Structural Levels of Mental Illness Stigma and Discrimination

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Abstract

Most of the models that currently describe processes related to mental illness stigma are based on individual-level psychological paradigms. In this article, using a sociological paradigm, we apply the concepts of structural discrimination to broaden our understanding of stigmatizing processes directed at people with mental illness. Structural, or institutional, discrimination includes the policies of private and governmental institutions that *intentionally* restrict the opportunities of people with mental illness. It also includes major institutions' policies that are not intended to discriminate but whose *consequences* nevertheless hinder the options of people with mental illness. After more fully defining intentional and unintentional forms of structural discrimination, we provide current examples of each. Then we discuss the implications of structural models for advancing our understanding of mental illness stigma, including the methodological challenges posed by this paradigm.

Keywords: Stigma, serious mental illness, sociological structures.

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During the past decade, advocates and researchers alike have described the adverse effects of the stigma of mental illness on people having this label. For the most part, this discussion has focused on explanatory models based on individual or psychological levels. These models, which have greatly increased our understanding of how to diminish stigma's impact, explain stigma by examining the social-cognitive elements of the stigmatizer, who perceives a stigmatizing mark, endorses the negative stereotypes about people with the perceived mark, and behaves toward the marked group in a discriminatory manner. A macrosocial level of analysis uncovers a separate set of factors that lead to discrimination against people labeled as mentally ill. Two such factors are the focus of this article: (1) policies of private and governmental institutions that *intentionally* restrict the opportunities of people with mental illness, and (2) policies of institutions that yield *unintended consequences* that hinder the options of people with mental illness. The article begins with a review of institutional and structural models as they generally explain the experience of racial stigma and discrimination. We quickly segue into specific examples of these phenomena in terms of mental illness stigma. We then explore the implications of structural levels of analysis for further development of a research program that seeks to improve the understanding of, and ultimately diminish, the stigma of mental illness.

General Model of Structural Discrimination

A better understanding of racism in America was achieved when civil rights activists (Carmichael and Hamilton 1967; U.S. Commission on Civil Rights 1981) and sociologists (Merton 1948; Friedman 1975; Hill 1988; Wilson 1990; Pincus 1996, 1999*b*) realized that discrimination affects people of color in ways not explained by the direct psychological effects of an individual's bigoted attitudes and behavior. They called this structural or institutional discrimination and realized that its effects might be either intentional or unintentional. *Intentional* institutional discrimination manifests itself as rules, policies, and procedures of private and public entities in positions of power that consciously and purposefully restrict rights and opportunities.[1] For example, Jim Crow laws, extending

[1]Some theorists distinguish institutional from structural forms of discrimination (Pincus 1999*a*). However, given that institutions are frequently included under the broader rubric of structures in sociological research, we thought the distinction was unnecessary and use the terms interchangeably. Instead, our discussion focuses on the heart of Pincus' distinction, whether the sociological level of discrimination is intentional or unintentional.

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from the end of the 19th to the middle of the 20th century, were examples of *public* institutional discrimination against people of color. These laws, largely enacted by Southern States, explicitly undermined the rights of African-Americans in such vital areas as employment, education, and public accommodation. Although persons carrying out the policy may not have intended these effects, a group of powerful people at the top of an institution intended to diminish the opportunities of racial and ethnic groups by passing laws or regulations (Mayhew 1968; Hill 1988; Pincus 1999*b*).

There are, however, public and private sector policies whose consequences restrict the opportunities of members of minority groups in *unintended* ways—instances where discrimination seemingly results without the conscious prejudicial efforts of a powerful few (Feagin 1978; Hill 1988). For example, many universities and colleges use the SAT or ACT to limit admission offers to students who have earned the highest scores (Pincus 1999*a*). Given that African-American and Hispanic students typically score lower than whites on these tests, selective universities that rely on the SAT or ACT for admissions are likely to prevent a disproportionate number of African-American and Hispanic students from being admitted. It seems unlikely that persons at the top of the organizations—in this case, college administrators—intend to restrict the prospects available to people of color. Nevertheless, the results of university admissions policies limit the opportunities for people because of their ethnic group status and the economic and historical forces that have forged that group's place in society (Merton 1948, 1957).

Examples From AIDS. One might argue that relevant lessons about structural discrimination might be further learned by studying the experiences of people with various stigmatized health conditions (e.g., cancer, tuberculosis, syphilis, AIDS). A review of the literature suggests, however, that social scientists have not applied the idea to the stigma of health conditions other than AIDS. Nevertheless, the experience of the stigma of AIDS is in many ways similar to that experienced by people with mental illness. Unlike with racism, the condition leading to the stigma typically does not occur until later in life and can often be hidden from the public. Hence, lessons from AIDS vis-à-vis structural discrimination are relevant to understanding this phenomenon in mental illness. One interesting report noted how instances of structural discrimination related to AIDS seemed to decrease from the 1980s to the 1990s in the United States (Heywood and Altman 2000). For example, during this period legislation was passed that better protected the privacy rights of people with AIDS. However, the authors noted that unfortunately privacy rights actually worsened in much of the developing world during this period. A second study conducted by the United Nations Office on AIDS measured similar concerns and found similar positive trends in another Western nation (Dubois-Arber and Haour-Knipe 2001). Examining legislation, written regulations, and actual practices, the study, conducted in Switzerland, revealed little institutional discrimination against people with AIDS. The gist of these findings is 2-fold. First, health policy analysts and legislators became aware of the harmful effects of institutional discrimination. Second, this awareness seems to have diminished the effects of this kind of discrimination for people with AIDS, at least in some Western nations.

Intentional Structural Discrimination and Mental Illness. A good example of intentional structural discrimination from the public sector is legislatures that enact laws restricting the rights and opportunities of people with mental illness. A prominent example from the private sector is the predominantly negative representations of people with mental illness in the news media. We consider each more fully in turn.

Law. One marker of institutional discrimination is State legislature decisions that limit the rights and opportunities of people with mental illness. In 1989, Burton (1990) searched the statutes in all 50 States for discriminatory laws using keywords representing mental illness (e.g., mentally ill, mentally incompetent). Ten years later, a similar search was completed of an expanded data base for the 50 States (Hemmens et al. 2002). The second study sought to determine whether States had passed laws restricting the civil rights of people with mental illness in five areas: voting, holding elective office, serving jury duty, parenting, and remaining married. Results of the two studies are summarized in table 1. The authors of the studies note that this kind of survey is somewhat imprecise because readers must infer the legislature's intent based on analyses of just one or two keywords. Nevertheless, interesting findings emerged when data were collapsed into two categories based on whether laws targeted mental illness or incompetence.

Note that approximately one-third of the 50 States restrict the rights of an individual with mental illness to hold elective office, participate in juries, and vote. Withholding the right to vote seems especially harmful given significant debate in the legal community about whether this restriction is even appropriate for convicted felons. Even greater limitations were evident in the family domain. Between 42 and 52 percent of States limit the right of people with mental illness to remain married. More than 40 percent of States limited the child custody rights of parents with mental illness.

Two other trends are noted from the table. First, States generally were more restrictive of mental illness

Table 1. Number of States restricting civil rights in 1989 and 1999 surveys

	1989	1999
Voting		
Mentally ill	19	19
Incompetent	11	12
Holding elective office		
Mentally ill	16	16
Incompetent	6	6
Serving jury duty		
Mentally ill	16	17
Incompetent	6	6
Parenting		
Mentally ill	20	21
Incompetent	1	1
Remaining married		
Mentally ill	26	21
Incompetent	1	1

Note.—Adapted from Hemmens et al. (2002).

than incompetence. "Mental illness" is a term the public seems to use as a general descriptor of people with psychiatric disorders. "Incompetence" is a legal term defining people who are unable to meet a community standard based on their mental illness. This distinction is discussed more thoroughly below. However, it is sobering to think that legislatures seem to be restricting rights based on a vague notion (or label) of mental illness rather than demonstration that individuals are incompetent or unable to perform in a manner that would qualify them for the civil right.

The second trend is the *lack* of change in the number of States with laws restricting civil rights based on mental illness. Other than in the area of divorce law, there has been no decrease in the number of States with laws that restrict the rights of people with mental illness. This is surprising given that concerns about stigma have become a major priority of advocacy groups across the country (Corrigan and Lundin 2001). The absence of change may represent legislative inertia: once a law is passed, it generally remains on the books unless the legislature actively votes to expunge it. What is needed in future research is evidence about whether these laws are actually used in State courts. For example, are there recent family court records that cite laws restricting parent rights based on mental illness?

News media. Mass communication sources including the news media provide the fundamental frameworks through which most Americans and other Westerners come to perceive and understand the contemporary world (Anderson 1997). Unfortunately, when the news media portray a group in a negative light, they propagate prejudice and discrimination. As summarized in table 2, survey analyses in several English-speaking countries have shown that newspapers frequently frame mental illness in a stigmatizing manner. Most articles discuss people with mental illness in terms of dangerousness or violent crime. Studies have shown that as many as 86 percent of stories dealing with mental illness focus on violence (Shain and Phillips 1991). Although more recent research suggests that these kinds of stories are becoming less prevalent (Wahl et al. 2002), at least a third of stories continue to focus on dangerousness. Also, the vast majority of remaining stories on mental illness focus either on other negative characteristics related to people with the disorder (e.g., unpredictability, unsociability) or on medical treatments. Notably absent are positive stories that highlight the recovery of many persons with even the most serious mental illnesses (Wahl et al. 2002). Although reduction in the proportion of negative stories is a positive trend, the overrepresentation of stories that perpetuate the stereotype of dangerousness is nevertheless an example of institutional stigma. These stories reflect informal industry norms applied by news editors and reporters *choosing* to promote sensationalistic portrayals of mental illness and violence.

Our brief discussion of the studies in table 2 reveals the difficulty in assessing institutional stigma. Consider the methodological and conceptual problems generated by research on the news media. The first problem relates to the validity of measurement. Are these kinds of content analyses and keyword counts a valid way to assess the prevalence of stigmatizing representations in the news media? Although various keywords were used as the basis for the content analysis, the studies in table 2 reported no effort to validate these codes as a comprehensive list of ways in which issues related to mental illness may be reported in the news media. And studies have not examined the stigmatizing valence of individual terms. For example, Wahl et al. (2002) argued that newspaper stories using person-first language (e.g., "person with schizophrenia" rather than "schizophrenic") were less likely to be stigmatizing (and actually could spread positive attitudes about mental illness) than other terms. Unfortunately, Wahl et al. provided no independent metric representing the relative impact of various words. Nevertheless, repeated findings of a high rate of stories about violence and mental illness seem to support the conclusion that a significant segment of the news media is perpetuating prejudicial images of people with mental illness. There is also some concern about the external validity of these analyses. Although the studies in table 2 made some effort to sample a variety of news sources, no systematic sampling plans were

Table 2. Summary of studies completing survey analyses of newspapers for stigmatizing representations of mental illness

Study citation	Methodology	Time span of survey	Findings
Day and Page (1986)	Coded articles from the Canadian Newspaper Index for "mental health"	1977–1984	There was a largely negative image of mental illness based on dangerousness, unpredictability, dependency, and unsociability.
Matas et al. (1986)	Coded 2 Canadian newspapers over 3 time spans using 7 keywords	1961 1971 1981	There were frequent portrayals of dangerousness and the need for an authoritarian mental health system.
Philo et al. (1996)	Content analysis of British and Scottish newspapers	Not specified	The most common story was violent attacks on others.
Shain and Phillips, (1991), study 1	Coded UPI stories using 5 keywords	1983	Eighty-six percent of the stories focused on violent crime.
Shain and Phillips, (1991), study 2	Coded 43 stories from 4 newspapers using 20 different descriptors	1988	Although there was a reduction in violent crime stories from the 1983 UPI sample, more than 40 percent of articles tied mental illness to violence.
Wahl (1996)	Coded 101 stories from 3 American newspapers in terms of schizophrenia	1989–1994	The most common themes were pharmacological treatments and scientific findings.
Wahl et al. (2002)	Coded 300 stories from 6 American newspapers over 2 time spans using "mental illness" as the keyword	1989 1999	Negative themes such as dangerousness dominated both samples, although the number of violent stories was reduced from 1989 to 1999.

Note.—UPI = United Press International. Adapted from Wahl et al. (2002).

evident so that a representative collection of news stories might be inferred. Methodological issues like these need to be addressed in future research if definitive conclusions are to be made about news stories as markers of institutional discrimination.

There is also a conceptual problem with using the findings in table 2 as a proxy for institutional discrimination. Are newspapers presenting a biased and erroneous view of mental illness or one that reflects reality? In other words, how accurate is the message? Some people might argue that frequent stories on mental illness and violent crime are not stigmatizing but rather reflect the actual level of danger inherent in people with some psychopathologies, especially psychotic disorders (Torrey 1994; Satel and Jaffe 1998). Carefully controlled epidemiologic evidence seems to support their assertion. Research completed in the United States and Britain shows a 2- to 6-fold increase in the rate of violence in samples of people with mental illness compared to samples of people without mental illness drawn from the general population (Swanson et al. 1990; Link et al. 1992; Stueve and Link 1997; Wessely 1997; Steadman et al. 1998; Corrigan and Watson 2003). When considering these numbers in terms of base rates, however, one finds mental illness to be a poorer predictor of violence compared with demographic variables like age, gender, and ethnicity. When epidemiological data from general population samples are used, analyses show that although mental illness may increase the likelihood of violence, its effect is perhaps not as large as that of other demographic factors such as gender (Corrigan 2002). The discrepancy between reality and perception must be better understood if institutional discrimination in the news media is to become a potent and useful construct in understanding the harmful impact of stigma on people with mental illness.

Unintentional Structural Discrimination and Mental Illness. In some types of structural discrimination, despite a commitment to neutrality, a policy or principle may result in less opportunity for a stigmatized group than for the majority (Pincus 1996, 1999*b*). For instance,

public policy that favors good business and cost-effective economic principles, both central to capitalism, would not seem to favor particular groups. Nevertheless, there are examples of unintended, discriminatory consequences based on this value. Insurance companies, for example, charge increased premiums in African-American communities where the crime rate is higher. Banks are less likely to provide mortgages to buyers in African-American neighborhoods where less collateral is available to secure a loan. Although both of these decisions seem to represent wise business practice—and do not seem to represent prejudicial intent on the part of insurers and lending companies—the result is still fewer financial resources being available in African-American communities.

Link and Phelan (2001) extended this kind of economic analysis in discussing examples of unintended structural discrimination related to mental illness. They argued, for example, that less money is allocated to research on and treatment for psychiatric illnesses than other health disorders because illnesses like cancer and heart disease have dominated the American public health agenda. In addition, many psychiatrists and other mental health professionals opt out of the public service system, which serves people with the most serious psychiatric and substance abuse disorders. Salaries and benefits are better in the private health sector, where providers are more likely to treat relatively benign illnesses like adjustment disorders and relational problems. Hence, the quality of services for people with serious mental disorders is often inferior to the quality of services for other conditions.

Problems with mental health insurance parity are another example of unintended structural stigma related to mental illness. The Mental Health Parity Act (MHPA), signed into law in 1997, required that lifetime and annual limits on mental health benefits be set at a similar level as medical and surgical benefits. However, there were notable limitations to the passed version of the act. The MHPA did not require employers to provide mental health coverage. Companies with 50 or fewer employees were exempt. Substance abuse disorders were not covered. Employers who demonstrated that the MHPA would drive up insurance costs by more than 1 percent could opt out.

As is often the case with structural discrimination, this act, although intended to be neutral, resulted in less opportunity for members of a particular group. First, the act led to fewer financial resources being available for psychiatric disorders, compared with medical illness, thereby yielding diminished opportunity for people with mental illness (Mercer 1998; Levinson and Druss 2000). Second, this disparity did not seem to reflect explicit prejudice on the part of Congress or the public. Most members of both houses, regardless of political affiliation, support equal care for mental health disorders, as does the American public (Hanson 1998). Instead, lack of support for many of the MHPA's provisions stems from financial concerns that are frequently at the root of other forms of structural discrimination: the MHPA makes for bad business. The tension between wanting to support treatment equity but not wanting to create a bad business environment is evident in public attitude; one review found that participants of national surveys on parity, on one hand, highly endorsed the idea of equal resources for mental health and medical diagnoses but, on the other hand, did not support paying higher premiums or redistributing funds from medical/surgical services to mental health services to accomplish this goal (Hanson 1998).

Disability Versus Label

Before discussing the implications of structural discrimination for further research on the stigma of mental illness, we examine an important distinction: Does what we are calling "discrimination" justly limit the privileges of *disabled people,* or does it unjustly harm *labeled individuals*? If one considers a precise meaning of incompetence or disability (Hahn 1984)—namely, because of the symptoms or other limitations that result from a mental disorder, a person is unable to demonstrate one or more current life functions—then it seems reasonable that some people with psychiatric disabilities may not qualify for some privileges and opportunities *as long as the disability is manifest.* A person who is paranoid and disoriented should probably not qualify for a gun permit. A person with grossly substandard hygiene should probably not be hired for a job that requires food handling. An important and difficult task for lawyers, ethicists, activists, and policy makers is the definition of situations where the restriction of rights or privileges because of disability may serve a larger social good.

Acknowledging the legitimacy of some institutional laws, rules, or procedures that limit opportunities for people with specific disabilities has implications for the research agendas outlined above. Namely, researchers examining instances of structural discrimination against people with mental illness need to keep in mind that sometimes the restriction may be justified and therefore not qualify as an example of baseless discrimination. One way to do this is to distinguish between limitations on the rights of individuals based on disability and limitations based on mental illness labels. This distinction is evident in the legal example reviewed in table 1. Hemmens et al. (2002) divided mental health–related laws in the table into those that targeted either people with "mental illness" or

people with "incompetence." Laws for incompetence seem to fulfill a socially valuable and reasonable purpose, assuming that government agents enforcing the law have the capability to reliably assess whether an individual is not competent enough to, for example, parent a child or serve on a jury.

The social value of restricting rights because a person is "mentally ill" is much more dubious. The term *mentally ill,* as used in many of these laws, reflects the negative effects of a label and not any measurable incompetence. Consider, for example, how the use of the term *mentally ill* to restrict rights could yield several examples of discrimination. People with relatively benign psychiatric illnesses such as adjustment disorders and phase of life problems, as well as those with more serious disorders who are adequately managing their illness, could lose rights. Hence, researchers attempting to discern structural examples of discrimination need to keep in mind this distinction.

Americans cherish their civil liberties. Hence, any effort by the public or private sector to limit those liberties based on disability due to psychiatric illness must be constrained by clear rules or assumptions. Four that are relevant and that affect research issues related to structural discrimination are discussed here.

Restricted Rights or Opportunities are Limited to Those That, When Not Competently Completed, Will Directly or Indirectly Harm Others. It is clear that not being able to properly use a gun may likely lead to physical harm to self or others and that poor hygiene in a restaurant could cause others to become physically ill. In cases like these, the government has a public interest in making sure that the disabilities of some people do not harm others. Exceptions and limitations to rights like these are implied in the "undue hardship" clause of the Americans With Disabilities Act (ADA), which states that reasonable accommodations need not be provided to a person with a disability if the resources needed for the accommodation would do harm given the capabilities of the business. We extend this clause by stating that any rightful opportunity that would be hindered by a psychiatric disability and cause public harm may justifiably be restricted because of that disability. Note, however, that the possible harm assumption suggests that any public rights or privileges that do *not* harm others should *not* be excluded by law or other institutional policy. For example, access to and enjoyment of most public accommodations (e.g., beaches, parks, theaters, hotels, restaurants) should not be restricted by disability or diminished functioning. Hence, searching for examples of structural discrimination should take into account the public harm concern.

Clear Definition of the Disability on Which a Person's Right is Withheld is Necessary. Disabilities that lead to judgments of incompetence and restriction of rights must be measurable using reliable and valid tools. These measurements need to assess constructs that are based on a comprehensive functional analysis that defines component activities of a restricted right that cannot be competently completed because of psychiatric disability. Hence, the definition of incompetence related to a specific right or opportunity must extend beyond vague targets, such as psychotic symptoms, to specific skill deficits that comprise the area of concern (e.g., parental rights) and are hindered by disabilities (e.g., inability to regularly serve nutritious meals). Specific laws, rules, or regulations that lack this kind of definition and corresponding assessment strategy may be structural discrimination.

Adequate Supportive Services Must Be Provided to Meet Competency Criteria. As stated in the "Restricted Rights" section above, the ADA includes a second principle—reasonable accommodation—that is relevant to understanding when rights and privileges can be withheld because of disability: public and private institutions must provide both environmental and interpersonal supports that assist the person with disabilities to function successfully and enjoy the full range of social opportunities. The idea of reasonable accommodation is based on sociopolitical notions that all human competencies (those of people with disabilities and people without disabilities) represent an interaction of the person's ability to complete a task and the resources of the environment in which this task occurs (Hahn 1984). Note, for example, that without many of the technological innovations of the 20th century, few office workers, with or without disabilities, could competently carry out their jobs. In this light, reasonable accommodations are those tools or environmental supports that a person with disabilities needs to perform a job.

According to the ADA, one cannot be considered incompetent if these kinds of accommodations are not provided. Although the ADA framers largely envisioned reasonable accommodations as environmental supports that assist those with ambulatory and sensory disabilities, the Federal Government stated that reasonable accommodations must also be applied to people with psychiatric disabilities (U.S. EEOC 1997). The exact nature of these accommodations continues to be worked out; nevertheless, some that have been mentioned for people with psychiatric disabilities on the job include supervision (e.g., having job coaches to provide support and counseling at work), job restructuring (e.g., reallocating marginal job functions), workplace modifications (e.g., providing room dividers or soundproofing to diminish distractions), and

sick time (e.g., permitting the use of accrued paid leave or unpaid leave for psychotherapy) (Behney et al. 1997). Hence, provision of reasonable accommodations needs to be considered when examining whether certain public or private rules and regulations represent structural discrimination.

Note how structural discrimination causes circular problems. The insufficient resources representing structural discrimination (e.g., failure to pass parity or to adequately support public services) will hinder services that provide reasonable accommodations. Without these services and accommodations, the person may remain disabled and more prone to the harm of discrimination.

The Right or Privilege is Reinstated When the Disability Diminishes. Given the importance of civil liberties to American culture, rights and opportunities that are restricted because of disability should be reinstated as soon as the specific disability is no longer relevant. This assumes not only that adequate definitions and measurement strategies exist for assessing the relevant disability but also that mechanisms exist for the regular and timely assessment of changes in the disability. At a minimum, some process must be evident that guarantees speedy assessment to persons with restricted rights who believe that their disability (perhaps with reasonable accommodation) no longer makes them incompetent or harmful.

Implications for Further Research

In the introductory paragraph of this article, we briefly alluded to the social-cognitive model of mental illness stigma (i.e., stigmatizing cue, prejudice, discrimination) as a backdrop for complementary structural paradigms. The social-cognitive model also suggests fundamental research strategies to test questions about stigma, approaches that are widely found in the growing body of research on mental illness stigma. Units of analysis in this kind of research almost exclusively represent the individual and include proxies of cognitive content and processes, as well as emotions, related to stigmatizing attitudes plus the behavioral consequences of these attitudes. Research designs that incorporate individual units of analysis are largely experimental and survey based.

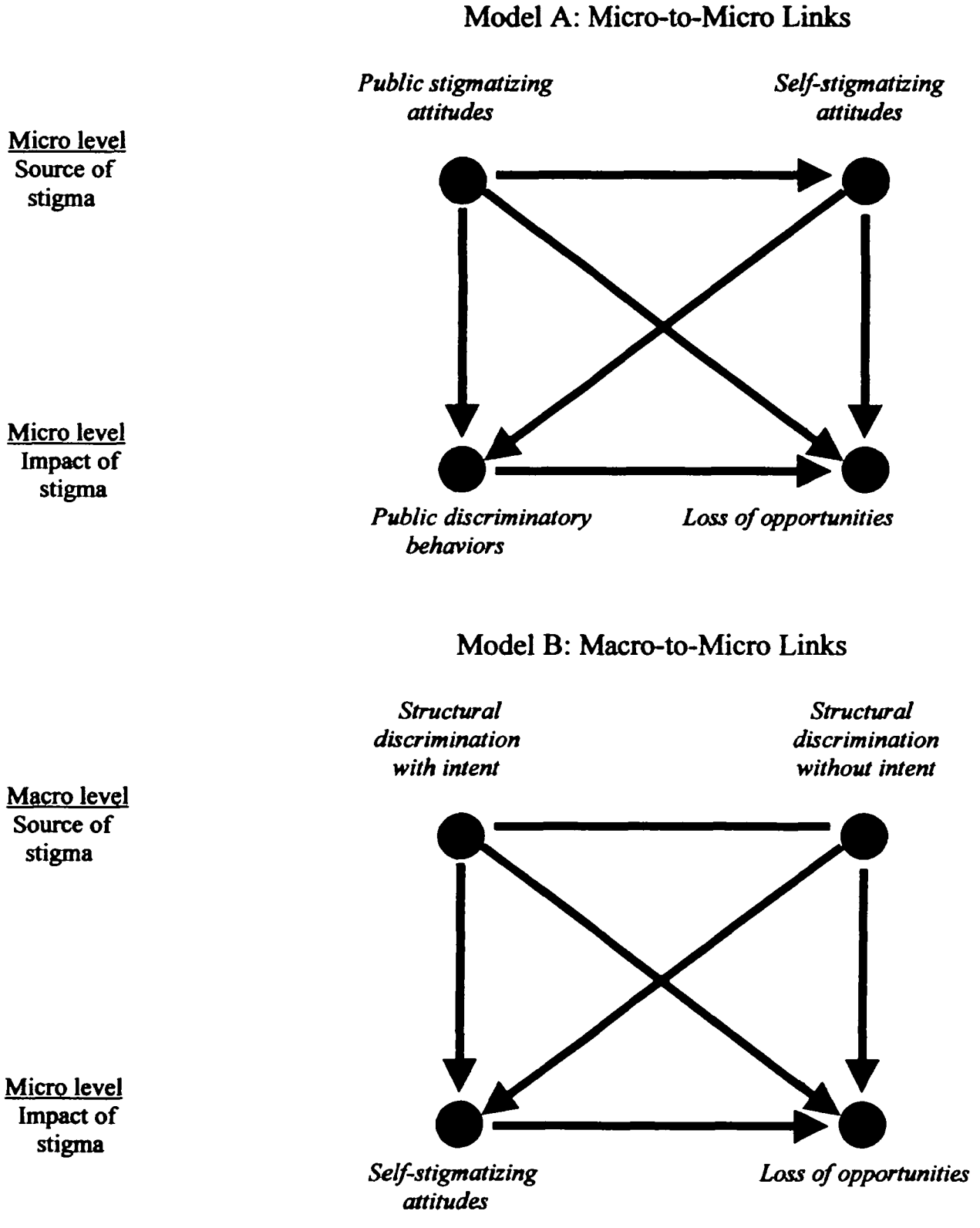
Structural discrimination involves processes that typically represent collective and macro-level units rather than individuals (e.g., how State governments deprive people of parental rights through laws or how the insurance systems of National Governments limit mental health benefits). The *aggregate* of individual properties may serve as a proxy for macro-level constructs. For example, an analytic unit representing State governments and parental rights might be the number of suits filed annually in Federal courts against specific family-related laws. An analytic unit for nation-specific collections of insurers might be the average premiums that the insured pay per year for mental health benefits. As these examples show, advancing research in this area would require a comprehensive list of aggregate, continuous variables that would represent the extent of structural discrimination.

Sociological methodologists note that analytic units representing the aggregation of individual variables are perhaps the methodologically and conceptually easiest approach to modeling macro-level processes. Similarly, categorical variables might be collected indicating whether a law currently active within a State restricts parental rights or whether a National Government has enacted the equivalent of the MHPA.

Macro-level constructs and corresponding measures provide an additional level of complexity to research design (Coleman 1986; Liska 1990). How are the links in causal models changed when macro-level variables are added to the mix? Model A in figure 1 is an example of a causal model for an individual-level paradigm of stigma and is contrasted with a mixed causal model that includes the structural paradigm of stigma (model B). Individual-level models represent micro-to-micro links (model A). Ample research has examined the relationship between public attitudes and subsequent discriminatory behavior outlined in model A (Corrigan, in press). These programs of study examine the associations of micro levels of data. Statistical models common to psychological research are fairly robust at testing these associations in a rigorous and valid manner.

Model B in figure 1 outlines what macro-level variables implied by structural discrimination add to causal models of stigma. In particular, these models highlight research questions that suggest how structural discrimination may affect attitudes that people with mental illness have about themselves and their life opportunities. For example, as a result of specific structural factors related to parity, do individuals with mental illness have restricted health care benefits? Does this restriction make individuals view mental health services as less effective? The macro-to-micro link was an important research agenda of sociologists in the first half of the 20th century (Faris and Dunham 1939; Blau 1960). However, analyses of this form diminished in the 1970s after a series of critiques concluded that only a small amount of variance in individual-level variables is attributable to macro-level variables (Alexander and Griffin 1976; Hauser 1977). For example, little of the variance in measures of opportunities and outcomes lost by individuals with mental illness may be explained by such structural-level variables as whether a State government has enacted mental health parity.

Figure 1. Macro and micro levels of analysis in mental illness stigma and discrimination



Liska (1990) responded to this criticism by arguing that although macro variables might account for relatively minor variance in micro-level individual variables (especially compared with other psychological predictors), the social scientist should not overlook the conceptual importance of macro-level variables per se. The presence of a mental health parity law is still theoretically important to understanding the impact of insurance benefits. Hence, the interesting research question may be not whether macro variables account for more variance than micro variables in a group's experience of stigma but rather whether "macro variable A" accounts for significantly more variance than "macro variable B" and thereby seems to have a bigger role as a macro variable in explaining the individual's experience of stigma.

Another important question is how macro and micro variables interact. For example, do self-stigmatizing beliefs have a greater impact upon individuals living in States with discriminatory laws or upon individuals in residential programs located in disadvantaged neighborhoods? In advancing research on mental illness stigma, social scientists need to continue to examine the balance between conceptual and methodological challenges offered by the macro-level analyses suggested by structural discrimination.

Conclusion

Mental illness strikes with a two-edged sword. On one side, people must struggle with the symptoms and disabilities that prevent them from achieving many of their life goals. On the other, the stigma of mental illness further hampers their opportunities and aspirations. Hence, efforts to understand the problems wrought by stigma and to develop programs that will diminish its impact will greatly advance the goals of people with mental illness. Models based on psychological paradigms have helped to explain some of the causes and effects of mental illness stigma. However, these models are limited in terms of explaining more macro-level causes and mediators of stigma. Structural models of stigma help us to understand how some forms of prejudice and discrimination arise at the level of the institution and reflect economic, political, and historical forces. Central to understanding structural stigma is distinguishing whether it is intentional or unintentional. The latter seems to reflect contemporary social structures that are reinvigorated by past forces that originally represented intentional institutional discrimination.

A structural model of discrimination has significant implications for the stigma research agenda and for developing programs that seek to diminish the stigma. Structural models reintroduce the methodological conundrums represented by the micro-to-macro link. Structural models also challenge the effectiveness of such individual-focused antistigma strategies as education and contact and instead suggest that radical social policies like those embodied in affirmative action are necessary. Note, however, that methodological challenges such as those engendered by structural models are necessary to more fully expand explanations of stigma and strategies for reducing it. Only with this kind of expanded scholarship can a better understanding of stigma be achieved.

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