RESEARCH ARTICLE

Stigma, caregiver burden, and expressed emotions: The moderating role of self-compassion in caregivers of substance use disorder

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Abstract

Objective: To investigate the moderating effect of self-compassion on the relationship involving stigma, caregiver burden and expressed emotions among caregivers of males diagnosed with substance use disorder.

Method: The correlational, quantitative study was conducted from June 1 to September 30, 2021, at the Department of Psychology, University of Central Punjab, Lahore, Pakistan, and comprised caregivers aged 40-55 years living with individuals with substance use disorder and actively performing caregiving duties for at least six months. Data was collected using validated tools. Data was analysed using SPSS 21.

Results: Out of the 300 subjects, 54(18%) were males and 246(82%) were females, with overall mean age 45±7.73 years. The caregiving duration ranged from 6 months to 20 years. Self-compassion significantly moderated stigma, caregiver burden and expressed emotions (p=0.001). The interaction effects of self-compassion with stigma, affect, behaviour, cognition and caregiver burden collectively explained 88% of the variance in expressed emotion. Self-compassion accounted for a significant change in expressed emotion (p<0.05).

Conclusion: Internalised stigma and caregiver burden predicted expressed emotions in caregivers of males with substance use disorder.

Keywords: Substance use disorder, Caregiver burden, Self-compassion, expressed emotion. (JPMA 74: 1948; 2024)

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Introduction

Stigma is a negative attitude that sets a person apart from others. It is more associated with drug addiction than other psychiatric disorders.[1] Society shows a negative attitude towards a person with substance use disorder (SUD); therefore, caregivers are stigmatised for having such persons in the family. Consequently, they use ineffective coping strategies to cope with stressors. Perceived stigma causes psychosocial problems among family members, which can lead to increased caregiver burden and expressed emotions.[2] Stigma can produce several problems, including psychological and social complications among family members,[3] which can further maximise caregiver burden, emotional burden and social isolation.

Caregiver burden is the emotional, physical, social and financial response to caregiving.[4] The empirical evidence reflected that duration of caregiving, perceived caregiver stigma, poverty, illiteracy and disengagement contribute to caregiver burden in the family.[5] A study[6] reported that patient characteristics, such as younger age and male gender, highly contribute to caregiver burden.

Self-compassion (SC) is defined as understanding the self-sufferings of others as well as the desire to help others.[7] SC reduces self-stigma, negative consequences, negative emotions and caregiver burden.[8,9] It increases life satisfaction, psychological wellbeing, happiness, self-efficacy and trustworthiness. Self-compassionate individuals have insight into their feelings of inefficacy, hardship and weaknesses. Therefore, rather than being critical and judgmental, they have a broad view of situations in which they are involved. Besides, they have lower levels of anxiety and insecurity and accept both positive and negative aspects of themselves. They are less likely to experience stigma, and their intrinsic motivation regulates their psychological wellbeing.[7]

One of the factors of addiction is the level of expressed emotion. Brown and Rutter[10] introduced the term 'expressed emotion', an interaction between family and patient through criticism and emotional over-involvement. Families of patients with mental illness use various coping strategies to manage stressors and caregiver burden. These coping skills are influenced by the caregiver's expressed emotions, social support, and quality of life. Stigma, excessive burden, stress, and pressure on families lead to higher levels of expressed feelings towards the patient.[3] Severe psychiatric symptoms and an increased number of admissions cause expressed emotions in the family members, which increases the likelihood of relapse in the

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patient.[11]

The transactional model of Lazarus and Folkman[12] deals with stress and coping. It states that stressful experiences result from a transaction between an individual and his environment. Adaptation to stressors is based on appraising the situation and using coping strategies. In this model, caregivers face stressors, including illness of family members, public stigma and caregiving responsibilities. These stressors expedite primary and secondary appraisals. Primary appraisal evaluates a situation as irrelevant, positive, and stressful. The secondary appraisal refers to how to cope with stressful events. After appraising the situation, individuals use cognitive and behavioural skills to reduce stressors. They may use either emotion-oriented or problem-oriented coping strategies. Caregivers use inappropriate coping skills to cope with stressors, showing expressed emotions towards patient. As a result of emotional expression, the risk of relapse among patient increases.[12]

Previous research has examined the multiple aspects of stigma and its presence in SUD,[13,14] but more attention needs to be paid to internalised stigma in caregivers. Caregivers who report higher levels of burden and stigma are also likely to report expressed emotions.[2] Thus, caregivers must develop compassion for themselves and their patients. Low levels of SC in caregivers lead to a caregiving burden, whereas higher levels improve their quality of life.[9] SC can mitigate the effect of public stigma on self-stigma. This is because self-compassionate individuals are less vulnerable to stigma and internalised public stigma.[7]

The current study was planned to identify the role of SC as a moderator in the relationship involving stigma, caregiver burden and expressed emotions among caregivers of males with SUD.

Subjects and Methods

The correlational, quantitative study was conducted from June 1 to September 30, 2021, at the Department of Psychology, University of Central Punjab, Lahore, Pakistan. After approval from the institutional ethics review committee, the sample size was calculated using the rule of thumb for validation studies as 5-10 participants for every item in the instrument.[15] The sample was raised using purposive sampling technique from different rehabilitation centres in Lahore after obtaining permission from the respective administrations. Those included were parents of caregivers aged 40-55 years who were physically and mentally healthy, were residing with individuals diagnosed with SUD, and were actively engaged in caregiving duties for a minimum of 6 months. Caregivers with any diagnosed physical or psychological conditions were excluded. Data was collected after taking informed consent from each participant.

Permission was obtained from the authors of the scales before their use in the study. The Burden Scale for Family Caregivers-Short version (BSFC-s) and the Family Questionnaire (FQ) were translated into Urdu by forward and backward method. The reliability of BSFC-s Urdu and FQ Urdu was assessed by re-administering the scales after a one-week interval. The researchers administered the questionnaires to the participants. A self-developed demographic questionnaire was used to gather data related to age, gender, education, duration of caregiving, knowledge about illness, relationship with the patient, occupation and socioeconomic status (SES). Stigma was measured using the Urdu version of 22-item Affiliate Stigma Scale (ASS).[16,17] The scale consists of 3 components: affect, cognition and behaviour. The items are rated on a 4-point scale ranging from 1=strongly disagree to 4=strongly agree. Cronbach's alpha on the current study was 0.94. Caregiver burden was measured using the 10-item BSFC-s.[18] All items are rated on a 4-point scale ranging from 0=strongly disagree to 3=strongly agree. The BSFC-s Cronbach-s alpha in the current study was 0.92. SC was measured using the Urdu version of the 26-item Self-Compassion Scale (SCS).[19] The scale consists of 6 subscales: self-appraisal, self-love, isolation, common humanity, over-identification, and mindfulness. Items are rated on a 5-point scale ranging from 1=rarely to 5=almost always. The reliability of the total scale in the current study was 0.92. Expressed emotions were measured using a 20-item Family Questionnaire (FQ).[20] The scale critical comments (CC) and emotional over-involvement (EOI) subscales. Items are scored on a 4-point scale ranging from 1=never to 4=often. The internal consistency reliability computed originally for the CC subscale was 0.92, and for the EOI subscale it was 0.79. In the current study, the corresponding values were 0.90 and 0.89, respectively. The reliability of the total scale was 0.94.

Data was analysed using SPSS 21. Descriptive statistics were used for demographic variables. The SES was categorised as upper class, middle class and lower class based on a reported income criterion.[21] There were multiple predictors in the study, such as stigma (affect, behaviour, cognition) and caregiver burden, therefore, multiple linear regression analysis was used to see the role of SC as a moderator in the equation involving stigma, caregiver burden and expressed emotion. Hierarchical multiple regression analysis was used to examine the moderating role of SC. In the first step, two variables were included: stigma and caregiver burden. In the second step,

SC was entered, while in the third step, products of stigma and SC, and caregiver burden and SC were entered. The main effect of SC was interpreted from step two, while the interaction effects were interpreted from step 3. Stigma was calculated by the mean score for each participant, with higher mean scores indicating greater levels of affiliate stigma. Binary modelling was used to systematically examine interaction effects between the predictors and SC. This method allowed for a comprehensive analysis of both main effects and interaction effects. Simple slope analysis was employed where appropriate. P<0.05 was considered significant.

Results

Out of the 300 subjects, 54(18%) were males and 246(82%) were females, with overall mean age 45±7.73 years. There were 42(14%) spouses and 258(86%) parents. Overall, 111(37%) subjects had knowledge about illness, and 189(63%) had no knowledge about the illness. In terms of education, 180(60%) subjects had primary education, and 120(40%) had secondary education. The caregiving duration ranged from 6 months to 20 years. There were 201(67%) subjects who were unemployed, 71(23%) were employed, and 28(9%) had their own businesses with interests in multiple areas. There were 47(15%) with upper class SES, 112 (37%) middle class and 141(47%) had lower class SES.

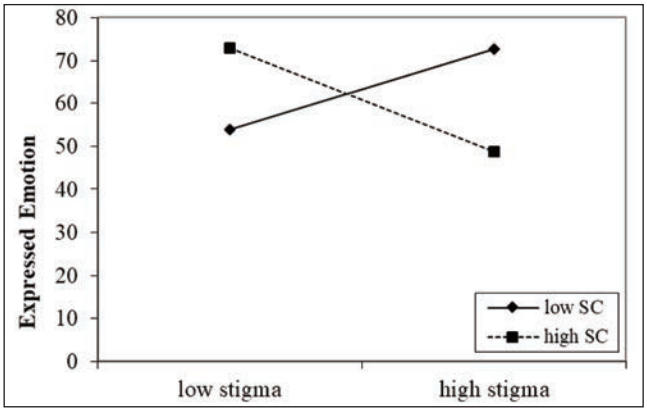

Figure-1: Stigma predicting expressed emotion in caregivers with high and low self-compassion (SC).

In hierarchical multiple regression analysis, model 1 was significant (F[5, 294]=362.295; p=0.001), with stigma, affect, behaviour, cognition and caregiver burden accounting for 86% of the variance in expressed emotion with R 0.92 and R^2 0.86. Model 2 was also significant (F[6, 293]=307.518' *p*=0.001), having R 0.92 and R2 0.86. Adding SC to the model resulted in a small, but statistically significant change ($\Delta R^2 = 0.003$, $p<0.05$), explaining 86% of the variance in expressed emotion. This means the effect was real and not due to chance, even though it was small. Model 3 was significant (F[11, 288]= 203.653; p=0.001), with the interaction of stigma and SC, cognition and SC , caregiver burden and SC accounting for 88% of the variance in expressed emotion with R 0.94 and R2 0.88. The interaction of affect and SC, and behaviour and SC was not significant (*p*>0.05) (Table).

The simple slope was significant (β = -0.008; p<0.05). It was observed that mean stigma 0.003±17.43 positively predicted expressed emotion among caregivers with low level of SC (Figure 1).

The simple slope for the differential role of caregiver burden in caregivers with high and low SC regarding expressed emotion was significant (β=0.01; *p*<0.05). Mean caregiver burden 0.003±7.95 positively predicted expressed emotion among caregivers with a low levels of SC (Figure 2). The simple slope for the differential role of cognition in caregivers with high and low SC regarding expressed emotion was significant (β = 0.02; *p*<0.05). Mean cognition 0.003±6.58 positively predicted expressed emotion among caregivers with a low levels of SC (Figure 3).

Table: Moderation through hierarchical regression for expressed emotion.

Variable	B	95% CI for B		SE B	B	R2	ΔR2
		LL	UL				
Step 1						0.86	0.86*
Constant	60.6*	59.9	61.3	0.34			
Stigma	0.16*	0.006	0.32	0.08	0.15*		
Affect	0.59*	0.21	0.98	0.19	0.23*		
Behaviour	0.84*	0.54	1.1	0.15	0.46*		
Cognition	-0.34	-0.76	0.08	0.21	-0.13		
Caregiver Burden	0.55*	0.42	0.68	0.06	0.28*		
Step 2						0.86	0.003*
Constant	60.6*	59.9	61.2	0.34			
Stigma	0.18*	0.02	0.33	0.08	0.19*		
Affect	0.51*	0.12	0.89	0.19	0.19*		
Behaviour	0.72*	0.40	1.0	0.16	0.39*		
Cognition	-0.32	-0.74	0.09	0.21	-0.13		
Caregiver Burden	0.53*	0.40	0.66	0.06	0.26*		
Self-compassion	-0.06*	-0.11	-0.01	0.02	-0.09*		
Step 3						0.88	0.02*
Constant	62.9*	61.8	64.0	0.56			
Stigma	0.06	-0.10	0.23	0.08	0.07		
Affect	0.18	-0.33	0.70	2.6	0.07		
Behaviour	1.2*	0.87	1.5	0.17	0.65*		
Cognition	-0.90*	-1.4	-0.40	0.25	-0.37*		
Caregiver Burden	0.56*	0.42	0.71	0.07	0.28*		
Self-compassion	-0.09*	-0.14	-0.04	0.02	-0.14*		
Stigma x SC	-0.008*	-0.01	0.001	0.004	-0.21		
Affect x SC	0.007	-0.01	0.025	0.009	0.07		
Behaviour x SC	-0.007	-0.01	0.004	0.006	-0.10		
Cognition x SC	0.02*	0.017	0.031	0.004	0.33*		
Caregiver burden x SC	0.01*	0.004	0.017	0.003	0.13*		

CI: Confidence interval, LL: Lower limit, UL: Upper limit, SC: Self-compassion. *$p<0.05$.

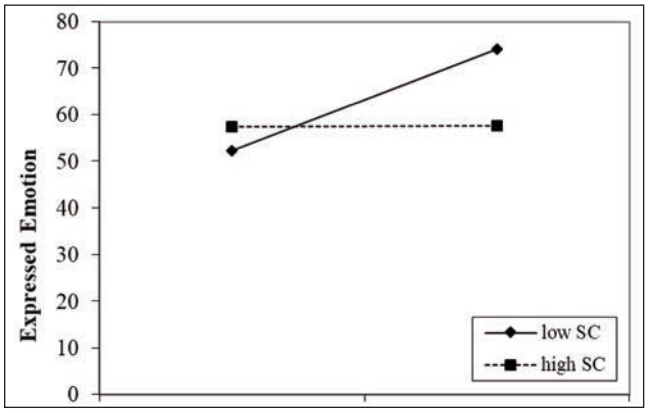

Figure-2: Caregiver burden predicting expressed emotion in caregivers with high and low self-compassion (SC).

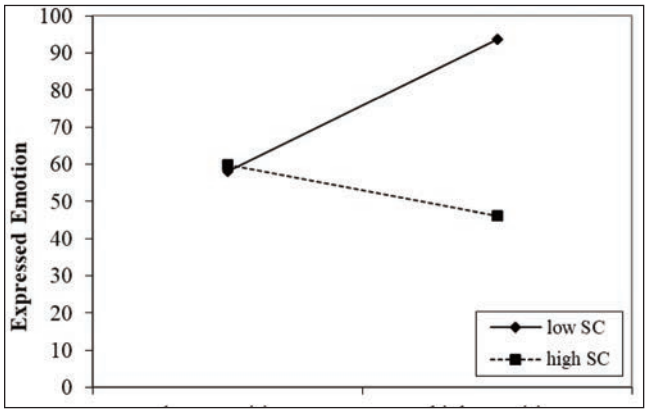

Figure-3: Cognition predicting expressed emotion in caregivers with high and low self-compassion (SC).

Discussion

The current findings indicate that SC moderates the relationship between stigma, caregiver burden and expressed emotion among caregivers of individuals with SUD. The results are consistent with earlier findings.[8,9] Similarly, the present study's findings are consistent with earlier reports[22,23] to the effect that SC moderates the relationship involving self-stigma, caregiver stress and life satisfaction. Studies in Pakistan also show that SC predicts psychological wellbeing and reduces individuals' stressors.[24] However, SC reduces caregiver burden in caregivers who use adaptive coping strategies. Pakistan is a culturally and ethnically diverse country that is home to a variety of Islamic religious branches, each with its own set of beliefs. Black magic, the evil eye, and Jinn (demon) possession are prevalent beliefs in society. As a result, people in this part of the world who face low literacy rates, poor SES and poor knowledge reported more stigma.[25]

The current study has limitations As the sample included caregivers of male patients only. For future studies, caregivers of female patients should also be included. The sample was collected from a few drug rehabilitation centres. Therefore, future researchers should select samples from different areas to increase generalisability of the findings.

Conclusion

Persons living with SUD patients are personally affected by the public stigma that prevails in society since they are closely associated with a stigmatised individual. As a result, these associates develop affiliate stigma, which makes them feel powerless and dissatisfied about their affiliation. They feel a burden in caring for the patient and show expressed emotion towards patients. There may be a risk of relapse due to these circumstances, and the family's expressed emotion may affect the patient's failure to recover. In the relationship of these variables, SC is a moderator where increasing the SC decreases stigma, caregiver burden and expressed emotion.

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Author Contribution:
IS: Data collection, analysis, study design and concept.
AA, AS: Data analysis, critical review and final approval.
AS: Critical review.