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Invisible Burden of Families of Individuals with Schizophrenia: Courtesy Stigma

Şizofreni Tanılı Bireylerin Ailelerinin Görünmeyen Yükü: Nezaket Damgası

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ABSTRACT

Objective: This study aims to explore in depth the experiences of "courtesy stigma" among families of individuals diagnosed with schizophrenia, to reveal the impacts of such stigma on families, and to examine the coping strategies they develop throughout this process.
Method: Designed with a qualitative approach, the study adopted a phenomenological design and conducted semi-structured interviews with 10 participants. Participants were family members living in the same household as the individual diagnosed with schizophrenia and assuming caregiving responsibilities. MAXQDA software was employed for data analysis, and inductive thematic analysis was applied. Related codes were grouped under categories, and these categories were combined to form themes.
Results: The analysis yielded the main theme of "Stigma in the Shadow of Courtesy". Under this theme, three categories were identified: implicit stigma, concealment stigma, and internalized stigma.
Conclusion: Families of individuals diagnosed with schizophrenia are exposed to implicit stigma in society, which negatively affects them. In this process, families sometimes internalize the stigma presented in the form of politeness without being aware of it; at other times, they develop coping strategies such as masking to protect themselves and their relatives with schizophrenia. Through empowerment-based interventions, it is possible to identify the existing strengths and resources of these families, thereby enhancing their coping skills and well-being. Developing awareness programs based on direct contact within social work practice is also crucial for reducing polite stigma. Furthermore, this study contributes to filling the gap in the social work literature by addressing the issue of polite stigma.
Keywords: Schizophrenia, courtesy stigma, stigma, family, social work

ÖZ

Amaç: Bu araştırmanın amacı, şizofreni tanısı olan bireylerin ailelerinin yaşadığı "nezaket damgası" deneyimlerini derinlemesine incelemek, söz konusu damgalamanın aileler üzerindeki etkilerini ortaya koymak ve bu süreçte geliştirdikleri başa çıkma stratejilerini incelemektir.
Yöntem: Nitel yöntemle tasarlanan araştırmada fenomenolojik desen benimsenmiş,10 katılımcı ile yarı yapılandırılmış görüşmeler yapılmıştır. Katılımcılar, şizofreni tanılı bireyle aynı evde yaşayan ve bakım sorumluluğu üstlenen aile üyelerinden oluşmuştur. Verilerin çözümlenme sürecinde MAXQDA yazılımı kullanılmış ve endüktif tema analizi tekniği uygulanmıştır. İlişkili kodlar kategoriler altında toplanmış ve bu kategoriler bir araya getirilerek temalar oluşturulmuştur.
Bulgular: Çözümleme sonucunda "Nezaketin Gölgesindeki Damga" ana teması ortaya çıkmıştır. Bu tema altında örtük damgalama, damgalamayı maskeleme ve damgalamayı içselleştirme olmak üzere üç kategori belirlenmiştir.
Sonuç: Şizofreni tanısı almış bireylerin aileleri, toplumda örtük damgalamaya maruz kalmakta ve bu durum onları olumsuz etkilemektedir. Bu süreçte aileler, kimi zaman nezaketle yapılan damgalamayı fark etmeden içselleştirmekte; kimi zaman ise şizofreni tanılı yakınlarını ve kendilerini korumak amacıyla maskeleme yaparak baş etme stratejileri geliştirmektedir. Güçlendirme temelli müdahalelerle, şizofreni tanısı almış bireylerin ailelerinin mevcut güçleri ve kaynakları keşfedilerek, başa çıkma becerilerinin ve iyilik hâllerinin artırılması mümkün olabilir. Nezaket damgasının azaltılmasında, sosyal hizmet uygulamalarında yer alacak temas yoluyla farkındalık programlarının geliştirilmesi de önem taşımaktadır. Ayrıca bu çalışma, nezaket damgası konusunu ele alarak sosyal hizmet literatüründe var olan boşluğun giderilmesine katkı sağlamaktadır.
Anahtar sözcükler: Şizofreni, nezaket damgası, damgalama, aile, sosyal hizmet

Introduction

Families of individuals diagnosed with schizophrenia live under the shadow of an invisible stigma. These families strive to gain social acceptance while simultaneously protecting their loved ones from negative judgments and criticism. However, this process often involves coping with the silent struggles of daily life. This invisible stigma is often not manifested openly and directly; rather, it manifests as social distancing, ignoring the disability and its accompanying problems, or excessive courtesy. In other words, stigma directed at the family or loved ones of individuals with disabilities manifests itself in subtle and implicit forms rather than overt exclusion. While this form of stigma may appear "kind" from the outside, it carries a different meaning for the stigmatized individual or family members. This seemingly courteous behavior at first glance often leads to a breakdown in social

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relationships, leaving families feeling excluded and isolated from society. This situation, defined as "courtesy stigma," can lead to the exclusion of the disabled individual's family or close circle from social life, weakening their support networks and deteriorating their psychosocial well-being.

The concept of "courtesy stigma" was first introduced by Erving Goffman in his 1963 work, Stigma: Notes on the Management of Spoiled Identity. Goffman employed this concept to describe the indirect stigmatization of individuals in close contact with those who are stigmatized, such as family members, friends, or caregivers. In this context, acts of courtesy by "normals" (individuals considered "normal" in society) that often make the stigmatized individual's impairment seem irrelevant can lead them to believe that social acceptance is broader and more unconditional than it actually is, ultimately leading the stigmatized individual to believe they are more accepted than they actually are (Goffman 1963). Therefore, this attitude, presented in the form of courtesy, on the one hand, provides a superficial appearance of acceptance in social relations. On the other hand, it can cause the stigmatized individual and his/her close circle to experience an illusion of acceptance without realizing the social exclusion.

Schizophrenia provides a prime example of understanding the social implications of courtesy stigma. According to the DSM-5, schizophrenia is defined as a complex neurodevelopmental disorder characterized by impairments in thought, perception, emotion, speech, and behavior, accompanied by distinct psychotic symptoms (American Psychiatric Association 2013). Schizophrenia is also interpreted and understood through the lens of the moral model. For example, it is frequently misrepresented in the media and society, associated with elements of fear, danger, and prejudice (Vahabzadeh et al. 2011, Owen 2012, Bademli et al. 2023), leading to the exclusion of individuals with disabilities from social interactions and the tendency for society to avoid associating with them (Goffman 1963). In this process, terms such as "mentally ill" and "psychotic" are used to describe individuals experiencing mental health problems, thus gaining a stigmatizing character (Artvinli 2020). Today, terms like "autistic," "schizophrenia," or "bipolar" have become part of a derogatory or insulting language, particularly among children and adolescents, and contribute to the stigmatization of individuals with mental illness. In cases of severe psychiatric diagnoses such as schizophrenia, not only the individual but also their close family members are subject to social stigma.

Studies in the literature indicate that stigma is a multifaceted phenomenon that affects not only the individual but also their immediate environment (Corrigan and Miller 2004, Karnieli-Miller et al. 2013, Arditti 2014). This is experienced as direct social exclusion, exposure due to kinship, and internalized stigma, resulting in social isolation (Gaolaolwe et al. 2023). One of the most fundamental problems experienced by individuals diagnosed with schizophrenia and their families is that their needs are rendered invisible by their immediate environment. Prokop-Dorner and Flis (2021) reported that caregivers of individuals with disabilities often fail to understand their relatives' and other people's situations and feel excluded. Similarly, Köroğlu and Hocaoğlu (2017) found that families often report being ostracized by relatives or friends if a close family member is diagnosed with schizophrenia.

Birenbaum (1970) demonstrated that when a family member has a stigmatized disorder, family members fear experiencing the "stigma of courtesy." However, they do experience this and use information control strategies to avoid this situation (regulating who and to what extent they share information about the disability, avoiding stigmatizing individuals, and managing information to maintain a "normal" appearance in society). However, information control alone is not a sufficient coping strategy. Families often develop reactions such as shame, guilt, social withdrawal, and avoiding help-seeking (Maiocco et al. 2017). Furthermore, family members may act together to conceal their stigmatized relative's "fault" from outsiders, and this joint effort essentially becomes the management of a shared stigma (the stigma of courtesy) (Goffman 1963). This situation not only exposes family members to the stigma of courtesy but also leads them to be viewed as potential "stigmatized individuals."

Some studies conducted in Türkiye have revealed that stigma also exists in the immediate circle of individuals diagnosed with schizophrenia (Gök and Çifci 2018, Öztürk et al. 2020, İnan et al. 2021, Arslan 2025). However, while there are studies on stigma in the social work field (Büber et al. 2015, Demir and Buz 2023), no research has been found specifically examining the experiences of families who face courtesy stigma.

The primary purpose of this study is to understand the experiences of families of individuals diagnosed with schizophrenia regarding courtesy stigma. Thus, aims to fill an important gap in the social work literature and to contribute to the role of social workers in practice.

Method

The study aimed to gain an in-depth understanding of the experiences of families of individuals diagnosed with schizophrenia regarding the stigma of courtesy. A qualitative method was chosen. Accordingly, a phenomenological design was employed, focusing on uncovering individuals' experiences, perceptions, and the meanings they attribute to a specific phenomenon (Yıldırım and Şimşek 2013). The primary research problem can be expressed as "How is the stigma of courtesy experienced by family members of individuals diagnosed with schizophrenia?" Sub-problems can be expressed as "How does the stigma of courtesy affect family members psychosocially?" and "How do family members cope with or adapt to this invisible stigma?"

Reflexivity

The data collection and analysis processes of the study were conducted with an awareness of the researcher's subjectivity. Interview transcripts were revisited, and a continuous back-reading process was conducted during the data interpretation process. Initially, data collection presented challenges due to families' tendency to conceal their situations. This, thanks to the researcher's field and academic experience, enabled the development of an approach that required patience and attention. As the interviews progressed, the questioning became more detailed and in-depth, fostering a welcoming atmosphere, and families felt understood. This fostered trust and fostered more open and detailed sharing. Furthermore, the researcher maintained an open and transparent stance throughout the interviews, explaining her role to the participants.

Sample

In this study, criterion sampling -a purposive sampling method- was chosen in accordance with the study's purpose and methodological suitability. The criteria used for participation in the study, in which participants volunteered, were being a family member directly related to an individual diagnosed with schizophrenia and responsible for their care, living in the same household as an individual with schizophrenia and voluntarily agreeing to participate in the study.

Participants were recruited through the Burdur Community Mental Health Center (CMHC). Families of individuals diagnosed with schizophrenia often tend to conceal their mental illness. In this context, contact was made through the Burdur CMHC to facilitate access to participants and quickly establish a trusting relationship. In qualitative research, particularly within the context of a phenomenological design, establishing a relationship based on trust and empathy between the researcher and the participant is critical (Yıldırım and Şimşek 2013). Furthermore, the accessibility of the Burdur CMHC to the researcher and the suitability of the field conditions enabled the efficient data collection process. Therefore, in line with the nature of the phenomenological design, Burdur CMHC was selected as a site that would allow participants to understand their experiences within their own context.

After obtaining the necessary permissions from the relevant institutions, the interviews were conducted in accordance with ethical principles. A total of 11 people participated in the study: 9 women and 2 men. The fact that the number of men in the study group was lower than the number of women reflects the fact that caregivers of individuals with disabilities are predominantly women. For example, Arasu and Shanbhag (2021) found that 97% of caregivers of children with disabilities are women, 82% of whom are mothers and 3% are fathers. One participant was hesitant during the interview and did not provide sufficient depth in her responses. Therefore, the data obtained were not included in the analysis, and the study was completed with 10 (8 women and 2 men) participants.

In studies using purposive sampling, the concept of saturation refers to the point at which no new information or themes emerge in the data. In a study conducted to test saturation, Guest and colleagues (2006) investigated how much data the first six interviews provided compared to 12, 18, 24, or more interviews. The results showed that 73% of the codes were identified in the first six interviews and 92% in the first 12 interviews. This result indicates that a significant degree of thematic diversity was achieved within the first 12 interviews. Similarly, Yıldırım and Şimşek (2013) stated that in studies conducted with a phenomenological design, the use of snowball or criterion sampling methods is appropriate and that the number of participants should generally not exceed 10. A study by Hennink and colleagues (2017) showed that code saturation was reached after nine interviews. To achieve a wide range of data across interviews, care was taken to ensure that participants varied in terms of variables such as gender, education level, occupation, and degree of relationship to the individual diagnosed with schizophrenia (mother, father, child, sibling). To protect the confidentiality of participants' identities, each participant was assigned codes such as "G1," "G2," and "G3." Detailed information about the participants' demographic characteristics is presented in Table 1.

Table 1. Demographic characteristics of study participants

Code	Age	Gender	Marital Status	Education Level	Occupation	Relationship
G1	43	Female	Married	Primary School	Worker	Niece
G2	45	Female	Married	University	Teacher	Father
G3	60	Female	Married	High School	Housewife	Mother
G4	72	Male	Married	High School	Retired teacher	Stepfather
G5	57	Female	Married	Primary School	Housewife	Mother
G6	39	Female	Married	Primary School	Housewife	Daughter
G7	56	Male	Married	High School	Retired (disability)	Son-in-law
G8	58	Female	Married	Primary School	Retired	Wife
G9	44	Female	Married	University	Housewife	Daughter
G10	63	Female	Married	Primary School	Housewife	Wife

Data Collection

The research was approved by the Burdur Mehmet Akif Ersoy University Non-Interventional Clinical Research Ethics Committee with decision number GO 2025/1788 dated June 18, 2025. It was conducted in accordance with the provisions of the Declaration of Helsinki. Following Ethics Committee approval, the necessary institutional approvals were obtained from the Burdur Provincial Health Directorate of the Ministry of Health of the Republic of Türkiye. Before beginning the interviews during the data collection phase, all participants were provided with an informed consent form and necessary explanations regarding the research. To protect the rights of the participants, the obtained data were anonymized, and code names were used instead of the participants' real names during data analysis and presentation of the findings.

Research data were collected using a semi-structured interview form developed by the researcher. The work of Goffman (1963) served as a guide in the preparation of the interview form. Additionally, the opinions of a social worker and a psychologist working in this field were also utilized. The semi-structured interview technique was chosen because it allows for flexible, in-depth data collection without adhering to a rigid framework. The flow of the interviews was primarily shaped by the participants' responses (Dömbekci and Erişen 2022). The interview form consisted of six descriptive and seven open-ended questions. The first section, which included descriptive questions, contained demographic information such as age, gender, marital status, and educational background. The second section contained a semi-structured interview form consisting of seven open-ended questions. Some of the questions in this section include:

1. What attitudes did people (relatives, neighbors, friends, etc.) adopt toward you after your relative was diagnosed with schizophrenia? (Have you noticed a sense of distance or hesitation in people's approaches to you or your family?)
2. How do you feel when people say things like "you're holding up so well," "you're so strong," or "no one else could care for you"? (Did these statements convey support/appreciation or a negative feeling? Why?)
3. Have you encountered people who appeared kind but didn't support you? Have you encountered people who gave the impression of "supporting you" but actually shirked their responsibilities? How did this make you feel?

In the first step of the interviews, a convenient time was agreed upon with the participants, and they were invited to the CMHC at the agreed-upon time. The interviews were then conducted face-to-face in the interview room at the Burdur CMHC in July and August 2025. Before each interview, participants were informed about the purpose and process of the research, and an informed consent form was provided to them. Permission was obtained to audio-record the interviews. Because one participant refused to be audio-recorded, the researcher took notes during the interview. All interviews with the other participants were audio-recorded. Each interview lasted between 30 and 40 minutes, and interviews continued until data saturation was reached. In other words, data collection was considered complete when it was determined that no new data or themes were identified.

Approximately six hours of audio recordings were taken during the interviews. The audio recordings were transcribed by the researcher, resulting in a 120-page Word document. Following the transcription process, the resulting written data were transferred to MAXQDA software which enables the creation, coding, and visualization of themes, categories, and codes in qualitative studies (Dereli 2023), making the data ready for analysis.

Data Analysis

In this study, inductive thematic analysis was used in data analysis. This technique was adopted to explore the experiences of courtesy stigma among families living with individuals diagnosed with schizophrenia. Inductive thematic analysis involves developing categories from raw data and transforming these categories into a framework that explains key themes and processes (Thomas 2003). Accordingly, the analysis process was conducted using the six stages defined by Braun and Clarke (2022) within the framework of thematic analysis. To gain familiarity with the data, the researcher transcribed and read interviews with participants repeatedly, aiming to become familiar with the data, and then carefully examined it. Initial codes were created by analyzing the data based on words, sentences, and discourses, and notable expressions were coded. These codes reflect important concepts related to the participants' experiences-the search for themes involved combining similar and related codes to identify a semantic pattern within the dataset. Categories were identified within this scope. Potential themes were reviewed, and the developing themes were compared with both coded and raw data to ensure semantic consistency among the themes. Defining and naming the themes was performed. Each theme was defined appropriately for its content and named according to the meaning it encompassed. In the final stage of preparing the report, the identified themes were reported in the results section of the research, supported by explanatory quotes.

Through this systematic analysis process, a conceptual framework was developed based on the participants' experiences, and an in-depth interpretation was conducted that aligned with the research objective. The codes, categories, and themes identified during the data analysis were supported by direct quotes from the participants, ensuring that the interpretations were grounded in their experiences. Furthermore, the steps taken during the research process were transparently communicated, and the data collection, analysis, and reporting processes were thoroughly explained. Finally, the Criteria for Reporting Qualitative Research (COREQ) (Tong et al. 2007), an internationally accepted guideline for reporting qualitative research, was adhered to.

Results

Following in-depth interviews with relatives of individuals diagnosed with schizophrenia, the central theme of "Stigma in the Shadow of Courtesy" was derived from the participants' experiences, feelings, and statements. This theme encompasses the invisible burden experienced by relatives of individuals diagnosed with schizophrenia in the face of indirect social judgments, the difficulties they face during the caregiving process, and the solutions they seek to cope with this stigma. Three categories were identified within the theme: "Implicit Stigma," "Stigma Concealment," and "Internalized Stigma." In the results and discussion section, the categories, and codes under this theme, along with participant statements, are presented under relevant headings and discussed in comparison with previous studies. The findings related to the theme, categories, and codes are summarized in Table 2.

Table 2. Relationships between theme, category, and codes

Theme	**Category**	**Codes**
Stigma in the Shadow of Courtesy	Implicit Stigma	Patience/Trial/Pity
		Apparent Support
		Curiosity/Asking Questions
		Not Being Believed/Ignored
		Social Distance
	Stigma Concealment	Normalization
		Isolation
		Hiding/Invisibility
	Internalized Stigma	Feared Person Image
		Feeling the Need to Explain
		Inability to Express Needs

Theme. Stigma in the Shadow of Courtesy

Category 1. Implicit Stigma

The implicit stigma category demonstrates that individuals with schizophrenia and their families are often implicitly and indirectly stigmatized and face social exclusion. This stigmatization experience is embodied under the codes "patience/trial/pity," "apparent support," "curiosity/asking questions," "not being believed/ignored," and "social distance." While the expressions found in this category may initially appear supportive and well-intentioned, they often negatively impact both the individual diagnosed with schizophrenia and their family members, leading to the neglect of their actual needs.

Code 1. Patience/Trial/Pity

Participants stated that their attitudes toward their families are shaped by concepts such as patience, trials, and pity, and that families are often portrayed in a passive role. While this attitude may seem supportive and well-intentioned at first glance, it reinforces feelings of loneliness and misunderstanding in families. While there are attempts to offer spiritual solace, concrete support is often not provided.

> *"They say, 'May God make it easy; it is not easy…' They say, 'May God help you.' We generally thought of it as passing things on. We couldn't take them to the hospital, so they didn't offer to help. No one asked if I needed anything. I was trying to do everything on my own. Because they hadn't experienced it, they didn't approach me sincerely." (G9, Daughter, 44)*
>
> *"…some people can look at a schizophrenic patient and their caregiver with pity. …I felt like they were looking at my sister (the disabled person) very negatively, and at me as well. Why are they looking at me? Is it out of pity, or is it to question why I'm caring (giving care)? I don't know what they're thinking or what kind of ideas they're coming up with, but when you feel that way, it makes you feel bad." (G1, Nephew, 43).*
>
> *"This is your trial… For example, some people say things like, 'You'll be fine in the afterlife.' Everyone knows that anyway. There's no such support, so it's just said whatever you say." (G8, Wife, 58)*

Code 2. Apparent Support

Participants' statements reveal that the caregiving experience of a family member living with an individual diagnosed with schizophrenia is too intense and complex to be expressed in words alone, demonstrating that this situation cannot be understood without firsthand experience. When expressing the challenges and needs of the caregiving process, family members emphasize the importance of concrete support, not just "gentle" expressions of support.

> *"It is not like they understand, it is not something you can just understand. You have to experience it… Saying 'I understand you' doesn't mean much. Maybe they don't want that either. They don't want to be told 'I understand,' but they want support. I think families who truly care for a schizophrenic patient need significant support." (G1, Nephew, 43)*
>
> *"For example, a day or two beforehand, relatives would say 'Okay, of course' (regarding the request for care). When the day comes, they'd say they're done. They'd say 'We really wanted it,' but they'd be denied with excuses. I'd say no one would help anyone." (G9, Daughter, 44)*

Code 3. Curiosity/Asking Questions

Implicit stigma can impact families not only through direct negative behaviors but also through indirect forms such as "curiosity and asking questions." Such behaviors can be perceived as a violation of personal privacy. Participant statements suggest that society's curiosity and interest can have a disturbing effect.

> *"And then there are those who are curious about what happened. How did it happen? I find it a bit upsetting that they're curious and asking questions. Because no one wants to be in that position…Oh, it's a shame; don't look with feelings of pity, which the patient already feels…It happens to me too…They talk about it as if they're getting paid, so they're being looked at." (G1, Nephew, 43)*

Code 4. Not Being Believed/Ignored

Participants sometimes encounter behaviors that appear as courtesy but are actually "not being believed" and "ignored." Such approaches create an invisible effect on family members. Therefore, while these behaviors may be perceived as a kind approach, they can create an isolating effect by rendering the experience invisible. Furthermore, the family feels compelled to prove the reality of the schizophrenia diagnosis.

> *"Those who learned about it acted as if nothing was wrong." (G8, Spouse, 58)*
>
> *"Sometimes there are those who say it (the schizophrenia diagnosis) is in their hands. I make statements like, 'It's not in their hands,' or 'It's not something they can control.'" (G5, Mother, 57)*

Code 5. Social Distance

Participants expressed that their close circle tends to maintain "social distance." In fact, stigma appears to exist not only in their social circle but also in family relationships. It appears that sometimes, the concerns of those around them about the schizophrenia diagnosis can create emotional distance as well as physical distance.

> *"When relatives want to come, they make us even sadder when we call them and they ask, 'Is your mother okay? Won't she do anything?'" (G9, Daughter, 44)*
>
> *"They said she has schizophrenia. They didn't say she has asthma, but they treated her like she had a bad illness. It was like she'd curse us if we came near her and misbehave if we went to visit her." (G7, Son-in-law, 56)*
>
> *"The son-in-law was a little worried, too, wondering if she'd hurt him..." G5 (Mother, 57)*
>
> *"It was clear one of them came (to the house) to avoid upsetting us. Because it was clear she was nervous..." (G1, Nephew, 43)*

Category 2. Stigma Concealment

This category encompasses various coping strategies developed by families due to their fear of stigma and social exclusion. Prominent among these are efforts to portray individuals diagnosed with schizophrenia and their lives as "normal" (normalization), withdrawal from social relationships and isolation (isolation), and efforts to hide and render the diagnosis invisible (hiding/invisibility). Through these strategies, families attempt to protect both the individual diagnosed with schizophrenia and themselves from stigma.

Code 1. Normalization

The first finding, which can be considered a defense mechanism against the stigma of courtesy, is conceptualized as "normalization." In this context, participants emphasized the need to accept individuals diagnosed with schizophrenia as "normal," pointing out the incomprehensibility of the schizophrenia diagnosis, the individual's intelligence, social functioning, or the fact that others may exhibit "more frightening" behaviors. This behavior can be interpreted as both an attempt to eliminate stigma and a search for social acceptance by individuals diagnosed with schizophrenia and their family members.

> *"We continued our normal lives. Outsiders say he does not look sick at all." (G5, Mother, 57)*
>
> *"My husband is like a normal person." (G10, Spouse, 63)*
>
> *"He is smart, intelligent." (G4, Father, 72)*
>
> *"Perhaps a normal person on the outside would not know about his illness if my father hadn't told him... We continued our normal lives like everyone else, my father, my mother, and everyone around us." (G2, Daughter, 45)*
>
> *"Everyone around me can do more horrific things than schizophrenics, but when you say 'undiagnosed schizophrenia,' you get scared." (G1, Nephew, 43)*

Code 2. Isolation

"Isolation" reveals the rupture in kinship relationships and the feeling of loneliness. Participants emphasize that kinship ties have weakened due to a lack of support and express that they have withdrawn from social interactions. This separation from relatives and their social circles causes family members to withdraw into their shells. This situation demonstrates that isolation can deepen on both an emotional and social level, revealing the intergenerational impact of the stigma associated with courtesy.

> *"I started to stay away from relatives. When my mother was ill, I started to dislike all my relatives. If they had supported us, we could have had better kinship relationships. Only during holidays and celebrations." (G9, Daughter, 44)*
>
> *"For example, it feels like you're suffering from your own problems. I'm left alone. I'm the only one, all alone right now. I have a father, and I'm the only one in the world. There are relatives, but there aren't any. We don't see each other." (G6, Daughter, 39)*

> *"...we went to visit a friend of my sister's. She had a mother. I checked in with her mother. I saw it in them, too...I felt it, the exclusion. Mothers feel it too. They withdraw into their shells. In other words, both the mother and the child withdraw into their shells." (G1, Nephew, 43)*

Code 3. Hiding/Invisibility

Society often tries to keep the diagnosis of schizophrenia "hidden/invisible." Participant statements reveal families' efforts to protect the social reputations of both the individual diagnosed with schizophrenia and themselves due to stigma.

> *"I keep it a secret from everyone, and I don't tell anyone. Only one or two people know. ...Now I'm saying, 'Look, look,' so I don't want anyone to think her husband is like this, too. Those who don't know are looking and asking, 'Is this man sick?' They don't really understand. Am I shy? I'm very shy." (G8, Wife, 58)*

> *"For example, a new person moved in with us. Of course, we don't say directly, 'My child is schizophrenic.' We say, 'He's a little depressed, and his mental state has deteriorated a bit." (G5, Mother, 57)*

> *"For example, I didn't want to tell everyone, friends, or neighbors. I mean, my child is like that. I don't want to hurt my child's pride." (G3, Mother, 60)*

> *"For example, if I said, 'My father is schizophrenic,' people would immediately think of that (fear, anxiety)." (G2, Father, 45)*

Category 3. Internalized Stigma

The internalization of stigma occurs when families reproduce social prejudices against individuals diagnosed with schizophrenia in their own perceptions and experiences. The stigma of courtesy, frequently encountered in society, leads families to adapt to these attitudes and discourses to a certain extent over time. The feared person image that society attributes to the diagnosis of schizophrenia is reflected in family discourse, and this image shapes both their social relationships and their own internal attitudes. Social perceptions sometimes lead families to feel obligated to explain the diagnosis of schizophrenia, and sometimes they may be unable to express their needs under the pressure of social stigma. This situation reveals how stigma permeates families' daily lives, not only as an external but also as an internalized experience.

Code 1. Feared Person Image

Although no questions were directly asked about fear in the study, participants reflected the "feared person image" that society places on schizophrenia when sharing their experiences and observations.

> *"People were shy at first. The first person we brought in was someone with schizophrenia, and they swore at them, beat them, and said 'do not go near them.' I sensed it." (G7, Son-in-law, 56).*

> *"He doesn't seem to have any obstacles; no one is afraid of my father." (G2, Father, 45).*

> *"He doesn't harm anyone, of course, because he's under my control now." (G6, Daughter, 39).*

Code 2. Feeling the Need to Explain

Participants' narratives reveal that when a family member is diagnosed with schizophrenia, they feel the need to explain. The participants' explanation behavior is a precaution to prevent stigma and reduce potential conflicts in social relationships.

> *"For example, when I first started talking to my wife, I didn't directly talk about myself. I told her, 'My father is schizophrenic.' Know this...you hear it around, or when you hear the word 'schizophrenic,' people's first thoughts come to mind very different things." (G2, Daughter, 45)*

> *"I mostly try to explain, you know, without complaining." (G1, Nephew, 43).*

Code 3. Inability to Express Needs

Participants' narratives indicate that family members struggle with the "inability to express their needs." Participants stated that they stopped expressing their needs due to the belief that their expectations would not be met. This indicates that participants have internalized the stigma they previously experienced.

> *"I started not making requests, because I didn't think I would get a positive response" (G9, Daughter, 44).*

> *"...let's say she's very close to my sister. I wouldn't tell her relatives from my father's side or my mother's side. Because if I did, they wouldn't have anything to do with her. They wouldn't care... if they only care from holiday*

> *to holiday... I can only count a few relatives. Other than that, there aren't any. I can't tell them. I don't know why. Maybe I can't tell them because they're not interested..." (G1, Nephew, 43)*

Discussion

The findings of this study showed that families experience the stigma of courtesy across three interconnected dimensions: "implicit stigma," "stigma concealment," and "internalized stigma." "Implicit stigma" reveals that seemingly supportive and well-intentioned discourse and behaviors create feelings of loneliness, misunderstanding, exclusion, and disregard for the family. The phrases "patience/trial/pity" suggest that families' primary expectations include spiritual solace, as well as the need for support and genuine empathy. Al-Sawafi et al. (2021) conducted a study with relatives living with individuals diagnosed with schizophrenia, emphasizing that families receive limited support from society. Similarly, Peng et al. (2022) found that caregivers of disabled individuals experience disparaging treatment from others due to the stigma surrounding the diagnosis of schizophrenia. A study by Karaköse et al. (2024) also reported that individuals with mental illness and their relatives are subjected to feelings of pity. Therefore, such approaches can lead families to feel isolated and misunderstood. In fact, feeling pity for individuals with disabilities and their relatives is like an implicit expression of stigma. It demonstrates that not only individuals with mental illness experience the consequences and effects of stigma, but also that prejudice and discrimination affect family members, caregivers, and others closely related to individuals diagnosed with schizophrenia (Sousa et al. 2012). It reveals that social support is often superficial and symbolic in nature. Such experiences create an implicit stigma that is felt by families, even if not directly expressed.

"Apparent support" emphasizes the importance of concrete support, not merely "courteous" expressions of support. For example, the disappointment, loneliness, and social isolation experienced by one participant when verbal promises of support were not translated into practice demonstrates the weakening of family relationships. While those close to families express their willingness to offer kind support when needed, they often refrain from doing so under various pretexts. Participants experience the apparent support provided by society in different ways. Gök and Ölmez's (2021) study, similar to this one, noted that social relationships are disrupted after a mental disorder diagnosis, and sometimes even the family itself fails to provide sufficient support. Saunders (2013) also noted that professional caregivers and family members caring for individuals with disabilities experience a lack of support. This leads them to believe that only they can provide patience and compassion during the care process, paving the way for both physical and mental health problems.

The stigma of courtesy sometimes manifests itself through "curiosity and asking questions." One participant emphasized that people's curious questions about "how things are going" do not actually convey genuine interest, but rather are a hurtful form of questioning. Therefore, it was concluded that social perception is often implicitly stigmatizing and divisive, rather than supportive. A similar finding was obtained in a study conducted by Karnieli-Miller et al. (2013), and it was stated that to cope with these negative social experiences, family members tried to hide the information, provide social support by disclosing it to the right people, and try to establish a balance regarding how much information to give to whom and when.

While this may seem like a kind approach, experiences such as being "not being bleieved/ignored" have an isolating effect on families. Angermeyer et al. (2003) reported that friends, neighbors, and even relatives distance themselves from either the individual diagnosed with schizophrenia or the entire family over time. This distancing behavior is not limited to physical distancing; it also manifests as disbelief in the seriousness of the schizophrenia diagnosis, ignoring it, showing no interest or curiosity, tending to change the subject, or engaging in mockery and gossip. This study also found that the schizophrenia diagnosis is not taken seriously or is ignored by some in the immediate circle. Some participants stated that, as part of the stigma of courtesy, the community minimizes and dismisses the difficulties experienced, attributing them to the individual's will. By attributing the diagnosis to the individual's will, a "courteous" discourse is being developed; however, this situation forces family members to explain and emphasize that the diagnosis is beyond their control. In other words, those who reduce mental disorders to individual causes such as "character weakness" or "personal inadequacy" do not seek help because they believe no solutions are possible for these problems (Özmen and Taşkın 2004).

It has been emphasized that relatives and close circle create a "social distance" from family members living with an individual diagnosed with schizophrenia. The study found that schizophrenia, unlike other physical illnesses, is socially labeled as "dangerous" and "bad," and this negatively impacts family relationships. Gater et al. (2014) found that after the individual begins living with a schizophrenic individual, their relatives avoid visiting. Some studies (Yin et al. 2020, Goldberg 2023) have indicated that the most pronounced forms of stigma against relatives with mental illness are social exclusion and isolation. Another study reported that family caregivers experience difficulties managing their relationships with neighbors due to stigma surrounding mental illness or fear that an individual diagnosed with schizophrenia may exhibit problematic behavior outside the family (Peng et al. 2022). The findings of this study demonstrate that stigma exists not only in the community but also within family relationships. Prejudices and fears surrounding a schizophrenia diagnosis emerge as a covert form of stigma, placing both the individual diagnosed with schizophrenia and their family in a marginalized position in social interactions.

"Stigma concealment" stands out as a strategy developed by families to counter the covert stigma emanating from society, limiting their visibility in relationships. The first finding, which can be considered a defense mechanism against the stigma of courtesy, is categorized as "normalization." This category emphasizes that an individual diagnosed with schizophrenia is an ordinary individual and even possesses strengths. In other words, stigma is eliminated by emphasizing that the individual and family lead an everyday life. Stein and Wemmaus (2001) reported that families focused on the strengths, social roles, and social functioning of members diagnosed with schizophrenia, emphasizing their status as "normal people," thus attempting to "normalize." However, family members also stated that they were occasionally discriminated against, often leading to stigmatization by concealing their identity (Gonzlez-Torres et al. 2007). In fact, this situation can be considered a reflection of the belief expressed by family members living with individuals diagnosed with schizophrenia that they are not considered normal by society. This stigma is internalized, and they attempt to mask their own lives by attempting to portray themselves as similar to society's "normal ideal." However, despite differing experiences, the definition of "normal" being limited to the criteria of the social majority increases the risk of exclusion for individuals and families diagnosed with schizophrenia.

Families may deliberately isolate themselves to protect against stigma. However, a family's choice to isolate itself is the result of a specific process. The lack of support from close relatives and the emotional burden of being left alone are particularly noteworthy as precursors to isolation. Isolation, in turn, weakens kinship ties. A study by Hayes et al. (2015) found that family caregivers of individuals diagnosed with schizophrenia experienced approximately ten times more social isolation than the comparison group. Another study indicated that caregivers of individuals with disabilities may experience feelings of shame and inadequacy due to their closeness, which can lead to withdrawal from the social environment (Mak and Cheung 2008). Consequently, families isolate themselves over time unless they receive social support.

Another form of stigma concealment, "hiding/invisibility," refers to concealing the diagnosis to protect both the individual diagnosed with schizophrenia and family members from stigma. One participant stated that her husband, who is diagnosed with schizophrenia, tends to conceal his diagnosis to avoid being socially labeled as "weak" or "powerless." The "strong male image," idealized by society, functions as a patriarchal reflection that legitimizes the norm of robustness. Sometimes, instead of the diagnosis of schizophrenia, a behavior of "hiding/invisibility" is implemented by using different disease names that are deemed more acceptable by society. Similarly, the literature emphasizes that families often prefer the more general term "disease" rather than the direct term "schizophrenia" in the post-diagnosis period (Saunders 2013, Attepe Özden and Tuncay 2018, Turtank and Künüroğlu 2022). Behind the family's tendency to conceal and remain invisible lies an effort to eliminate the anxiety and uneasiness that would arise upon learning of the mental disorder. Koschorke and colleagues (2017) also found that caregivers are concerned about the behaviors and symptoms of individuals with mental illness becoming known to others and that they take responsibility for managing this information. One mother's attempt to conceal her child's schizophrenia diagnosis to avoid stigmatization, and another participant's concealment of the diagnosis due to negative social stereotypes, demonstrate the rationale behind this behavior. Consequently, family members experience anxiety and distress due to stigma and, therefore, conceal the diagnosis to avoid adverse public reactions (Al-Sawafi et al. 2021).

Finally, the category of "internalized stigma" illustrates that families perpetuate society's stigmatizing discourses within their own lives. "Feared person image", "feeling the need to explain", and "inability to express needs" serve as key indicators of internalized stigma. The "feared person image" reflects society's prejudices and fears toward schizophrenia, demonstrating that families also perceive and experience this perception. The perception that schizophrenia involves violence increases the social exclusion of families (Köroğlu and Hocaoğlu 2017). While participants emphasized that individuals diagnosed with schizophrenia are not actually afraid of them and that they do not harm their environment, this suggests that such a perception exists subconsciously. Turtank and Künüroğlu (2022) stated that parents often fear ostracism and adverse reactions when they share their child's illness with their family. This demonstrates that stigma is not merely an external social reaction; families internalize it through their own perceptions and adapt over time.

Families' "feeling the need to explain" can be considered an indicator of an adaptation mechanism to internalized stigma. For example, one participant stated that they felt compelled to disclose their father's schizophrenia diagnosis before even mentioning themselves. This demonstrates that, as Goffman (1963) noted, stigma affects not only the diagnosed individual but also their immediate circle of acquaintances. Sometimes, families use "selective disclosure" to control the diagnosis and provide information to those around them to reduce stigma, prevent negative impacts on the social environment of an individual diagnosed with schizophrenia, or prevent misunderstandings (Mak and Cheung 2008). This suggests that families feel the need to disclose information to protect themselves from the stigmatizing perspective of society proactively. Similarly, İnan et al. (2021) reported that relatives of individuals diagnosed with schizophrenia develop explanatory strategies to cope with stigma.

The code "inability to express needs" suggests that families refrain from expressing their needs due to the belief that their expectations will not be met. Problems experienced are not shared with others due to concerns about stigma or lack of understanding, and families quietly suppress their needs due to loneliness, lack of support, and frustration (Gök and Ölmez 2021). Families describe being unable to express their needs due to the anticipation of inadequate attention or support from their social circle. Furthermore, some caregivers inform close relatives about the schizophrenia diagnosis and express their need for support; however, when they feel disrespected, discriminated against, or ridiculed, they are unable to express their need (Heydarikhayat et al. 2025). In a study conducted by Gater et al. (2014), caregivers reported that despite being extended family, they feel isolated in caring for an individual diagnosed with schizophrenia and do not receive the support they expect from other family members and friends. When participants do not receive the support and attention they expect from their social circle, they choose to avoid expressing their needs over time. This suggests that families have internalized stigma.

The study has some limitations. First, the study is limited to families receiving services from Burdur CMHC in July and August 2025. Therefore, the findings reflect the situation during this period. Furthermore, the data collected in the study were based solely on the opinions of family members. Therefore, the conclusions reached are limited to the context and participants in the study. Finally, it was not possible to reach the siblings of individuals diagnosed with schizophrenia during the interviews conducted with family members.

Conclusion

Using a psychiatric social work framework, this study explored how families of individuals diagnosed with schizophrenia experience courtesy stigma. The findings reveal that families encounter exclusionary, invisible, and distancing attitudes, often disguised as courtesy. This leads to negative psychosocial impacts on families and increases isolation. Furthermore, the combination of caregiving responsibilities and the stigma experienced in social interactions creates intersectional problems for families. Stigma directly affects not only the individual diagnosed with schizophrenia but also the family members living with them and assuming caregiving responsibilities, highlighting the inadequacy of social support.

The literature indicates that direct contact is the most effective approach in reducing negative attitudes toward individuals with mental illness (Corrigan et al. 2001, Corrigan et al. 2002, Adu et al. 2024). However, this contact should not be limited to the individual; it should also include the family. Therefore, developing social contact-based awareness programs to reduce the stigma of courtesy is crucial in social work practices. Social contact can reduce prejudice and discrimination against both individuals and their families, contributing to the alleviation of the stigma that families experience. Contact is one of the most effective tools for social change in combating prejudice and discrimination (Çuhadar Gürkaynak, 2012). Social contact plays a crucial role in achieving the goals of social work and empowering individuals.

Families of individuals diagnosed with schizophrenia are subject to implicit stigma in society, which negatively impacts them. In this process, families sometimes internalize the stigma imposed through courtesy without realizing it; other times, they develop masked coping strategies to protect their relatives diagnosed with schizophrenia and themselves. It is important for social workers working in this field to implement empowerment-based psychosocial support programs for families. Furthermore, the longevity of these interventions will strengthen families' coping processes (Arslantaş and Adana 2011). At the same time, empowerment-based interventions can help identify the existing strengths and resources of families of individuals diagnosed with schizophrenia, thereby improving their coping skills and well-being.

Furthermore, involving families in the care process can both support treatment adherence and strengthen social functioning. Therefore, it is important to increase psychosocial support programs for families. These programs can raise awareness of families' experiences of stigma and contribute to their ability to fulfill their caregiving responsibilities more effectively.

In this study, the concept of "burden" is addressed in the context of the pressure social stigma exerts on families, rather than the responsibility of care itself, and is considered a form of family stigma. This approach offers a different perspective to the literature. It emphasizes that when using the concept of "burden" in social work, care should be taken to avoid labeling the caregiving responsibilities of individuals with disabilities as a "burden." By focusing on the concept of "courtesy stigma," which has been limitedly addressed in the national literature, the study highlights the processes through which families are exposed to both overt and covert stigma. Future research is recommended to examine this concept in depth across different disadvantaged groups and contexts.

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