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Review Article

Family Stigma: A Concept Analysis

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SUMMARY

Purpose: Stigma negatively affects individuals as well as entire families; therefore, it is necessary to understand "family stigma" in order to reduce the social and emotional distress of families suffering from stigma and prevent the resulting avoidance of social support and treatment. Thus, this study clarifies the concept of "family stigma" by using concept analysis method.

Methods: In order to analyze the concept, we reviewed the relevant literatures. Characteristics that appeared repeatedly throughout the literature were noted and categorized.

Results: Three key defining attributes were identified: (a) others' negative perceptions, attitudes, emotions, and avoidant behaviors toward a family, because of the unusualness of the family, including the negative situations, events, behaviors, problems or diseases associated with that family, or because of the unordinary characteristics or structures of that family; (b) others' belief that the unusualness of the family is somehow harmful, dangerous, unhealthy, capable of affecting them negatively, or different from general social norms; and (c) others' belief that the family members are directly or indirectly contaminated by the problematic family member, so that every family member is also considered as harmful, dangerous, unhealthy, capable of having a negative effect on others, or different from general social norms.

Conclusion: The results of this study are expected not only to guide future research but also to enhance family care in nursing practice.

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Introduction

Stigma is a barrier that can prevent patients with mental illnesses from getting appropriate treatment or care (Cooper, Corrigan, & Watson, 2003). In fact, about 50%–60% of people with mental distress avoid treatment or care because of fear of being stigmatized (Substance Abuse and Mental Health Services Administration, 2003). For this reason, many previous psychiatric studies have focused on stigmas related to mental disorders, especially those associated with schizophrenia, drug addiction and such (Corrigan, Watson, & Miller, 2006). However, it is important for nurses to understand that patients with mental disorders are not the only people who suffer from stigma. In fact, many people suffer from stigma with reasons varying from person to person (Mwinituo & Mill, 2006). More importantly, because of the fear of being stigmatized, such people tend to be avoid interpersonal relations and isolate themselves from society (Lefley, 1989); moreover, they often lack support and medical care because of their stigma. Health professionals, including nurses, can also express negative attitudes or have negative stereotypes because of stigma, which could lead them to disrespect those afflicted, hindering trust and rapport between health professionals and their patients (Mwinituo & Mill, 2006).

More importantly, stigma is not limited to the individuals experiencing it directly; family members associated with those individuals can also be affected (Lefley, 1989). Thus, it is essential for health professionals to better understand this phenomenon, especially with regard to how it affects a family unit. Nonetheless, there has been a lack of agreement on the definition regarding family stigma so far, even though a number of studies have examined families' stigmatization experiences. However, it is important to clarify family stigma as a concept so that its theoretical and practical aspects can be better studied. This, in turn, could lead to the development of research tools for measuring it. For this reason, in this study, we analyzed the aspects of family stigma by using the concept analysis method (Walker & Avant, 2005).

Concept analysis is a method for deriving precise theoretical and operational definitions of certain words, terms or symbols by clarifying their constituent properties. This method differs from

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other strategies, such as concept synthesis or concept derivation; concept synthesis refers to the method of developing new concepts, while concept derivation refers to the translation of concepts across disciplines (Rodgers & Knafl, 2000; Walker & Avant, 2005). Since the concept of family stigma is neither a wholly new concept nor a concept originating from another discipline, we deemed concept analysis the most appropriate method. Therefore, we used concept analysis in order to clarify the meaning of the term "family stigma".

As mentioned above, family stigma is not a new concept. However, no previous study has attempted to describe its attributes or to define it precisely. Furthermore, no study in the nursing field has explored it as a concept. There are, however, two previous studies that explored concepts related to family stigma. First, Lee and Lee (2006) used concept analysis to clarify "stigma" as used by Walker and Avant (2005). According to their results, stigma has four attributes: "devaluing", "labeling", "negative stereotypes", and "discrimination". However, their study focused on stigma as experienced by individuals, and did not consider how it affected families. Second, Larson and Corrigan (2008) did study family stigma, but only focused on families in which a member had some form of mental illness.

To fill this gap, the present study defined general family stigma and examined its characteristics by using the concept analysis method described by Walker and Avant (2005). A literature review was used to define the concept. In addition, this study investigates the antecedents, attributes, consequences, and empirical referents of family stigma. Finally, three case studies—model, borderline, and contrary cases—are provided to better elucidate the concept of family stigma.

Methods

Study design: A concept analysis

Concept analysis is a way of examining the structure and function of specific concepts, allowing us to clarify and refine ambiguous concepts in nursing theories. Thus, concept analysis is important and useful for theorists in constructing relationships between concepts, as well as hypotheses and instruments for researching these concepts (Walker & Avant, 2005). There are three major approaches to analyzing concepts, all of which are derived from Wilson's method (1963): Walker and Avant (1983, 1988, 1994), Chinn and Jacobs (1983, 1987), and Chinn and Kramer (1991). These approaches are somewhat different in terms of the steps and the ordering of the analytic process. We employed the method developed by Walker and Avant; unlike Chinn and Kramer's method, which emphasizes various contexts and situations to determine the nature of the concept, Walker and Avant's method elucidates the concept by providing antecedents, consequences, and empirical referents (Hupcey, Morse, Lenz, & Tasón, 1996; Rodgers & Knafl, 2000; Walker & Avant).

The specific procedures for this method are listed as follows:

(a) Select the concept to be analyzed.
(b) Determine the aim and purpose of the study.
(c) Identify all uses of the concept.
(d) Determine the defining attributes of the concept.
(e) Construct model cases illustrating this concept.
(f) Construct additional cases, including borderline, related, contrary, invented, and illegitimate cases.
(g) Identify the antecedents and consequences of the concept.
(h) Identify empirical referents.

However, according to Walker and Avant (2005), even though they provided eight steps that seems sequential for analyzing the concept, in fact the steps can be iterative. In other words, it can be flexible in terms of its analysis procedure. In addition, many previous studies that used the Walker and Avant method also showed flexibility in arranging the steps and laying out the results (Brush, Kirk, Gultekin, & Baiardi, 2011; Gray & White, 2012). Thus, in this paper, we show family stigma in sequence of antecedents, attributes and consequences for readers' ease of understanding. Also, we provide a model case and additional cases. Specific layout of this paper is as the following:

(a) Select the concept to be analyzed.
(b) Determine the aim and purpose of the study.
(c) Identify all uses of the concept.
(d) Identify antecedents of the concept.
(e) Identify attributes of the concept.
(f) Identify consequences of the concept.
(g) Identify empirical referents.
(h) Construct a model case illustrating this concept.
(i) Construct additional cases, including borderline and contrary cases.

Data collection

A literature review was conducted to define the concept "family stigma". To find the relevant literature, we used three online databases: CINAHL, PsycINFO, and PubMed. We limited our search to studies published between January 1985 and December 2012. These literature databases were searched using the keywords "family stigma". In the case of PubMed, we used a combinations of MeSH terms—"attitude", "social stigma", "family stigma", and "stereotyping". If the studies did not include familial aspect of stigma or if the studies were written in languages other than English or Korean, those studies were not reviewed. Specific procedures for data collection are illustrated in Figure 1.

Data analysis

Relevant studies were screened and then read in detail. Characteristics of family stigma that appeared repeatedly throughout the literature were recorded and categorized into antecedents, attributes, and consequences. Studies were continuously read until achieving informational saturation. As a result, a total of 16 relevant studies were reviewed. Information from reviewed studies contributed to the final decisions for antecedents, the cluster of attributes and consequences.

Results

Definitions and use of the concept "family stigma"

Walker and Avant (2005) recommended using dictionaries, thesauruses, and any possible literature to identify the use of the concept. However, the word "family stigma" could not be found in either the dictionary or Wikipedia. Thus, we searched for "stigma" in general. According to *The American Heritage Dictionary* (2012), stigma is "an association of disgrace or public disapproval with something, such as an action or condition". It is derived from the Latin *stigma* or *stigmat-,* meaning "tattoo mark" or "indicating slave or criminal status". According to *Nisus Thesaurus*, synonyms of stigma are "brand", "mark", and "stain". The word "brand" is defined as "a name given to a product or service", "mark" is "a distinguishing symbol", and "stain" is defined as "a symbol of disgrace of infamy" (*Nisus Thesaurus*, 2006). Moreover, the word "stigma" has various definitions according to different disciplines.

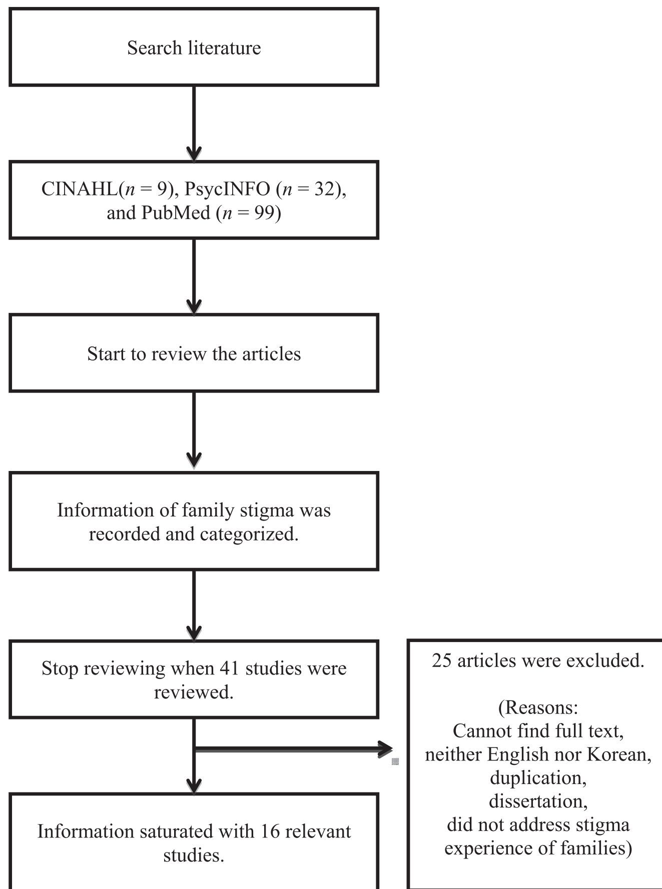

Figure 1. Flow diagram of data collection.

In medicine, it stands for "a visible indicator of disease" or "a small bodily mark, especially a birthmark of scar, that is congenital or indicative of a condition or disease". Similarly, in psychology, stigma means "a bleeding spot on the skin considered to be a manifestation of conversion reaction". Finally a more archaic use of the term is "a mark burned into the skin as a visible identifier of a person as a criminal or slave; a brand". Wikipedia has an entry on "social stigma" instead of "stigma" or "family stigma". It defines "social stigma" as "the extreme disapproval of, or discontent with, a person on the grounds of characteristics that distinguish them from other members of a society".

In the psychology literature, Goffman (1963) was the first to define the concept of stigma. Goffman defined stigma as a visible mark—for example, scars from burns—that distinguished a discredited group of people from the general population. However, the meaning has since become more complex, now describing not only the mark itself, but also the consequences of having it, including negative stereotypes, prejudice, and discrimination (Goffman; Hinshaw, 2005; Larson & Corrigan, 2008). Three types of stigma have been defined: structural stigma, public stigma, and stigma by association. First, a structural stigma refers to imbalance and injustice seen in a social institution. For example, it could refer to poor quality of care given by health professionals towards a stigmatized individual or group. Second, public stigma describes the negative attitudes of the general population towards a stigmatized group. Finally, stigma by association is defined as discrimination due to having a connection with an individual who is stigmatized (Larson & Corrigan; Werner, Goldstein, & Heinik, 2011).

In our review of the literature, several studies were found describing stigma in families. Family stigma related to mental disorders was described by Larson and Corrigan (2008). They provided three stereotypes associated with family stigma: shame, blame, and contamination. Families with a member who has a mental disorder could experience shame because others might blame them for somehow being responsible for the disorder. In addition, all family members can be considered somehow "contaminated" because of the close relationship they have with the stigmatized family member.

Lefley (1989) also examined family burden and stigma related to mental disorders. She reported that even though discussing the stigmatization toward mentally ill people is crucial, it is also important to understand the effects of the stigma on the entire family, including both the immediate household and extended family.

Furthermore, several studies have explored families' stigma experiences qualitatively. Those experiences examined by previous studies have been associated with HIV, Alzheimer's disease, depression, drug addiction, emphysema, sexual identity and so on (Brickley et al., 2009; Corrigan et al., 2006; Mwinituo & Mill, 2006; van Dam, 2004; Werner, Goldstein, & Buchbinder, 2010; Werner et al., 2011).

Antecedents

Walker and Avant (2005) defined antecedents as "those events or incidents that must occur prior to the occurrence of the concept". In terms of family stigma, several antecedents can be shown as leading up to the occurrence of the phenomenon.

The first antecedent is the overall unusualness of the family (Figure 2). One example of unusualness is the occurrence of highly negative events in a family. Specifically, this refers to the occurrence or history of negative situations, events, incidents, problems, or diseases in one family, which affect either the whole family or one member. This can include being involved in a crime or having a very ill family member. If the illness requires a high caregiver burden, co-occurring with unpredictable, chronic behavioral problems or conflicts with neighbors, then the antecedent could be much stronger and would more likely lead to that family being stigmatized (Lefley, 1989). The second example of unusualness is having unordinary family characteristics or structures, one that is markedly different from the norm of general society. Families with homosexual parents, single-parent families, minority families, or families who are members of pseudo-religions are examples of unordinary family units.

The next antecedent is the spread of information about that family to the wider public. In other words, people in the neighborhood or town come to know the supposedly negative aspects of that family, such as the negative incident that they were involved in, the illness of the family member, or the unordinary characteristics or structure of that family.

Defining attributes of the concept

According to Walker and Avant's (2005) methodology, in order to determine the defining attributes of family stigma, we must identify the attributes associated with it. For this reason, we reviewed the relevant literature, and then noted and summarized the characteristics that repeatedly appear. The characteristics were revised and modified based on the decisions by the authors. Finally, three key defining attributes were identified for family stigma (Figure 2):

(a) others' negative perceptions, attitudes, emotions, and avoidant behaviors toward a family (and every family member), because of the unusualness of the family, including the

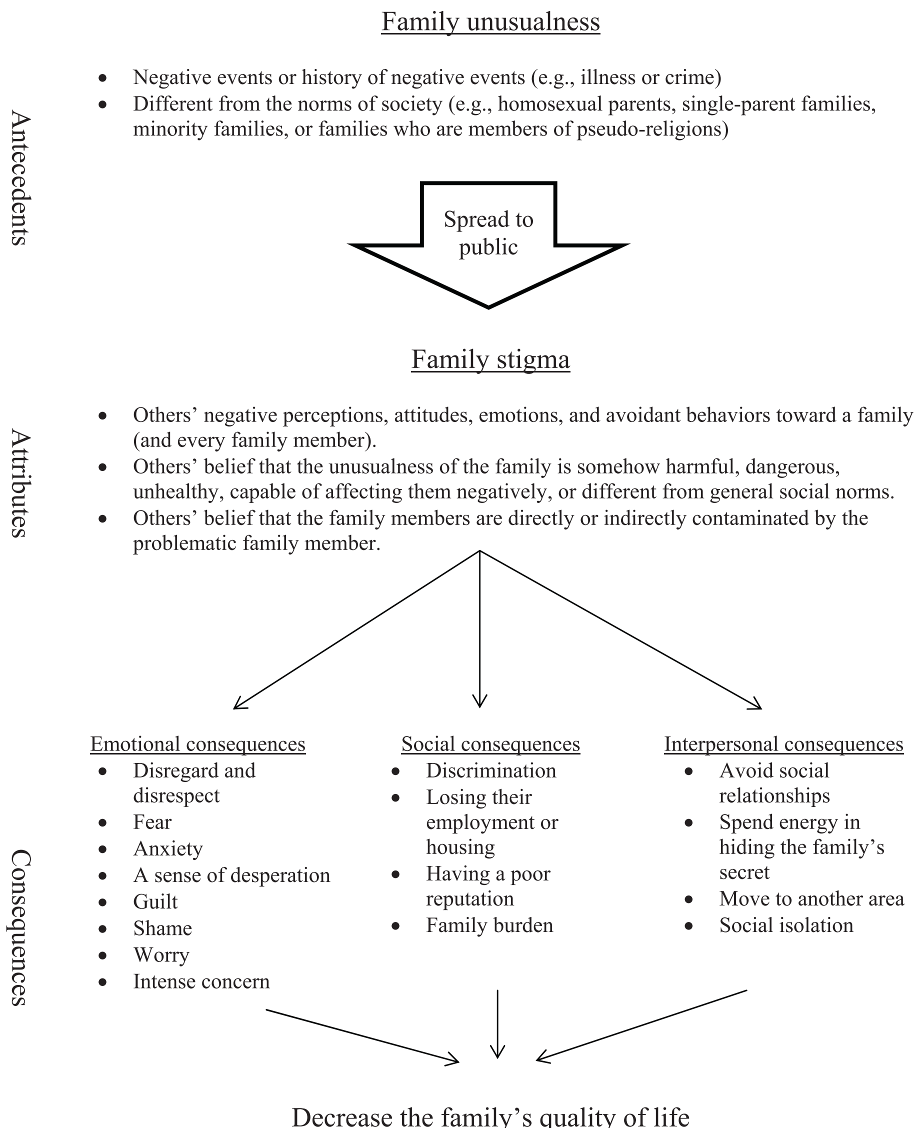

Figure 2. Conceptual model of family stigma.

negative situations, events, behaviors, problems or diseases associated with that family, or because of the unordinary characteristics or structure of that family (Corrigan et al., 2006; Larson & Corrigan, 2008; Phelan, Bromet, & Link, 1998; van Dam, 2004; Werner et al., 2011);

(b) others' belief that the unusualness of the family is somehow harmful, dangerous, unhealthy, capable of affecting them negatively, or different from general social norms (Brickley et al., 2009; Hinshaw, 2005; Pirutinsky, Rosen, Shapiro Safran, & Rosmarin, 2010); and

(c) others' belief that the family members are directly or indirectly contaminated by the problematic family member, so that the every family member is also considered as harmful, dangerous, unhealthy, capable of having a negative effect on others, or different from general social norms (Corrigan et al.; Larson & Corrigan; van Dam; Waller, 2010).

Consequences

Walker and Avant (2005) defined the consequences of a concept as the outcomes or results of the occurrence of the concept. The emotional consequences of the family experiencing a stigma are typically the feeling of disregard and disrespect. Related to that, they feel shame, fear, anxiety, a sense of desperation, guilt, worry, and intense concern (Brickley et al., 2009; Dalky, 2012; Larson & Corrigan, 2008; Mwinituo & Mill, 2006; van Dam, 2004; Werner et al., 2010; Wong et al., 2009). In addition, socially, they could experience discrimination, such as losing their employment or housing, having a poor reputation, family burden and so on (Larson & Corrigan; Lefley, 1989; Pirutinsky et al., 2010; van Dam). Consequently, they might avoid social relationships, spend energy in hiding the family's secret, or move to another area, and it could lead to family's social isolation (Corrigan et al., 2006; Mwinituo & Mill, 2006). Finally, they would be unable to get consistent help or support, and thus, their quality of life would decrease (Figure 2).

Empirical referents

Empirical referents are the categories of actual phenomena that make us measure and recognize its existence or presence. Once identified, the empirical referents are useful in regard to developing the instrument since they are developed based on theoretical analysis of the concept (Walker & Avant, 2005).

So far, there is no measurement specifically measuring general family stigma. The majority of studies have used qualitative methods for examining a family's subjective stigma experiences. However, others have employed more quantitative measures—-most of them modified existing measurements, and those scales were specific to certain conditions. For example, they evaluated the family stigma due to mental illness, the family/marriage stigma and the family stigma due to Alzheimer's disease. Corrigan et al. (2006) used the first seven items from the short form of the Attribution Questionnaire, measuring primary stigma related to mental illness (Corrigan et al., 2002; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). The items were as listed as blame, anger, pity, help, dangerousness, fear, and avoidance. In addition, Pirutinsky et al. (2010) interviewed subjects by adapting the 13-item Explanatory Model Interview Catalogue for Outpatient Psychiatry and Stigma (Raguram & Weiss, 1997) to examine culturally specific aspects of family and marriage stigma. Thus, the scale includes items such as "difficult to marry" as well as "avoidance", "refuse to visit", "think less", and "hide family's problem". Finally, there is also a family stigma scale specific for families in which a member has Alzheimer's disease (Werner et al., 2011). It has three main dimensions: caregiver's stigma, lay persons' stigma and structural stigma. As this scale was developed based on a qualitative study on family members giving care to AD patients, it is more specific to measure family stigma experienced by the family whose member has AD.

In terms of measuring a general family stigma based on the attribute from this study, the empirical referents seem to be very diffused and complicated. For example, other's negative perception and beliefs are critical parts in the concept of family stigma. However, those parts are hard to measure and sometimes hard to guess from the family's position, since they involve others' invisible emotions to uncertain attitudes and behaviors. Thus, it seems to more appropriate to measure both attributes and consequences—emotional, social and interpersonal consequences—at the same time, when quantifying the phenomenon of family stigma experienced by a family. Of course more in-depth study is needed in this area. However, according to the scales measuring family stigma listed above, they also included not only the attributes defined in this study—blame, dangerousness, avoidance, refusal to visit, but also the consequences —anger, fear, hiding of the family's problem, in order to measure the family stigma.

Cases

The concept analysis method described by Walker and Avant (2005) uses case studies to clarify the concept and its attributes. A model case is an example case that depicts the concept with all of the defining attributes. A borderline case is a case that contains most, but not all of the defining attributes. Finally, an example of a contrary case is what is "not the concept" (Walker & Avant, 2005).

Here is the model case described by the child of an alcoholic father:

> My name is Sally. I'm 10 years old and I'm living with my mom, dad, and my 17-year-old sister, Lucy. My dad is an alcoholic. I don't know when he became an alcoholic, but maybe it was when I was really young. I can't remember it at all, but I can't ask my mom or my sister about it. I'm not allowed to talk or ask about it at home. I also can't talk about my father's problem anywhere else or with anybody at all. But all the neighbors and my friends at school already know about it. It's not really surprising, because when my father gets drunk, he starts to fight with my mom and with neighbors very loudly. Everybody always talks about my father's drinking and what he does when he's drunk whenever they talk about my family or me. Even though my sister did well on her exam last month, they still talked about her like, "She got a good score even though her family has a problem. Her father is an alcoholic." None of my friends ever want to come to my house. They say their parents don't allow it. So more and more I can't ask them to come over, and more and more I can't visit my friends' houses either, because if I don't invite them to my house, I can't go to their houses to play. I'm not at all welcomed by their families. They think I behave badly and that I'm screwed up somehow, because I've been raised in a really dangerous and unsafe place.

This model case shows all of the three attributes of family stigma. Sally's entire family is experiencing others' negative attitudes, emotions, and avoidance because of Sally's alcoholic father. Other people, including her peers and neighbors, do not want to establish any sort of relationship with the family, because they believe that her home is unsafe and that Sally herself has been somehow affected by her adverse home environment. The parents of her peers in particular do not want their children to play with Sally, since they believe that Sally behaves inappropriately like her father. This case study illustrates perfectly the phenomenon of family stigma and describes the situation of a family experiencing family stigma.

Here is the borderline case spoken by one of the neighbors of Tony's family:

> When Tony was 15 years old, he and his family moved next door to us. That was last year. When they had just moved into town, everyone began wondering why they hid themselves and didn't get along with their neighbors. Soon, it got out that Tony's father, Simon, was an alcoholic. He always made a lot of trouble for those around him: he was easily roused into fighting with his neighbors, broke others' windows, and yelled at his family. At first, no one wanted to visit their house, speak with their family, or meet them at all. However, as neighbors, we began to worry about Tony and his mother, Susan. We thought that they might be vulnerable and needed our help and support. So, I started inviting Tony and Susan to dinner with us. While it was difficult at first for them to connect with their neighbors and community, several other neighbors and I tried our best to help them. Eventually, they started feeling more comfortable meeting people and talking about their family's problems. We encouraged and helped them find a number of community resources that could give them support.
>
> Now, Tony's family seems to be in a much better position. With the help of a chemical dependency treatment agency, Simon decided to get treatment, and he's now been sober for six months. Tony and Susan are also attending weekly Alcoholics Anonymous (AA) family groups. They get support from the group, and they also support others who have similar experiences with alcoholism by sharing their experiences. Now they're easily getting along with others in the community, and fewer and fewer people seem to talk about Simon's alcoholism.

Tony's family's story is a borderline case. This story has two out of the three attributes of family stigma. Initially, the neighbors had negative perceptions, attitudes, and emotions about the family because Tony's father was an alcoholic. Thus, they avoided contact with the family since they believed that alcoholic behaviors were unsafe and might negatively affect them. However, Tony's family did not actually experience family stigma, mainly because the neighbors did not believe that the other family members (Tony and Susan) were in any way harmful or dangerous to them. Rather,

these neighbors decided to help them by establishing a relationship with Tony and Susan and then aided them in getting community support.

Finally, here is the case of Mary's family, which is a contrary case:

> Mary is a 35-year-old Korean-American woman. Although she'd been married for 10 years, she recently divorced her husband. She also has a 10-year-old daughter, Dena, making her a single parent. Dena is her main concern in life: at first, she was very worried that Dena's delicate feelings would be hurt because Dena now lacked a father, and because Mary feared that neighbors would stigmatize her and Dena for the divorce. However, Mary's neighbors, including Dena's friends and the parents of those friends, told her that they didn't care about her divorce. Some neighbors didn't even know about it. Dena remains a happy girl and has many friends. Mary and Dena are still invited to neighbors' dinner parties, just as they were before the divorce. Nothing seems to have changed, save for people giving Mary the occasional word of condolences.

This final case is an example of a contrary case, as it contains none of the attributes of family stigma. Mary's family became a single-parent family. Despite her neighbors knowing about the divorce, they did not express any negative emotions, attitudes, or behaviors toward her family. In addition, the neighbors did not think that the divorce would be harmful, unhealthy, or in any way affect them negatively. As such, Mary and Dena continued to get along with their neighbors.

Discussion

Although many families suffer from stigma experiences because of family issues, no study has explored this concept at length. Thus, in this paper, we analyzed family stigma using the method described by Walker and Avant (2005). Family stigma is caused by a degree of unusualness in the family unit. This unusualness could differ by culture and society—the examples we found from the reviewed literature were negative events, illness, or incidents occurring in a single family. Another main example was families that differed somewhat from the general society in terms of their structure or characteristics, such as homosexual families or single parent families. Three attributes of family stigma were examined: (a) others' negative perceptions, attitudes, emotions, and avoidant behaviors toward a family (and every family member); (b) others' belief that the unusualness of the family is somehow harmful, dangerous, unhealthy, capable of affecting them negatively, or different from general social norms; (c) others' belief that the family members are directly or indirectly contaminated by the problematic family member, so that the every family member is also considered harmful, dangerous, unhealthy, capable of having a negative effect on others, or different from general social norms.

Finally, we explored the consequences of family stigma. Stigmatized families could experience negative emotional consequences, such as fear, anxiety, guilt, shame, worry, intense concern, and a sense of desperation. In addition, they might experience a variety of social consequences, such as discrimination, losing their job or housing, gaining a bad reputation, or feeling family burden. Finally, they could experience interpersonal consequences, such as avoiding social relationships, expending energy to hide the family's secret, or moving to a different location. All of these consequences would lead to decreases in the families' quality of life.

Since defining family stigma has not been done before within the nursing field, we expect that our analysis of it will contribute to the theory of this field in several ways. First, we expect that our analysis of family stigma could promote communication between nursing researchers. Concept analysis can help other researchers better understand a phenomenon, which can then lead to more developed theories and further research of that phenomenon (Walker & Avant, 2005). Thus, our analysis of family stigma is expected to serve as a foundation for developing further theories, models, and, eventually, measurement tools in nursing.

Next, our results can contribute to family-related research, because the description of family stigma that we developed is a consolidation of current viewpoints about stigmatized families. Stigma, as described above, has changed in meaning over time. Initially, stigma referred to visible marks such as scars or burns. However, it has since had various other meanings. Like stigma, the definition of family stigma as noted in this paper reflects current viewpoints about the topic. For example, homosexual families and families with a member afflicted with diseases such as AIDS, Alzheimer's, and depression were all examples of stigmatized families. Considering that these examples were based on relatively recent literature, we can say that they represent current viewpoints about stigmatized families. Representing current viewpoints about families and their stigma experiences is meaningful for nursing research, because it captures critical characteristics at the current point in time (Walker & Avant, 2005). However, according to Walker and Avant, the meaning of the concept will continue to change over time, meaning that the results of current concept analyses are not the final product. Hence, it is important that this concept is re-analyzed in the future.

Understanding family stigma is essential for nursing practice. Indeed, our results have several possible implications for nursing practice. First, family stigma has a clear negative effect on families' health statuses—as illustrated above, family stigma can cause families numerous difficulties. Family members might experience not only emotional suffering but also social discrimination, including being denied or losing their employment and housing (Larson & Corrigan, 2008). For this reason, family members may avoid social relationships and isolate themselves to hide their family's secret. Although most families who experience family stigma tend to require some help or support, meaning that family stigma plays a large role in preventing them from getting help from society. Therefore, we expect that our analysis of family stigma can help health care providers have a broader view and provide care beyond the medical problems that patients are suffering from. In particular, we also expect that health care providers can come to understand each family's situation and how the stigma of that situation can cause people to suffer from emotional distress, expend energy in concealing the family's secret, and avoid social relationships. In addition, we hope that our results will help health care providers be more sensitive to the discrimination that such families might experience in society.

Second, one study among the reviewed literature reported on families being stigmatized by health care providers; family stigma from health care providers is directly linked to poor quality of care (Mwinituo & Mill, 2006). Family stigma makes patients lose confidence and trust in health care providers, thus hindering any attempt at a healthy therapeutic relationship between these two parties. We hope that our results will make health care providers re-examine their own perceptions and stereotypes about their patients and patients' families.

There are several limitations in this paper. First, the studies were screened and reviewed by only the first author. Therefore, there might be some bias in the study selection and the information that contributed to defining the attributes, antecedents, and consequences. Second, cultural factors are important to the concept of family stigma. In fact, most of the reviewed studies were centered in specific cultural groups, such as Vietnamese, Asian and Caucasian

populations in the U.S., Ghanaians, and Jewish populations. However, such cultural aspects were not considered.

Conclusion

This study analyzed the concept of "family stigma" by using the concept analysis method. The defining attributes, antecedents, and consequences of family stigma are illustrated in Figure 2. In addition, we presented model, borderline, and contrary cases to better illustrate family stigma as a concept.

Health care providers, including nurses, meet numerous patients daily and tend to focus only on patients' medical conditions. The results of our analysis of family stigma will hopefully not only extend the body of knowledge on nursing theory and practice but also pave the way for health care providers to view and care for their patients more deeply and thoughtfully, beyond just focusing on their medical conditions.

According to the findings, as well as the limitations, there are several suggestions for further research. Above all, experiences of family stigma will likely differ by culture. Therefore, there is a need to examine family stigma within the context of specific cultures. Qualitative research methods would be excellent for exploring this issue. Next, on the basis of the findings of this study and future ones, we stress the need for developing an assessment tool to measure family stigma. This would be helpful in enhancing not only nursing research but also nursing clinical practice.

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The first author contributed to study conception, data collection, data review, data analysis, and drafting of the manuscript. The second author contributed to critical revision of the manuscript as well as supervision.

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