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REVIEW ARTICLE

Stigma in relation to families living with parental mental illness: An integrative review

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ABSTRACT: Stigma is a pervasive social mechanism with negative ramifications for people who experience mental illness. Less is known about the stigma experiences of families where a parent has a mental illness. This review aims to identify and synthesize evidence on the concept of stigma and stigma-related experiences and outcomes reported by parents and children living with parental mental illness. An integrative review method was employed, with PRISMA (Preferred Reporting Items of Systematic Review and Meta-Analyses) guidelines to search and select literature and extract and analyse data. This approach allows for inclusion of theoretical and empirical literature and for concept definition. Fifty-eight papers, mostly from the USA, Australia, and the UK, met the inclusion criteria. Stigma was primarily conceptualized in families as a marked difference that was negatively appraised, and which could be internalized. Some articles examined how underpinning assumptions could shape the behaviour of individuals and groups and be embedded within social institutions and structures. For parents, mental illness stigma was interconnected with stigma relating to perceived violations of social and cultural norms related to parenting. Children's experience of stigma resulted in bullying, embarrassment, guilt and social isolation, and efforts to conceal their parent's mental illness. One outcome was that stigma prevented children and parents from seeking much needed supports. Public health policies and campaigns that focus exclusively on promoting open disclosure of mental illness to foster community education outcomes are unlikely to be effective without additional strategies aimed at preventing and redressing the structural impacts of stigma for all family members.

KEY WORDS: children, family, mental illness, parent, stigma.

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INTRODUCTION

The stigma associated with mental illness is a complex, pervasive social mechanism that exists across societies and cultures. The adverse impacts of stigma affect not only the individual with the stigmatized condition, but also their family, including children (Corrigan 2004). This review aims to identify and synthesize evidence on the concept of stigma and stigma-related experiences and outcomes reported by parents and children living with parental mental illness. Such information can inform the development and evaluation of public health campaigns and family-based mental health interventions.

Hinshaw (2007) defined stigma as pervasive and a ‘...global devaluation of certain individuals on the basis of some characteristic they possess, related to membership in a group that is disfavoured, devalued, or disgraced by the general society’ (p. 23). There are three stigma phenomena commonly discussed in the field of mental illness; public stigma (arising from the general public), self-stigma (when an individual internalizes a stereotype about themselves), and associative stigma (stigmatization because of an individual’s association with another) (Reupert & Maybery 2015). With relevance to the current review, Goffman (1963) conceptualized stigma as ‘an attribute that is deeply discrediting, but it should be seen that a language of relationships, not attributes, is really needed’ (p. 3). From this standpoint, stigma is considered not as an individual attribute but as a social process that occurs interactively, between people and, between people, organizations and social structures.

Traditionally, much of the focus on families, stigma, and mental health examines families where a child (adult or dependent) presents with a mental health or behavioural issue (Wyder & Bland 2014). Such studies highlight the stigma associated for their parents, typically the mother, where the child’s mental health problems are seen to result from faulty parenting or inappropriate discipline (Hinshaw 2005).

Other research in the field of mental illness has focused more generally on a range of family members, including partners, children, and siblings of those with a mental health concern, and their experiences of stigma (for recent examples, see Koschorke *et al.* 2017; Krupchanka *et al.* 2018). Overall, having a relative with a stigmatizing condition such as a mental illness has been found to lead to social exclusion and shame, resulting in much effort by families to conceal their relationship with their relative and/or their relative’s illness (Hine *et al.*

2018). These stigma experiences may impact adversely on the individual with the mental illness and their families’ psychological and physical health (Angermeyer *et al.* 2003; van der Sanden *et al.* 2015).

The present review examines one particular family constellation: families where a parent has a mental illness, a factor which may (but not always) pose as a risk factor for children’s mental health and well-being (Rasic *et al.* 2014). The mechanisms conferring this risk include genetic vulnerability, family dysfunction, and the social adversities associated with mental illness including poverty (Reupert & Maybery 2016). However, not all children whose parents have mental illness will be adversely impacted nor will all children be affected in the same way (Reupert & Maybery 2016). Gladstone *et al.* (2006) make the point that having a parent with mental illness does not automatically confer psychological difficulties; instead they urge for a ‘re-casting’ of these young people as competent and active contributors to family life. Understanding their stigma experiences is a crucial aspect of this endeavour.

Overall, although there is a plethora of research on stigma there is relatively little that attempts to consider the ways that stigma manifests and is experienced in the lives of families with parental mental illness. This review aims to address that gap, synthesizing evidence on the concept of stigma for this cohort and illuminating stigma-related experiences and outcomes reported by parents and children living with parental mental illness. We also aim to examine the review findings against the broader body of work on stigma across the social sciences and consider how the results might be used to inform the development of effective stigma reduction strategies and interventions.

METHOD

An integrative review methodology, as described by Whittmore and Knaf (2005), was adopted for this study. This form of review employs systematic processes for searching and selecting appropriate literature, extracting data and evaluation, data synthesis, and presentation. The strength of this review method is synthesis of a range of literature (theoretical and empirical) and methodologies (qualitative and/or quantitative), to ensure inclusion and diversity. This approach is inclusive of concept definition. Analytic processes move past simply summarizing articles but instead aim to integrate or synthesize findings in a new way as pertains to the review aims (Whittmore & Knaf 2005).

Search strategy

PRISMA (Preferred Reporting Items of Systematic Review and Meta-Analyses) guidelines were followed for the review process (Moher *et al.* 2009). The literature reviewed was obtained using Boolean search techniques in PsycINFO, MEDLINE, Soc Index, and CINAHL plus databases. The following search strategy was used; stigma OR discrimina\$ OR stereotype OR prejudice AND parent OR mother OR father OR maternal OR paternal OR caregiver OR family OR child OR youth OR adolscen\$ OR offspring AND mental illness OR mental disorder OR psychiatric disorder.

Inclusion and exclusion criteria

To be included, papers had to address families living with parental mental illness and focus on parents with a mental illness and/or their children (both dependent and adult children), the other parent, and/or other family members such as grandparents. Extended family members were included as acknowledged important sources of support for families living with parental mental illness. Papers could be focused on stigma by design (e.g. in the research question) or the issue of stigma could arise in the results section. English language, primary research, and theoretical papers were included. Editorials, conference proceedings, dissertations, and book chapters were excluded. Those solely focused on substance use were also excluded. Given the broad changes in understandings of mental illness over time (Thorncroft *et al.* 2016), the search was limited to the previous 17 years up to December, 2019.

Screening

Titles and abstracts were reviewed by two independent researchers against the inclusion and exclusion criteria. Full texts of retained articles were then extracted and screened. Consensus discussion between 2 researchers resulted in a total inclusion of 58 articles. See Figure 1 for the Prisma diagram of the screening process.

Analysis

Specific data relevant to the aim were extracted from the identified papers, including sample characteristics and method (if empirical), references to the concept of stigma, and experiences of stigma for different family members. As per Whitemore and Knaf (2005), a constant comparison method was employed for analysis of data in order to facilitate the distinction of patterns,

themes, variations, and relationships. A matrix was used to code and extract relevant data including concepts, which were compared item by item by two independent researchers, with similar data categories grouped together (Whitemore & Knaf 2005). Consensus was reached by discussion and referring back to the original papers. Once the data extraction matrix was complete, one researcher integrated the data across all included papers, with similarities and differences highlighted. These findings were discussed and compared by two researchers, until consensus was reached. In the final step, data were synthesized into an integrated thematic presentation of findings.

Assessment of methodological quality

The process of assessment for the methodological quality of the identified qualitative, quantitative, and mixed method studies was undertaken using the Mixed Method Appraisal Tool (MMAT; Hong *et al.* 2018). Even though there is some contention about scoring papers in the MMAT, increasingly researchers are doing so, along with a summary of the study limitations (see for example, Delgado *et al.* 2017). In the rating process for this review, five criteria were assessed and rated for each study. Quality ratings were reported using stars ranging from one star (20% of the quality criteria have been met) to five (100% of criteria met) (as indicted by the number of asterisks).

RESULTS

See Table 1 for an overview of the studies identified. Most were empirical papers and originated from the USA (14) with other studies commonly conducted in the UK (7) and Australia (8). Across the papers, a variety of methodologies were employed, including the use of in-depth qualitative scale interviews and an analysis of population-based registers. Some included analyses of documents (e.g. legislature or medical records). Rather than specific diagnoses, most papers referred to severe, persistent, or serious mental illness.

Across the 58 papers, the following themes were identified: Conceptualizations of stigma; Experiences of stigma for families; Outcomes of stigma for families.

Conceptualizations of stigma

Definitions and conceptualizations of stigma varied across literature. The findings of this theme have been grouped into two sub-categories: Definitions of stigma

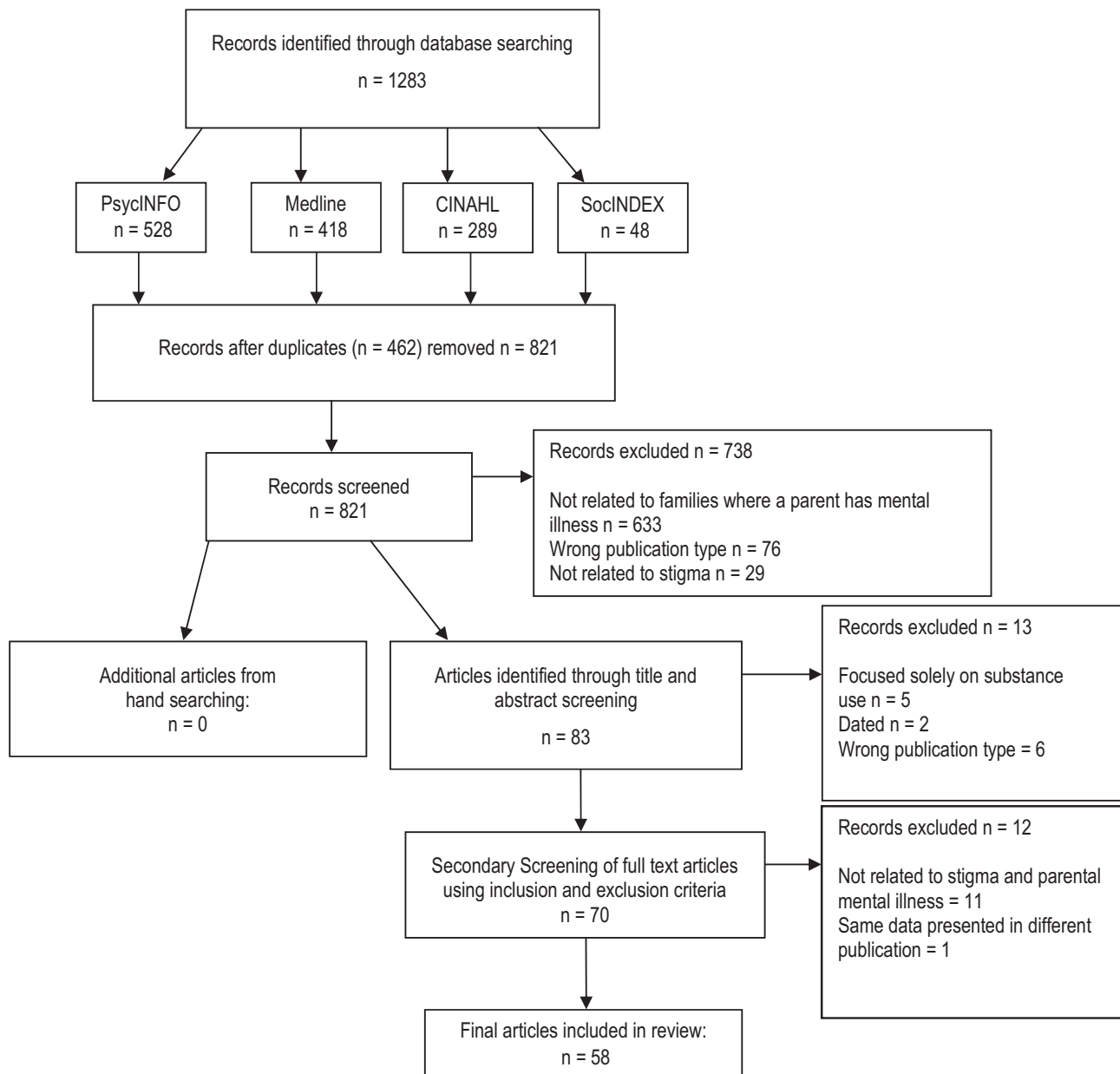


FIG. 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram. Study selection process.

and Antecedents, which are defined as the context preceding stigma phenomenon for families.

Definitions of stigma

'Stigma' was defined in a variety of ways. Some of the empirical papers did not intentionally investigate stigma but instead presented and discussed stigma as an experience reported by participants without a clear definition of the concept. Other authors used established definitions of stigma. Gonzalez et al. (2007, p. 41) for

instance, refer to Link *et al.* (2004) definition of stigma, namely, 'a separation of individuals labelled as different from "us" who are believed to possess negative traits, resulting in negative emotional reactions, discrimination, and status loss for the stigmatized persons'. Other papers (Haug Fjone *et al.* 2009; Mascayano *et al.* 2015) referred to the seminal work of Goffman (1963).

Several authors provided their own definition of stigma, typically reporting stigma as involving negative appraisal by others. For example, Einhaus (2009) described stigma in terms of difference, where the

TABLE 1 *Included papers (n = 58)*

Author and year	Country	Design, method, and participants	Key findings on stigma	Limitations	Quality score
1. Ackerson (2003)	USA	Qualitative design Individual interviews with $n = 12$ mothers and 1 father with severe mental illness	-Harassment and abuse of children -Diagnosis used against parents after divorce	-Participant sample was primarily mothers.	*****
2. Bartsch <i>et al.</i> (2016)	Australia	Qualitative design Focus groups with $n = 11$ mothers and 1 father with past or present diagnosis of borderline personality disorder	-Fear of being judged by family members, services, and broader community which discouraged help-seeking	-Participant sample was primarily mothers.	*****
3. Behague <i>et al.</i> (2012)	Brazil	Prospective birth cohort study (1982) Longitudinal epidemiological and ethnographic sub-study findings from $n = 5914$ Pelotas birth cohort	-Stigmatizing identification of teen childbearing as violation of age-appropriate norms	-Sample focused only on teen mothers due to small number of teen fathers. -21-23% loss to follow-up in epidemiological data. -Ethnographic findings presented in narrative form without themes/ categories.	***
4. Benders-Hadi and Alexander (2013)	USA	Mixed methods study on prevalence and needs of mothers in 1 psychiatric hospital Medical records of $n = 50$ mothers, patient surveys and focus groups	-Stigma associated with having a mental illness and parenting -Presumed to be bad parent	-Qualitative data analysis not specified. -Qualitative findings presented in narrative form without themes/categories.	**
5. Bhatia, Tucker and Kapoor (2003)	India	Mixed methods study $n = 32$ participants with schizophrenia and their caregivers: family burden, social functioning, brief psychiatric rating, and semi-structured questionnaires	-Family found the disruptive behaviour of the person with schizophrenia embarrassing -Social networks restricted as result	- Participants selected from one hospital -No reporting of nonresponse rate	***
6. Bhugra <i>et al.</i> (2016)	United Nation member states	Secondary document analysis of domestic laws ($n = 193$ countries) Review of Family Codes, Civil Codes, Marriage and Divorce Laws from various databases are people with mental illness, and family members.	-Stereotypes that people with mental illness lack capacity to consent and cannot enter marital contract of own free will -Concerns about heritability of mental illness in offspring -37% countries explicitly prohibited marriage of people with mental illness -In 11% countries, the presence of mental illness can render marriage void		N/A
7. Bosch, Riebschleger and van Loon (2017)	Netherlands	Qualitative phase of mixed methods study Face-to-face interviews with $n = 18$ Dutch children (12-21) whose parents had mental illness	-Children can experience guilt, shame and embarrassment about parental mental illness and 'weird' behaviours -May distance themselves from parent, and perceive parent negatively	-Interviews conducted in Dutch and translated to English. Translation process not detailed	****

(Continued)

TABLE 1 (Continued)

Author and year	Country	Design, method, and participants	Key findings on stigma	Limitations	Quality score
8. Callister, Beckstrand and Corbett (2011)	USA	Qualitative descriptive design Individual interviews with $n = 20$ immigrant Hispanic women scoring positive for symptoms of Post-Partum Depression	-Perceived stigma of mental illness was barrier to mothers seeking mental health support	-Limited explanation of study design and method. -Findings not clearly presented according to accepted practice.	***
9. Chan et al. (2019)	Hong Kong	Qualitative design Individual interviews with $n = 15$ mothers with various mental illnesses	-Self-stigma, self-doubt, and shame about being a mother with mental illness -Damaged self-efficacy -Feelings of not being accepted by others due to community beliefs about their harming others	-Member checks unable to be conducted.	*****
10. Christoffersen, Poulsen and Nielsen (2003)	Denmark	Population-based register study of children born in 1966 Time proportional modelling of data for suicide risk factors	-Stigmatization and social exclusion of children and parents increased risk of attempted suicide	-Data limited to that collected in registers. Some data may be missing.	*****
11. Cogan et al. (2005a)	UK	Qualitative study Interviews with $n = 20$ children of parents with mental illness, compared with 20 children whose parents did not have mental illness.	-Children aware of stigmatizing attitudes of others towards parent's illness but less likely to hold stigmatizing views themselves due to experience of living with parent -Concealed parent's illness from others, which lowered support seeking	-Qualitative design not specified. -Researcher reflexivity not discussed.	****
12. Cogan et al. (2005b)	UK	Multi-method study Adolescent Coping Scale and interviews with $n = 20$ children of parents with mental illness compared with children of 'well' parents	Fear of discussing parental issues with others such as teachers, preferring to keep secret -Prevented them seeking effective support and advocacy	- No discussion of the role of researcher/reflexivity	***
13. Corrigan et al. (2005)	USA	Document analysis of legislation Relevant bills introduced in 2002 in 50 states analysed for structural stigma in relation to people with mental illness Bills categorized in terms of their effect on liberties, protection from discrimination, and privacy using terms	-Half of bills reduced protections for parents who have a mental illness, including reduced parental rights -Half of bills expanded protections including not allowing use of mental health status in child custody cases		NA
14. Cremers et al. (2014)	Ireland	Qualitative design Interviews with $n = 6$ mothers using a mental health service in rural Ireland	-Little privacy or anonymity in close knit and small-minded rural community -Mothers concerned about impact of stigma on families -Embarrassed about interactions with health professionals. Hiding struggles with their illness to avoid community judgement		NA

(Continued)

TABLE 1 (Continued)

Author and year	Country	Design, method, and participants	Key findings on stigma	Limitations	Quality score
15. Dam et al. (2018)	Denmark	Qualitative design Individual interviews with $n = 11$ adults whose parents have mental illness	-Self-stigma and shame in relation to their parent's illness and feelings of being less worthy -Discrimination experienced at school	- Use of convenience sample.	****
16. Darlington and Feeney (2009)	Australia	Mixed methods design Cross-sectional survey ($n = 232$) and interview data ($n = 360$) of child protection and mental health professionals and $n = 4$ parent interviews	-Service delivery can be affected by stigma and stereotyping -Stereotyped views of clients with needs across mental health and child protection -Parental needs may not be met due to stereotyping	- No discussion of the role of researcher/reflexivity	****
17. Davidson and Scott (2018)	UK	Qualitative design Individual interviews with $n = 7$ asymptomatic adolescents whose parents had bipolar disorder and $n = 6$ unrelated parents with bipolar disorders	-Youth preferred non-stigmatizing service and non-clinical interventions -Parents preferred clinical services and early interventions	- Rationale for mixed design not discussed. - Research question not clearly stated. - Article writes about 'parent'-worker dyads but only interviewed mother-clients. -Limited discussion of the quantitative survey results.	***
18. Diaz-Caneja and Johnson (2004)	UK	Qualitative design Individual interviews with $n = 22$ mothers with schizophrenia, bipolar affective disorder or severe depression with psychotic symptoms	-Widespread assumptions that women with mental illness cannot be adequate mothers -Stigma prevents mothers talking openly about their illness -Fear others will judge them as inadequate mothers -Stigma associated with having lost custody of a child	- No discussion of researcher reflexivity/role in research.	****
19. Einarson (2012)	Canada	Discussion paper Challenges for healthcare providers in treating women with mental illnesses during pregnancy	-Stigma evident in attitudes of health professionals and not just the public -Stigma is a risk factor for mothers' negative mental health outcomes due to help-seeking delays		N/A
20. Einhaus (2009)	USA	First person account Retrospective account of having a mother with schizophrenia	-Shame about mother being different and different housing to that of friends -Not knowing about parental mental illness had protected him from 'self-stigma'		N/A
21. Fisher <i>et al.</i> (2011)	Resource constrained countries	Expert statement report Outcomes of World Health Organization meeting of international researchers on perinatal mental health in resource constrained countries	-Need to develop non-stigmatizing and accessible services for mothers		N/A

(Continued)

TABLE 1 (Continued)

Author and year	Country	Design, method, and participants	Key findings on stigma	Limitations	Quality score
22. Fudge and Mason (2004)	Australia	Qualitative design Youth consultation process – focus groups ($n = 6$) with 33 children aged 7-12 with a parent with mental illness and focus groups ($n = 2$) with 16 children aged 13-20 and $n = 9$ individual interviews.	-Lack of public understanding of mental illness -Children teased and bullied about parental mental illness -Need for universal education and stigma reduction to reduce child impacts	-Some inconsistencies in data collection and recording methods	****
23. Gatsou <i>et al.</i> (2017)	UK	Qualitative design Focus groups with $n = 16$ professionals on their experiences of working with families where parents have mental illness	-Parents experienced stigma and shame about mental illness and feared being judged -Professionals found stigma affected ability to engage with families about mental illness and gain families trust -Stigmatizing language in public social policy re families with mental illness	-No limitations identified	*****
24. Gonzalez-Torres <i>et al.</i> (2007)	USA	Cross sectional survey Baseline data of $n = 500$ caregivers of people with Bipolar Disorder participating in a treatment program. Measures of stigma, mood, burden, and coping.	-Stigma correlates included gender, age, culture, age of onset of illness, education of caregiver, available support networks -Recovery may lead to alleviation of perceived stigma for caregivers	-Exploratory study, employed theoretical sampling, which could have limited participation from those not engaged with mental health networks	*****
25. Gray, Robinson and Seddon (2008)	UK	Qualitative design Interviews with $n = 65$ professionals from health, social care, and voluntary sectors about their views on the needs of young carers of adults with mental health problems	-People with mental illness are a highly stigmatized group including their children	-Sample interviewed was not a good fit with stated research aim - Very little analysis or interpretation of the data was evident.	**
26. Haug Fjone <i>et al.</i> (2009)	Norway	Qualitative design Interviews with $n = 20$ children (8-22 years) whose parents have mental distress	-Children struggle to present themselves as 'normal' with peer groups to avoid stigma -Feelings of shame, guilt, stigma related to parent behaving differently in public compared with other parents -Self stigma common	- Findings are general and broad, much of the content is not directly related to the research questions - The analysis is limited by an overreliance on inductive interpretation and a lack of evidence in assumptions and examples provided	**
27. Hinshaw (2005)	USA	Theoretical paper Historical analysis based on review of literature on stigma in relation to parents and children with mental illness	-Social policies convey stigmatizing messages for families of adolescents -Courtesy stigma: families may also be blamed and stigmatized -For children, courtesy stigma about parent's illness involves being viewed as part of deviant, disturbed family		N/A

(Continued)

TABLE 1 (Continued)

Author and year	Country	Design, method, and participants	Key findings on stigma	Limitations	Quality score
28. Hinshaw (2004)	USA	Discussion paper Draws on personal narrative and wider literature to discuss stigmatization and silence on parental mental illness	-Stigma signals invisible mark of shame related to membership of deviant or castigated group -Strong likelihood that castigated individual will internalize the degradation		N/A
29. Jayakrishnan <i>et al.</i> (2015)	India	Descriptive correlational study design Survey of $n = 63$ adult children of parents with schizophrenia, mood disorder or other mental illness measuring self-esteem and perceived stigma	-Perceived stigma = negative qualities of adult child perceived by them on giving care to parent -No significant relationship between self-esteem and perceived stigma	-Convenience sample derived from visitors to a hospital, may not be representative of all children whose parents have a mental illness - Detail of the perceived stigma questionnaire is not provided so it is not possible to ascertain if this is a reliable measure - Insufficient detail of the statistical analysis	*
30. Jeffery <i>et al.</i> (2013)	UK	Cross-sectional telephone survey Survey of $n = 2026$ community psychiatric service users regarding discrimination about their role as parent, or starting a family, in previous 12 months	- $n = 304$ reported discrimination (73% women) -Included being seen as unfit parent, stopped from having children, not allowed to see children, not getting support needed, children avoiding their parent, children's difficulties blamed on parent's mental health	- Study gathered stigma experiences over the past 12 months only -Authors identify insufficient probing follow-up questions in interviews as a limitation	****
31. Kaplan <i>et al.</i> (2009)	USA	Discussion paper Describes educational intervention targeting states identifying parents with mental illness as 'aggravated circumstance' following analysis of Adoption and Safe Families Act of 1997 (ASFA) state statutes	-Negative beliefs about risk to children led to legislation with unfair impact on families with parental mental illness -Greater risk of child welfare involvement and parental rights terminated		N/A
32. Klausen (2016)	Norway	Qualitative case study design Single case study of mother with mental illness, drawn from a qualitative study of $n = 30$ mental health service users	-Mothers with mental illness experience triple burden of discrimination: diagnosis of mental illness; gender and motherhood stigmatized	-Context analysis developed from a co-constructed narrative based on one case study	****
33. Kornaros <i>et al.</i> (2018)	Sweden	Qualitative design Individual interviews with $n = 15$ nurses; data analysed using hermeneutical approach	-Nurses noted stigma when referring parents with mental health issues to other agencies	-Analysis and interpretation are broad and general and beyond data presented No discussion of the role of researcher/reflexivity	***

(Continued)

TABLE 1 (Continued)

Author and year	Country	Design, method, and participants	Key findings on stigma	Limitations	Quality score
34. Koschade and Lynd-Stevenson (2011)	Australia	Exploratory quantitative design Questionnaires with $n = 202$ individuals asked to respond to hypothetical scenario describing teenage girl with mother diagnosed with either schizophrenia or depression	-Differentiates between primary and associative stigma: -Primary stigma experienced by 'marked' person -Associative stigma experienced by person 'contaminated' by association with 'marked' person	-Sample of psychology students and general population drawn from one location - Variables including social norms and health beliefs were not considered	****
35. Krumm and Becker (2006)	Worldwide	Discussion paper Discusses some of the factors playing a role in family planning among women with mental illnesses	-Due to stigma associated with mental illness, fewer roles available to mothers -'Successful' mothering difficult to attain -Mothers conceal parenting challenges, and mental distress due to fear of custody loss		N/A
36. Laegsgaard <i>et al.</i> (2010)	Denmark	Qualitative design Focus groups with $n = 17$ parents and children with depression and multiple cases of depression in their family	-For adults with depression, self-stigma associated with blaming self for the impact of the illness, loss of control and failing to contribute to society	Self-selected sample of participants who had already participated in a genetic study may not be representative of the population - No discussion of the role of researcher/reflexivity	***
37. Mascayano <i>et al.</i> (2015)	Chile	Qualitative design Individual interviews conducted with $n = 20$ people (some parents) with severe mental illness re cultural factors that maintain stigma on mental illness	-Key factor shaping stigma for women was loss of capacity to accomplish family roles, that is taking care of children -In Chilean culture, stigma is rooted in gendered social characteristics and shared familial roles	- No limitations identified	*****
38. McCormack <i>et al.</i> (2017)	Unclear	Qualitative design Individual interviews with $n = 7$ adult children (20-45) whose parents had mental illness	-Shame and stigma associated with sense of alienation and inferiority	-Findings and interpretation appear underdeveloped and with potential bias against parents. Results indicative of family violence are interpreted as mental illness outcomes	**
39. Miller (2009)	USA	Discussion paper Presents clinical dilemmas in perinatal mental health care, ethical issues posed by these situations, and guiding principles clinicians may use to resolve ethical conflicts	-Stigma of health professionals comes from lack of specialized training in mental health and paternalistic attitudes -Risk of adverse outcomes for mothers and children as a result		N/A
40. Morris <i>et al.</i> (2013)	USA and Canada	Quantitative survey design Medical geneticists ($n = 308$) surveyed on stigma towards psychiatric disorders	-Geneticists who discussed psychiatric disorders the least with families had significantly higher levels of stigma	- Potential bias in self reporting of behaviours not substantiated by patient/family reporting	*****

(Continued)

TABLE 1 (Continued)

Author and year	Country	Design, method, and participants	Key findings on stigma	Limitations	Quality score
41. Murphy <i>et al.</i> (2017)	Australia	Qualitative narrative design Individual interviews with $n = 13$ adult children who had lived with parents with mental illness during childhood	-Absorbed social and community stigma at young age leading to self-stigma -Grew up being aware of being 'different' to others and need for secrecy	- Research questions not clearly articulated - Sample age meant that participants were asked to develop narratives regarding events from decades ago -No discussion of the role of researcher/reflexivity	**
42. O'Shea <i>et al.</i> (2004)	Ireland	Quantitative survey design Consultant psychiatrists ($n = 148$) surveyed on their views of children visiting psychiatric wards when parent was hospitalized	-Stigma is mental illness and hospitalization seen as potentially harmful for children, with avoidance and exclusion from visiting	No identified limitations	*****
43. Oskouie <i>et al.</i> (2011)	Iran	Qualitative design Interviews with $n = 10$ children (17-26) whose parents had mental illness, family members ($n = 3$), and health workers ($n = 4$)	-Children had shame about parent's illness and self-stigma, worrying about developing mental illness themselves -Stigma is a barrier to children sharing their experiences and seeking help	- The research questions were unclear and interview questions appeared incongruent with the purpose of exploring outcomes - No discussion of the role of researcher/reflexivity	**
44. Östman (2008)	Sweden	Qualitative design Interviews with $n = 8$ children (10-18) whose parents have a mental illness	-'Associated stigma' where children saw their whole family as being stigmatized	- Limited quantity of raw data included - Authors reported that there was no triangulation of the data	**
45. Reupert and Maybery (2009)	Australia	Qualitative design Interviews with $n = 11$ fathers with a mental illness	-Mental illness assumed by others to be the cause for all behaviours and issues -Stigma related to gender stereotypes, for example men supposed to be strong -Fathers access to children minimized or not available	- Relatively small sample and recruitment processes potentially limits generalizability	*****
46. Riebschleger, Onaga, Tableman, and Bybee (2014)	USA	Qualitative design Focus groups ($n = 3$) with parent consumers of a community mental health agency	-People judged and looked down on them, considered them to stupid or bad -Perceived children were embarrassed or ashamed of parent's illness	- Discussion and analysis sections are very brief	***
47. Rossen <i>et al.</i> (2014)	Denmark	Qualitative design Interviews conducted with $n = 7$ relatives and informal carers of Iraqi mental health outpatients	-Experienced having a relative with mental illness as shameful -Resulted in isolation and not being able to ask for help -Shame related to cultural views on mental illness as embarrassing	- Small sample with recruitment barriers due to characteristics of the marginalized population. -Data analysis conducted by one researcher, triangulation methods not reported	***

(Continued)

TABLE 1 (Continued)

Author and year	Country	Design, method, and participants	Key findings on stigma	Limitations	Quality score
48. Russo <i>et al.</i> (2015)	Australia	Qualitative design Focus groups ($n = 2$) (conducted in Dari) and interviews (conducted in Dari or English) ($n = 10$) with a total of $n = 38$ recently migrated Afghanistan-born women with at least one Australian-born child	-Cultural attitudes towards mental illness compounded stigma -Clash between expected care because of their culture and received care	-Recruitment method may have excluded more socially isolated participants -Demographics and sociocultural characteristics not reported	****
49. Savvidou <i>et al.</i> (2003)	Greece	Qualitative design Interviews with $n = 20$ mothers of dependent children who were inpatients on a psychiatric unit	-Assumption they would be bad parents due to mental illness (e.g. violent, irresponsible) -Social isolation due to negative social and family attitudes towards mental illness	-The discourse analysis process is inadequately described -No discussion of the role of researcher/reflexivity	***
50. Seamone (2012)	USA	Discussion paper Discusses how to improve the assessment of child custody cases involving combat veterans with posttraumatic stress disorder	-Negative attitudes of others on parenting abilities of people with mental illness and ability of person with PTSD caused by combat to keep children safe -Veterans have lost custody of children in custody cases		N/A
51. Solantaus and Puras (2010)	Europe	Discussion paper Describes professional development program which aims to raise awareness of the public and professionals regarding families where a parent has mental illness.	-Parent blaming indicates prevailing stigma -Children who were separated from parents and placed in foster care or orphanages also stigmatized as children of 'lunatics'		N/A
52. Tabak <i>et al.</i> (2016)	England, Finland, Germany, Italy, Norway, Poland and Scotland	Qualitative design Focus groups and interviews conducted with $n = 96$ professionals, parents with mental illness, adult children and partners of parents with mental illness.	-Families kept the illness a secret to avoid shame -In keeping family's secret, children were not able to ask for support -Also made it more difficult for others to identify needs of these young people	-Findings are inadequately developed -Analysis lacks clarity due to inclusion of data from two separate cohorts (parents and health professionals)	***
53. Trondsen and Tjora (2014)	Norway	Qualitative design Interviews with $n = 13$ participants of an online self-help group for adolescent girls (15 to 18) with a parent with mental illness	-Girls experienced 'courtesy stigma' -Lack of openness about parent's mental illness led to children blaming themselves for the illness	- No limitations identified	*****
54. van der Sanden <i>et al.</i> (2015)	Netherlands	Qualitative design Interviews with $n = 23$ immediate family members (partner, parent, child, sibling) of people with mental illness	-Person with mental illness and their family are affected by stigma -Lack of information from health professionals perceived as stigmatizing by family members -Family held responsible for illness, and/or rejected or abandoned	- Sample recruited from support groups may not be representative of the population. -Coding undertaken by one researcher. -Findings are awkwardly grouped, analysis appears under-developed.	**

(Continued)

TABLE 1 (Continued)

Author and year	Country	Design, method, and participants	Key findings on stigma	Limitations	Quality score
55. van der Sanden <i>et al.</i> (2016)	Netherlands	Cross sectional online survey design Measured prevalence of 14 coping strategies of $n = 503$ family members of people with mental illness	-Family stigma by association correlated with greater psychological distress and less perceived closeness -Perceived hereditary of mental illness associated with perceptions of public stigma	- Sample drawn from a 'panel', which is not adequately described - Measures may not have been effective in capturing all variables associated with psychological distress and quality of life.	****
56. van Doesum <i>et al.</i> (2016)	Nine countries from North America, Europe, Australia	Cross sectional survey design Mental health professionals ($n = 45$) responded to questionnaire on strategies to recruit children whose parents have a mental illness into support programs	-Stigma was the main barrier to successful recruitment of children to prevention programs	-No identified limitations	*****
57. Viganò <i>et al.</i> (2017)	6 European countries	Pre/post survey design Professionals ($n = 131$) completed skills and knowledge questionnaire pre- and post-training program on supporting children of parents with mental illness	-Stigma raises the issue of discrimination for person and their family -Professionals viewed stigma as extremely important concern when supporting children	-Only short-term impact of the intervention was able to be measured due to the short-time frames which collected self-reported knowledge acquisition and not behaviour change.	***
58. Widemalm and Hjärthag (2015)	Sweden	Qualitative design Analysis of $n = 301$ online forum posts from 35 forum threads from people who had a parent with mental illness	-Stigmatization of people with mental illness had a burdening effect on their child's situation -Lower English language skills discouraged help-seeking	- Authenticity of data and data sources could not be verified due the study being an analysis of on-line content	*****

mother was considered 'different' from other mothers. Corrigan *et al.* (2005) extended the notion of 'difference' by pointing out that stigma also involves others' appraisal that the individual with the stigmatizing condition is responsible and blamed for that condition.

Laegsgaard *et al.* (2010) used the term self-stigma to denote 'the internalization of stigmatizing attitudes by the stigmatized person themselves' (p. 471) while Hinshaw (2005) observed 'the insidiousness of stigmatization is evidenced by the fact that virtually all of the individual's attributes come to be interpreted in light of the mark or flaw (p. 715).

Stigma was also defined in terms of prejudice and discrimination. For example, Corrigan *et al.* (2005) highlighted the policies of private and governmental institutions that restrict the opportunities of stigmatized groups. He employed the term 'disclosure stigma' to describe how this can lead individuals to conceal their stigmatized characteristics, in interactions with such institutions. Similarly, Jeffery *et al.* (2013) defined stigma in structural terms, involving prejudice and discrimination and as 'an individual's perception that they have been treated unfairly' (p. 121).

The final way that stigma was defined was through association. Koschade and Lynd-Stevenson (2011) differentiated between *primary* stigma, experienced by a 'marked' person, and *associative* stigma, which is encountered by someone who is 'contaminated' through their association with a marked individual (p. 93).

Antecedents of stigma

The context or antecedents preceding the stigma phenomenon for families includes three key elements; social and cultural norms, structural discrimination, and the family environment. The antecedent that was most frequently identified was associated with *social and cultural norms* about parenting and in particular motherhood. Pervasive negative attitudes regarding mental illness and assumptions about the capabilities of people with mental illness, especially in relation to parenting (Jeffery *et al.* 2013), gave rise to prejudice and inequality. In addition to the diagnosis of mental illness, gender and motherhood also seemed stigmatizing to these women, who were already in exposed positions

because of their illness and its challenges (Klausen 2016). There were examples of sexism, racism, and a general distaste for diversity which was interpreted as deviance and punished with exclusion (Krumm & Becker 2006). Children, for example, could be targeted for having 'weird' parents (Bosch *et al.* 2017). Men who displayed their emotions and vulnerability within a masculine culture in Chile were at risk of '... perceived or anticipated stigma from community members regarding mental illness (which is) contingent on adherence to socially constructed gender identities' (Mascayano *et al.* 2015, p. 258).

A second category of antecedent was *structural discrimination*, identified within institutions of law, medicine and education. In legal settings, discrimination was apparent in terms such as 'unsound mind' (Bhugra *et al.* 2016) with the connotation that judgement in all matters is impaired by a mental illness. Researchers in the US identified that in the drafting of child protection legislation, including parental mental illness as an 'aggravated circumstance' resulted in an increased likelihood of these parents having their children removed from their custody (Kaplan *et al.* 2009). In one first person narrative, the silence surrounding parental mental illness was medically instructed and sanctioned in that a psychiatrist explicitly recommended that parents not discuss a father's psychiatric condition or symptoms with their children (Hinshaw 2005). Other researchers found that health professionals took a negative (Kornaros *et al.* 2018) or paternalistic attitude towards patients who aspired to be parents, cautioning against pregnancy due to an over-emphasis on genetic inheritance of psychiatric conditions (Bhugra *et al.* 2016; Koschade & Lynd-Stevenson 2011).

The third category of antecedent was the *family environment*. Within families, the ways in which parental mental illness was understood, managed, and communicated could potentially promulgate increased internalized stigma. Researchers found that concealment of the illness from others (Hinshaw 2005), topic avoidance in family discussion (Reupert & Maybery 2009) and a lack of language to describe the experience of mental illness in positive or neutral terms (Murphy *et al.* 2017), all led to increased levels of internalized stigma. A lack of understanding of how health services could potentially assist or support compounded family isolation and marginalization. The family context, influenced by broader social and cultural norms, reinforced an intra-family silence surrounding mental illness which led to intense feelings of difference for children,

exacerbated by the absence of explanation (Haug Fjone *et al.* 2009). A strong reluctance to seek resources outside the confines of the family was found to stem from a fear of detection and social rejection (Gonzalez *et al.* 2007).

Experiences of stigma for families

Children and families experienced stigma related to parental mental illness in a variety of ways. These are presented according to the respective attributes for children, and for parents.

Children and youth reported feeling embarrassment and shame in relation to their parents' mental illnesses (Bosch *et al.* 2017; Cogan *et al.* 2005a; Dam *et al.* 2018; Hinshaw 2005; Oskouie *et al.* 2011; Östman 2008; Riebschleger *et al.* 2014; Rossen *et al.* 2014; Widemalm & Hjärthag 2015). One common attribution made by children was that their family was 'different' and that this was an issue that they felt should be hidden from outsiders (Dam *et al.* 2018; Einhaus 2009; McCormack *et al.* 2017; Murphy *et al.* 2017; Östman 2008; Tabak *et al.* 2016; Widemalm & Hjärthag 2015). The shame developed over time and was associated with a realization that their families were different and considered inferior and dysfunctional (Gonzalez *et al.* 2007; McCormack *et al.* 2017; Murphy *et al.* 2017). Bosch *et al.* (2017) noted that some children internalized this stigma and blamed themselves, or felt guilty, for their parent's illness.

Parents also described feeling embarrassed (Hinshaw 2005), ashamed, and/or guilty over the potential effects of their illness on children (Chan *et al.* 2019; van Doesum *et al.* 2016; Gatsou *et al.* 2017; Hinshaw 2005) and were fearful of the negative reactions or judgements from others, including health and support services (Chan *et al.* 2019; Bartsch *et al.* 2016; Cogan *et al.* 2005b; Cremers *et al.* 2014, 2016; Gatsou *et al.* 2017). In Laegsgaard *et al.* (2010, p. 475) self-blame was experienced, based on perceptions about the parent's illness associated with a 'loss of control and the failure to contribute to family life and to society' (Laegsgaard *et al.* 2010, p. 475).

Outcomes for parents and children

A primary outcome of stigma for parents and their children was public ostracism and subsequent social isolation. Exclusion from meaningful participation in everyday activities associated with work, friendships, and family was reported, which for some, led to

poverty, a diminished social status, and for some, suicide (Christoffersen *et al.* 2003, Klausen 2016; Mays-cayano *et al.* 2015; Östman 2008).

Another outcome of stigma was parents' and children's lack of desire, or ability to seek help, or engage with mental health services and supports (Ackerson 2003; Bartsch *et al.* 2016; Calliste *et al.* 2011; Cogan *et al.* 2005a, 2005b; Cremers *et al.* 2014; Diaz-Caneja & Johnson, 2004; Hinshaw 2005; Kaplan *et al.* 2009; Miller 2009; Morris *et al.* 2013; O'Shea *et al.* 2004; Oskouie *et al.* 2011; Rossen *et al.* 2014; Russo *et al.* 2015; van der Sanden *et al.* 2015; Widemalm & Hjar-tag, 2015). To avoid shame, children were asked to keep the family's secret; this in turn led them to avoid-ing social activities thus reducing opportunities for social development, and to seek help (Cogan *et al.* 2005a, 2005b; Murphy *et al.* 2017; Oskouie *et al.* 2011; Tabak *et al.* 2016). Likewise, parents who felt com-pelled to conceal family problems (Hinshaw 2005), reduced children's access to prevention support (Van Doesum *et al.* 2016). 'A culture of secrecy' emerged where 'anticipated public ridicule and embarrassment' was deemed to be a greater risk than 'having unmet emotional and practical needs' (Murphy, Peters, Wilkes & Jackson, 2017, p. 335).

Haug Fjone *et al.* (2009) reported that some young people tried to emulate others, to be 'normal', by finding solitude and developing artistic expression. A lack of information and openness about parental mental illness led to children blaming themselves for their parents' problems (Hinshaw 2005; Trondsen & Tjora 2014); feel angry towards the parent due to a lack of understanding of their parents' behaviours or symptoms associated with mental illness (Östman 2008; van der Sanden *et al.* 2016) or avoiding a relationship with the parent altogether (Bosch *et al.* 2017; Jeffery *et al.* 2013).

Some studies found that children experienced bully-ing and teasing at school (Fudge & Mason 2004) were socially avoided and excluded from communal events (Dam *et al.* 2018; Gatsou *et al.* 2017; Hinshaw 2005; Koschade & Lynd-Stevenson 2011; Oskouie *et al.* 2011). These experiences resulted in disengagement from education for young people, limiting access to lei-sure activities and vocational options (Gray *et al.* 2008). Nonetheless, some outcomes of experiencing stigma were positive because children reported that having to deal with the reactions of others promoted resilience and empathy (Corrigan *et al.* 2005).

Further demonstrating the intertwined nature of stigma, discriminatory child welfare practices resulted in parents feeling grief, loss, and fears about the impact

of such practices on children (Kaplan *et al.* 2009). As a result, women concealed their parenting challenges when they experienced mental distress (Cremers *et al.* 2014). Fathers hid symptoms of illness and avoided seeking help for mental health problems to mitigate further loss of access to their children (Reupert & Maybery 2009). The blame placed on both women and men who have a mental illness and are parents, can lead to children being placed in care and separated from the parent, triggering further stigmatization for the child as well (Solantaus & Puras 2010). Similarly, the fathers who experienced various mental health issues in Reupert and Maybery's (2009) interview study reported being 'blamed' for any difficulties their chil-dren exhibited.

DISCUSSION

Though stigma is a well-established issue in the general mental health literature, careful consideration is required as to the specific ways that stigma manifests, is experienced, and impacts families where a parent has a mental illness. Given the growing interest in par-ental mental illness as a public health issue (Reupert & Maybery 2016), it is timely to focus on the ways that stigma is experienced by these families and the out-comes faced by parents and children, to inform strate-gies for stigma reduction. The observation that stigma was highlighted in studies with children and parents when it was not a specific focus of those studies demonstrates that it is an issue of concern for families. A sophisticated understanding of how stigma manifests and impacts vulnerable families is required and the studies that defined it narrowly as 'difference' do little to progress this field.

In respect to the conceptualization of stigma, a key finding from the review is that stigma in relation to families where a parent has a mental illness does not originate only from negative conceptions of, and atti-tudes towards, mental illness itself. Rather, for parents with mental illness, stigma is compounded by, and interconnected with, a set of social expectations of par-enthood against which they are liable to be judged (or to judge themselves). This dimension of stigma includes elements of perceived gender stereotype fail-ure, particularly mothers' perceived failure to fulfil an appropriate nurturing role whilst having a mental ill-ness (Diaz-Caneja & Johnson 2004), of diminished par-enting capability associated with mental illness (Savvidou *et al.* 2003) and of blame and shame for a form of genetic contamination by which parents who

have a mental illness are seen as bearing responsibility for mental health problems being passed on to their children (Koschade *et al.* 2011).

When a parent has a mental illness, whole families are liable to experience the social ostracism that is a common consequence of stigma. Moreover, everyone in the family is drawn into attempts to manage stigma, with by far the most common reported response being attempts to conceal the parent's mental illness from others, including professionals and services (Hinshaw 2005) which Corrigan *et al.* (2005) describe as 'disclosure stigma'.

Gronholm *et al.* (2016) found that young people with mental health difficulties engaged in 'conditional' disclosure to manage complex help-seeking processes and the perception of risk associated with disclosure. This nuanced way of thinking about stigma, and disclosure may be significant to future research with families where a parent has a mental illness. Reconceptualizing stigma in relation to disclosure can reframe how we understand silence and concealment in families as a response to stigma that has its own consequences. The silence surrounding parental mental illness is associated with, and contributes to, family members having low mental health literacy. This can lead to further self-stigmatization and social withdrawal for the whole family, potentially increasing the consequences that follow from intergenerational experiences of illness and thus, negatively impacting access to effective support and treatment (Trondsen & Tjora 2014).

Goffman's definition of stigma has been used to frame the illness experience in terms of a blemish of character (in Goffman's language) through which individuals, including parents with mental illnesses, are assumed to be incapable, and accordingly, face public devaluation, rejection and internalized negative self-beliefs (Corrigan & Watson 2002). Less commonly noted but potentially useful here is how Goffman's investigation included the notion that stigma attaches itself to people, through others' perception that they fail to live up to 'socially standardized anticipations' relating to their 'conduct and nature as an instance of [a] category' (Goffman 1963, p. 69). The findings of this review demonstrate the importance of recognizing this sometimes-forgotten aspect of stigma – and as noted above, some of the most powerful impacts of stigma have been found when parents are judged, worry about being judged, or judge themselves as failing to live up to the requirements of the category of 'parent'.

These findings also highlight the importance of recognizing the place of relationality in the concept of

stigma, or the need for a 'language of relationships' (Goffman 1963, p. 3). This review shows that it is not only a set of essential negative meanings associated with a stigmatized characteristic that give rise to stigma, but also how characteristics are given meaning and interact with a network of relationships and relational expectations within which individuals live their lives. The findings of this review make clear are that these networks of relationships and social role expectations differ for different individuals, and hence the impacts of stigma differ. Thus, for parents, stigma is centred on shame for their (in)ability to fulfil an idealized parenting role and blame for their children's problems, and for children, teasing, bullying, and embarrassment at not having a 'normal' parent.

Another important finding is the way in which experiences of stigma are related to power and reflect socially standardized role expectations that are gendered. Link and Phelan (2001) argue for an ongoing recognition of the role of power and discrimination in how stigma operates on certain characteristics and particular social roles. This perspective also recognizes that the stigma associated with socially standardized and sanctioned gender roles cannot be properly interrogated without recognizing the structural role of power and discrimination within which such gender roles exist. Other review findings illustrate the importance of moving beyond a micro-sociological focus on interactions, role performance, and identity management to consider, for instance, legal frameworks in which rights and sanctions for parents who have a mental illness are established, and the structure of institutional spaces in which people receive treatment.

IMPLICATIONS FOR RESEARCH AND POLICY

A number of researchers have been rethinking stigma to consider not only the intentions of individuals who hold relative amounts of power, as discussed by Link and Phelan (2001), but also to examine the roles of multiple institutional actors (e.g., media and government) in promoting stigma in the form of broad, active processes of blaming and shaming of specific groups. For example, the work of Tyler and Slater (2018) broadens the use of stigma in a way that moves beyond an examination and alteration of individual attitudes to interrogate the struggles of the stigmatized against social structures that re/produce and mark them as inferior.

These arguments have special resonance within the field of parent and family mental health and suggest the potential for connecting work regarding stigma in families with parental mental illness to critical work in social policy (Crossley 2018), the sociology of parenthood (Gillies 2014), the sociology of childhood (Gladstone *et al.* 2006), and the sociology of stigma (Tyler 2018). For instance, though a number of the identified papers noted the negative impacts of demanding social and gendered expectations around parenthood and the responsibilities of parents for the wellbeing and mental health of their children, this was not connected to a critical consideration of what preceded the ways that stigma was experienced by families. As Tyler (2018) encourages us to ask – where do these norms come from, who do they serve and how might they be challenged or transformed? Other critical work in the sociology of parenthood suggests a useful background here in examining how moral responsibilities of parenting have been historically framed and increasingly individualized (Gillies 2014) and how media representations of families and structural locations such as class and gender actively embed these individualized responsibilities as common-sense ideas (Jensen 2014).

Similarly, among the papers identified there was a focus on ways in which, when parental mental illness is present, whole families become stigmatized, by professionals, services, and in policy (as for instance by referring to them as ‘problem families’, for example Cameron 2011). Again, there is potentially useful work from other social scientists that examines and critiques the ways in which certain families have been actively stigmatized over time, through being positioned as social problems in ways that individualize their problems and creates them as targets of punitive and stigmatizing policy interventions – often referred to as ‘troubled’ or ‘problem’ families (Crossley 2018; Crossley & Lambert 2017). Given the barriers to accessing mental health services that disclosure stigma and self-stigma pose, it is incumbent on mental health advocates and leaders to address this stark disconnect. Robust advocacy within the media and political discourse must challenge dominant perceptions of parenting with mental illness and enable informed debate surrounding social norms as they relate to parenting.

RELEVANCE FOR CLINICAL PRACTICE

To promote views that family members bring valuable knowledge that can contribute to addressing complex social problems, clinicians, and services might adopt co-

production principles with children and parents in their work. Clinicians need to acknowledge the role that some children assume in these families as carers and provide opportunities for children to be active contributors to their parents’ treatment plans (Reupert *et al.* 2008). Such efforts serve to reframe children’s contributions and experiences away from objects of pity (Gladstone & Stasiulis, 2017) to stories of resilience, autonomy and hope.

LIMITATIONS AND FUTURE RESEARCH

There are limitations in both the review methodology and the papers identified. It is acknowledged that different papers may have been identified if diagnostic specific search terms such as depression or schizophrenia were employed. Some of the common methodological issues in the qualitative papers concerned the role of researcher reflexivity, which is surprising given the focus of stigma. Other limitations across studies included a focus on a single country, or participant group (e.g., from a single agency or setting), an inadequate discussion or presentation of results, or a lack of rationale for the methodology employed. Overall, there is a paucity of research conducted in low income countries and the means by which culture influences stigma experiences. Relatedly, how members from more than one stigmatized group (for example, gender, mental illness, and cultural identify) experience stigma and discrimination needs further nuanced attention. How stigma might impact extended family members and in particular grandparents, could also be investigated, especially as there were no included papers that explored this demographic. Further research might consider whether and how disclosures and conversations about parental mental illness, conducted within and outside of the family (in settings such as schools and workplaces), might be used to promote mental health literacy and anti-stigma messages. Likewise, identifying community members and health professionals who do not associate negative connotations to these families might help to develop anti-stigma strategies. Finally, more research is urgently required that develops and evaluates community, organizational, and policy level anti-stigma interventions for these families.

CONCLUSION

This review highlights the importance of recognizing that the mental illness label itself is not the only basis for the experience of family stigma, and that attention is also needed on issues of blame and shame related to

the performance of individuals against socially standardized and idealized roles associated with their membership of mother, father, and child. There is scope to expand on the treatment of power in relation to stigma for these families, especially around the construction, communication, and social enforcement of normative evaluations of the performance of parenting and family life. On a micro level, families need inclusive, solution-focused language to talk about mental illness among themselves and be given the opportunity to share their worries and challenges in a non-blaming manner. They may also be encouraged to identify and celebrate the strengths that come with addressing adversity. However, the focus of many current anti-stigma activities on being open about mental illness (Henderson *et al.* 2013) is not likely to address the breadth of family experience identified in the present review.

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