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Parent's Alcoholism Severity and Family Topic Avoidance about Alcohol as Predictors of
Perceived Stigma Among Adult Children of Alcoholics: Implications for Emotional and
Psychological Resilience

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Abstract

Alcoholism is a highly stigmatized condition, with both alcohol dependent individuals and family members of the afflicted experiencing stigmatization. This study examined the severity of a parent's alcoholism and family topic avoidance about alcohol as two factors that are associated with family members' perceptions of stigma. Three dimensions of stigma were considered: discrimination stigma, disclosure stigma, and positive aspect stigma. In addition, this study assessed associations between perceived stigmatization and individuals' experiences of depressive symptoms, self-esteem, and resilience. Adult children of alcoholics ($N = 622$) were surveyed about family conditions, perceived stigma, and their emotional and psychological well-being. Regression analyses revealed that the severity of a parent's alcoholism predicted all three types of stigma for females, but not for males. In addition, family topic avoidance about alcohol predicted all types of stigma for males and discrimination stigma and positive aspect stigma for females. With few exceptions, the three types of stigma predicted depressive symptoms, self-esteem, and resilience for both male and female adult children of alcoholics. The results are discussed in terms of their implications for promoting a family environment that mitigates stigma and encourages emotional and psychological well-being.

Parent's Alcoholism Severity and Family Topic Avoidance about Alcohol as Predictors of Perceived Stigma Among Adult Children of Alcoholics: Implications for Emotional and Psychological Resilience

In 2012, approximately 3.3 million deaths worldwide were due to the harmful use of alcohol (WHO, 2014). Individuals who abuse alcohol are susceptible to a variety of negative health outcomes (Rehm et al., 2009) and display inappropriate social behaviors (Klingemann, 2001; Schomerus et al., 2011a). General societal perceptions tend to characterize alcohol dependent individuals as irresponsible and lacking in self-control (Schomerus et al., 2011b). Research in the United Kingdom found that 54% of the population believes alcohol dependent individuals are personally to blame for their own problems (Crisp, Gelder, Goddard, & Meltzer, 2005). In the U.S., a person's own bad character or the way they were raised are more likely to be identified as reasons for alcoholism than they are for other types of mental illness (Schnittker, 2008). In addition, people prefer greater social distance between themselves and alcoholics than between people with mental illness (Crisp et al., 2005). The negative social perceptions of alcoholics likely contribute to feelings of stigma (Room, 2005). Not only does stigma affect the afflicted individual, but also members of his or her family (WHO, 2014). Children of parents with an alcohol dependency may be reluctant to discuss a parent's alcoholism with others if they feel pressured to keep it a secret or to avoid negative stereotypes (Afifi & Olson, 2005; Burk & Sher, 1990; Caughlin & Petronio, 2004; Lam & O'Farrell, 2011). Thus, the stigma of a parent's alcoholism may prevent children from addressing concerns and coping with their surroundings.

The first goal of this study is to identify features in families of alcoholics that may be associated with increased perceptions of stigma among adult children of alcoholics (ACoA). The first condition that is likely associated with greater stigmatization is the severity of a parent's

alcoholism. Parents with more severe alcoholism are likely to possess traits and enact behaviors that make it difficult for children to conceal their parent's dependency (Velleman & Templeton, 2007), thereby exposing themselves to greater scrutiny and potential stigma. The second condition is the extent to which family members avoid discussing the topics of alcohol and alcoholism. Children growing up in families that embrace conversation demonstrate fewer adjustment problems, better social skills, and increased self-esteem compared to children whose families discourage discussion (Reuter & Koerner, 2008; Tajalli & Ardalán, 2010). Families that avoid communicating about alcohol dependency reinforce perceptions that alcoholism is a taboo and embarrassing condition worthy of stigma, whereas those that encourage discussion about the illness might allow family members to express concerns, take ownership of their situation, and grapple more publicly with their circumstances. Thus, we investigate the severity of a parent's alcoholism and family topic avoidance regarding alcohol as predictors of stigma for ACoA.

The second goal of this study is to examine the relationship between stigmatization and ACoA's emotional and psychological well-being. Studies have shown that stigma in various social contexts is associated with emotional distress (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Miller & Kaiser, 2001). For example, individuals who encounter stigma related to HIV-AIDS tend to experience increased depressive symptoms and anxiety (Lee, Kochman, & Sikkema, 2002; Gonzalez, Solomon, Zvolensky, & Miller, 2009). In addition, individuals with schizophrenia tend to report decreased self-efficacy and difficulty coping with stressors (Kleim et al., 2008). Along these lines, we examined depressive symptoms, self-esteem, and resilience as potential emotional and psychological outcomes of stigmatization for ACoA. The following sections articulate our logic and report the results of a study designed to test our predictions.

Antecedents and Outcomes of Stigma for ACoA

Stigma can be broadly defined as a negative appraisal of an individual based on a particular characteristic, including disorders, ethnicity, drug abuse, or disability (Goffman, 1963). The concept of stigma has evolved to focus on specific aspects of stigma including perceived stigma, experienced stigma, and self-stigma (Brohan, Slade, Clement, & Thornicroft, 2010). Perceived stigma describes how stigmatized individuals think others view their condition (Van Brakel et al., 2006). Experienced stigma refers to stigmatized people's encounters with discrimination (Van Brakel et al., 2006). Self-stigma is the internalization of being stigmatized, which can manifest as shame, guilt, and fear (Corrigan & Miller, 2004; Corrigan et al., 2010). Because this study is interested in the perceptions and experiences of stigma held by family members of the stigmatized, we sought to identify variables that encompassed each of these aspects of stigma. In addition, some individuals find that coping with a stigmatizing condition can be an empowering experience (Stuart, 2014), so we were motivated to include a variable that accounted for strength in character as a result of being stigmatized.

With these goals in mind, three particular types of stigma were most relevant for characterizing the experiences of ACoA: discrimination stigma, disclosure stigma, and positive aspect stigma (Dinos et al., 2004; King et al., 2007). *Discrimination stigma* is the negative behavior that results from prejudice towards a person with a socially undesirable condition (Corrigan, 2005; King et al., 2007). Examples of discrimination stigma include job loss or condescending attitudes and behaviors from others. *Disclosure stigma* refers to people's reluctance to discuss or otherwise reveal their undesirable condition due to fears of being embarrassed or rejected. Individuals experiencing disclosure stigma are typically aware of the stigma associated with their condition or circumstances and refrain from disclosure because they feel embarrassed or guilty about it. *Positive aspect stigma* occurs when individuals perceive that

a difficult situation has made them stronger and developed desirable character traits. Those who perceive positive aspect stigma believe that their exposure to difficult circumstances have made them more empathetic and resilient, and therefore less susceptible to negative stigma. In the sections that follow, we examine the antecedent conditions and outcomes of stigma for ACoA.

Antecedent Conditions that Promote or Inhibit Stigma for ACoA

The social stigma that alcohol dependent individuals face has been well-documented (Crisp et al., 2005; Link et al., 1999; Schomerus et al., 2011b); however, stigma is not limited to the afflicted individual. Family members may also face stigma as a result of sharing their home with an alcohol dependent individual, but significantly less is known about the factors that may contribute to perceptions of stigma among the family members of alcoholics. Identifying features of the family environment that may exacerbate stigma is important for helping families promote more positive circumstances to forestall children's stigmatization. We identify two features of the family context that may correspond with perceptions of stigma for ACoA: the severity of a parent's drinking problem and topic avoidance about a parent's alcoholism.

The first factor that may predict stigma for ACoA is the severity of a parent's alcohol dependency. Given that social alcohol consumption is a normative behavior in most cultures, children are less likely to feel stigmatized if their parent's alcohol consumption falls within the norms of socially acceptable drinking behavior (cf. Room, 2005). In situations where a parent's drinking is more severe and non-normative, however, they are likely to enact behaviors that make their condition more visible and less acceptable to outsiders. For example, people with a severe alcohol dependency have the potential for abusive behaviors and higher relationship distress (Murphy, O'Farrell, Fals-Stewart, & Feehan, 2001; WHO, 2014). Thus, the increased severity of a parent's alcoholism makes it riskier for children to engage in behaviors that may

reveal their parent's dependency to outsiders, such as inviting friends into their home, bringing the parent to school events, or talking about their family situation with others. In turn, these experiences are likely to be associated with feelings of marginalization and exclusion for ACoA and an inability to disclose information about their family out of fear of embarrassment or rejection (e.g., Keyes et al., 2010; King et al., 2007). Moreover, embarrassment or prejudice towards ACoA because of their parent's drinking problem may make it difficult for them to find any silver lining in their circumstances. Accordingly, we advance the following hypothesis:

H1: The severity of a parent's alcoholism is positively associated with discrimination and disclosure stigma and negatively associated with positive aspect stigma.

The second factor that may influence perceptions of stigma among ACoA is a family's topic avoidance about alcoholism. Although experiences may vary, alcoholic families often encounter high levels of conflict, communication problems, inconsistent messages, a failure to maintain rituals, and a lack of cohesion (Connor, Donovan, & DiClemente, 2004; Klostermann & O'Farrell, 2013). Alcohol dependent individuals often communicate to their families with denial and aggression, which may make family members reluctant to broach topics that may elicit a negative reaction (Straussner & Fewell, 2011). In fact, family members are often discouraged from communicating about the topic of alcohol to avoid upsetting the alcohol dependent parent (Black, 1982). Families of alcoholics may experience a chilling effect due to the coercive power of the alcoholic parent, where members refrain from expressing concern for fear of negative consequences (Afifi & Olson, 2005; Solomon, Knobloch, & Fitzpatrick, 2004). Children may be particularly vulnerable to pressures to conceal family secrets due to the imbalance of family power structures (Afifi, Merrill, & Davis, 2014). Consequently, discouraging communication about alcohol establishes the topic as taboo (Roloff & Ifert, 2000),

which reinforces perceptions that a parent's alcoholism is something that is embarrassing, shameful, and not to be discussed. Suppressing conversation can lead to psychological issues detrimental to ACoA's long-term well-being (c.f., Schrod, Ledbetter, & Ohrt, 2007). In addition, avoiding discussion about a variety of topics can lead to loneliness, impulsivity, stress, and relationship dissatisfaction (Afifi, Merrill, & Davis, 2014; Caughlin & Golish, 2002), which is unlikely to make ACoA feel as though they were strengthened by their circumstances. Thus, we advance the following hypothesis linking topic avoidance about alcoholism with stigma:

H2: Topic avoidance about alcoholism is positively associated with discrimination and disclosure stigma and negatively associated with positive aspect stigma.

Emotional and Psychological Outcomes of Stigmatization

Perceptions of stigma may correspond with individuals' ability to cope with their condition, situation, or environment. Experiences of stigma are associated with emotional distress (Miller & Kaiser, 2001; Rüscher et al., 2009), low self-efficacy (Kleim et al., 2008), anxiety (Lee, Kochman, & Sikkema, 2002; Norman, Windell, Lynch, & Manchanda, 2011), depressive symptoms, and decreased self-esteem (Johnson & Stone, 2009). These findings suggest that the stigma associated with having an alcohol dependent parent may predict children's emotional and psychological well-being. Moreover, alcoholic families tend to have a strong conformity orientation (Rangarajan & Kelly, 2006), which means that the family discourages independent thought and conversation, especially about topics that are considered taboo. Children from high conformity families tend to demonstrate more anxiety, communication apprehension, and lower self-esteem than children from less conformity oriented families (Afifi, Merrill, & Davis, 2014; Fitzpatrick & Ritchie, 1994), which may stem from their inability to promote an individual identity that is distinct from the stigmatizing conditions of their family.

On the other hand, some individuals who experience stigma report a sense of strength from overcoming adversity (Shih, 2004; Stuart, 2014). Similarly, some ACoA have demonstrated the capacity to positively adapt to adverse family circumstances and display resilience (Johnson, Gryczynski, & Moe, 2011; Palmer, 1997). To further explore relationships between stigma and ACoA's emotional and psychological well-being, this study examines three potential outcomes of stigma: depressive symptoms, self-esteem, and resiliency.

One potential emotional outcome of stigmatization is depressive symptoms. Those who experience *depressive symptoms* often describe negative feelings that include sadness, anger, and loss (Cassano & Fava, 2002). Depressive symptoms have been identified as a relevant mental health concern for many ACoA (Rangarajan & Kelly, 2006). Notably, perceived stigma is associated with increases in depressive symptoms (Grov, Golub, Parsons, Brennan, & Karplak, 2010). The experience of discrimination stigma is also associated with an array of mental and physical health conditions (Ahern, Stuber, & Galea, 2007). Individuals who feel stigmatized often feel isolated or alone (Dinos, Stevens, Serfaty, Weich, & King, 2004), which are factors that also contribute to depressive symptoms (Kim, Thibodeau, & Jorgensen, 2011; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). As a result of stigmatization, individuals are less likely to seek treatment for their mental health issues (Eisenberg, Downs, Golberstein, & Zivin, 2009), which may exacerbate depressive symptoms. Thus, perceptions of stigma may add to the depressive symptoms experienced by ACoA. Accordingly, we advance the following hypothesis:

H3: Discrimination and disclosure stigma are positively associated with depressive symptoms and positive aspect stigma is negatively associated with depressive symptoms.

ACoA's self-esteem may also be associated with their perceptions of stigma. *Self-esteem* refers to an individual's perception of their self-worth (Baumeister, 1993). Individuals with high self-esteem tend to have increased self-confidence, whereas individuals with low self-esteem tend to experience feelings of inadequacy. In previous research on individuals with serious mental illness, stigma was associated with decreased self-esteem (Ilic et al., 2011; King et al., 2007; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Among ACoA, feeling excluded or silenced as a result of a parent's alcohol dependency may be associated with diminished self-esteem (Barnard & Barlow, 2003). In general, ACoA do tend to have lower self-esteem than children raised in non-alcoholic homes (Rangarajan & Kelly, 2006; Beesley & Stoltenberg, 2002). In contrast, individuals who experience positive aspect stigma may have a more positive self-image because they have witnessed their own capacity for overcoming adversity (Shih, 2004; Stuart, 2014). Accordingly, we advance the following hypothesis:

H4: Discrimination and disclosure stigma are negatively associated with self-esteem and positive aspect stigma is positively associated with self-esteem.

A final aspect of ACoA's psychological well-being that may be related to stigma is their capacity for resilience. *Resilience* refers to the ability of an individual to positively overcome unfavorable conditions (Goldstein & Brooks, 2006; Palmer, 1997). The objective in achieving and maintaining resilience is the ability to overcome psychological risk (Friedman & Chase-Lansdale, 2002). Children often develop resilience based on protective factors in their environment that compensate for their exposure to negative conditions or experiences (Velleman & Templeton, 2007). Types of protective factors include support from the family, support at school, or support from local services. Whereas some individuals feel empowered by overcoming stigma (Shih, 2004; Stuart, 2014), others may struggle to overcome the hardships

and setbacks from being stigmatized. For example, one study found that discrimination stigma among individuals living with HIV/AIDS is negatively associated with their capacity for resilience (King & Orel, 2012). Thus, ACoA who experience discrimination and disclosure stigma may struggle to become resilient, whereas those who experience positive aspect stigma may demonstrate more resilience because they are able to see how their circumstances have contributed to their strength. Following this logic, we propose the following hypothesis:

H5: Discrimination and disclosure stigma are negatively associated with resilience and positive aspect stigma is positively associated with resilience.

Method

To investigate our hypotheses, we developed an online survey to examine the associations between the severity of a parent's alcoholism, family topic avoidance about alcoholism, perceived stigma, and ACoA's emotional and psychological well-being in adulthood. Participants were recruited for the study through listervs and websites geared towards providing support for family and friends of alcoholics (e.g., www.ncadd.org; www.al-anon.alateen.org; www.breining.edu). Individuals were eligible to participate in the study if they were 18 years of age or older, were a self-proclaimed child of an alcoholic parent, and had Internet access. The first 200 individuals to complete the survey received a \$15 gift card to a national retailer.

Sample

The sample consisted of 622 ACoA (537 female, 85 male). Participants ranged in age from 18 to 87 ($M = 47.96$, $SD = 14.41$). Most of the respondents were White or Caucasian (91.5%), with others identifying as Hispanic/Latino (4.3%), Native American (2.2%), African American (2.2%), Asian-Pacific Islander (1.4%), Middle Eastern (0.2%), and 1.4% other.

Respondents lived in 48 different states, as well as Canada and the Virgin Islands.¹ The majority of participants had an alcoholic father (76.6%), with relatively fewer alcoholic mothers (23.4%).²

Procedures

The researchers posted announcements about the study in online listservs and websites with a link to complete the online survey. Individuals who were interested in participating in the study were instructed to follow the link where they were asked to provide their consent to participate in the study and complete an online survey. The survey included measures to assess the severity of a parent's alcoholism, family topic avoidance about alcoholism, perceptions of stigma, depressive symptoms, self-esteem, and resilience. At the end of the survey, participants were instructed to email a completion code to the researchers if they were interested in receiving a \$15 gift card.³ The survey was launched in October 2012 and ended in December 2012.

Measures

All multi-item scales were subjected to a confirmatory factor analysis to ensure unidimensionality, internal validity, and external validity (Hunter & Gerbing, 1982). Criteria for a good fit factor structure were set at $\chi^2/df < 3.0$, $CFI > .90$, and $RMSEA < .10$. All scales achieved an acceptable model fit. Composite scores were computed as the mean of scale items.

Severity of a parent's alcoholism. Three items were combined to establish a comprehensive measure of the severity of a parent's alcoholism. The items included: (a) "On average, how many days per week does/did your father/mother drink?"; (b) "On average, how many drinks does/did your father/mother have in one sitting?" (A drink is defined as = one 2oz shot of liquor, OR one mixed drink with one 2oz shot of liquor, OR 12 ounces of beer, OR one 4 ounce glass of wine); and (c) "How would you characterize the severity of your father's/mother's alcoholism?" (With options of functional alcoholic, intermediate alcoholic, and chronic severe

alcoholic). The number of days a parent drank each week was positively correlated with the number of drinks he/she had in each sitting ($r = .19, p < .05$) and the characterization of severity ($r = .20, p < .05$), and the number of drinks in each sitting was positively associated with the characterization of severity ($r = .29, p < .001$). Given that the individual items were positively correlated, we created a composite variable for the severity of a parent's alcoholism that averaged the z-scores across the three items ($M = .02, SD = .61$).

Topic avoidance about alcohol. We developed items to measure the extent to which the family discussed or avoided the topic of alcohol. Participants responded to four items on a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*): (a) "In my family, we were open about the topic of alcohol" (reverse coded); (b) "In my family, we avoided the topic of alcohol;" (c) "I felt comfortable talking to my alcoholic parent about his/her alcoholism" (reverse coded); and (d) "My siblings and I avoided the topic of our parent's alcoholism" ($M = 4.91, SD = 1.56, \chi^2/df = 1.12, RMSEA = .01, CFI = .99, \alpha = .68$).

Stigma. We used King et al.'s (2007) stigma scale to measure perceptions of stigma. The stigma scale was originally developed to assess perceptions of stigma related to mental illness, so the items were revised to reflect stigma associated with being an ACoA. Average reliability for the scale in various studies ranged from $\alpha = .84$ to $\alpha = .89$ (Garg, Chavan, & Arun, 2012; Mizock & Mueser, 2014). Respondents used a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*) to report their perceptions regarding three types of stigma: discrimination, disclosure, and positive aspect. *Discrimination stigma* was measured with four items: (a) "Sometimes I feel that I am being talked down to because of my parent's alcohol problems;" (b) "Very often I feel alone because of my parent's alcohol problems;" (c) "I would have had better chances in life if I had not had an alcoholic parent;" and (d) "Having an alcoholic parent makes me feel that life is

unfair” ($M = 3.61$, $SD = 1.56$, $\chi^2/df = 1.19$, $RMSEA = .02$, $CFI = .99$, $\alpha = .68$). Five items measured *disclosure stigma*: (a) “I worry about telling people I have an alcoholic parent;” (b) “I do not feel embarrassed because of my parent’s alcoholism” (reverse coded); (c) “I avoid telling people about my parent’s alcoholism;” (d) “I feel the need to hide my parent’s alcoholism from my friends;” and (e) “I find it hard telling people I have an alcoholic parent” ($M = 3.22$, $SD = 1.61$, $\chi^2/df = 1.27$, $RMSEA = .02$, $CFI = .99$, $\alpha = .82$). Finally, three items measured *positive aspect stigma*: (a) “Having an alcoholic parent has made me a more understanding person;” (b) “People have been understanding of my parent’s alcoholism;” and (c) “My parent’s alcohol problems have made me more accepting of other people” ($M = 4.48$, $SD = 1.55$, $\chi^2/df = 1.35$, $RMSEA = .02$, $CFI = .99$, $\alpha = .67$).

Depression. Depressive symptoms were measured by the Center for Epidemiologic Studies Depression Scale (CESD-R; Wood, Taylor, & Joseph, 2010). Reliabilities in various studies have ranged from $\alpha = .85$ with general populations to $\alpha = .90$ among psychiatric populations (Edwards, Cheavens, Heiy, & Cukrowicz, 2010; Sowislo & Orth, 2013). Participants responded using a 6-point scale (1 = *strongly disagree*, 6 = *strongly agree*) indicating agreement with statements that described their feelings in the past week. Six items measured depressive symptoms: (a) “I felt depressed;” (b) “I thought my life had been a failure;” (c) “I had crying spells;” (d) “I felt sad;” (e) “I could not get going;” and (f) “I am happy with how I look” (reverse coded) ($M = 3.04$, $SD = 1.28$, $\chi^2/df = 1.64$, $RMSEA = .04$, $CFI = .99$, $\alpha = .84$).

Self-Esteem. To assess self-esteem we used items that assessed the degree of confidence in one’s personal values and self-image (Blascovich & Tomaka, 1991). Reliabilities in various studies have ranged from $\alpha = .86$ to $\alpha = .92$ (Kernis, Lakey, & Heppner, 2008; Seery, Blascovich, Weisbuch, & Vick, 2004). Respondents reported their agreement with items on a 5-point scale (1

= *strongly disagree*, 5 = *strongly agree*). Five items were adopted to measure self-esteem: (a) “I feel that I am a person of worth, at least on an equal plane with others;” (b) “I feel that I have a number of good qualities;” (c) I take a positive attitude toward myself;” (d) “All in all, I am inclined to feel that I am a failure” (reverse coded); and (e) “I am able to do things as well as most other people” ($M = 3.86$, $SD = .91$, $\chi^2/df = 1.42$, $RMSEA = .03$, $CFI = .99$, $\alpha = .88$).

Resilience. Resilience was measured by items that assessed the degree to which participants believe they have the ability to cope with adversity, maintain life balance, and a positive outlook (Wagnild & Young, 1993). Reliabilities in various studies have ranged from $\alpha = .70$ to $\alpha = .87$ (Abiola & Udofia, 2011; Sagone & De Caroli, 2013). Participants indicated their level of agreement with six items using a 6-point scale (1 = *strongly disagree*, 6 = *strongly agree*): (a) “Keeping interested in things is important to me;” (b) “I can usually find something to laugh about;” (c) “My belief in myself gets me through hard times;” (d) I can usually look at a situation in a number of ways;” (e) “When I’m in a difficult situation, I can usually find my way out of it;” and (f) “I have enough energy to do what I have to do” ($M = 4.58$, $SD = .93$, $\chi^2/df = 2.4$, $RMSEA = .06$, $CFI = .98$, $\alpha = .82$).

Results

To assess alcoholism severity and topic avoidance as factors that predict perceptions of stigma, and how perceptions of stigma predict depressive symptoms, self-esteem, and resiliency, we conducted preliminary and substantive analyses using two-tailed tests of statistical significance and an α of .05. Given that our sample was heavily skewed with female participants, we were concerned that the results with a combined sample may reflect the experiences of daughters of alcoholics but not generalize to the experiences of sons of alcoholics. Thus, we divided the sample by sex and ran our analyses on males and females separately to be able to

assess the relative strength of the associations for each sex. Based on a sample size of 537 females, power to detect small effects ($r = .10$) was .64 and power to detect medium ($r = .30$) and large ($r = .50$) effects exceeded .99 (Cohen, Cohen, West, & Aiken, 2003). Based on the sample size of 85 males, power to detect small effects ($r = .10$) was .15, medium effects ($r = .60$) was .82, and large effects ($r = .50$) exceeded .99 (Cohen, Cohen, West, & Aiken, 2003).

Preliminary Analyses

As a starting point, we assessed all of the bivariate correlations among our variables for males and females (see Table 1). For females, alcoholism severity was positively associated with discrimination stigma and disclosure stigma. Topic avoidance was positively associated with discrimination stigma and negatively associated with positive aspect stigma. Discrimination stigma and disclosure stigma were positively associated with depressive symptoms and negatively associated with self-esteem and resilience. Finally, positive aspect stigma was negatively associated with depressive symptoms and positively associated with self-esteem and resilience. For males, topic avoidance was positively associated with discrimination stigma and disclosure stigma. Discrimination stigma was positively associated with depressive symptoms and negatively associated with self-esteem and resilience. Disclosure stigma was positively associated with depressive symptoms and negatively associated with self-esteem. Finally, positive aspect stigma was positively associated with self-esteem and resilience.

Tests of Hypotheses

We conducted regression analyses to test our hypotheses. The first set of analyses contained each of the three stigma types as dependent variables with alcohol severity and topic avoidance about alcoholism entered as independent variables (see Table 2). The severity of a parent's alcoholism was positively associated with discrimination and disclosure stigma for

females, but none of the associations were significant for males. Thus, H1 received partial support for females but was not supported for males. Regarding H2, family topic avoidance about alcoholism was positively associated with discrimination stigma and negatively associated with positive aspect stigma for females, and it was positively associated with both discrimination stigma and disclosure stigma and negatively associated with positive aspect stigma for males. Thus, H2 was partially supported for females and fully supported for males. Taken together, alcoholism severity and topic avoidance about alcoholism accounted for 7% of the variance in discrimination stigma for females and 17% of the variance for males, 2% of variance in disclosure stigma for females and 12% variance for males, and accounted for a nonsignificant portion of variance in positive aspect stigma for females and 8% variance for males.

The second set of analyses examined depressive symptoms, self-esteem and resilience as outcomes of stigma (see Table 3). Each emotional or psychological outcome was treated as a dependent variable, alcoholism severity and topic avoidance about alcoholism were entered as covariates on step one, and because the three types of stigma are highly correlated we entered each type of stigma as a predictor in separate models on step two. Discrimination and disclosure stigma were positively associated with depressive symptoms for both males and females, and positive aspect stigma was negatively associated with depressive symptoms for females; thus, H3 was supported for females and partially supported for males. The three types of stigma accounted for 4% to 11% of variance in depressive symptoms for females and 11% to 25% of variance for males. When self-esteem was the outcome variable (H4), discrimination and disclosure stigma were negatively associated with self-esteem and positive aspect stigma was positively associated with self-esteem for both females and males; thus, H4 was fully supported. The three types of stigma accounted for 5% to 11% of variance in self-esteem for females and 9% to 36% of the

variance for males. Finally, consistent with H5, discrimination and disclosure stigma were negatively associated with resilience and positive aspect stigma was positively associated with resilience for females, whereas only discrimination stigma and positive aspect stigma predicted resilience for males. The three types of stigma accounted for 3% to 5% of variance in resilience for females and 7% to 8% of the variance for males.

Discussion

The goals of this study were (a) to identify features of families of alcoholics that promote perceptions of stigma and (b) to examine the emotional and psychological outcomes of stigmatization for ACoA. Results indicated that the severity of a parent's alcoholism and family topic avoidance about alcoholism are both significant predictors of stigma for females, but only family topic avoidance is a significant predictor of stigma for males. In addition, results indicated that with few exceptions, both male and female ACoA who feel stigmatized experience increased depressive symptoms and decreased self-esteem and resilience. These results suggest that mitigating stigma is an important step in promoting emotional and psychological well-being for ACoA, and they point to features of the family system that can be manipulated to manage perceptions of stigma among family members of an alcoholic.

Alcoholism, Family Topic Avoidance, and Stigma

There are a variety of reasons that individuals coping with alcohol dependency may feel stigmatized. Individuals with an alcohol use disorder are often viewed as irresponsible (Schomerus et al., 2011b) and face implicit and explicit discrimination that can lead to the internalization of stereotypes (Corrigan et al., 2010) and fear of rejection (Room, 2005). Less is known about the experience of stigma among close friends and family members of those afflicted with alcoholism. Our results point to two factors that are associated with stigma.

First, our findings indicate that the severity of a parent's alcoholism is positively associated with discrimination stigma and disclosure stigma for female ACoA. Given that severe drinking dependencies are likely to have more visible symptoms (Klingemann, 2001; Schomerus et al., 2011a), children of alcoholics likely struggle to keep their parent's alcoholism a secret. They may also witness their parent being stereotyped or stigmatized, resulting in a heightened awareness of the stigmatizing effects of alcoholism (Burk & Sher, 1990; Koschade & Lynd-Stevenson, 2011). The results for male ACoA, however, showed no significant association between the severity of a parent's alcoholism and perceived stigma. The males' effect size for disclosure stigma and positive aspect stigma were similar to or larger than the female effect sizes, but the small sample size for males may have limited our ability to detect significant effects. Notably, the males' effect for disclosure stigma was also in the opposite direction of the effect for females. If that effect is robust and significant in larger samples, we wonder why males may be less prone to disclosure stigma than females under especially severe conditions of alcoholism. One explanation may be that males tend to disclose less than females to begin with (Dindia & Allen, 1992). If males are unlikely to want to disclose information about their family in general, perhaps they experience disclosure stigma less acutely than females. Notably, the association between the severity of alcoholism and positive aspect stigma was nonsignificant for both sexes. This finding suggests that silver linings are neither more, nor less, apparent to ACoA with particularly severe family alcoholism. One explanation for this result is that ACoA may become desensitized to their circumstances when dealing with a parent's alcoholism that is especially severe. To the extent that ACoA accept alcoholism as the family norm and possibly distance themselves from a parent with severe alcoholism (Rubin, 1996), they may feel as though they are coping with their family situation but not particularly strengthened by the experience.

The second feature in families coping with alcoholism that influences stigma is topic avoidance about alcoholism. For females, topic avoidance about alcoholism was positively associated with discrimination stigma and negatively associated with positive aspect stigma. For males, topic avoidance was positively associated with both discrimination and disclosure stigma and negatively associated with positive aspect stigma. Prohibiting discussion about alcohol in the family may suppress one's ability to express concern, understand what is going on, and cope with the effects of having an alcoholic parent (Smart & Wegner, 1999). The results for positive aspect stigma imply that when families allow for discussion about alcoholism children may have a clearer understanding of their parent's illness and their own role within the family. The ability to talk about alcoholism provides an opportunity to express needs or request support (Derlega, Metts, Petronio, & Margulis, 1993; Gewirtz & Gossart-Walker, 2000), which may buffer children from suppressing stressful experiences (Pennebaker, 1985; Bareket-Bojmel & Shahar, 2011). Notably, there are a variety of reasons why topic avoidance might be functional for families of alcoholics (Afifi, Caughlin, & Afifi, 2007); for example, individuals may not want to burden other family members with distressing information or may fear that discussing particular topics will elicit aggressive behaviors. In addition, collective agreement to hide an illness from individuals outside the family unit may establish a functional boundary that bolsters family cohesion (Caughlin & Petronio, 2004). Nevertheless, it is important that families try not to declare alcoholism a taboo topic in the event that people need to discuss it. Feeling like you cannot talk about the issue makes it more taboo and, therefore, more stigmatizing.

Emotional and Psychological Outcomes of Stigma

Perceptions of stigma may be both positively and negatively correlated with individuals' well-being. ACoA are known to experience low self-esteem and high levels of depressive

symptoms (Johnson & Stone, 2009). Studying perceptions of stigma may help to illuminate why negative emotional and psychological characteristics are common among ACoA. Yet, ACoA have also been able to demonstrate resilience and strength in coping with their circumstances (Johnson, Gryczynski, & Moe, 2011). Thus, understanding the role of positive aspect stigma may help ACoA to find the silver lining in their family experiences.

Recall that discrimination stigma and disclosure stigma were both positively associated with depressive symptoms and negatively associated with resilience and self-esteem, with only one exception for males' disclosure stigma not significantly predicting resilience. These findings suggest that ACoA who consider their parent's alcoholism to be embarrassing, damaging, secret, or taboo will struggle to overcome the hardships associated with alcohol dependency. Notably, children of alcoholics have a greater likelihood of becoming substance abusers themselves as compared to children of non-alcoholic parents (WHO, 2014). Thus, helping ACoA to overcome feelings of prejudice, discrimination, and shame may help to improve their mental well-being, as well as their physical health. Although family members have limited control over the severity of their loved one's dependency, finding ways to reframe the illness may be instrumental to promoting more positive outcomes. For example, characterizing alcoholism as an illness, rather than a character flaw, may help ACoA to recognize that their parent has little control over their condition. Just as children of cancer patients are unlikely to feel ashamed or embarrassed of their parent's illness, perhaps ACoA who are able to reframe alcoholism as an uncontrollable disease will experience less stigma.

This study also examined positive aspect stigma as a unique form of stigma that reflects the ways in which individuals are strengthened from having suffered hardship. Our results indicated that positive aspect stigma was negatively associated with depressive symptoms for

females and positively associated with self-esteem and resilience for both sexes. Finding empowerment and strength through a difficult experience may have several implications for ACoA. First, the ability of ACoA to separate themselves from the negative family environment and demonstrate awareness of their parent's illness may prevent them from subscribing to the similar habits and characteristics of the substance abuser (Johnson, Gryczynski, & Moe, 2011). In addition, ACoA who have been resilient to stigmatization may be a good source of support for ACoA who are still struggling to cope. Practitioners working with ACoA should encourage them to view their situation through a lens of empowerment rather than victimization in order to encourage more positive emotional and psychological outcomes for ACoA in adulthood.

Although we reasoned that the conditions in families of alcoholics predict perceptions of stigma, which in turn predict well-being for ACoA, we are not arguing for a causal model and we recognize the potential for reciprocal effects. ACoA who are resilient to their circumstances and have high self-esteem may be less likely to feel stigmatized, whereas individuals who suffer from depressive symptoms may feel doubly stigmatized due to their own mental health and their family situation (Schomerus et al., 2011b). Similarly, individuals who feel stigmatized may refrain from discussing their health condition out of shame or embarrassment (King et al., 2007). The possibility of reciprocal relationships among our variables highlights the potential for a downward spiral in families of alcoholics, such that the severity of a parent's alcoholism and the inability of families to discuss it contribute to feelings of stigma that diminish ACoA's emotional and psychological well-being, which in turn contribute to increased stigmatization and more reluctance to discuss their situation. Longitudinal research is needed to tease out the direction of these effects and the potential for reciprocal influence.

Strengths, Limitations, and Future Directions

There were several strengths to this study. One strength of the study is its relatively large sample size. By tapping into online support resources for family members of alcoholics, we were able to recruit a rather large group of ACoA from across the country. Second, we examined both the antecedents and outcomes of stigmatization among ACoA. Whereas most research on stigma takes for granted that various conditions are stigmatizing, we looked at features of the alcoholic family that might promote more or less perceived stigma among ACoA. Finally, we considered three different types of stigma rather than general perceptions of stigmatization. Focusing on the root sources of discrimination, disclosure, and positive aspect stigma may help to better understand how specific experiences in alcoholic families are related to stigmatization.

There are also some limitations to this study. First, the sample was largely recruited through online support programs, so the majority of the sample was already seeking help to cope with a family member's alcoholism; therefore, it is unlikely that our study attracted individuals who were feeling particularly distressed or stigmatized by their circumstances. To identify differences in the perceptions of stigma, it may be beneficial to conduct a similar study among a non-support seeking population of ACoA. Another limitation of this research was that the majority of participants were female. Although separate analyses for males and females still uncovered many significant effects for male ACoA, future research on stigma and ACoA should attempt to incorporate an equal number of male and female participants to better compare and contrast perceptions and experiences across genders. Similarly, the majority of alcoholic parents in this study were fathers, which limits the generalizability of these findings to families with an alcoholic mother. Future studies should attempt to obtain a more balanced sample of ACoA with alcoholic fathers and alcoholic mothers. Furthermore our effect sizes were relatively small, thereby limiting our ability to make recommendations for policy or interventions but the hope is

that these results shed light on an interesting pattern of associations that require further investigation and may have important implications on ACoA well-being. The reliance on self-reports, gathered at one point in time, is also a limitation of the study. Although self-reports have value, ACoA were asked to reflect on past experiences that may not be as salient as they once were. Another shortcoming of self-reports is the various interpretations that individuals may make as they read and reflect on survey questions. Therefore, these participant reports are subject to some common biases by asking them to reflect on previous experiences about nonspecific events. Constructing a study design that asks participants to evaluate their current family situation over the course of several weeks may help to reduce such biases.

Based on the results of this study, there are several avenues for future research. First, future studies may want to obtain information from more than one member of an alcoholic's family. Examining the perceptions of multiple family members and the ways in which their experiences are interrelated can provide important insight into the functioning of the family system as a whole. It may also reveal how relationships with a non-alcoholic parent and/or siblings can mitigate perceptions of stigma and various emotional and psychological outcomes for ACoA. In addition, future research should do more to examine the ways that ACoA cope with the stigma they experience. By gathering personal accounts of how ACoA manage stigma, researchers may gain a clearer understanding of what skills aid in bolstering positive aspect stigma and mitigating discrimination and disclosure stigma. Finally, future research should also consider observing actual communication behavior within the family to see if other factors besides topic avoidance promote stigmatization. Various communication features, such as openness, positivity, conflict management, or aggressiveness may be influential in shaping experiences of stigma for ACoA.

References

- Abiola, T., & Udofia, O. (2011). Psychometric assessment of the Wagnild and Young's resilience scale in Kano, Nigeria. *BMC Research Notes*, *5*, 509-513. doi: 10.1186/1756-0500-4-509
- Afifi, T. D., Caughlin, J., & Afifi, W. A. (2007). Exploring the dark side (and light side) of avoidance and secrets. In B. Spitzberg & B. Cupach (Eds.), *The dark side of interpersonal relationships* (3rd ed., pp. 61-92). Mahwah, NJ: Erlbaum.
- Afifi, T. D., Merrill, A., & Davis, S. M. (2014). Examining family secrets from a communication perspective. In L. Turner & R. West (Eds.), *The Sage handbook of family communication* (pp. 169-183). Sage Publications.
- Afifi, T. D., & Olson, L. (2005). The chilling effect in families and the pressure to conceal secrets. *Communication Monographs*, *72*, 192-216. doi: 10.1080/03637750500111906
- Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence*, *11*, 188-196. doi: 10.1016/j.drugalcdep.2006.10.014
- Al-Anon Family Group. (2012). *Membership Survey*. Virginia Beach, VA: Al-Anon Family Group Headquarters.
- Almeida, J., Johnson, R. M., Corliss, H. L., Molnar, B. E., & Azrael, D. (2009). Emotional distress among LGBT youth: The influence of perceived discrimination based on sexual orientation. *Journal of Youth and Adolescence*, *38*, 1001-1014. doi: 10.1007/s10964-009-9397-9

- Bareket-Bojmel, L., & Shahar, G. (2011). Emotional and interpersonal consequences of self disclosure in a lived, online interaction. *Journal of Social and Clinical Psychology, 30*, 732-759. doi: 10.1521/jscp.2011.30.7.732
- Barnard, M., & Barlow, J. (2003). Discovering parental drug dependence: Silence and disclosure. *Children and Society, 17*, 45-56. doi: 10.1002/chi.727
- Baumeister, R. (1993). *Self-esteem: The puzzle of low self-regard*. New York: Penum. doi: 10.1007/978-1-4684-8956-9
- Beesley, D., & Stoltenberg, C. D. (2002). Control, attachment style, and relationship satisfaction among adult children alcoholics. *Journal of Mental Health Counseling, 24*, 281-298.
- Black, C. (1982). *It will never happen to me!* Denver, CO: Medical Administration Press.
- Blascovich, J., & Tomaka, J. (1991). Measures of self-esteem. In J. P. Robinson & P. R. Shaver (Eds.), *Measures of personality and social psychological attitudes* (pp. 115-160). San Diego, CA: Academic Press. doi: 10.1016/B978-0-12-590241-0.50008-3
- Brohan, E., Slade, M., Clement, S., & Thornicroft, G. (2010). Experiences of mental illness stigma, prejudice and discrimination: A review of measures. *BMC Health Services Research, 10*, 80-91. doi: 10.1186/1472-6963-10-80
- Burk, J. P., & Sher, K. J. (1990). Labeling the child of an alcoholic: Negative stereotyping by mental health professionals and peers. *Journal of Studies on Alcohol and Drugs, 51*, 156-163.
- Cassano, P., & Fava, M. (2002). Depression and public health: An overview. *Journal of Psychosomatic Research, 53*, 849-857. doi: 10.1016/S0022-3999(02)00304-5

- Caughlin, J. P., & Golish, T. (2002). An analysis of the association between topic avoidance and dissatisfaction: Comparing perceptual and interpersonal explanations. *Communication Monographs, 69*, 275-296. doi: 10.1080/03637750216546
- Caughlin, J. P., & Petronio, S. (2004). Privacy in families. In A. L. Vangelisti (Ed.), *Handbook of family communication* (pp. 379-412). Mahwah, NJ: Lawrence Erlbaum Associates.
- Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences* (3rd ed.). Mahwah, NJ: Erlbaum.
- Connor, G. J., Donovan, D. M., & DiClemente, C. C. (2004). *Substance abuse treatment and the stages of change: Selecting and planning interventions*. Mishawaka, IN: The Guildford Press.
- Corrigan, P. W. (2005). *On the stigma of mental illness: Practical strategies for research and social change*. Washington, DC: American Psychological Association.
- Corrigan, P. W., & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health, 13*, 537-548. doi:10.1080/09638230400017004
- Corrigan, P. W., Morris, S., Larson, J., Rafacz, J., Wassel, A., Michaels, P., Wilkniss, S.,...& Rüsçh, N. (2010). Self-stigma and coming out about one's mental illness. *Journal of Community Psychology, 38*, 259-275. doi: 10.1002/jcop.20363
- Crisp, A. H., Gelder, M. G., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: A follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry, 4*, 106-113.
- Derlega, V. J., Metts, S., Petronio, S., & Margulis, S. T. (1993). *Self-disclosure*. Newbury Park, CA: Sage.

- Dindia, K., & Allen, M. (1992). Sex differences in self-disclosure: A meta-analysis. *Psychological Bulletin*, *112*, 106-124. doi: 10.1037/0033-2909.112.1.106
- Dinos, S., Stevens, S., Serfaty, M., Weich, S., & King, M. (2004). Stigma: The feelings and experiences of 46 people with mental illness. *The British Journal of Psychiatry*, *184*, 176-181. doi: 10.1192/bjp.184.2.176
- Edwards, M. C., Cheavens, J. S., Heiy, J. E., & Cukrowicz, K. C. (2010). A reexamination of the factor structure of the Center for Epidemiologic Studies Depression Scale: Is a one-factor model plausible? *Psychological Assessment*, *22*, 711-715. doi: 10.1037/a0019917
- Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review*, *66*, 522-541. doi: 10.1177/1077558709335173
- Fitzpatrick, M. A., & Ritchie, L. D. (1994). Communication schemata within the family. *Human Communication Research*, *20*, 275-301. doi: 10.1111/j.1468-2958.1994.tb00324.x
- Friedman, R., & Chase-Lansdale, P. (2002). Chronic adversities. In M. Rutter & E. Taylor (Eds.), *Child and Adolescent Psychiatry* (4th Ed., pp. 261-276). Blackwell.
- Garg, R., Chavan, B. S., & Arun, P. (2012). Stigma and discrimination: How do persons with psychiatric disorders and substance dependence view themselves? *Indian Journal of Social Psychiatry*, *28*, 121-130.
- Gewirtz, A., & Gossart-Walker, S. (2000). Home-based treatment for children and families affected by HIV and AIDS: Dealing with stigma, secrecy, disclosure, and loss. *Child and Adolescent Psychiatric Clinics of North America*, *9*, 313-330.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Goldstein, S., & Brooks, R. B. (Eds.). (2005). *Handbook of resilience in children* (pp. 3-15).

New York: Springer. doi: 10.1007/b107978

Gonzalez, A., Solomon, S. E., Zvolensky, M. J., & Miller, C. T. (2009). The interaction of mindful-based attention and awareness and disengagement coping with HIV/AIDS-related stigma in regard to concurrent anxiety and depressive symptoms among adults with HIV/AIDS. *Journal of Health Psychology, 14*, 403-413. doi:

10.1177/1359105309102193

Grov, C., Golub, S. A., Parsons, J. T., Brennan, M., & Karplak, S. E. (2010). Loneliness and HIV-related stigma explains depression among older HIV-positive adults. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 22*, 630-639. doi:

10.1080/09540120903280901

Hunter, J. E., & Gerbing, D. W. (1982). Unidimensional measurement, second-order factor analysis, and causal models. In B. M. Straw & L. L. Cummings (Eds.), *Research in organizational behavior 4* (pp. 267-299). Greenwich, CT: JAI Press.

Ilic, M., Reinecke, J., Bohner, G., Rottgers, H. O., Beblo, T., Driessen, M., Frommberger, U., & Corrigan, P. W. (2011). Protecting self-esteem from stigma: A test of different strategies for coping with the stigma of mental illness. *International Journal of Social Psychiatry, 58*, 246-257. doi: 10.1177/0020764010392058

Johnson, J. L., Gryczynski, J., & Moe, J. (2011). Treatment issues and interventions with young

children and their substance-abusing parents. In S. L. Straussner & C. H. Fewell (Eds.), *Children of substance-abusing parents: Dynamics and treatment* (pp. 101-125). New

York, NY: Springer Publishing Company, LLC.

- Johnson, P., & Stone, R. (2009). Parental alcoholism and family functioning: Effects on differentiation levels of young adults. *Alcoholism Treatment Quarterly*, 27, 3-18. doi: 10.1080/07347320802586601
- Kernis, M. H., Lakey, C. E., & Heppner, W. L. (2008). Secure versus fragile high self-esteem as a predictor of verbal defensiveness: Converging finding across three different markers. *Journal of Personality*, 76, 477-512. doi: 10.1111/j.1467-6494.2008.00493.x
- Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B. F., & Hasin, D. (2010). Stigma and treatment for alcohol disorders in the United States. *American Journal of Epidemiology*, 172, 1364-1372. doi: 10.1093/aje/kwq304
- Kim, S., Thibodeau, R., & Jorgensen, R. (2011). Shame, guilt, and depressive symptoms: A meta-analytic review. *Psychological Bulletin*, 137, 68-96. doi: 10.1037/a0021466
- King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Passetti, F.,...& Serfaty, M. (2007). The stigma scale: Development of a standardized measure of the stigma of mental illness. *British Journal of Psychiatry*, 190, 248-254. doi: 10.1192/bjp.bp.106.024638
- King, S., & Orel, N. (2012). Midlife and older gay men living with HIV/AIDS: The influence of resiliency and psychosocial stress factors on health needs. *Journal of Gay & Lesbian Social Services: The Quarterly Journal of Community & Clinical Practice*, 24, 346-370. doi: 10.1080/10538720.2012.721669
- Kleim, B., Vauth, R., Adam, G., Stieglitz, R., Hayward, P., & Corrigan, P. (2008). Perceived stigma predicts low self-efficacy and poor coping in schizophrenia. *Journal of Mental Health*, 17, 482-491. doi: 10.1080/09638230701506283
- Klingemann, H. (2001). *Alcohol and its social consequences: The forgotten dimension*. Copenhagen: WHO Regional Office for Europe. doi: 10.1007/978-94-015-9725-8

- Klostermann, K., & O'Farrell, T. J. (2013). Treating substance abuse: Partner and family approaches. *Social Work in Public Health, 28*, 234-247. doi: 10.1080/19371918.2013.759014
- Koschade, J. E., & Lynd-Stevenson, R. M. (2011). The stigma of having a parent with mental illness: Genetic attributions and associative stigma. *Australian Journal of Psychology, 63*, 93-99. doi: 10.1111/j.1742-9536.2011.00009.x
- Lam, W. K., & O'Farrell, T. J. (2011). Dynamics of substance-abusing families and implications for treatment. In S. L. Straussner & C. H. Fewell (Eds.), *Children of substance-abusing parents. Dynamics and treatment* (pp. 49-75). New York, NY: Springer Publishing Company, LLC.
- Lee, R. S., Kochman, A., & Sikkema, K. J. (2002). Internalized stigma among people living with HIV-AIDS. *AIDS and Behavior, 6*, 309-319. doi: 10.1023/A:1021144511957
- Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health, 89*, 1328-1333. doi: 10.2105/AJPH.89.9.1328
- Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services, 52*, 1621-1626. doi: 10.1176/appi.ps.52.12.1621
- Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior, 38*, 177-190. doi: 10.2307/2955424

- Miller, C. T., & Kaiser, C. R. (2001). A theoretical perspective on coping with stigma. *Journal of Social Issues, 57*, 73–92. doi: 10.1111/0022-4537.00202
- Mizock, L., & Mueser, K. T. (2014). Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. *Psychology of Sexual Orientation and Gender Diversity, 1*, 146-158.
- Murphy, C. M., O'Farrell, T. J., Fals-Stewart, W., & Feehan, M. (2001). Correlates of intimate partner violence among male alcoholic patients. *Journal of Consulting and Clinical Psychology, 69*, 528-540. doi: 10.1037/0022-006X.69.3.528
- Norman, R. M. G., Windell, D., Lynch, J., & Manchanda, R. (2011). Parsing the relationship of stigma and insight to psychological well-being in psychotic disorders. *Schizophrenia Research, 133*, 3-7. doi: 10.1016/j.schres.2011.09.002
- Palmer, N. (1997). Resilience in adult children of alcoholics: A nonpathological approach to social work practice. *Health & Social Work, 22*, 201-209. doi: 10.1093/hsw/22.3.201
- Pennebaker, J. W. (1985). Traumatic experience and psychosomatic disease: Exploring the roles of behavioral inhibition, obsession, and confiding. *Canadian Psychology, 26*, 82-95. doi: 10.1037/h0080025
- Rangarajan, S., & Kelly, L. (2006). Family communication patterns, family environment, and the impact of parental alcoholism on offspring self-esteem. *Journal of Social and Personal Relationships, 23*, 655-671. doi: 10.1177/0265407506065990
- Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., Teerawattananon, Y., & Patra, J. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet, 373*, 2223-2233. doi: 10.1016/S0140-6736(09)60746-7

- Reuter, M. A., & Koerner, A. F. (2008). The effect of family communication patterns on adopted adolescent adjustment. *Journal of Marriage and Family*, *70*, 715-727. doi: 10.1111/j.1741-3737.2008.00516.x
- Roloff, M. E., & Ifert, D. E. (2000). Conflict management through avoidance: Withholding complaints, suppressing arguments, and declaring topics taboo. In S. Petronio (Ed.), *Balancing the secrets of private disclosures* (pp. 151-179). Mahwah, NJ: Lawrence Erlbaum Associates.
- Room, R. (2005). Stigma, social inequality, and alcohol and drug use. *Drug and Alcohol Review*, *24*, 143-55. doi: 10.1080/09595230500102434.
- Rubin, L. (1996). *The transcendent child: Tales of triumph over the past*. New York, NY: Harper Perennial.
- Rüsch, N., Corrigan, P. W., Wassel, A., Michaels, P., Olschewski, M., Wilkniss, S., & Batia, K. (2009). A stress-coping model of mental illness stigma: I. *Predictors of cognitive stress appraisal*. *Schizophrenia Research*, *110*, 59-64. doi: 10.1016/j.schres.2009.01.006
- Sagone, E., & De Caroli, M. E. (2013). Relationships between resilience, self-efficacy, and thinking styles in Italian middle adolescents. *Procedia – Social and Behavioral Sciences*, *92*, 838-845. doi: 10.1016/j.sbspro.2013.08.763
- Schnittker, J. (2008). An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance. *Social Science Medicine*, *67*, 1370-1381. doi: 10.1016/j.socscimed.2008.07.007.
- Schomerus, G., Corrigan, P. W., Klauer, T., Kuwert, P., Freyberger, H. J., & Lucht, M. (2011a). Self-stigma in alcohol dependence: Consequences for drinking-refusal self-efficacy. *Drug and Alcohol Dependence*, *114*, 12-17. doi: 10.1016/j.drugalcdep.2010.08.013

- Schomerus, G., Lucht, M., Holzinger, A., Matschinger, H., Carta, M. G., & Angermeyer, M. C. (2011b). The stigma of alcohol dependence compared with other mental disorders: A review of population studies. *Alcohol and Alcoholism, 46*, 105-112. doi: 10.1093/alcalc/agq089
- Schrodt, P., Ledbetter, A. M., & Ohrt, J. K. (2007). Parental confirmation and affection as mediators of family communication patterns and children's mental well-being. *Journal of Family Communication, 7*, 23–46. doi: 10.1080/15267430709336667
- Seery, M. D., Blascovich, J., Weisbuch, M., & Vick, S. B. (2004). The relationship between self-esteem level, self-esteem stability, and cardiovascular reactions to performance feedback. *Journal of Personality and Social Psychology, 87*, 133-145. doi: 10.1037/0022-3514.87.1.133
- Shih, M. (2004). Positive stigma: Examining resilience and empowerment in overcoming stigma. *The ANNALS of the American Academy of Political and Social Science, 591*, 175-185. doi: 10.1177/0002716203260099
- Smart, L., & Wegner, D. M. (1999). Covering up what can't be seen: Concealable stigma and mental control. *Journal of Personality and Social Psychology, 77*, 474–486. doi: 10.1037/0022-3514.77.3.474
- Solomon, D. H., Knobloch, L. K., & Fitzpatrick, M. A. (2004). Relational power, marital schema, and decisions to withhold complaints: An investigation of the chilling effect on confrontation in marriage. *Communication Studies, 55*, 146-167. doi: 10.1080/10510970409388610

- Sowislo, J. F., & Orth, U. (2013). Does low self-esteem predict depression and anxiety? A meta-analysis of longitudinal studies. *Psychological Bulletin, 139*, 213-240. doi: 10.1037/a0028931
- Straussner, S. A., & Fewell, C. H. (Eds.). (2011). *Children of substance-abusing parents: Dynamics and treatment*. New York, NY: Springer Publishing Company.
- Stuart, H. (2014). Definition and process of stigma. In S. O. Okpaku (Ed.), *Essentials of global mental health* (pp. 78-84). NY: Cambridge University Press. doi: 10.1017/CBO9781139136341.011
- Tajalli, F., & Ardalan, E. (2010). Relation of family communication patterns with self-efficacy and academic adjustment. *Journal of Psychology, 14*, 62-78.
- Van Brakel, W. H., Anderson, A. M., Mutatkar, R. K., Bakirtzief, Z., Nicholls, P. G., Raju, M. S., & Das-Pattanayak, R. K. (2006). The participation scale: Measuring a key concept in public health. *Disability and Rehabilitation, 28*, 193-203. doi: 10.1080/09638280500192785
- Velleman, R., & Templeton, L. (2007). Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment, 13*, 79-89. doi: 10.1192/apt.bp.106.002386
- Wagnild, G. M., & Young, H. M. (1993). Development and psychometric evaluation of the resilience scale. *Journal of Nursing Measurement, 1*, 165-178.
- Wood, A. M., Taylor, P. J., & Joseph, S. (2010). Does the CES-D measure a continuum from depression to happiness? Comparing substantive and artifactual models. *Psychiatry Research, 177*, 120-123. doi: 10.1016/j.psychres.2010.02.003
- World Health Organization (2014). *Global Status Report on Alcohol and Health*. Geneva.

Note

1 Even though the sample is skewed, participants are representative of the support groups from which we recruited; for example, Al-Anon membership is 86% female and 91% Caucasian (Al-Anon Family Groups Membership Survey, 2012).

2 The original sample consisted of 968 respondents. In that sample, 346 individuals indicated that both parents were alcoholics. These individuals were eliminated from the sample for this particular paper to allow for more parsimonious analysis of the severity of a parent's alcoholism as a predictor of stigma. This resulted in a sample of 622 individuals.

3 After the 200 gift cards had been distributed, we posted an announcement at the start of the survey indicating that all of the available gift cards had been claimed, but that individuals were welcome to still complete the survey without receiving compensation.

Table 1

Bivariate Correlations

	V1	V2	V3	V4	V5	V6	V7	V8
V1: Severity of Alcoholism	---	.11	.04	-.07	.07	.09	.02	-.12
V2: Topic Avoidance	-.06	---	.41**	.33**	-.27*	-.06	-.10	-.11
V3: Discrimination Stigma	.21**	.13**	---	.65**	-.26*	.43*	-.58*	-.28*
V4: Disclosure Stigma	.12*	.06	.40**	---	-.28*	.28*	-.39**	-.20
V5: Positive Aspect Stigma	.01	-.10*	-.20**	-.30**	---	-.02	.32**	.29*
V6: Depressive Symptoms	.08	-.04	.32**	.19**	-.19**	---	-.57**	-.23
V7: Self-Esteem	-.07	-.05	-.34**	-.24**	.24**	-.52**	---	.57**
V8: Resilience	.01	-.05	-.23**	-.17**	.22**	-.51**	.63**	---

Note. Female ($N = 537$) scores are reported below the diagonal, male ($N = 85$) scores are reported above the diagonal.

* $p < .05$. ** $p = .01$.

Table 2

Alcoholism Severity and Topic Avoidance as Predictors of Stigma

	Discrimination Stigma		Disclosure Stigma		Positive Aspect Stigma	
	Females $R^2 \Delta$ β	Males $R^2 \Delta$ β	Females $R^2 \Delta$ β	Males $R^2 \Delta$ β	Females $R^2 \Delta$ β	Males $R^2 \Delta$ β
<u>Step One</u>	.07***	.17***	.02*	.12**	.01	.08*
Alcoholism Severity	.22***	-.00	.12*	-.11	.01	.10
Topic Avoidance	.15***	.41***	.07	.35**	-.11*	-.28**

Note. Females, $N = 537$; Males $N = 85$. Cell entries are $R^2 \Delta$ statistics and standardized β coefficients.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 3

Stigma as a Predictor of Emotional and Psychological Well-Being

	Depressive Symptoms				Self-Esteem				Resilience			
	Females		Males		Females		Males		Females		Males	
	$R^2 \Delta$	β	$R^2 \Delta$	β	$R^2 \Delta$	β	$R^2 \Delta$	β	$R^2 \Delta$	β	$R^2 \Delta$	β
<u>Step One</u>	.01		.01		.01		.01		.00		.02	
Alcoholism Severity		.08		.10		-.07		.03		.12		-.11
Topic Avoidance		-.04		-.08		-.06		-.10		-.05		-.09
<u>Step Two</u>												
Discrimination Stigma	.11***	.34***	.25***	.55***	.11***	-.34***	.36***	-.67***	.05***	-.24***	.07*	-.29*
Disclosure Stigma	.04***	.18***	.11**	.37**	.05***	-.23***	.14***	-.41***	.03***	-.17***	.04	-.21
Positive Aspect Stigma	.05***	-.21***	.00	-.05	.05***	.23***	.09*	.32*	.05***	.22***	.08*	.31*

Note. Females, $N = 537$; Males, $N = 85$. Cell entries are $R^2 \Delta$ statistics and standardized β coefficients.

* $p < .05$ ** $p < .01$. *** $p < .001$.