Blame, Shame, and Contamination: The Impact of Mental Illness and Drug Dependence Stigma on Family Members

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Family members of relatives with mental illness or drug dependence or both report that they are frequently harmed by public stigma. No population-based survey, however, has assessed how members of the general public actually view family members. Hence, the authors examined ways that family role and psychiatric disorder influence family stigma. A national sample (N = 968) was recruited for this study. A vignette design describing a person with a health condition and a family member was used. Family stigma related to mental illnesses, such as schizophrenia, is not highly endorsed. Family stigma related to drug dependence, however, is worse than for other health conditions, with family members being blamed for both the onset and offset of a relative’s disorder and likely to be socially shunned.

Keywords: stigma, family, mental illness, drug dependence, other health conditions

The New Freedom Commission (Hogan, 2003) highlighted stigma as a major barrier to the mental health goals of Americans and recommended concerted efforts to change public opinion and to diminish prejudice. Although the New Freedom Commission report was not explicit about family stigma, it clearly recognized that barriers to family participation significantly impede mental health care. This paper addresses the complexity of what is called family stigma. Stigma not only harms many people with mental illness or drug abuse or both but also injures family members who are associated with these individuals. Goffman (1963) called this courtesy stigma, the prejudice and discrimination that is extended to people not because of some mark (e.g., mental illness, disorder) that they manifest but rather because they are somehow linked to a person with the stigmatized mark. Surveys have shown that family members with relatives who have mental illness or drug dependence disorders report significant experience with family stigma. However, to our knowledge, no survey based on a national sample has been conducted to determine whether the public, in fact, endorse stigmas about family members. The goal of this study is to examine family stigma in a sample drawn from the general adult public. We first review the stigma experienced by families: blame, shame, and contamination.

Then we examine how family members in various roles—parents, children, spouse, and siblings—interact with family stigma.

Public Stigma Applied to People With Mental Illness and Drug Dependence Disorders

Common stereotypes about people with mental illness seem to parallel those with drug dependence and include dangerousness and blame (Angermeyer, Matschinger, & Corrigan, 2004; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Generally, research shows that psychiatric disorders are viewed as more blameworthy than physical health conditions such as cancer and heart disease (Corrigan et al., 1999; Weiner, Perry, & Magnusson, 1988). Research has focused on stereotypes related to attributions about personal responsibility and blame (Corrigan, 2000). Investigators have found that research participants who blame relatives for the onset of the relatives’ mental illness or drug dependence are more likely to react angrily to those relatives, to withhold help, to avoid them socially, and to support coercive mental health services (Corrigan et al., 1999, 2000; Corrigan, Markowitz, Watson, Rowan, & Kubik, 2003; Corrigan, & Miller, 2004). Research that compares the public stigma of mental illness to drug dependence consistently shows that persons with drug dependence are judged to be more responsible for their disorder (Corrigan et al., 1999; Link et al., 1999; Weiner, Perry, & Magnusson, 1988). The difference between perceptions of drug depen-

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1 In this article, we distinguish the stigma experienced by people with psychiatric disorders from family stigma by labeling the former “primary stigma.”
dence and mental illness is expected to emerge when family stigma is the dependent measure.

Stigma and Family Members

The themes of blame and shame are seen in surveys of families of individuals with psychiatric disorders in which family members discuss their experience with family stigma. Large-scale studies have shown that between a quarter and a half of family members believe that their relationship with a person with mental illness should be kept hidden or is otherwise a source of shame to the family (Angermeyer, Schulze, & Dietrich, 2003; Phelan, Bromet, & Link, 1998; Ohaeri & Fido, 2001; Phillips, Pearson, Li, Xu, & Yang, 2002; Thompson & Doll, 1982; Shibire et al., 2001; Wahl & Harman, 1989). Shame seemed to be linked to blaming the family for the member’s psychiatric disorder. Findings from a group of 178 family members showed that about 25% worried that other people might blame them for their relatives’ mental illness (Shibire et al., 2001).

Blame and shame seem to lead to discrimination in the form of social avoidance. Three large studies reported that about a fifth to a third of family members reported strained and distant relationships with extended family or friends or both because of a relative with mental illness (Oestman & Kjellin, 2002; Shibire et al., 2001; Struening et al., 2001; Wahl & Harman, 1989). However, another study found a much smaller rate, with only 10% of a sample reporting occasional avoidance by a few people (Phelan et al., 1998).

Note that all the studies we reviewed examined family stigma from the perspective of the family, that is, whether family members perceive members of the general public stigmatizing them because of their relatives with mental illness. Hence, the first goal of this study was to conduct a survey using a national sample to determine how a subset of the American public actually views family stigma. In addition to descriptive statistics representing the endorsement of family stigma, our survey also included a comparison between the family stigma of mental illness and a physical health condition for which patients are frequently blamed: emphysema (Chapple, Ziebland, & McPherson, 2004). Consistent with research on primary stigma (Weiner et al., 1988), we expected the family stigma of mental illness to be more severe than that related to emphysema. Also note that these previous studies limited their research to the family stigma that stems from a family member with mental illness; we were unable to find any studies examining how family members of people with drug dependence disorders experience family stigma. An additional goal of this study was to examine family stigma for drug dependence disorders. Consistent with the research on primary stigma, family stigma due to drug dependence is hypothesized to be worse than for mental illness.

How Stigma Varies by Family Role

Family stigma may vary by family role: parent, spouse, sibling, or child (Corrigan & Miller, 2004). Struening et al. (2001) examined this question in terms of parents in two different samples. Almost half of one sample (N = 281), comprised mostly of mothers, reported some concern about being blamed for their children’s mental illness. Typically, blame is attributed to bad parenting skills; for example, the mother’s incompetence led to the child developing a mental illness. Results from a second sample (N = 180) reported by Struening et al. (2001) reported the same concerns though at a lower rate: about 10% of mothers experienced being blamed. Siblings and spouses are often blamed for family members who mismanage their illness. In describing causal attributions about human behavior, Weiner (1995) distinguished between onset and offset attributions. As applied to health conditions, onset attributions answer questions regarding how a set of symptoms started. Offset attributions reflect the regular recurrence of symptoms (e.g., the treatments a person must participate in to experience a cure). Siblings and spouses are often blamed for a relative’s disease offset; namely, they fail to help the person with mental illness adhere to treatment such that the person unnecessarily relapses. A study of 164 siblings hinted at this stigma; survey participants were concerned about relatives with mental illness remaining adherent to treatment regimens and perceptions that relapse was somehow the participants’ fault (Greenberg, Kim, & Greenley, 1997). Unlike the kind of responsibility experienced by parents, sibling blame seems to mirror public expectations that family members who are somehow currently associated with adult children with mental illness (e.g., siblings) or who have opted to live with the adult (e.g., spouses) have greater responsibility for current status. This is evident in the reduced shame experienced by family members who do not live with the relative with mental illness as compared to those who do (Phelan et al., 1998).

The child of a person with mental illness is often viewed as contaminated by the parent’s mental illness. One investigation attempted to test this finding using a more carefully controlled vignette experiment (Mehta & Farina, 1988). Results showed that students portrayed in the vignettes as having a father who is depressed, alcoholic, or an ex-convict were viewed as having more difficulty than the other groups. Another study illustrated the complexity of contamination on children, in this case, of parents with alcoholism or mental illness (Burk & Sher, 1990). A sample of 570 adolescents was more likely to rate teenagers with stigmatized parents as more socially negative than teens with parents who do not abuse alcohol and do not have a mental illness.

A Comparison of Family Stigma and Primary Stigma

Finally, the data in this paper provide an answer to a fundamental question about family stigma: how bad is it? One way to address this question is by comparing the family stigma applied to mental illness and drug dependence versus that experienced by emphysema. A second question, though, is how bad is family stigma for a specific health condition compared to corresponding primary stigma? We answer this question by comparing responses made by the
Methods

The data for this study come from the Family Stigma Survey collected by Time-Experiments for the Social Sciences (TESS; NSF Grant 0094964, Diana Mutz and Arthur Lupia, Investigators). TESS uses a national online research panel recruited by Knowledge Networks (KN). KN recruits for its sample via list-assisted random digit-dialing techniques on a sample frame consisting of the entire United States’ telephone population. Recruits are provided free WEB-TV access in return for completing surveys that are sent to them via e-mail weekly.

For this study, KN randomly identified and solicited 1,307 individuals from its overall panel for the Family Stigma Survey from March 26, 2004 to April 8, 2004; 74% completed the survey \( N = 968 \). The sample was 51.9% female, with a mean age of 47.0 years \( (SD = 16.5, \text{ range } 18–95) \). The sample was 72.5% White, 11.7% Black, 11.0% Mexican Americans, and 4.8% other. Of the sample, 15.8% had less than a high school education, 32.1% were high school graduates, 27.8% had completed some college, and 24.4% had a bachelor’s degree or higher. Post-survey stratification weights were used to adjust sample demographics to values consistent with the 2000 U.S. Census. Variables used to determine stratification weights include gender, age, race/ethnicity, geographic region in the United States, and level of education. Data reported in this paper represent weight-corrected cases. Despite efforts to attain a true probability sample, there are limits to the KN approach. Most prominent of these are limiting the sample to phone-bearing households that do not have the Internet but wish to approach. Most prominent of these are limiting the sample to phone-bearing households that do not have the Internet but wish to do so via WEB-TV.

Vignette Conditions

Each respondent was randomly assigned to read a vignette that varied across four conditions: disease of the person with the disorder, role of the corresponding family member, gender of the person with the disorder, and gender of the family member. One such vignette follows:

[John Smith/Joan Smith] is the [father/mother/son/daughter/brother/sister/husband/wife] of [Frank/Fran Smith, a 30-year-old [man/woman] with [schizophrenia/drug dependence/emphysema]]. [Frank/Fran] lives with [his or her] family and works as a clerk in a nearby store. [Frank/Fran] has been hospitalized several times because of [his or her] illness. The illness has disrupted [his or her] life significantly.

The quality of specific terms used to describe health conditions can influence the reaction of respondents. For example, problems related to “psychiatric disorder” are broader than the idea of mental illness alone and include areas such as drug dependence (Martin, Pescosolido, & Tuch, 2000). We addressed this problem by providing respondents with types of mental health problems as listed in the DSM. Moreover, we adopted labels from the MacArthur Mental Health Module of the 1996 General Social Survey (GSS) for the two psychiatric conditions in order to facilitate comparison with previous research (Pescosolido, Monahan, Link, Sueve, & Kikuzawa, 1999). Mental illness was “schizophrenia” and drug dependence was “drug dependency.” Based on earlier research by Weiner et al. (1988) on attributions across health conditions, we decided on emphymesa as the comparison physical health disorder. Consistent with the labels of the GSS MacArthur Module, we decided on a label that represented a specific disorder rather than a generic category. We chose emphymesa on the possibility that its connection with smoking might increase the level of blame associated with it (Chapple, Ziebland, & McPherson, 2004).

Family roles were limited to four dominant ones found in previous research on family stigma (Corrigan & Miller, 2004): parents, children, siblings, and spouses. Some evidence suggests that family stigma may vary by the gender of the family role; for example, mothers may be stigmatized more harshly than fathers (Corrigan & Miller, 2004; Leffey, 1992). Hence, vignettes randomly varied the gender of the family member. In like manner, gender of the person with the health disorder was also randomly varied by vignette. We decided not to vary other sociodemographics of vignette participants because earlier research, for the most part, failed to show them to be relevant in stigmatizing people with psychiatric disorders (Pescosolido et al., 1999).

To capture the effects of these many variations on several outcomes by means of direct questioning would be cumbersome and time-consuming. This dilemma can easily be managed, however, by using a factorial survey design (Rossi & Nock, 1982) similar to those employed by previous national probability surveys of attitudes toward persons belonging to stigmatized groups (Link et al., 1999; Phelan et al., 2000). In vignette experiments that incorporate factorial survey designs, respondents are presented with descriptions of a fictional person who varies across theoretically relevant dimensions (i.e., type of health condition, hire versus promotion decision, gender, age, and ethnicity). The different versions of the vignette that are created in this way are randomly assigned to respondents. Respondents then answer questions about the described person in terms of relevant outcome variables. In addition to manipulating and then measuring the effects of several independent variables at one time, this factorial survey design also allowed the strengths of the experimental method to be brought to bear in our study. By experimentally manipulating one of the individual’s characteristics (e.g., whether NAME’s health condition is psychotic disorder, drug dependence, or emphymesa) while holding all others constant, we were able to attribute any differences in attitudes and behavioral intentions specifically to variation in that characteristic. Because respondents were assigned randomly to vignettes, differences in responses could be attributed to variations in the stimulus rather than to variations in respondents’ characteristics. The profiles required to accomplish a factorial survey design can be produced using distribution-generating algorithms available in standard statistical packages.

Dependent Measures

After reading the vignette, respondents were instructed to respond to 14 items using seven-point Likert scales (e.g., 7 = strongly agree). Seven of the items were about the person with the health disorder, while seven were about the family member. The first seven items were from the short form of the Attribution Questionnaire, which has been shown to be a reliable and valid measure of primary stigma (Corrigan et al., in press; Corrigan et al., 2003, 2002). For example, “it is [Frank’s/Fran’s] own fault that [he or she] is in the present condition.” These studies include confirmatory factor analyses which support the reliability and content validity of measures. The items selected from the short form of the Attribution Questionnaire represented the single item that loads most into the seven factor solution of the confirmatory factor analysis.

The selection of seven items reflecting family stigma was based on our review of relevant content areas from three sources. First,
we reviewed the common themes that describe the primary stigma of mental illness and drug dependence used in prior research (Corrigan, 2005). Although this information largely influenced the first seven items relevant to how the public views the person with the health disorder, we also considered it in developing items reflecting family stigma. Second, we reviewed the common themes that family members have used to describe their experience with family stigma (Corrigan & Miller, 2004). Third, we conducted a focus group of family members to augment our list of items reflecting family stigma. During a 60-minute session, seven members of families with a person with psychiatric disorder (57.1% female, including and across all four family roles) answered questions about their general understanding of stigma and prejudice. They also responded to examples of stigma applied to their family member with psychiatric disorder and to examples of stigma applied to them as family members. Analyses of the responses of focus group participants endorsed the themes of blame, shame, and contamination found in our literature review. In addition, a content analysis of transcripts of the focus group yielded additional family stigma items, such as onset responsibility (family member to blame for person getting disorder), offset responsibility (family member to blame for person relapsing), pity, contamination (illness could rub off), shame, incompetence (the family member was not very good as a parent, sibling, spouse, or child), and avoidance (the respondent would not want to socialize with the family member). For example, “[John/Joan] bears some responsibility for [his or her] [insert relationship] originally getting ill.”

Items assessing primary stigma were always presented to research participants before family stigma items to prime stereotypes related to the health condition. Items within each domain (i.e., primary stigma and family stigma) were presented in random order.

Results

The research questions guiding this paper suggest a three-step approach to analysis. First, we conducted a series of descriptive analyses to examine how the public endorses family stigmata for families that have members with one of these three health conditions. This included an inferential analysis to examine how family stigma varied by disorder. Second, we examined how stigma varied by family role. Third, we determined how family stigma compared to primary stigma by comparing the mean score on selected primary stigma items to the scores on family stigma items.

How Does Family Stigma Vary by Health Condition?

Mean and standard deviations of responses to the seven overall family stigma survey items is summarized in the Overall row of Table 1. Results of a oneway MANOVA with the seven items as dependent variables were significant, $F(14, 1886) = 13.31, p < .001$. Subsequent oneway ANOVAs showed that all seven items differed significantly across the three health conditions (F ranges from 3.95, $p < .05$ to 54.18, $p < .0001$). Post hoc Tukey’s test examined the differences between pairs of health conditions. Results suggest that families of people who are drug dependent are viewed in the most stigmatizing manner, that is, these families are viewed as more responsible for onset (drug dependence-schizophrenia, $p < .0001$; drug dependence- emphysema, $p < .001$) and offset of the disorder (drug dependence-schizophrenia, $p < .0001$; drug dependence-emphysema, $p < .001$), more likely to be contaminated (drug dependence-schizophrenia, $p < .0001$; drug dependence-emphysema, $p < .001$), more ashamed of afflicted family member (drug dependence-schizophrenia, $p < .0001$; drug dependence-emphysema, $p < .001$), and less competent in their family role (drug dependence-schizophrenia, $p < .0001$; drug dependence-emphysema, $p < .001$). Families of people with drug dependence and schizophrenia were viewed as more pitiable ($p < .05$) than those with emphysema.

Additional analyses examined whether survey participants endorsed any specific family attitudes higher than others. Results of a within-Group ANOVA for the subgroup of survey participants randomized to the schizophrenia vignettes, with the seven family stigma items as dependent variables, was significant, $F(6, 1842) = 108.19, p < .001$. Subsequent contrasts showed the group most agreed with withholding pity ($p < .05$), viewing the person as incompetent in his or her family role ($p < .05$) and as socially avoiding the family member ($p < .05$) compared to the remaining four items. The within-Group ANOVA for the group assigned to drug dependence was also significant, $F(6, 1950) = 52.42, p < .001$. Subsequent contrasts showed withholding pity ($p < .05$) and contamination ($p < .05$) as the two items most highly endorsed by survey participants.

How Does Family Stigma Vary With Family Role?

Table 1 also includes the mean and standard deviations of participant responses to family stigma items organized by family role and health condition. Results of a $4 \times 3$ (family role by health condition) MANOVA with the seven family stigma items as dependent variables yielded significant main effects for family role, $F(21, 2805) = 10.18, p < .001$, as well as a significant interaction, $F(42, 5628) = 2.53, p < .001$. Subsequent $4 \times 3$ ANOVAs were then conducted for the seven family stigma items individually. Significant main effects for family role were found for onset blame ($F = 2.45, p < .05$), contamination ($F = 8.09, p < .001$), offset blame ($F = 3.95, p < .05$), and withholding pity ($F = 1.35, ns$). Subsequent post hoc Tukey’s tests examined pairwise differences. Results showed that parents and spouses are viewed to be more responsible for the onset ($p < .05$) of the person’s schizophrenia, drug dependence, and emphysema than children and siblings. Schizophrenia, emphysema, and drug dependence were likely to contaminate children ($p < .05$) more than other family roles. Parents are viewed as more responsible for the person’s schizophrenia or drug dependence relapse than children ($p < .05$). Generally, siblings were the least pitied of the four groups.

How Does Family Stigma Compare to Primary Stigma?

The final question examined in this paper was how the public endorses family stigma compared to primary stigma. Means and standard deviations of participant responses to
the seven primary stigma items are summarized in Table 2 by health condition. Results of a one-way MANOVA were significant, $F(14, 1890) = 99.56, p < .001$. Subsequent ANOVAs for each of the seven items were all significant; $F$ ranged from 7.85, $p < .05$ to 319.02, $p < .001$. Post hoc Tukey’s test showed that primary stigma for drug dependence was the worst. The sample rated the person with drug dependence as more dangerous ($p < .05$), fearful ($p < .05$), blameworthy ($p < .05$), anger arousing ($p < .05$), and likely to be avoided ($p < .05$). They were also rated as less pitiable
and worthy of help (p < .05). The person with schizophrenia was rated as more dangerous (p < .05), fearful (p < .05), and likely to be avoided (p < .05) than the person with emphysema. Results showed that the person with emphysema was viewed as more responsible (p < .05) for his or her disorder than the person with schizophrenia.

Table 3 represents the mean and standard deviation of the total scores for primary stigma and for family stigma. Results of a 3 x 2 ANOVA suggested that primary stigma was endorsed more highly than family stigma, F(1, 939) = 409, p < .001. Post hoc Tukey’s tests examined the differences between primary and family stigma across the health conditions. In all cases where paired tests yielded significant results, survey participants endorsed primary stigma more than family stigma. In terms of schizophrenia, participants rated primary stigma greater. Total score was also ranked more highly for drug dependence.

Discussion

Surveys of family members of people with mental illness or drug dependence conclude that family members experience significant family stigma. They report being blamed for the onset of their relative’s disorder, held responsible for relapse, and being viewed as an incompetent family member (Corrigan & Miller, 2004). This has led to feelings of shame and contamination. Our study was guided by the following question: How does a sample of the American public actually view family members of people with mental illness or drug dependence? Several interesting trends emerged. First, the public does not seem to highly endorse family stigma of mental illness or drug dependence. A second way to determine the depth of family stigma is to compare it to primary stigma using the same vignette. Results suggest the sample in this study was less likely to endorse stigmatizing attitudes about family members compared to people who directly experience the health conditions. Survey participants, on average, produced higher overall stigma scores for people with drug dependence disorders and with schizophrenia than other family members. Survey participants were also more likely to avoid people with schizophrenia and with drug dependence disorders compared to their family.

A second question asked the following: Despite the low level of family stigma, does the public discriminate among health conditions? Results suggest that families with a relative with drug dependence disorder are viewed most harshly. Compared to the vignettes of people with schizophrenia and emphysema, results showed that family members with relatives who were drug dependent were blamed more for the onset of their relatives’ conditions and for relapses, although this latter difference was not significant between the vignettes on drug dependence and those on schizophrenia. Family members in the vignette on drug dependence were viewed as more likely to be contaminated.

<table>
<thead>
<tr>
<th>Survey items</th>
<th>Schizophrenia</th>
<th>Drug dependence</th>
<th>Emphysema</th>
</tr>
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<tbody>
<tr>
<td>Primary stigma</td>
<td>2.99 0.68</td>
<td>3.91 0.78</td>
<td>2.49 0.80</td>
</tr>
<tr>
<td>Courtesy stigma</td>
<td>2.41 0.81</td>
<td>2.84 0.84</td>
<td>2.40 0.81</td>
</tr>
</tbody>
</table>
by the disorder, more shameful, and more likely to be avoided socially.

Family stigma of people with mental illnesses like schizophrenia was less deleterious. We chose emphysema as a physical health condition because of the perception that people suffering with this disorder are more blameworthy because of a past smoking history (Chapple et al., 2004). And, in fact, the primary stigma related to blame was more highly endorsed for emphysema than schizophrenia. However, no difference was found in blaming family members for emphysema compared to schizophrenia. In fact, the only family stigma item that differed significantly across these two groups was for pity, with the schizophrenia family members viewed as more pitiable than the emphysema group.

Feeling shame because of mental illness or public stigma might have significant impact on illness career (Pescosolido & Boyer, 1999). Research has shown that people with greater stigma are later to admit their illness, less likely to begin treatment, and more likely to drop out of treatment prematurely (Corrigan, 2000). Shame and self-blame are frequently the stigma that lead to diminished illness career. Clinicians may opt to adjust treatments so that stigma does not become a barrier to participation. For example, clinicians could avoid words that are likely to elicit stigma. These include references to onset and offset responsibility and to feelings of shame.

Combined with our earlier findings, these results suggest that families with a relative who is dependent on drugs are viewed in a stigmatizing manner by the public while those with a relative with mental illness are not. What might account for the difference between this public survey and the perceptions of families with mental illness? The difference may represent a history effect, that is, family stigma has diminished over the five plus years since these family surveys were completed (Phelan et al., 1998; Wahl & Harman, 1989). This seems unlikely given other recent data that suggest that primary stigma has actually worsened over the past four decades (Phelan, Link, Stueve, & Pescosolido, 2000). Alternatively, the disparity between family perceptions and public report may represent the effects of social desirability. Members of the general public are unwilling to endorse the family stigma that, in fact, exists and to risk social disapproval.

Social scientists have tested a variety of implicit measures that measure stigma without the influence of the desirability effect (Fazio, Jackson, Dunton, & Williams, 1995; Greenwald & Banaji, 1995). Future research should include implicit measures to determine if the low rate of family stigma in terms of mental illness is still evident. The difference between public perceptions and family reports may represent self-stigma. Namely, families with a relative with mental illness may internalize prejudice (Corrigan & Miller, 2004; Corrigan & Watson, 2002) which, in turn, diminishes the self-esteem and self-efficacy of family members. If self-stigma accounts for family reports of family stigma, then future research should find any significant association between internalized stigma and a family member’s perception of how others stigmatize him or her.

A third goal of this study was to determine whether family stigma varies by role. Does the public view parents, siblings, children, and spouses differently? Results suggest a difference in perception, but the specific difference depends on the type of stigma. Results showed that adults in a family with an immediate relationship with the person with a health condition—parents and spouses—are more likely to be viewed as responsible for the health condition. This effect was found for all three conditions, although parent and spouse blame was significantly worse for the relative with drug dependence. Parents were also viewed as significantly more responsible for the relapse for children in the two psychiatric vignettes on psychiatric conditions. Children were more likely to be viewed as contaminated by all three disorders than the other groups, with drug dependence once again showing statistically more contamination than schizophrenia or emphysema. In all, these findings suggest that the public distinguishes between the role of parents and children in terms of stigma and judges family role most harshly in families that have a person with drug dependence.

Despite these positive findings, this study is limited. First, the technology used to recruit and test research participants resulted in some bias in the sample. Research participants were required to be phone users with sufficient interest in web-mail to be willing to sign up for KN efforts. This group was obviously not an unbiased subset of the population. Second, the measures used in the study were mostly single items with no clear information about their psychometrics. This problem could be partially overcome when future studies are able to replicate these findings using the same measures.

Advocacy groups have sought to erase family stigma and associated discrimination, that is, they are to blame for their loved one’s illness and should be kept away from the person with mental illness, especially during treatment. Efforts by parental advocacy groups like the National Alliance for the Mentally Ill (NAMI), the largest group of this kind in the United States, have diminished the stigma and promoted appropriate affirmative action: increase parental involvement in treatment. Antistigma efforts have included protest, asking participants to suppress their negative attitudes about a group; education, contrasting the myths of mental illness with the facts; and contact, decreasing stigma by fostering interactions between a person with mental illness and a group where such stereotypes might exist. Most of the research on stigma change has focused on decreasing primary stigma. However, primary stigma seem like adequate candidates for also diminishing family stigma.

References


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