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Minority Stress Among Parents of Individuals with Severe Mental Illness: A Qualitative Study

Maja Marija Muškić

majamarija.muskic@gmail.com

Insula County Hospital

Anita Lauri Korajlija

Faculty of Humanities and Social Sciences

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Abstract

Background

Parents of individuals with severe mental illness often face persistent stigma and chronic stressors that may be conceptualized within the minority stress framework. Despite growing attention to caregiver burden, the minority stress experiences of parents remain poorly understood.

Aim

To examine the presence and manifestations of minority stress among parents of adult individuals with severe mental illness and to explore whether its expression varies by their child's diagnosis.

Method

Semi-structured interviews were conducted with 13 mothers of adults with severe mental illness, recruited from a large psychiatric institution in Croatia. *Participants' children* were diagnosed with schizophrenia spectrum disorders, depressive and anxiety disorders, substance use disorders, bipolar disorder, and personality disorders. Data were analyzed using Braun and Clarke's reflexive thematic analysis within a constructivist interpretivist framework.

Results

Four main themes were identified: identifying with a minority identity, distal and proximal stressors, coping and social support, and psychological and somatic health outcomes. Experiences consistent with minority stress were particularly salient in accounts provided by mothers of individuals with schizophrenia spectrum disorders and, to a lesser extent, substance use disorders. Such experiences were less prominently reflected in accounts relating to other diagnostic groups.

Conclusion

The findings indicate that parents of adults with severe mental illness experience minority stress processes, with particularly pronounced expressions among parents of individuals with schizophrenia and, to a lesser extent, among those caring for individuals with substance use disorders, while such processes were not clearly identified in other diagnostic groups. These findings highlight the importance of recognizing diagnosis-specific parental burden and underscore the need for tailored, family-focused support.

Introduction

Parents of individuals with severe mental illness are often exposed to complex and long-term challenges that extend beyond the direct demands of caregiving. In addition to managing symptoms, treatment adherence, and crisis situations, parents frequently encounter broader social responses, including stigma, social exclusion, and limited institutional support (Dey et al., 2012). These experiences can have a substantial impact on their psychological well-being and quality of life.

One theoretical framework that may offer a deeper understanding of these experiences is the minority stress model (Meyer, 2003). Minority stress refers to chronic stress arising from exposure to stigma, prejudice, and discrimination, which is socially produced and structurally embedded. Within this framework, stress processes are typically conceptualized as both distal (external stressors such as discrimination) and proximal (internal processes such as anticipated stigma, concealment, and internalized negative beliefs) and are associated with adverse mental health outcomes (Hatzenbuehler, 2009; Meyer, 2003). Although originally developed in the context of sexual minority populations, the model has been increasingly applied to other stigmatized groups (Frost, 2020; Botha & Frost, 2020).

In the context of severe mental illness, stigma often extends beyond the individual to their family members. Parents may be perceived as responsible for their child's condition, leading to social withdrawal, concealment, and experiences of shame and isolation (van der Sanden et al., 2013; Darlami et al., 2015). At the same time, parents frequently assume long-term caregiving roles that involve sustained emotional, practical, and financial demands (Dey et al., 2012). These intersecting experiences suggest that parents may be exposed to stress processes that resemble those described within the minority stress framework.

Previous research has documented elevated levels of stress, reduced quality of life, and substantial emotional burden among these parents (Guðmundsson & Tomasson, 2002). However, these experiences have typically been examined in fragmented ways, focusing on individual aspects such as caregiver burden, coping or social support. Less attention has been paid to how these experiences may be interconnected within a broader, socially embedded stress process. It remains unclear whether and how parents come to experience themselves as occupying a marginalized or "minority-like" social position as a result of their caregiving role.

Although caregiver burden has been shown to vary across psychiatric conditions, limited research has explored whether stigma-related stress processes differ depending on the child's diagnosis. Given that conditions such as schizophrenia and substance use disorders are associated with particularly high levels of public stigma, it is plausible that parents' experiences may differ in both intensity and form (Barry et al., 2014).

Addressing these gaps requires an approach that can capture the complexity, context, and subjective meaning of parents' experiences. Because minority stress has not previously been examined in this population, qualitative inquiry is particularly appropriate for exploring how parents interpret and make meaning of stigma-related experiences and for identifying the specific stress processes that may characterize their experiences. Existing minority stress research has largely focused on other

stigmatized minority groups and has predominantly relied on predefined conceptualizations of minority stress. An exploratory qualitative approach therefore enables an in-depth examination of whether, and in what ways, minority stress processes are reflected in the experiences of parents of individuals with severe mental illness.

Accordingly, the present qualitative study aimed to examine the presence and expression of minority stress among parents of adult individuals with severe mental illness and to explore whether its manifestation varies according to the child's diagnosis. By applying the minority stress framework to a caregiving context, this study seeks to extend its theoretical scope and contribute to a more nuanced understanding of diagnosis-specific parental burden. Accordingly, the present study was guided by the following research questions: (1) Do parents of adults with severe mental illness experience stress processes consistent with the minority stress framework, and if so, how are these processes expressed in their everyday lives? (2) Do the manifestations of minority stress differ depending on the psychiatric diagnosis of the affected child?

Method

This study employed a qualitative research design to explore the experiences of minority stress among parents of adults with severe mental illness. The study was guided by a constructivist–interpretivist paradigm and employed reflexive thematic analysis.

Data were collected through semi-structured individual interviews using a specifically developed semi-structured interview guide. The interview protocol consisted of two sections. The first section included demographic questions (e.g., age, marital status, relationship to the patient, and the patient's psychiatric diagnosis). The second section comprised open-ended questions designed to facilitate rich, in-depth accounts of parents' caregiving experiences, exposure to stigma-related stressors, and their perceived psychological impact.

Researcher characteristics and reflexivity

The interviews were conducted by the [details omitted for double-anonymized peer review]. Reflexivity was supported through the use of post-interview field notes and ongoing reflection on how the researcher's professional background might influence data collection and interpretation. The analysis was discussed regularly among the research team to enhance reflexivity and analytic rigor.

Setting

The study was conducted at a psychiatric hospital providing both inpatient and outpatient services for individuals with severe mental illness within the public healthcare system. The setting was selected because parents regularly visit the facility to maintain contact with their hospitalized family members, which facilitated access to eligible participants. Interviews were conducted in a private room within the

hospital to ensure confidentiality and a comfortable environment for participants to share their experiences.

Research population

The study sample consisted of 13 mothers of adults diagnosed with mental illness, reflecting both the greater involvement of mothers in caregiving roles and their more frequent presence at the institution during the recruitment period. Participants were recruited using purposive sampling, with attending psychiatrists assisting in the identification of eligible parents who were involved in the care of their adult child. They were selected purposively to ensure variation in the child's diagnosis. All invited participants agreed to take part in the study, and no refusals were recorded. Data collection and analysis were conducted concurrently and continued until the data were considered sufficiently rich and no substantially new patterns of meaning were identified in subsequent interviews. Sample included mothers of individuals diagnosed with schizophrenia spectrum disorders, depressive and anxiety disorders, substance use disorders, bipolar disorder, and personality disorders. Participants ranged in age from 46 to 72 years. Three were divorced and seven had sought mental health support. Seven participants reported having sought mental health support for themselves.

Procedure

Ethical approval

for this study was obtained from the Ethics Committee of the Department of Psychology, Faculty of Humanities and Social Sciences, University of Zagreb (Approval No. EPOP_2023_24_46) and the Ethics Committee of Insula County Special Hospital for Psychiatry and Rehabilitation (Class: 520-06/24 – 01/01; Registration No. 2169-30-02-24-02). All procedures performed in this study were conducted in accordance with the ethical standards of the responsible institutional research committees, the Code of Ethics of the Croatian Psychological Chamber, and the principles of the Declaration of Helsinki and its later amendments. Written informed consent was obtained from all participants prior to their participation in the study.

Individual semi-structured interviews were conducted face-to-face in a private room at the psychiatric institution. All interviews were conducted by the first author, and each participant was interviewed once. The interview guide was developed based on existing literature on stigma, caregiving, and minority stress, and was refined to ensure clarity and relevance. Topics included stigma, social reactions, coping, support, and psychological well-being. Interviews were audio-recorded with participants' permission and lasted on average 56 minutes.

Following each interview, the researcher prepared field notes to document contextual observations and initial analytic reflections. Audio recordings were transcribed verbatim for the purposes of analysis, after which the recordings were permanently deleted. Any potentially identifying information was replaced

with codes to ensure confidentiality. All data were treated as confidential, and participant identities were known only to the principal researcher.

Analysis

Data were analyzed using Braun and Clarke's reflexive thematic analysis (Braun & Clarke, 2006). This approach was selected as it allows for an in-depth exploration of participants' subjective experiences while acknowledging the active and interpretative role of the researcher in the analytic process. The analysis followed a reflexive, inductive, and iterative process aimed at identifying patterns of meaning across the dataset, while being theoretically informed by the minority stress framework. The unit of analysis was participants' accounts of their caregiving experiences and stigma-related stressors.

Analysis began after transcription and involved repeated reading of the transcripts and field notes to achieve familiarity with the data. Initial codes were generated inductively, staying close to participants' accounts. Codes were organized into broader categories and subsequently developed into themes and subthemes, which were reviewed, refined, and defined through an iterative process. Attention was paid to both shared patterns and variations in participants' experiences.

The primary coding was conducted by the first author, who engaged in reflexive memo writing to support analytic depth. Regular consultations with the research mentor were used to discuss developing interpretations. However, in line with reflexive thematic analysis, themes were not treated as emerging through consensus, but as the result of the researcher's interpretative engagement with the data. Data were managed and analyzed manually without the use of qualitative software. Trustworthiness was enhanced through reflexive memo writing, post-interview field notes, and regular discussions with the research mentor, which supported critic al reflection on emerging interpretations throughout the analytic process.

Results

The analysis generated four interrelated themes capturing parents' experiences within the minority stress framework: (1) identifying with a minority identity, (2) distal and proximal stressors, (3) coping and social support, and (4) psychological and somatic health outcomes. Minority stress experiences were most pronounced among parents of individuals with schizophrenia and were also identifiable among parents of individuals with substance use disorders, whereas such experiences were less evident or not clearly articulated in other diagnostic groups.

Identifying with a minority identity

Parents reported a shift in how they perceived themselves in relation to others, often emphasizing a sense of difference from other families. This was reflected in comparisons with other parents, changes in everyday conversations, and a growing perception of social distance and altered belonging.

These experiences were most explicitly articulated by parents of individuals with schizophrenia, who described a strong awareness of being different and perceived differently by others. Among parents of individuals with substance use disorders, similar experiences were present but less directly expressed and were often intertwined with feelings of shame and self-blame. In contrast, parents of individuals with other psychiatric diagnoses did not clearly describe this type of shift, even when reporting caregiving burden or emotional strain.

"After everything started, I felt like we were no longer like other families. Other parents talk about school, holidays, and everyday plans, while we talk about which therapies he must attend, who are good psychiatrists, and how we're going to manage financially. I don't feel like I belong among them anymore. It's like we live in a completely different reality." (schizophrenia group)

Distal and proximal stressors

Parents described a range of distal and proximal stress experiences. Distal stressors were primarily related to interactions with broader social systems, including healthcare services, educational institutions, and, in some cases, law enforcement. These experiences included dismissive attitudes, lack of support or information, and stigmatizing responses from professionals and the wider community. Accounts highlighted situations in which parents' concerns were minimized, their child was labelled in stigmatizing ways, or their family circumstances were insufficiently understood.

"When I went to ask about my child's legal rights, such as access to financial support, the psychiatrist just looked at me and said, 'And what do you want?' That stayed with me. You're already struggling as a parent, and then even professionals treat you as if you're asking for too much, instead of, simply, trying to understand what your child is entitled to." (schizophrenia group)

"I don't doubt that people talk behind my back. Once someone said I was 'dragging my retard around the city' (derogatory term used by others). That's something you don't forget." (substance use group)

Alongside these experiences, parents described internal responses, including shame, guilt, self-blame, and heightened alertness in social situations. Many reported anticipating negative reactions, carefully managing what they disclosed about their child's condition, and modifying their behavior to avoid potential judgment.

"You become constantly alert. Even when things are calm, you're waiting for something to happen. And at the same time, you think about how others will react, what they'll say, whether you should even explain anything at all." (schizophrenia group)

"Over time, you learn to be careful about what you say and to whom. Where to go and where you are not welcomed. You don't share everything anymore, because you never know how people will react." (substance use group)

Coping and social support

Parents described a range of strategies used to manage ongoing stress, including both adaptive and less adaptive patterns. Many described coping through acceptance. Some reported efforts to maintain daily routines and engage in everyday activities as a way of managing emotional strain. Some identified religion and prayer as important sources of comfort.

“When I feel overwhelmed, I try to keep myself going by doing something around the house, going out for coffee, talking to someone. I try not to let it take over everything.” (schizophrenia group)

“Prayer and faith gave me some kind of peace, when everything else felt uncertain, that was something I could hold on to.” (substance use group)

Others, however, described less effective coping patterns, including substance use, emotional suppression and avoidance. For some, distress was managed internally and accumulated over time.

“We are not people who argue or express things openly. We keep it inside, and it just builds up until it becomes too much.” (schizophrenia group)

“My husband started drinking heavily… instead of dealing with it, he escaped into alcohol.” (substance use group)

Social support emerged as a complex and variable aspect of parents’ experiences. Contact with other parents of children with mental illness was described as particularly meaningful, as these relationships provided understanding, validation, and a sense of shared experience.

“With other parents in similar situations, you don’t have to explain yourself. They already understand. That kind of support is something you can’t really get anywhere else.” (schizophrenia group)

In contrast, support from the broader social environment was often described as limited. Some parents reported a lack of understanding within their families and wider social networks, while others described withdrawal from social interactions due to perceived judgment.

“I never had support from my own family. I was told to just endure and deal with it on my own.” (substance use group)

“We don’t really talk about it with others, people are judgmental, and you feel like there’s no one you can really turn to.” (schizophrenia group)

Psychological and somatic health outcomes

Parents described a range of psychological and physical difficulties associated with long-term caregiving. These experiences were most prominently reported by parents of individuals with schizophrenia and substance use disorders. At the psychological level, participants reported persistent

emotional strain, including anxiety, sadness, and chronic worry. Many described a constant sense of responsibility and mental preoccupation, often accompanied by emotional exhaustion and reduced capacity to function in daily life. Feelings of helplessness and loss of control were also frequently reported.

"For me it was hard to even walk down the stairs anymore. I had to sit and move step by step. I was shaking. I stopped cooking. I was just waiting to die. As a mother, I always felt I had to fix things, but here I realized I had no control and that was devastating." (schizophrenia group)

"I was mentally exhausted to the point that I lost focus even at work, which I had always loved. At one point, I just broke and had to admit to myself that I couldn't handle it on my own anymore." (substance use group)

Psychological strain was often accompanied by physical symptoms, including sleep disturbances, chronic fatigue, and pain conditions, which participants associated with prolonged stress.

"First came the insomnia, and then the pain got worse, my back, my knees, everything. It felt like all the stress had moved into my body. I was constantly tired, but I felt like I couldn't allow myself to stop. Only later did I realize how much it had affected my body." (schizophrenia group)

For some parents, these difficulties reflected a broader decline in both psychological and physical functioning over time.

"I felt like something inside me was constantly breaking down, it wasn't just worry anymore, it was everything." (substance use group)

Discussion

The present findings suggest that parents of individuals with severe mental illness experience stress processes consistent with the minority stress framework. These processes were most clearly expressed among parents of individuals with schizophrenia and substance use disorders and were associated with adverse psychological and physical health outcomes.

While minority stress model (Meyer, 2003) has been primarily applied to stigmatized social groups, emphasizing the role of distal (e.g., discrimination) and proximal stressors (e.g., internalized stigma, vigilance) in shaping mental health outcomes (Hatzenbuehler, 2009; Meyer, 2003), its application to caregiving populations, remains largely unexamined in the existing literature. The present findings extend this framework by indicating that similar stress processes emerge in the context of caregiving, particularly when the child's condition is associated with strong societal stigma. In addition to distal and proximal stress processes, parents accounts reflected a broader shift in self-perception, characterized by a sense of difference from others, as well as cumulative psychological and somatic consequences associated with prolonged exposure to stigma-related stress.

The present findings further demonstrate that this experience varies across diagnostic groups. The more explicit articulation of social difference among parents of individuals with schizophrenia may be understood in relation to the particularly stigmatized nature of this diagnosis (Angermeyer & Dietrich, 2006), as well as its chronic and often visible course. In contrast, the more implicit and emotionally mediated expressions among parents of individuals with substance use disorders, characterized by shame and self-blame, are consistent with literature highlighting moralization and blame associated with addiction (Room, 2005; Schomerus et al., 2011). Among parents of individuals with other psychiatric diagnoses, experiences of social difference were less clearly articulated and were more often expressed through general caregiving burden rather than stigma-related identity processes. These findings suggest that the intensity and form of minority stress processes may depend on the specific stigma attached to different mental health conditions.

The identification of distal and proximal stressors further supports the applicability of the minority stress framework in this context. The distal stressors described in this study, particularly stigmatizing interactions with professionals and systemic barriers, align with existing research on structural and interpersonal stigma within mental health care systems (Corrigan et al., 2014; Thornicroft et al., 2009). At the same time, proximal processes such as heightened vigilance, selective disclosure, and ongoing anticipation of negative reactions can be understood as manifestations of internalized stigma and anticipated rejection (Quinn & Chaudoir, 2009). Rather than representing isolated experiences, these findings suggest a dynamic interplay between external conditions and internal responses, through which stigma becomes internalized and sustained over time. This process highlights how stress in caregiving contexts may accumulate and persist, even in the absence of explicit stigmatizing interactions.

Coping and social support emerged as key factors shaping parents' experiences within the context of ongoing stress. While adaptive coping strategies such as acceptance, maintenance of daily routines, and meaning making through religion were identified as important resources, the presence of maladaptive patterns, including avoidance and substance use, highlights the limits of individual coping under conditions of prolonged and cumulative stress (Lazarus & Folkman, 1984; Solomon & Draine, 1995). Importantly, social support appeared to function as a critical buffering factor within this process. In line with the minority stress framework, supportive relationships may mitigate the impact of stigma-related stressors, whereas their absence may further exacerbate distress. In the present study, support from other parents with similar experiences was described as particularly meaningful, suggesting that shared experiential understanding plays a central role in reducing feelings of isolation and validating parents' experiences. At the same time, limited understanding and support from the broader social environment appeared to contribute to withdrawal and increased psychological strain. These findings indicate that social support in caregiving contexts may function both as a protective resource and, when absent or insufficient, as an additional source of stress (Solomon, 2004; Repper & Carter, 2011).

The psychological and somatic consequences identified in this study further highlight the long-term impact of caregiving in stigmatized contexts. While previous research has documented elevated levels of psychological distress and physical health problems among caregivers (Schulz & Sherwood, 2008;

Vitaliano et al., 2003), the present findings extend this body of work by situating these outcomes within a broader minority stress model. Specifically, the findings suggest that prolonged exposure to stigma-related stressors, combined with internalized responses such as vigilance, emotional strain, and a persistent sense of responsibility, may contribute to cumulative psychological and physical burden over time. This is consistent with conceptualizations of chronic stress as a process that gradually affects both emotional functioning and physiological health (McEwen, 1998). Importantly, these outcomes were most pronounced among parents of individuals with schizophrenia and substance use disorders, further supporting the role of diagnosis-specific stigma in shaping the intensity of stress-related consequences.

The findings have several implications for clinical practice and research. First, they highlight the need for increased awareness among healthcare professionals of the broader psychosocial experiences of parents, particularly the role of stigma-related stress and challenging interactions within institutional systems. These findings suggest that family-oriented interventions should not focus solely on caregiving skills, but also explicitly address stigma-related processes, including social withdrawal, emotional burden, and anticipatory concerns about negative evaluation (Dixon et al., 2001). Second, the importance of peer support identified in this study indicates that shared experiential understanding may play a central role in buffering the impact of stigma-related stress. This supports the development of structured peer-based support groups and community-based programs specifically tailored to parents of individuals with severe mental illness. Third, the observed differences across diagnostic groups suggest that parental experiences of stress are not uniform, but are shaped by the type and intensity of stigma associated with specific conditions. This highlights the need for more differentiated, diagnosis-sensitive approaches to family support, particularly for parents of individuals with schizophrenia and substance use disorders.

Limitations

Several limitations should be considered. First, the findings are based on participants' subjective accounts and therefore reflect personal interpretations of experiences rather than observable social interactions. Second, the purposive sample was relatively small and heterogeneous with regard to the children's diagnoses, limiting the depth of analysis within individual diagnostic groups. Third, participants who agreed to participate may have been more willing to discuss their experiences than parents who declined or were less engaged with healthcare services. Consequently, the findings should be understood as context-specific and not intended for statistical generalization. Nevertheless, the depth and consistency of participants' accounts support the credibility of the findings.

Conclusion

The present study applied the minority stress framework to a previously underexamined population, demonstrating that parents of adults with severe mental illness experience complex and enduring stress processes shaped by stigma, caregiving demands, and social context. Participants described experiences of stigma, social exclusion, anticipated negative reactions, and substantial psychological

burden, suggesting that caregiving may involve stressors extending beyond the practical demands of care. Experiences consistent with minority stress appeared particularly salient in accounts provided by mothers of individuals with schizophrenia spectrum disorders and, to a lesser extent, substance use disorders. These findings extend the minority stress framework to a caregiving context and highlight the importance of family-focused interventions that address stigma-related stress among parents.

Declarations

Conflict of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Author Contribution

M.M.M. conceptualized the study, conducted the literature review, collected the data, performed the qualitative data analysis, interpreted the findings, and wrote the first draft of the manuscript. A.L.K. contributed to the study design and methodology, participated in the interpretation of the findings, supervised the research process, and critically reviewed and revised the manuscript. Both authors contributed to the development of the manuscript, read and approved the final version, and agree to be accountable for all aspects of the work.

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Data Availability

The semi-structured interview guide used in this study is provided as supplementary material. The interview transcripts and other qualitative data generated during the study are not publicly available because they contain sensitive information and, despite anonymisation, could potentially compromise participant confidentiality. To ensure analytic transparency, the Supplementary Methodological Appendix

provides a detailed account of the qualitative data analysis process, including coding procedures, theme development, and the progression from raw data to the final themes.

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Supplementary Files

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