyata Husada Samarinda, for its support and guidance throughout the study.

AUTHORS CONTRIBUTION

1. Astati contributed to the study conception and design, data collection, data analysis and interpretation, and drafted the initial manuscript.
2. Siti Kholifah supervised the research process, provided critical intellectual input, revised the manuscript, and approved the final version for publication.
3. Rusdi contributed to data analysis, interpretation of results, and critical revision of the manuscript.
4. Desy Ayu Wardani contributed to methodological guidance, data interpretation, and critical revision of the manuscript.

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