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The Associated Stigma of Family Members of Depression Patients: A Qualitative Study

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Abstract: *Objective:* To understand the intertwined stigma experiences of the families of depression patients, providing a basis for implementing targeted interventions for depression patients and their families. To provide a basis for targeted interventions for patients with depression and their families. *Methods*: Based on the principle of data saturation, the family members of depressed patients in the mental health department and psychological outpatient clinic of a tertiary hospital in Hangzhou from March to May 2025 were selected by the purpose sampling method, and the semi-structured interview method was used to conduct in-depth interviews with the research subjects, and the Colaizzi 7-step analysis method was used for data analysis. *Results*: A total of 4 themes, and 8 sub-themes were extracted, namely cognitive responses (cognitive biases), emotional responses (internalized stigma and self-blame, feelings of shame, worries and concerns), behavioral responses (concealing the illness, social avoidance), and the potential impact of associated illness stigma (impact on the profession of relatives, emergence of internal family conflicts). *Conclusion:* Healthcare workers should gain an in-depth understanding of the associated stigma faced by the families of patients with depression and provide targeted psychological support. At the same time, there should be a call for society to pay positive and appropriate attention to patients with depression and their families, improving the families' understanding of the illness so that they can cope with the associated stigma in a positive manner.

Keywords: Depression; Caregiver; Stigma; Nursing

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1. Introduction

Depression, as a common mental illness, is characterized by significant and persistent low mood, reduced interest, and loss of pleasure, presenting high morbidity, high recurrence, high suicide rates, and high disability rates [1, 2]. According to reports, there are approximately 322 million people with depression worldwide, accounting for 4.4% of the global population [3]. Currently, there are approximately 95 million people suffering from depression in China, with about 280,000 suicides each year, and 40% of those suffer from depression [4]. Depression recovery treatment is a protracted procedure. In addition to worrying about the patient's ability to recover from their disease,

family members of patients with depression also feel depressed and discriminated against, which contributes to a collective sense of shame about the condition [5]. After experiencing prejudice, family members developed a comprehensive definition of linked illness stigma that takes into account cognitive processes, negative emotional experiences, and behavioral changes [6]. It is precisely because of the existence of associated illness stigma that family members feel ashamed of having a relative with a mental illness while having to care for him/her, leading to behaviors of withdrawal or avoidance in social settings. Family members experience anxiety and distress, resulting in an increased caregiving burden, higher levels of psychological distress, and a lower quality of life [7]. Moreover, current research shows that more than half of the family members of individuals with depression experience mild to moderate associative stigma [8]. However, existing research on associated stigma mainly focuses on the families of patients with severe mental disorders, such as schizophrenia or caregivers of individuals with neurological diseases like Alzheimer's, with less attention given to the families of those with depression. Therefore, this study aims to understand the experience of perceived stigma among the family members of patients with depression, providing a reference for developing precise intervention plans in the future.

2. Materials and methods

2.1. Research subject

This study employed purposive sampling to select the family members of depression patients from the Mental Health Department and Psychological Outpatient Clinic of a tertiary hospital in Hangzhou from March 2025 to May 2025 as the research subjects. The inclusion criteria of the study are: (1) Family members are aged 18 years or older; (2) Family members of patients who have a clear diagnosis of depression, Meets the ICD-11 Classification of Mental and Behavioral Disorders: Clinical Description and Key Points for Diagnosis of Depression [9]; (3) Living with a formally diagnosed depression patient and taking on the primary care responsibilities (such as the patient's spouse, children, parents, or other caregivers related to the depression patient, etc.); (4) Directly caring for the patient for more than 3 months; (5) Voluntarily participating in this study and signing an informed consent form. The exclusion criteria are: (1) Paid caregivers (such as nannies, nursing staff, etc.); (2) Individuals who cannot communicate effectively; (3) Vulnerable groups, including those with mental illnesses, cognitive impairments, critically ill patients, pregnant women, and illiterates.

The sample size is determined based on data saturation, which means that when the newly added interview data no longer generates new topic, the research data reaches a saturation state [10]. In this study, a total of 15 interviews with the families of patients were collected. Among them, there are 4 men and 11 women; ages range from 30 to 65 years; education level: 2 people with elementary school education or below, 5 people with junior high school to high school education, and 8 people with college education or above; marital status: 13 married, 2 divorced; employment status: 11 employed, 3 retired, 1 unemployed; relationship to the patient: 7 mother-daughter pairs, 2 father-daughter pairs, 4 spouses, 1 mother-son pair, and 1 sister. The general information of the respondents can be found in **Table 1**. This study has been approved by the hospital's ethics review committee (2025 Research No. 0324). All respondents provided informed consent and voluntarily participated in the survey.

Table1. General information of the respondents

Number	Gender	Age	Educational level	Relationship with patients	Marital status	Employment Status
A1	Woman	42	Undergraduate	Mother	Married	In business
A2	Man	54	Undergraduate	Father	Married	In business
A3	Woman	56	college	Mother	Married	In business
A4	Woman	58	Junior high school	Mother	Married	Retirement
A5	Man	59	college	Couple	Married	Retirement
A6	Woman	45	Elementary school	Couple	Married	In business
A7	Woman	52	Elementary school	Mother	Married	In business
A8	Man	48	Undergraduate	Couple	Married	In business
A9	Woman	42	college	Mother	Divorced	In business
A10	Man	48	college	Father	Divorced	In business
A11	Woman	53	Junior high school	Mother	Married	In business
A12	Woman	60	Junior high school	Couple	Married	Retirement
A13	Woman	36	Junior high school	Mother	Married	In business
A14	Woman	30	Undergraduate	Sister	Married	Unemployed
A15	Woman	45	Junior high school	Mother	Married	In business

2.2. Research methods

Research literature on family stigma related to mental illness around the research theme and consult experts in psychiatry and psychology [11, 12]. Based on the specific manifestations of depression, draft a preliminary interview outline, conduct pre-interviews with two family members of patients meeting the criteria for depression, and finalize the interview outline based on the interview findings.

The content is as follows: (1) What do you know about depression? How did you come to understand it?; (2) How did you feel when you learned that a family member was diagnosed with depression? What psychological or emotional changes did you experience?; (3) How do you cope when the patient shows symptoms related to the illness?; (4) Do others (colleagues, friends, etc.) know about your family's situation? Has their attitude towards you changed? Will you deliberately hide it? What are the reasons for hiding?; (5) After a family member falls ill, how do you think the people around you view this situation?; (6) After a family member falls ill, what impact has it had on your life and family?; (7) Do you have any additions or suggestions?

2.3. Data collection

This study adopts a semi-structured interview method for data collection, and the specific operational process is as follows: Before the interview is conducted, the participants must be fully informed about the academic value of the research, the specific implementation steps, and data confidentiality measures. It should be clearly explained that the interview process will be recorded in its entirety and notes will be taken, while also signing an informed consent form that has passed ethical review. Additionally, both parties must jointly negotiate and determine a suitable time and place for the interview. The interview environment should be chosen to be an independent and enclosed space to minimize external interference factors to the greatest extent possible. During the interview process, the researcher engages with the interviewee based on a pre-established interview outline, and can flexibly

adjust the order and wording of questions according to the actual conversation progress, focusing on guiding the interviewee to fully express their subjective feelings on the core research topics. In this process, the researcher not only needs to pay attention to the interviewee's verbal expressions but also closely observe their non-verbal behaviors, such as facial expressions and body language, while maintaining an empathetic listening attitude. It is suggested that each interview lasts between 30 to 50 minutes, to ensure sufficient information is obtained while also considering the interviewee's level of attention.

2.4. Data organization and analysis

The family members of the patients included in the study will be randomly numbered in order from A1 to A15. Following the Colaizzi seven-stage analytical framework of the descriptive phenomenological method, the interview data were systematically processed: audio transcriptions and on-site records will be completed within 24 hours after the interview, the text will be reviewed word by word and analyzed, extracting key statements related to the core research topics [13]. By repeatedly comparing, identify high-frequency and analytically valuable viewpoints, summarize their common attributes, and merge and encode content with similar characteristics, based on the encoding results, cluster and integrate concepts to initially define theme categories. Based on this, the initial theme is optimized and improved through logical reasoning and theoretical connections, constructing a hierarchical thematic framework. Finally, the analysis results are verified using cross-validation methods, and respondents are invited to participate in member checks, thereby ensuring the authenticity of the research conclusions and enhancing the explanatory power of the research findings.

3. Results

3.1. The expression of associated disease stigma

3.1.1. Cognitive bias

Some family members have a lack of understanding regarding the patient's psychological/ physiological illnesses, which manifests as simply attributing abnormal behaviors to 'rebellion' or 'subjective resistance,' further exacerbating the disconnection between the family's emotional investment and cognitive limitations. A09: "I didn't understand this illness very well, at first I would argue with him, thinking he simply didn't want to go to school, without considering that he had a problem." A10: "At first I didn't understand, I couldn't comprehend why she, who was doing well before and had always been the class leader in middle school, and was very lively, would have this illness." A14: "The environment around us makes parents feel that she is rebellious. Previously, when her second sister was in high school, she was hospitalized due to gallbladder inflammation, but at that time, she had escaped with her classmates. So the family felt that there was a previous example of rebellion, and they believed that her behaviors at home indicated that she was rebellious. In rural areas, people don't regard her psychological issues as a very serious problem." A15: "We love her very much, including her grandparents, and just can't understand why she would be like this."

3.1.2. Emotional response

(1) Internalization of stigma and self-blame

Some family members of patients tend to attribute the patient's illness to their own inadequate care or improper behavior, which in turn triggers feelings of guilt and self-blame. A01: "As a daughter, seeing

my mother in this situation makes me feel like I didn't take good care of her, I feel very guilty for not timely caring about my mom, and I have a bit of self-blame." A02: "At first, there was a bit of self-blame, wondering how this situation could happen and whether we, as parents, didn't do well enough." A03: "I also feel guilty for not discovering her condition sooner. If I had noticed it early and taken her to see a doctor this morning, would she be much better off? Sometimes, seeing her like this makes me feel low, and I occasionally feel unhappy." A04: "Sometimes when I see other kids being lively and healthy, I feel a bit guilty and blame myself. How did it suddenly become like this? I wonder if I did something wrong, or if I put too much pressure on her. When I see her unhappy, I also feel very unhappy." A05: "I feel guilty for not taking her to the doctor in time, for not finding a good hospital or doctor, or a good solution; I've been going in circles." A15: "Her father also mentioned me, claiming that the private school had spoiled her. I considered whether the environment was the true cause, but I did not deny it. I had high hopes for her when she started the private school, and I believed that she would get better under the influence of her peers. In addition to feeling bad, I question whether she would have fared better if she had attended the middle school where she could have advanced straight. "

(2) Stigma

Patients' relatives may experience feelings of embarrassment as a result of inappropriate responses or prejudice from others regarding the patient's condition. A10: "Because I am aware of this sickness, my daughter told a classmate about her medication that day. For fear of being held accountable if something goes wrong, some parents may advise their kids not to play with my daughter or make too much contact. Other parents may reject her if they learn about it, which could affect her psychologically and cause her classmates to distance themselves from her. " A11: "Last year, we had a new neighbor move in next door. They disturbed us several times, and that person next door even insulted us, saying I was crazy. In the end, the villagers sorted it out." A15: "She has a good friend. Previously, her mother asked me to send them to a tutoring class together, a one-on-two ratio would be fine, and I agreed since they are good friends and can attend together. Then a day later, that parent called me and said they had decided on one-on-one instead. From their child, I learned about my child's situation, that my child is emotionally unstable, and they wanted my child to stabilize emotionally before considering anything else."

(3) Worries and concerns

The patient's family members have significant anxiety about the patient's disease prognosis and are worried that the progression of the disease may negatively impact her learning abilities and future reproductive functions. A04: "At first, she was diagnosed in Shanghai, and of course, I was very worried. One reason is my concern for her studies; she is repeating a year and will take the college entrance examination this year. Right now, she doesn't want to study and can't focus on reading. She brought her books to the hospital, but she doesn't want to look at them, which makes me worry about her exams. Another reason is my concern for her physical and mental state; her condition affects us, and if she is unhappy, we will also be unhappy." "A06: 'He often tells me that he doesn't want to live anymore. Of course, I'm worried about him and don't want him to think in a bad direction.' A10: 'I'm going to be so anxious. If anything happens to her in the next three or four days, I'll regret it for the rest of my life.' A13: 'I'm worried that if she doesn't go to school because of this issue, that would definitely be unacceptable. What will happen in the future? She's still so young. She can't just laze around at home every day. I'm also anxious about her studies and her future. What will happen if she doesn't go out to work. "

3.1.3. Behavioral response

(1) Concealing the illness

The patient's family members adopted a maladaptive coping strategy of concealing the patient's condition due to embarrassment about disclosing it to others. A01: "My daughter has not seen her grandmother for a long time and will ask. I can't directly tell her that her grandmother is sick and hospitalized, so I just tell her that her grandmother went back to her hometown to take care of some matters and will come back after it's done." A03: "Relatively close relatives know, but friends and neighbors do not. Some friends ask why they haven't seen my daughter for a long time; I find it inconvenient to tell them, so I just lie to them, it's unavoidable. Some might come to my house looking for me, and I tell them I'm not home because I'm feeling unwell and getting my health checked; I just don't want them to know that my daughter is the one who is sick in the hospital." A04: "Apart from close people, only her older sister, brother-in-law, and we know about it. No one else has been told, as it's not convenient, and we don't want others to know about this matter." Family member A05: "She is very proud and wouldn't want others to find out. Only her daughter knows, none of the other relatives or friends know, and we haven't told them. If we get a call, we just respond cleverly and won't say anything." A07: "At home, only her brother, father, and a cousin know; nobody else is aware. She is ill and doesn't want to tell anyone. What's the use of telling others? We don't know how they would think or how they would treat her. Relatives hardly communicate as it is, so no one has mentioned anything." A012: "Of course I will hide it. It's not a good thing, and it's not something good to talk about with others, which makes me a bit insecure. At first, no one else knew except us. Now that I have to work, I really can't take any more leave there, so I told my sister to help take care of her for a few days. After going to university, I've been renting a place on my own so that she can easily take her medicine, and I'm afraid that her classmates will look at her differently if they find out. This time I took leave to bring her to see the doctor, but I cannot tell my boss that it's because of this leave, so I said it's for stomach issues."

(2) Social avoidance

Family members may consciously cut back on or altogether stop participating in their initial social activities out of fear of being criticized or disclosing family problems.A03: "Since she got sick, my communication with previous friends and colleagues has obviously decreased. Sometimes when my friends invite me to go shopping, I say I have something to do and can't go out because, firstly, I need to be with her whenever I have time, and secondly, I'm worried that others will ask about her." A06: "I used to chat with people in the village occasionally, but since he got sick, I have to stay by his side all the time, and my interaction with others has significantly decreased." A10: "My friends often ask me why they haven't seen me for several days. My little brother used to drink tea with me regularly, so if I don't go, they will definitely ask." A11: "Before I retired, I used to go out gathering with my colleagues and friends, but gradually I went out less and less. Now we contact each other on WeChat, but even that has become infrequent. I just don't have the time or energy to talk anymore, and I don't feel like it either." A12: "With other colleagues, I avoid discussing my daughter's situation because I don't want them to know, and I socialize with colleagues very rarely now."

3.2. The potential impact of associated disease stigma

3.2.1. The impact of the patient's occupation

Working family members decide to conceal the presence of depressive patients from their superiors in order to prevent prejudice at work. Family members' job performance suffers as a result of alternating between taking care of the sick and their work due to the conflict between their roles at work and providing care. A01: "I run my own store, and since she was diagnosed, I closed the store early." A07: "During her hospitalization, I took leave from my boss and didn't have work, but I didn't tell my boss the truth; I said she had a bad cold and needed to be hospitalized, fortunately, my boss agreed." A15: "When I was working before, as soon as the teacher called, it was either about not doing homework or arguing with classmates or swallowing pills. I immediately asked for leave from my workplace and rushed to the school. I keep taking leave."

3.2.2. Family disputes arise within

Patients with depression may become more emotional and exhibit illogical emotional outbursts in their words and actions against family members as a result of their heightened emotional unpredictability and decreased efficacy in self-expression. Family disputes and a functional imbalance in the family system result from the communication problems and misunderstandings that arise among family members. A03: "The family atmosphere is no longer as open as it used to be, where we could say anything we wanted. Now, we worry about touching on points that might upset her, and we are concerned that we might inadvertently bring her back into a bad emotional state. So, we are quite careful with what we say in our daily conversations; there are some things we cannot say in front of her." A04: "Previously, we lived with our eldest daughter, and with the presence of small children, it could get quite noisy. My younger daughter would scold her nephew, and I would also scold her, which made her unhappy. Later, I didn't want her condition to worsen, so we decided to move out. We no longer live together." A011: "Before I went to work, he would cry behind me, and sometimes I couldn't even eat breakfast and had to go to work. My mom was diagnosed with rectal cancer last year, but given his situation, I can't take care of my mom right now, so I can only let my sister take care of her." A014: "There is a big conflict with my parents. Whenever school is mentioned, she avoids the topic, and she is unwilling to tell us why she doesn't want to go to school anymore. It feels like everyone in the family can't do their own things. We have to pay attention to her, because if we focus on our own things and ignore her, she will say that we don't care about her. But if we do pay attention to her, she says we shouldn't bother her." A015: "I have two kids, and before I either worked or accompanied them, picking them up and taking them to tutoring classes, but now, with her situation, I inevitably pay less attention to the other child."

4. Discussion

4.1. Families of patients with depression have cognitive biases

The interview's findings indicate that the family members' cognitive bias toward depression is focused on the dual problems of "misreading behavior" and "misunderstanding of the disease." Some family members overemphasize outside influences or attribute psychiatric issues to character defects, which oversimplifies the patients' issues. This kind of thinking directly contributes to the stigma associated with disease, which makes families first choose combative communication over professional assistance. Additionally, some family members mistakenly attribute the patient's pathological symptoms to a lack of family education, which makes the family feel even more guilty and insecure. These cognitive biases can exacerbate emotional control issues by causing family members to

communicate confrontationally with the patient. The societal stereotypes surrounding mental illnesses can act as an invisible driving force for families to feel expected shame, which hinders both patients and their families from seeking social support. Therefore, it is particularly important to strengthen the dissemination of knowledge about depression, correct the family's proper understanding of the illness, and change inherent perceptions. Healthcare professionals can start from cognitive restructuring, using mindfulness cognitive therapy[14] to help families deconstruct their existing beliefs, applying an enhanced awareness of their thoughts, feelings, and bodily sensations into their daily lives, thus increasing the families' understanding and detachment from negative thoughts about depressive symptoms.

4.2. There is an urgent need to address the bad feelings that families of depressed patients endure.

The findings of this interview demonstrate that patients' relatives feel negative feelings as internalized stigma, shame, self-blame, fear, and concern. Family members of people with mental illnesses frequently experience intense guilt when they internalize the unfavorable assessments from others as their own self-perception. This psychological conundrum is actually a reflection of society's ingrained biases against mental illness; many family members already bear psychological costs before they ever face discrimination because of the pervasive misconceptions in society. Families are also affected by the patients' recovery chances. They are genuinely concerned about their children's future romantic and marital problems as well as the scholastic standstill brought on by the illness. Therefore, healthcare providers must consider the mental health of their main caregivers during the entire process of delivering psychological therapies for patients with depression. For caregivers who are experiencing severe psychological distress, prompt, tailored psychological support interventions should be put in place based on the results of dynamic assessments. In order to foster emotional awareness and stress management, family members of patients may benefit from interventions that use techniques like free association, transference, and countertransference through Balint groups and group psychotherapy [15, 16].

4.3. Defensive strategies for behavioral responses

According to the interview results, some family members of depressed patients have adaptation challenges managing the stigma attached to the illness, which causes them to hide or avoid the patient's sickness. This is similar to the conclusions of studies on family caregivers of other diseases [17]. Such avoidant coping behaviors may cause family members to avoid seeking professional help out of fear of stigma, leading patients to miss the best opportunity for intervention, which is detrimental to their recovery. The potential exclusion in the job and dating market due to a history of depression further exacerbates the motivation for family members to conceal it. Therefore, nursing staff need to strengthen the development of specialized psychological nursing skills by promoting the process of disease acceptance among family members, guiding them to express their internalized feelings of shame in a reasonable manner, and simultaneously implementing systematic and personalized psychological counseling programs, such as mindfulness psychological interventions, to help family members establish positive coping mechanisms [18]. At the same time, there is a call to incorporate 'mental health literacy' into the national education system to gradually reverse the stereotypical perceptions of mental illness and promote a positive transformation of this understanding across generations.

4.4. The potential impact of reducing the stigma associated with comorbidities should not

be overlooked.

The interview's findings demonstrate that the effects of the stigma attached to it have gone beyond the level of the individual and are disrupting family systems' ability to function. There is a great deal of friction for some family members between their caring and employment responsibilities. Although hiding their circumstances at work might help them keep their reputation intact for a while, it may cause long-term occupational burnout that will impact their everyday work and family life. Discord within the family can also result from communication taboos that stifle emotional expression or by certain family members neglecting secondary children because they are overly preoccupied with the patient. The construction of an intelligent medical service ecosystem, using measures such as the 'Internet + ' mobile application service platform and a 'one-stop' intelligent guidance service system, can provide patients with smart and efficient consultation services, further alleviating the pressure on family members accompanying them and optimizing their time management [19]. Patients' recuperation is greatly aided by the harmony of the family environment. During the long-term caregiving process, family members may unavoidably experience negative emotions that are challenging to communicate because of the impact of the sickness. The patient's and the family's overall quality of life may be negatively impacted by the disruption of other family members' daily routines, which over time may result in differing degrees of internal conflict. Positive psychology interventions can cultivate self-prompted positive emotions, positive behaviors, or therapeutic methods or conscious activities for positive cognition [20]. As a result, nurses are able to perform health education, offer focused positive psychological counseling to family members, help the patient's family change their perspective, and enhance their acceptance of the illness [21, 22].

5. Conclusion

The everyday lives of patients, their families, and often the entire family are negatively impacted by the complicated stigma, cognitive biases, unpleasant emotions, and negative coping that family members of depressed patients endure. To lessen the bias that the public brings, it is recommended that information about depression be made more widely known. Medical staff should also pay attention to the joint stigma and psychological needs of family members while treating patients, and help family members establish a positive cognitive framework through group psychological counseling and family therapy to help family members correctly cope with joint stigma and improve their psychological resilience, which not only promotes the recovery process of patients, but also realizes the overall health gain of the family unit through the systematic reconstruction of family psychosocial functions.

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