Shame, blame, and contamination: A review of the impact of mental illness stigma on family members

PATRICK W. CORRIGAN & FREDERICK E. MILLER

University of Chicago Center for Psychiatric Rehabilitation, Evanston Northwestern Healthcare, Illinois, USA

Abstract
In his classic text, Goffman (1963) defined courtesy stigma as the negative impact that results from association with a person who is marked by a stigma. Family members of relatives with mental illness are frequently harmed by this kind of stigma. Using a social cognitive model of mental illness stigma, we review ways in which various family roles (e.g., parents, siblings, spouses) are impacted by family stigma. We distinguish between public stigma (the impact wrought by subsets of the general population that prejudge and discriminate against family members) and vicarious stigma (suffering the stigma experienced by relatives with mental illness). Results of our review suggest parents are blamed for causing their child’s mental illness, siblings and spouses are blamed for not assuring that relatives with mental illness adhere to treatment plans, and children are fearful of being contaminated by the mental illness of their father or mother. The current body of literature suggests several important directions for future research including identification of stereotypes in addition to shame, blame, and contamination that harm family members; developing rigorous research methods that validate the link between stigmatizing attitudes and discriminatory behaviors; and testing programs that help to erase the various manifestations of family stigma.

Keywords: Stigma, courtesy stigma, family

My then 13-year-old daughter summed it up this way: ‘If David’s body were hurting, people would send gifts, but because it is his mind that is hurting, they throw bricks.’ And so we were thrust into the stigma/blame loop. [People would say] “She’s the one with the crazy son. Maybe he’s crazy because she is?” (Ben-Dor, 2001, p. 330).

“Growing up with a mentally ill mother was oppressive and worrisome, and it interfered with the development of my sense of self. I was terrified that I was like my mother and therefore had something wrong with me. Acutely self-conscious, I felt inferior to other children.” (Lanquetot, 1988, p. 337).
Introduction

Stigma not only harms many people with mental illness, it 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 they manifest, but rather because they are somehow linked to a person with the stigmatized mark. Several models have been developed over the past decade to explain the impact of mental illness. In this paper, we use these conceptual perspectives as a heuristic for organizing the existing body of research about the stigma experienced by family members. Research has also examined various ways to erase the stigma experienced by people with mental illness. This paper ends by extrapolating some of these findings to anti-stigma programs that may enhance the life opportunities of family members harmed by prejudice and discrimination.

Three caveats are offered before proceeding further. First, writing about “family stigma” may unintentionally exacerbate the stigma experienced by people with psychiatric disorders. Family stigma is defined vis-à-vis relationship to a person with mental illness which may suggest that the family member is somehow “tainted” by his or her association with relatives with the disorder. The harm that results from this association is due to some pernicious quality of the person marked by mental illness. This kind of inference would be false. The prejudice and discrimination that results from being labeled “mentally ill” is a social injustice committed by the public, not a failure of the person with psychiatric disorder (or, for that matter, any of his or her family members). We do not wish to perpetuate the stigma of people with mental illness by focusing on the stigma experienced by their family members.

Second, in writing about family members, and distinguishing them from individuals with psychiatric disorder, we may unintentionally suggest that people with mental illness are not capable of assuming a family role; that being “family” is the purview of a parent or spouse of someone with mental illness but not the person him or herself. This kind of assumption further robs people with mental illness of a key part of what it means to be human which is not our intent (Olkin, 2002). We refer to “family stigma” here as an efficient way to talk about the prejudice and discrimination experienced by people because of relationship. In using this term, we do not mean to imply that people with mental illness are incapable of being competent parents, spouses, siblings, or other relatives.

Third, we must remember that the family that is the object of this discussion of stigma actually implies a variety of diverse roles: parents, spouses, siblings, children, and other relatives of people with mental illness. Family stigma is not a monolithic phenomenon; it likely varies depending on the relationship with the person with mental illness. For example, parents may be stigmatized by public attitudes related to blame for the onset of a person’s mental illness or parental incompetence leading to child’s mental illness. Brothers and sisters may often be blamed for illness offset, siblings who are not able to control their symptoms or disabilities. Children of people with mental illness may be viewed as contaminated by their parents. Our paper will highlight this distinction wherever evidence has examined how a specific family role affects stigma.

Public stigma and the family

Study of mental illness stigma has been largely informed by two independent research traditions: social psychological paradigms that model the cognitive and motivational processes that lead an individual to stigmatize, and sociological paradigms that explain how various economic, political, and historical forces produce social structures which promote
and maintain prejudice and discrimination directed at a specific group. Existing research on family stigma found in a systematic literature review largely represents the individual-psychological paradigm. Hence, the focus of our paper is limited to the former paradigm, though we end the paper with some musings on how more research on structural stigma will further advance our knowledge on family stigma. Farina (2000) and Mehta and Farina (1988) hypothesized two reasons why the public may extend the stigma of mental illness to families. (1) People who appear together in public seem alike. (2) If someone opts to associate with a marginal person, he or she cannot be worth much. Unfortunately, research has not attempted to test explanatory models like his. Instead, research on family stigma has largely been descriptive, cataloguing the different negative beliefs about families. When organizing public stigma according to the stereotype, prejudice, and discrimination schema discussed above, research has uncovered two recurring trends. Many family members of people with mental illness experience significant discrimination and this discrimination is attributable to a set of common stereotypes. These two issues are discussed more fully in turn.

**Discriminatory impact**

Although the social cognitive model of public stigma suggests that stereotypes and prejudice yield discrimination, and hence we might logically begin a discussion of public stigma by discussing the stereotypes and prejudice used against families, we decided to present our review on public stigma in reverse order to answer two questions. Is there evidence that stigma negatively impacts people with mental illness? If yes, what stereotypes/prejudices might account for these discriminatory behaviors? Research on the public stigma experienced by people with mental illness has shown avoidance at multiple different levels is the frequent, and perhaps most pernicious, discriminatory result of the various stereotypes about mental illness (Link, Cullen, Frank, & Wozniak, 1987; Penn et al., 1994; Martin, Pescosolido, & Tuch, 2000). This includes employers who do not want to work with, landlords who do not want to live near, and neighbors who do not want to socialize with people with mental illness.

Researchers have evaluated whether family members experience similar kinds of avoidance and found mixed results. Three large studies on four samples reported about a fifth to a third of family members reported strained and distant relationships with extended family and/or friends because of a relative with mental illness (Wahl & Harman, 1989; Shibre et al., 2001; Struening et al., 2001; Ostman & Kjellin, 2002). However, another study found a much smaller rate with only 10% of a sample reporting occasional avoidance by a few people (Phelan, Bromet, & Link, 1998). A respondent in a qualitative study described this problem eloquently: “We have lost many friends, one by one they’ve backed off from us... my girls were very upset... they would come to me and say, ‘why do they pretend not to see us?’” (Veltman, Cameron, & Stewart, 2002, p. 110).

Unlike research on people with mental illness, research on family stigma showed that avoidance seemed to be more marked in social spheres other than the work world. We did not find any research that showed family stigma interfered with interactions on the job. However, stigma and avoidance were noted in other important spheres of family and friend interaction. Writing about experiences with her son, Lanquetot (1988) said, “Last year, I cried for three hours straight when good friends withdrew an invitation to a holiday dinner because we wanted to bring our son with us.” (p. 340). Respondents in another study believed family stigma undermined future marriage opportunities not only for the person with mental illness, but for his or her relatives (Shibre et al., 2001). A second qualitative
study noted strains within faith communities. “Our relationship with the church faltered. The church was not there for parents of a mentally ill child. It seemed that the minister couldn’t even talk about mental illness.” (Corrigan & Lundin, 2001, p. 292)

Generally, studies tended to look at family roles generically in terms of the avoidance question. However, two studies showed that perceived avoidance varied with family role and the nature of the relationship. Rate of perceived avoidance for spouses was almost twice that for parents (Phelan, Bromet, & Link, 1998; Ostman & Kjellin, 2002). Studies also showed that perceived avoidance varied with the regularity of interactions between family members and the person with mental illness. Studies showed that parents not living with the family member with mental illness reported less perceived avoidance than parents who did (Phelan, Bromet, & Link, 1998). Finally, studies examined whether demographics of individual family members were associated with perceived avoidance. One study showed higher educated family members were more likely to report perceived avoidance (Phelan, Bromet, & Link, 1998). Viewing education as a proxy of SES, Phelan and colleagues provided three interpretations of this association: higher status individuals might be more perceptive of avoidance, they may be overly sensitive and misinterpret others comments as rejections, and their presumably higher educated friends and relatives may be less tolerant of the family member with mental illness.

Discrimination and shame. Avoidance is closely related with the sense of shame reported by many families with mental illness. Survey 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 otherwise be a source of shame to the family (Thompson & Doll, 1982; Wahl & Harman, 1989; Phelan, Bromet, & Link, 1998; Ohaeri & Fido, 2001; Shibre et al., 2001). The qualitative interviews conducted by Veltman and colleagues (2002) echoed this finding; “My daughters are ashamed that their father is not well. The stigma is seen on their foreheads.” (p. 110). This sense of shame did not seem to be related to a general distaste for people with significant health disorders but rather seemed to be specific to mental illness. One study showed family shame was 40 times more prevalent in families with people with mental illness compared to families who have members with cancer (Ohaeri & Fido, 2001).

The relationship between shame and avoidance is complex. Shame as used in these studies is a nonspecific component of stigma; it does not delineate the attitudes that might lead to a harmful result. Moreover, it is unclear whether shame’s effect on avoidance is the result of public stigma or self-stigma. In terms of public stigma, shame is what the general population might expect family members to feel because of their association with relatives with mental illness. In order to prevent this shame from rubbing off on them, the public opts to avoid family members. Alternatively, the relationship between shame and avoidance may be understood in terms of self-stigma. Namely, family members who are shamed by a relative with mental illness may want to hide from the public. Future research needs to sort out the relative functions of shame as public versus self-stigma in terms of discrimination and avoidance.

Stereotypes and prejudice

As we argued in the previous section, shame seems to be a nonspecific prejudice which the public expresses about families with relatives with a mental illness. There are two types of stereotype which may account for this sense of shame: blame, and contamination. These vary depending on the family role involved.
Parents are to blame for child’s mental illness. Research on the stigma experienced by people with mental illness has found that the public frequently blames them for their symptoms and disabilities (Weiner, Perry, & Magnusson, 1988; Corrigan et al., 2000; Corrigan, Markowitz, & Watson et al., in press). Similar research has also suggested that the public views family members, especially parents, as responsible for the relative’s mental illness. Findings from a group of 178 family members showed that about 25% worried that other people might blame him or her for the relative’s mental illness (Shibre et al., 2001). Struening and colleagues (2001), however, reported mixed findings on two independent samples. Almost half of one sample \( n = 281 \) who were mostly mothers reported some concern about blame while only about 10% of a second sample of mothers \( n = 180 \) reported this kind of concern. Typically, blame is attributed to bad parenting skills. The mother’s incompetence, for example, led to the child developing a serious mental illness. More recently, biological models including genetic paradigms have replaced fallacious notions that serious mental illness was caused by bad parenting. This perceived revolution in medicine is expected to change the idea of parental responsibility from incompetent mothering to blame for procreating (Phelan, 2002; Phelan, Cruz-Rojas, & Reiff, 2002).

From where do parental notions of blame come? Some of this might represent most parents’ sense of responsibility and concern about anything that happens to their children. However, there is also compelling evidence that the public learned about parental blame from mental health providers (Lefley 1989, 1992). Dominant models on the cause of serious mental illnesses during the first half of the 1900s focused on parental weaknesses as causing the early developmental problems of children (Sullivan, 1927; Fromm-Reichmann, 1947; Bateson, Jackson, Haley, & Weakland, 1956; Bowen, 1961). In criticizing ideas like this, Goldstein (1981) condemned many therapists who viewed parents as “crazy-making families”; according to this wrong-headed philosophy, parents should leave their relative with mental illness in peace so that professionals can provide the real support and care needed by the patient. Although these theories diminished in the 1960s, their influence remains prevalent and have spread to public notions about parental blame (Lefley, 1992).

Siblings and spouses are to blame for people mismanaging 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 questions about what conditions are necessary for a set of symptoms to remit; e.g., in what treatments must a person participate 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 stay treatment adherent so 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 their 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 (like siblings) or who have opted to live with the adult (e.g., spouses) have greater responsibility for current status. This is evident by reduced shame experienced by family members who do not live with the relative with mental illness, compared to those who do (Phelan et al., 1998). Additional research is needed to see if this association holds up for spouses, siblings, and others who currently reside with the relative with mental illness.
Child is contaminated by parent’s mental illness. Early researchers writing about stigma identified a common stereotype experienced by those with health conditions: contamination (Jones et al., 1984). Close association with the stigmatized person would lead to diminished worth. This might result from an infectious process; perhaps a bacterium would jump from patient to peer causing him or her to develop the same symptoms. Alternatively, it may represent some more subtle psychological process that results from associating with a person with mental illness. Given the nature of the relationship, children are especially likely to be perceived as contaminated by a parent’s mental illness.

This kind of stereotype has been demonstrated in a variety of studies. One investigation examined responses of a sample drawn from the general population to a hypothetical vignette (Weyand, 1983). Results suggested that participant attitudes about a son were diminished by the father’s stigmas. A subsequent study attempted to test this finding using a more carefully controlled experimental design (Mehta & Farina, 1988). A total of 120 research participants were randomly assigned to one of six vignettes that described the father of a college student. Vignettes varied by the mark used to describe the father: old, depressed, alcoholic, amputee, ex-convict, or job that requires travel away from the home. Research participants were then asked to rate how difficult college is for the student across several domains. Results showed students with a father who is depressed, alcoholic, or an ex-convict were viewed as having more difficulty than the other groups. Remember that information was solely provided about the father so these findings suggest the student was contaminated by the father’s stigmas.

Another study on two samples illustrated the complexity of contamination on children, in this case of parents with alcoholism or mental illness (Burk & Sher, 1990). The first sample of 570 adolescents was more likely to rate teenagers with stigmatized parents as more socially negative than teens without parents with mental illness or alcoholism. The second sample of 80 adult mental health workers pretty much replicated the findings of the first group. On one hand, these results echo our earlier conclusions that children may experience contamination from the stigma of their parents. Moreover, these findings reflect an earlier point made in this paper; i.e., mental health service providers are a prominent source of family stigma. Note however, that these findings may be interpreted alternatively. Given the concern of parental alcoholism and mental illness on the development of children (Williams & Corrigan, 1992), perhaps these ratings by mental health workers and peers are an accurate perception of the kind of psychological stressors which these children must endure. Future research needs to sort out whether perceptions representing contamination are accurate perceptions or stigmatizing misperceptions.

Vicarious impact

Typically, the impact of stigma is conceived as the direct result of negative attitudes and behaviors towards a group of people, in this case family members of people with mental illness. However, research also shows that family members suffer when they note the impact of prejudice and discrimination on their relative with mental illness. Consider this mother’s statement about her son; “He keeps it from some people. He’s cautious about who he tells because of the stigma. He doesn’t want to be associated with mental illness. He’s afraid to be associated with that.” (Veltman et al., 2002, p. 110). Findings of survey studies of family members show concern about the stigma experienced by the relative with mental illness is significantly higher than the impact of stigma on non-ill family members. Between a half and two thirds of family members have expressed concern about the stigma experienced by their relative (Wahl & Harman, 1989; Struening et al., 2001). Family members have agreed that
stigma hurts the relative’s self-esteem, ability to keep friends, success in obtaining a job or place to live, and acceptance by mental health professionals. Family members are acutely aware that stigma is a major hurdle to the recovery of their relative.

**Future directions**

The review of existing studies on family stigma has uncovered interesting trends that describe the experience. The review also suggests multiple directions for future research on this issue. Four especially important directions are considered here.

1. *Other stereotypes need to be identified.* Three stereotypes about families with relatives with mental illness were discussed in this paper—shame, blame, and contamination—and seemed to be endorsed by as many as half of available family members. What about the other half; are they not bothered by public or self-stigma? As we argued earlier in the paper, some family members might respond with righteous anger or may be indifferent to the issue altogether. Alternatively, perhaps research thus far has only sampled some of the stereotypes that harm family members. Shame, blame, and contamination may represent only some of the stereotype domains in families with mental illness; other, equally important stereotypes that may harm people with mental illness include dangerousness (people with mental illness are potentially violent and should be avoided) and incompetence (people with mental illness are not able to handle the demands of independent living). Parents might also be the butt of incompetence stigma; namely, they are to blame for their child’s mental illness because they were incompetent at parenting. Additional input from families might yield even more stereotypes than those considered thus far in this paper.

Most of the studies reviewed here were surveys in which family members responded to pre-identified items representing various stereotypes. The pool of stereotypes in these studies relied on researcher preconceptions. Future research needs to incorporate qualitative methods to obtain a comprehensive picture of family experiences with stereotypes. Relevant factors likely to affect family stigma includes ethnicity and other relevant demographics. Recent research by our group used a qualitative study design to examine attitudes about mental health in an African American sample (Matthews, Corrigan, Smith, & Rutherford, 2003). Although findings were not specific to family stigma, they nevertheless showed how attitudes vary by cultural group. Preliminary findings suggest several interesting perceptions about mental illness that seem distinct to African Americans: admitting mental illness may suggest that your religion or church has let you down; mental illness and mental health are luxuries for the rich; and a person of color needs to be careful when receiving care in the largely White mental health care system. Qualitative research on families may yield similar distinctive views about stereotypes.

2. *The impact of stigma needs to be distinguished from family burden.* Future research needs to discern the various impacts of family stigma from burden. A caution about the term “burden” before proceeding (Gubman & Tessler, 1987). Burden may suggest some kind of onus or responsibility on the part of relatives with mental illness, such as they choose the symptoms and disabilities that led to family problems. This is not the intent of most researchers nor do we mean to extend this kind of prejudice here. We agree with Gubman and Tessler who have argued that referring to *family impact* may be a way to avoid this kind of stigma and have adopted their language here. Family impact may be distinguished into objective and subjective forms (Maurin & Boyd, 1990; Baronet, 1999). Objective impact represents the negative effects of symptoms and disabilities on the household and demands...
of caregiving; it represents manifest data that reflect a diminished quality of life and standard of living when residing or regularly interacting with a person with mental illness. Subjective impact refers to family member appraisals of the living situation separate from whatever objective data might show.

Objective and subjective impact provide a difficult conundrum for distinguishing and explaining the harm caused by stigma. Is the lack of support from extended family and friends the result of prejudice or representing an exhausted support network? In writing about the experiences of people with mental illness, we used the metaphor of a two-edged sword to explain this interaction (Corrigan & Penn, 1999). Loss of many life opportunities may result from symptoms and disabilities on one hand, and/or the stigma that results from the public’s reaction to these symptoms on the other. Researchers need to consider the interaction of both when trying to explain the impact of either side alone.

We have developed a three part method to determine whether a negative event represents stigma or some other component of the experience of mental illness (Corrigan & Watson, 2002) based on the social cognitive model of stigma: stereotype, prejudice, and discrimination. As an example, consider the problem of distinguishing low self-esteem in a person with mental illness due to stigma vs. due to depression. If the former is a relevant cause, the person would be aware of a corresponding stereotype about mental illness (e.g., people with mental illness are all incapable of being productive members of society), apply that stereotype to him or herself (I must be an incompetent member of society because I am mentally ill), and report diminished self-esteem as a result (I feel bad about myself because I can’t be a productive member of my community). The same model would hold for understanding the role of stigma in family members. In cases where family stigma, and not subjective impact, causes low self-efficacy, a mother would be aware of the stereotype (e.g., Bad parenting and general incompetence causes a person’s schizophrenia.), apply it to herself (My son has schizophrenia because I was a rotten parent), and report lowered self-efficacy (Why try to build bridges with my neighbors; I am fundamentally flawed). Establishing this connection is the first step to developing plans for erasing the stigma discussed more fully below.

(3) Research needs to also be conducted on public samples. Much of the research on public stigma was gleaned from family samples. Hence, the literature reflects what families believe the public views them. These perceptions are clearly important but research is also needed to directly assess how the general population views family members. Absent this kind of information, we are uncertain whether anti-stigma programs should focus on the public, on family member perceptions, or on both. Two independent variables that should be included in this kind of research on family stigma is stereotype content and family role. Levels of stereotype content might include shame, blame, contamination, incompetence, and other stereotypes that emerge from the kind of qualitative studies suggested above. Family roles would include parents, spouses, siblings, children and other relatives of people with mental illness. Findings would help to substantiate the assertions made in this paper; namely, the content of stereotypes, and hence their impact, vary by family role.

A difficult task of this kind of research has been demonstrating that endorsement of a particular stereotype leads to discriminatory behavior, the attitude–behavior link. Several strategies have been used to establish this link. Instruments like the Social Distance Scale (SDS: Bogardus, 1925; Link et al., 1995) have been validated as proxies of behavioral discrimination. Typically, these are Likert scale items representing a research participant’s willingness to engage a person with mental illness in situations at work, church, dating, or the neighborhood. Although no scale currently exists for family discrimination, extrapolat-
ing from the existing SDS would not be difficult; e.g., How likely would you join a church (synagogue or mosque) group that included a mother of a person with mental illness? Unfortunately, these scales represent behavioral intention and not actual behavior, though some social psychologists argue that behavior intention can be a robust measure of actual behavior (Azjen & Fishbein, 1980).

(4) Ways to erase family stigma need to be studied. The ultimate worth of any research program on stigma will be its ability to generate programs that diminish stigma’s impact. Our literature review failed to uncover any studies examining strategies that seek to diminish family stigma. Nevertheless, we would argue that the very existence of groups like the European Family Association on Mental Illness in Europe, National Alliance for the Mentally Ill in the United States, the Schizophrenia Society in Canada, and various manifestations of Schizophrenia Fellowship in Europe and Australia is evidence that families believe destigmatizing mental illness is a priority. What does the research community have to offer these advocacy groups in terms of improving their anti-stigma efforts?

Perhaps the first question to be addressed is whether any change in public stigma related to mental illness will result in less harm to parents, siblings, spouses, children and other relatives? If family stigma is a “courtesy” passed on because of association with a marked person with mental illness, then it seems reasonable to expect less harm to families caused by stigma when the prejudice and discrimination directed towards people with the actual disease diminishes. There are several anti-stigma programs currently active in the United States; perhaps the largest and most ambitious of these is the Elimination of Barriers Initiative (EBI). This CMHS-supported program conducted by the Gallup Organization and Vanguard Communication is seeking to set up grass-roots anti-stigma programs in eight states. Although the stigma experienced by people with mental illness is EBI’s principal target, an interesting question of the concurrent evaluation program will be whether stigmatizing attitudes and behaviors towards family members have also diminished.

Elsewhere we have expressed concerns about whether general anti-stigma programs lead to robust changes in the important power groups that matter in the lives of people with mental illness; e.g., landlords, employers, police officers, policy makers, and primary care physicians (Corrigan, in press). Although changing the general population’s attitudes about and behaviors towards people with mental illness and their families is laudable, more important is to assure that people in positions of power do not prejudge or discriminate. Adding to this concern are data that suggest public services announcements have a relatively weak effect changing the population’s opinions about a social issue. Hence, we have argued that anti-stigma programs may be more potent when crafted to challenge the prejudices and discrimination of specific groups. Extrapolating this assertion to family stigma, we would expect anti-stigma programs to be most effective when targeting groups of concern to families, and the specific attitudes and behaviors of this group. For example, NAMI developed a Provider Education Program for line staff at public agencies to counter any stigma they might unwittingly endorse with the lived experiences of family members and consumers.

Three general strategies might be incorporated into targeted programs seeking to reduce public endorsement of family stigma: education, protest, and contact (Corrigan & Penn, 1999; Watson & Corrigan, 2004). Education programs seek to contrast myths about a group (e.g., All mothers, because of stunted psychological development, cause their child’s mental illness.) with facts (Most serious mental illnesses—especially schizophrenia and the affective disorders—are biological illnesses. Neither parents, nor the person with the illness, are to blame.) There is some evidence that this kind of contrast leads to less endorsement of stigmatizing attitudes (Penn et al., 1994; Penn, Kommana, Mansfield, & Link, 1999).
Protest seeks to stop or replace disrespectful images of a group by a moral appeal. For example, advocacy groups have conducted letter writing campaigns to get media groups to edit a movie or stop a television show that perpetuates stigmatizing images of people with mental illness. Although protest may yield unintended rebound effects on attitudes (Don’t tell me what to think; I know that bad parenting causes mental illness!) (Macrae, Bodenhausen, Milne, & Jetten, 1994), there is evidence that coordinated boycotts can convince TV show producers to change their message (Wahl, 1995). Wonderland, a TV show about a fictional forensic psychiatric hospital, was pulled by ABC after just two episodes because of angry protests by advocacy groups. Television and movies are replete with stigmatizing images of family members (e.g., crazy-making mothers, feckless brothers who let the siblings relapse, and incipient psychotic offspring) which should be the targets of similar protests.

Research suggests the best way to improve attitudes about people with mental illness is contact (Corrigan et al., 2001, 2002); people from the general population who interact with an individual with mental illness are likely to be less prejudicial than individuals without this kind of contact. In like fashion, we would expect public stigma about family members would diminish as individuals had contact with parents, spouses, siblings etc. Note that accomplishing this goal requires an active decision on the part of family members to come out. Neighbors and co-workers typically do not know that a person is a relative of an individual with mental illness unless that person self-discloses. Research on contact suggests this kind of disclosure will ultimately lead to less stigma for family members. However, there are also costs for parents or siblings to publicly discuss their relative’s mental illness (Ralph, 2002). Specific co-workers and neighbors who hear this information might react negatively and the family member might suffer some specific discriminatory results (e.g., the car pool does not want a father of a person with mental illness riding with them after hearing the story about his son).

Final thoughts
Perhaps the take-away message that is common to all parts of this paper is that the stigma experienced by family members is a complex and multi-leveled phenomenon. Recognizing the current impact of stigma, advocates have begun to tackle this problem at its various levels. Researchers need to partner with advocates to help them gain a better understanding of causes of the problem and ways to erase it. The resulting product will be as important to the wellbeing of family members as the various psychosocial strategies that have been developed and tested to help them better live with their relative’s illness.

References


