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Endorsement of stigma about families with member suffering from schizophrenia

Nada Dragojević[1], Milica Gligorović[1] & Ivona Milačić-Vidojević[1]

[1] Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia

Summary

This study is exploring the structure of endorsement of stigma about families with member suffering from schizophrenia and the relations of stigmatizing stereotypes to demographic variables, previous contacts and self-assessed knowledge about mental illnesses.

Statistically significant differences in degree and structure of stigmatization of various family roles are found, particularly in between parents and siblings. More blame for onset or offset of illness is attributed to parents, in agreement with results of other studies. The respondents also think that parents in comparison to siblings are less competent and more easily contaminated, and should bi more ashamed and avoided. Comparison of stigmatization of family roles of mother and father shows that fathers are thought of as being less competent and mothers as being more exposed to contamination, the result which could be reflecting the cultural impact.

Further investigations are needed to define delicate inter-relations between cognitive aspects, emotions which lie in the core of stigmatizing stereotypes and the behaviors which could follow such stereotyped opinions and feelings.

1. Introduction

Primary public stigma refers to the impact of prevalent negative attitudes and behaviors that members of the public have and direct toward persons with disabilities and mental illnesses, while courtesy stigma refers to the negative effect due to association with a person who is marked by a stigma (12). Courtesy stigma or stigma by association (20) could have harmfull effects on members of families with a mentally ill member and consequently may disrupt the structural and dynamic framework of these families.

Stigma comprises stereotypes about people with mental illness, as if they were deviant, troublesome, emotionally unstable, incapable, unpredictable etc. Stereotypes can lead to certain expectations which members of marginalized groups often incorporate and, as a consequence, behave in an expected manner. Stigma channels attention toward deficits and vulnerabilities of people with disability, thereby diverting attention away from the process of stigmatization itself, from the stigmatizers and from the social context that supports stigma. (17). According to theories of group interactions people who are different are seen as disrupting the harmony of groups or society. So fear of being ostracized from group leads to meticulous conformity to group norms (16) and accordingly to internalization of stereotypes and negative attitudes toward members of marginalized groups. In addition to this explanation stemming from models of social psychology, and the sociologically oriented explanation of prejudices toward marginalized groups (19) in explaining stigma about marginalized groups the individual-psychological paradigm (14) put an accent on deeply rooted psychological factors (fear of unknown, defense mechanisms, the possibility of externalizing aggression etc.) .

According to study results (6, 31), members of the public take persons with psychiatric disorders more responsible for onset of their illness than persons with cancer or heart disease. Also, study participants prone to blame people with psychiatric and substance use disorders are more likely to avoid those people, to withhold pity, react with anger and support coercive mental health services (6, 7, 8, 9).

People who are mentally ill may internalize this public stigma, starting to feel as if stereotypic opinions, that lay in the core of stigma, were justified. A survey of mental health patients in Hong Kong reveals 75% of them who report experiencing stigma and

discrimination and hiding about the illness as the most frequently used coping strategy (2).

Family stigma i.e. stereotypes about relatives of a person with mental illness, includes blaming the relatives for onset of illness and its relapse, expecting that they should be ashamed, that the illness could somehow rub off onto them, that they are incompetent in performing their family roles and that they should be avoided and pitied. These themes are based on the list of items reflecting family stigma expressed by focus group of relatives of persons with mental illness (3) and they have been formulated upon consulting an exstensive literature. Much of the burden carried by families is related to stigma and social isolation. Without social support, families feel more exposed to the impact of illness and stigma. Actually, 10-50% of relatives expressed that the relationships with extended families or with friends or neighbors became more distant after the onset of mental illness (23, 24, 26, 27, 29, 30) or autism of a family member (10). Surveys exploring whether family members perceive themselves as being stigmatized show that app. 25% of them worry if other people might blame them for the relative's mental illness (26) while 25-50% appear to believe that the condition of their relative should be a source of shame to the family (1, 24, 25, 26, 28, 30).According to study exploring self-stigma of family members (18) family members who live together with their mentally ill relative express more feelings of shame compared to those members who did not live together. A study with siblings of a mentally ill as participants points to siblings' perception of brother/sister's relapse as being somehow their fault (13).

Alongside surveys dealing with problems of primary stigma and the related self-stigmatization of mentally ill persons and their family members another line of studies explores family or courtesy stigma i.e. endorsement of stigma about relatives of persons with mental illness. According to large study results general public participants' stigmatizing/non-stigmatizing answers ratio indicates that family stigma related to mental illness is not highly endorsed (4). Regarding the interaction between family roles and different aspects of stigma, the study shows parents of children with psychiatric disorder more likely to be blamed for onset and offset of disorder, while children of parents with psychiatric disorders are rather perceived as contaminated by illness of their parents.

Also mothers are stigmatized more than fathers (3, 18). Public blame of family member for the onset of a relative's mental illness leads to withholding pity and assistance to family members (5).

2. Study goals

We tried to explore the way in which general public perceive different family members' roles in the structure of families with person with mental illness. Study goals were to explore general population tendency toward stigmatization of family members of a person with schizophrenia, to establish correlations between constructs of the Family Stigma Questionnaire (FSQ), to differ proneness toward stigmatization of various family roles, and to establish relations of constructs of the scale to demographic variables, self-assessment of one's own knowledge about mental illness, and to the level of previous contact with persons with mental disorders.

3. Method

3.1. Sample and procedure

The first semester students of Faculty of Special Education and Rehabilitation, during the course of Introduction to General Psychology, after being taught issues of psychological assessment, of construction and application of questionnaire and of the factors of successful communication, each were given instruction to apply FSQ and LOF to 4 participants from general population. They have had to obey strict criteria for selecting the participants, to inform them about the aim of the study and to get their consent. After rigorous checking and elimination of incomplete questionnaires, we got the sample comprising of 808 respondents, members of general population. The sample had the following characteristics (*see table 1*).

Table 1. The sample structure

	Gender		Age			Education		Profession			
	m	f	18-25	26-44	>45	Elem. and secondary	High	Unemployed	Worker	Clerk	Prof/manager
N	409	399	280	245	283	376	432	101	333	243	131
%	50.6	49.4	34.7	30.3	35	46.5	53.5	12.5	41.2	30.1	16.2

3.2. Instruments

Two questionairres were applied.

The **Family Stigma Questionnaire** - FSQ (4) was originally designed to measure stigma aimed at family members of a person with mental illness.

The vignette for the tendency toward father stigmatization reads:

Predrag is Nikola's father. Nikola is 30 years old man with schizophrenia. Nikola lives with his family and works as clerk at a nearby store. Nikola has been hospitalized several times because of his illness. The illness has disrupted his life significantly.

Text in the other three vignettes is the same, only instead of the father, the mother, brother or sister are mentioned.

The FSQ is a seven point Likert scale, where response 1 indicates that the respondent strongly disagrees with the statement, 7 that he strongly agrees, and 4 is a neutral response (neither agrees nor disagrees). A higher score in each item indicates a higher level of parent or sibling stigmatization.

Respondents were asked if for the onset or for the relapse of illness they blame family members, if they should be ashamed, pitied or avoided or if they could be contaminated by illness. For each of the 7 items a score indicating the intensity of the relevant construct was calculated.

The **Level of Familiarity Questionnaire** – LFQ (15) measures the level of contact with the person with the mental illness. It contains 11 questions which indicate various degrees of contact, and subjects were required to state if they had encounters

described in situations stated in the questionnaire. Each item is ranked on a scale of 1-11, where 11 means the highest, and 1 the lowest level of contact. For the needs of our study, we divided scores into two categories. Category 1 are contacts that are not personal (e.g. I watched a TV program describing a person with a mental illness), while the Category 2 indicates personal contacts with a person with a mental illness. Ranks from 1 (I never saw a person that I knew was mentally ill), to 5 (I have often observed persons with a mental illness), were in Category 1, and ranks from 6 (I have worked with a person with a mental illness), to 11 (I have a mental illness), were in Category 2.

Along the general socio-demographic data about respondents also were gathered the data about self-assessment of participants relevant to the level of knowledge about mental illnesses.

Statistical data processing, other than descriptive statistics, included the Pearson correlation coefficient, ANOVA analyses, t-test, and Scheffe post hoc test.

4. Results

4.1. Constructs related to intensity of stigmatization

Descriptive statistics of the endorsement of courtesy stigma produced overall score mean value (M= 3.285), and separate score mean values for family members (M-father = 3.449, M-mother = 3.448, M-sister = 3.119, M-brother= 3.125) thereby indicating an under average predisposition to stigmatize families with a member suffering of schizophrenia.

Nevertheless, results for seven constructs of FSQ show that respondents are more prone to pity all family members (M=4.807) and think that close contact with the stigmatized person could cause reflection of symptoms on family members (M=5.365). The mean values for these variables exceed the neutral point.

Study exploring the presence of stigma about relatives of persons with autism with FSQ applied to sample of general population reveals the same tendency (22).

4.2. Differences in stigmatization of various family roles

Statistically significant differences are obtained in the degree and the structure of stigmatization of various family roles, especially those between parents and siblings. The results are shown in table 2.

Table 2. Differential stigmatization of family roles (t-test)

Relation	Mother-father	Sister-father	Brother-father	Sister-mother	Brother-mother	Brother-sister
Var1	0.368	0.000	0.000	0.000	0.000	0.416
Var2	0.009	0.634	0.005	0.003	0.000	0.001
Var3	0.928	0.000	0.000	0.000	0.000	0.015
Var4	0.322	0.002	0.025	0.008	0.106	0.145
Var5	0.002	0.000	0.000	0.000	0.000	0.174
Var6	0.117	0.000	0.000	0.000	0.000	0.836
Var7	0.338	0.361	0.083	0.047	0.004	0.230

Variables: 1. responsibility for onset, 2. contamination, 3. responsibility for relapse, 4. shame, 5. incompetence, 6. tendency of avoidance, 7. pity;

For the **onset of illness** the participants of our study blame parents significantly more in comparison to siblings. No significant differences have been found between blaming a mother or a father, or between blaming a brother or a sister.

As for the construct of **contamination**, among participants prevail opinion that illness could reflect more on mother than on father, more on parents than on siblings, on father more than on brother, on mother more than on sister, on mother more than on brother and on brother more than on sister. The only insignificant difference of this construct is the one between father and sister, and for this we have not found plausible explanation.

The **responsibility for relapse** has been significantly more attributed to parents than to siblings and more to brother than to sister. There is no significant difference in blaming mother or father for deterioration of the child's condition.

As for opinion that family members should feel **ashamed** of their relative's condition, the mean values for ranks are significantly greater for parents than for

siblings, except when mean values of scores for mother or brother are compared (p=0.078). The difference between scores for mother and father is insignificant.

Another way of stigmatization underlies the opinions about **competence** of family members in performing their family roles. Participants significantly more often state the incompetence of parents (that he/she is not a good father/mother to their child) then of siblings of a person with schizophrenia. Significant difference between scores for mother and father indicates that fathers are more frequently stigmatized for being incompetent in their family role.

Participants also show distinctive prevalence of **tendency toward avoiding** parents over avoiding siblings of the person with mental illness. Differences in this tendency are insignificant for mean values of scores for mother and father, and for brother and sister.

As for the tendency to feel **pity** for family members, participants are more likely to feel pity for mother than for sibling.

4.3. Inter-correlations of FSQ variables

For the family role of father the results show that tendency to blame father for the onset of illness is in positive correlation with blaming him for the relapse. These two tendencies are in positive correlation with opinions that he is incompetent, that he should be ashamed and avoided, and deprived of pity. Opinion that father could be contaminated by illness is positively correlated with opinions that he should be taken responsible for the relapses, that he should be pitied, but neither ashamed nor avoided. Opinion that he is incompetent in performing his role is positively correlated with blaming him for onset or offset of illness and with opinions that he should be ashamed or avoided. Tendency to avoid father is in positive correlation with blaming him for onset or offset of illness, with opinions that he is incompetent and that he should be ashamed. Feeling pity for father is in positive correlation with opinion that father could be contaminated by illness but in negative one with blaming him for the onset of illness.

Inter-correlations of FSQ variables when evaluating sister's role are the same as for father and are presented in table 3.

Table 3. Inter-correlations of FSQ variables (for sister's role)

		Var.1	Var.2	Var.3	Var.4	Var.5	Var.6	Var.7
Var.1	Pearson Correlation		-.024	.342**	.251**	.379**	.269**	-.086*
	Sig. (2-tailed)		.501	.000	.000	.000	.000	.015
Var.2	Pearson Correlation	-.024		.086*	-.141**	.001	-.075*	.180**
	Sig. (2-tailed)	.501		.015	.000	.984	.032	.000
Var.3	Pearson Correlation	.342**	.086*		.120**	.286**	.223**	-.009
	Sig. (2-tailed)	.000	.015		.001	.000	.000	.806
Var.4	Pearson Correlation	.251**	-.141**	.120**		.313**	.348**	-.031
	Sig. (2-tailed)	.000	.000	.001		.000	.000	.373
Var.5	Pearson Correlation	.379**	.001	.286**	.313**		.431**	-.007
	Sig. (2-tailed)	.000	.984	.000	.000		.000	.840
Var.6	Pearson Correlation	.269**	-.075*	.223**	.348**	.431**		.000
	Sig. (2-tailed)	.000	.032	.000	.000	.000		.995
Var.7	Pearson Correlation	-.086*	.180**	-.009	-.031	-.007	.000	
	Sig. (2-tailed)	.015	.000	.806	.373	.840	.995	

Variables: 1. responsibility for onset, 2. contamination, 3. responsibility for relapse, 4. shame, 5. incompetence, 6. tendency of avoidance, 7. pity

Assessments of mother's role show almost the same inter-correlations. Difference is in positive correlation between opinion that mother could be contaminated and blaming the mother for onset (0.024) or the offset of illness (0.006), but the correlation of this variable with avoiding tendency is missing. One more difference is negative correlation between opinion that mother should be ashamed and the readiness to feel pity for her (0.015).

As for evaluation of the role of brother, the differences have been found in the absence of correlation between blaming for onset of illness and feelings of pity, and between opinion about contamination and tendency of avoidance

4.4. Interaction of FSQ constructs and socio-demographic variables

4.3.1. Gender and FSQ

Male participants showed more stigmatizing attitudes than female participants. Male participants significantly more frequently held opinion that mother ($F=5.995$, $p=0.015$) and brother ($F=5.514$, $p=0.019$) should be ashamed and that sister ($F=8.348$, $p=0.004$) and brother ($F=8.691$, $p=0.003$) were responsible for deterioration of sibling's

condition. But as for opinions about father of person with mental illness male participants have not shown any more stigmatizing attitude than female participants.

4.4.2. Age and FSQ

Significant interaction between age and FSQ has been found only for the construct of feeling pity for brother (F=4.674, df =2, p=0.010) and near to significant correlation for feeling pity for mother (p=0.067) and for sister (p=0.072). The most pronounced tendency to feel pity was found in answers of participants of age 25-45 and the least pronounced in the answers of the youngest participants.

4.4.3. Level of education and FSQ

Level of education was found to be related to construct of blaming mother of person with mental illness for the relapse. Participants of lower education are more likely to hold opinion that mothers are responsible for the relapse in comparison to participants of higher education (F=4.032, df=1, p=0.045).

4.4.4. Profession and FSQ

The only significant difference between worker's and manager's attitudes was found regarding opinion that sister could be contaminated by brother/sister's illness (F=3.239, df=3, p=0.022). This opinion is more pronounced in managers (Scheffe post hoc test = 0.529, p=0.025).

4.5. Self assessment knowledge about mental illness and FSQ

Participants who claim to have more knowledge about mental illnesses are the least inclined to feel pity for any family member (p=0.001-0.009).

4.6. Previous contact with person with mental illness and FSQ

Participants who had no direct contact with persons with mental illness, in comparison to those who had direct contacts, were more predisposed to blame mother (F=5.046, p=0.025), father (F=4.201, p=0.041) and brother (F=4.002, p=0.046) for the onset of illness and to think that mothers are incompetent in performing their family role (F=5.248, p=0.022).

4.7. Stigmatization of family members of male or female person with mental illness

No significant differences have been found.

5. Discussion

Tendency in general population to stigmatize family members of a person with schizophrenia is below neutral point (4=neither agree nor disagree). This is in agreement with finding low endorsement of family stigma related to mental illness (4). But on the other hand these results contradict data on parents of children with ASD who are reporting perception of being stigmatized (10, 21). These discrepancies perhaps are due to members of the public who prefer to deny their stigmatizing attitudes. Showing above average mean values for variables of pity and contamination the result of present study is in favor of that explanation. The variables are not overtly stigmatizing and for that they are different from blaming variables. This is even more so since the constructs of contamination and pity bear certain ambiguity. Contamination can be understood both as an effect of schizophrenia symptoms on family dynamics, and as a possibility that certain symptoms "rub off onto" or "graze" family members. Feeling of pity can be interpreted as feeling pity for families with marginalized member with or without deeper empathy for family members. Indicator of ambiguity of the emotion of pity comes from findings of a study (11), according to which the emotion of pity does not lead to pro-social forms of behavior. Mean values of contamination and pity variables obtained in a study examining stigmatization of families with member with autism (22) are also high. The respondents of the study are ready to pity the relatives of autistic persons and to think the illness could rub off onto them but they are nevertheless prone to blame parents for the relapse of the disabling condition.

Generally the structure of FSQ variables inter-correlation presents an indication of a tendency in general public to connect blaming family members for onset or offset of illness and for their incompetence on the one hand, and having an opinion that they should be ashamed, avoided, and not pitied on the other. According to this result the most stigmatizing stereotypes (of blaming) seem to be connected with negative feelings and negative behavioral tendencies. That the blaming of family for the onset of illness is related to withholding pity and assistance to family members (5) could mean involvement of the defense mechanism of rationalization. Opinion that illness could rub off onto family members leads on the other hand to feeling of pity, but does not lead to

avoidance or to opinion that they should be ashamed. Thus it seems as if these two constructs, of blaming the family members and of having an opinion that they could be contaminated, were two distinct constructs. The first one, that of blaming, is overtly stigmatizing. As for the second one, the contamination, it seems as if some defense mechanisms were taking place, because even if it is not connected with avoidance tendency it is related to blaming for relapse and to opinion about incompetence of family members. In addition, highly positive correlation between constructs of contamination and feeling of pity indicates the possibility of answering in socially desirable way.

The results of present study show different attitudes in stigmatization for different family roles. Participants in general express less stigmatizing attitudes toward brother/sister compared to mother/father. More blame for onset and offset of illness is attributed to parents, in agreement with other studies (4, 5, 22). The respondents also think that parents in comparison to siblings are less competent and more easily contaminated, and should bi more ashamed and avoided. Comparison of stigmatization of family roles of mother and father shows that fathers are thought of as being less competent and mothers as being more exposed to contamination, the result which could be reflecting the cultural impact. This is in accordance with finding that respondents are more prone to pity mother than siblings. Similarly, tendency to blame brother for the relapse of sibling's condition is more intensive than tendency to blame sister, as well as the opinion that he could be more easily contaminated.

As for gender differences, male participants expressed more stigmatizing attitudes toward mother's and sibling's role, but not so toward father's role. They were more prone, in comparison to female participants, to blame siblings for relapse of the condition and think as if mother and brother should be ashamed. A different structure of responses was obtained in study examining stigmatization of families with an autistic member (22). The results of this study indicate that male participants were more prone to avoid all family members of autistic person and think that parents should be ashamed, while female participants were more prone to think that mothers could be contaminated. The result about women having less stigmatizing attitudes than men was confirmed in another study (5). A possible explanation could be that women are more protective due to socially imprinted or perhaps also genetically coded role of caregivers.

A difference between more and less educated participants was found in construct of blaming mothers for the relapse, the result which was more pronounced for less educated. The result is in agreement with results of another study (5) and points to the necessity of educating the public.

Similar result was obtained for the interaction of variable of previous contact with persons with mental illness and the tendency to stigmatize. Namely, participants who had no direct previous contacts with persons with mental illness were more predisposed to blame parents and brother for the onset of illness and to hold opinion that mothers are incompetent in performing their family role. The result obtained point once again to the necessity of full integration of persons with mental illness.

To the importance of having knowledge about mental illnesses points the finding that participants who claim to have more knowledge don't express the tendency to feel pity for any family member. The finding also points to the ambiguity of feeling of pity.

Further investigations are needed to define delicate inter-relations between cognitive aspects, emotions which lie in the core of stigmatizing stereotypes and the behaviors which could follow such stereotyped opinions and feelings. Different anti-stigma strategies have to be invented to defeat various stigmatizing stereotypes embodied in attitudes toward family members of persons suffering of schizophrenia.

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