CHAPTER II

THEORETICAL FRAMEWORK

This chapter aims to explain the existing theories of stigma and discrimination in the context of mental illness as conceptualized by different social theorists and the empirical studies that have been done in this area. It needs to be mentioned here that most of the studies that have been delved into have helped in building theoretical understanding of the concepts.

Theoretical Framework of Stigma

This section explains the existing theoretical frameworks of stigma in the context of mental illness. Research since Goffman’s seminal essay from 1963 has been incredibly productive, leading to elaborations and refinements of the concept of stigma.

Social interactionist theory of stigma. Goffman’s pioneering work provides a conceptual framework based on social interactionist theory. According to Goffman (1963: 3), stigma is an attribute that is deeply discrediting and the person carrying that stigma is different from the rest or of less desirable kind. He states that the stigmatized self arises when there is an undesirable discrepancy between one’s virtual social identity (what society expects of him/her in a given situation at a given point of time) and actual identity (what the person actually is). Thus the stigma makes the person less desirable and different from the ones who are ‘normal’ (Goffman 1963: 5) i.e., those who do not carry the stigma. According to this theory, stigma arises when there is a feeling of inferiority, which arises from the failings, vis-à-vis social expectations that the person carrying stigma has.
According to Goffman although a social intercourse between a normal and stigmatized person can happen at various points spread across a time span, he delves largely on ‘mixed contacts’ i.e., immediate social contact of a normal person with a stigmatized one in same the social situation (1963: 12). In such social intercourses, Goffman opines that both the normal and the stigmatized adjust their lives to avoid each other; but in most cases the adjustment is more on the part of the latter. These adjustments can be in many ways – avoiding social contacts due to fear and anxiety of being rejected by the normal, cowering him/her self or portraying that he/she has bravado.

Mixed social contacts produce anxiety among both normal and stigmatized people – anxiety on the part of the normal of how to avoid the stigmatized person and anxiety of the latter of how to deal with rejection, so that he/she can be accepted by the normal. However, most cases of mixed contacts give rise to a categorization wherein either the stigmatized person is treated like someone better than he/she actually is or someone worse than he/she actually is or the stigmatized person is totally ignored. In cases where the failing is not obvious, the uncertainty is not about acceptance by the normal but the question is of sharing the information about his/her shortcomings (Goffman 1963).

For Goffman (1963), stigma is a public mark; something which can be noticed by the rest and which results in a ‘spoiled identity’. Thus for Goffman stigma is the idea that somehow one is imperfect given the norms that the society has set for him/her. His expression of spoiled identity makes clear that stigma is comprised of a global attribution about the self as bad. A spoiled identity therefore reflects a whole self spoiled by some condition or behaviour (Lewis 1998). Stigma thus reflects the spoiled identity which is shame inducing, and this shame and stigma are likely to reflect the spoiled identity, whether the stigma is visible or not.
Goffman’s conceptualization of the term *stigma* is not restricted to people with mental illness alone, rather his understanding arises from diverse groups of people, like ex-convicts, people with different sexual preferences, people with some sort of disability and/or deformity and so on. Therefore, his conceptualization of stigma does not encompass the specificities of mental illness per se, i.e., the conceptualization is more generic.

The core crux of Goffman’s theorization of stigma is comprised of feelings of inferiority, which arise from the failings vis-à-vis social expectations that the person carrying stigma has and realization of the same. This feeling thus raises a question of acceptance of the stigmatized person by the normal. It’s very evident from the following paragraph:

‘The central feature of the stigmatized individual’s situation in life can now be stated. It is a question of what is often, if vaguely, called “acceptance.” Those who have dealings with him fail to accord him the respect and regard which the uncontaminated aspects of his social identity have led them to anticipate extending, and have led him to anticipate receiving; he echoes this denial by finding that some of his own attributes warrant it’ (Goffman 1963: 8)

Goffman’s theorization of stigma is more of a social construct, wherein he concentrates on social interaction patterns and the fashion in which stigma operates within that. He opines that people with stigma are not quite human. In his words,

‘The standards he [the person with stigma] has incorporated from the wider society equip him to be intimately alive to what others see as his failing; inevitably causing him…to agree that he does indeed fall short of what he really ought to be. Shame becomes a central possibility, arising from the individual’s perception of one of his own attributes as being defiling things to possess, and one he can readily see himself not possessing’ (p: 7)

According to him stigma operates in relation to what others view about the person; although the feelings of being stigmatized may happen in the absence of others, it is more associated with feelings based on social interactions with others (mixed social contacts) or an anticipation of such
social interactions (Lewis 1998); thus stigma is a public mark, significantly marked by social interactions.

**Labelling theory – an approach to understand deviance.** Since the middle of the 1960s, there has been a lively and continuing discussion over what is referred to as ‘labelling’ or the ‘societal reaction’ theory or perspective of deviance and social control (Petrunik 1980). Labelling theory was advanced and was considered a ‘new’ perspective because it moved away from the traditional positivist paradigm to an interpretive paradigm (Petrunik 1980: 214).

The labelling process is a process of stigmatization in which those who do not comply with accepted behaviours are marked out for avoidance and ostracism. Labelling theory conceives deviance as a social construction rather than an objective quality intrinsic to any particular act.

Deviance, which is a collective action, is a ‘consequence of the application by others of rules and sanctions to an “offender”’ (Becker 1963: 9). Deviance is defined as socially constructed negative moral meanings that are situationally generated to describe behaviour and personal attributes perceived as different and disturbing to certain people. So deviance refers to the behaviours and attributes that people find problematic wherein the basis of such definitions lies on the definer’s interests, which are felt to be jeopardized or threatened in some way by these acts or conditions (Pfuhl and Henry 1993: 22 - 23). When such concerns are connected with power and sanctioned legitimately the label of deviance is attained. Deviant is thus termed as a person who is the norm breaker and violates the norms or rules set within a society or group.

**Lemert’s Perspective of Deviance.** Labelling theory draws much of its base from Lemert’s (1973) perspective of deviance. Lemert’s approach to deviance is important because he talks about primary and secondary deviance. According to this approach a person’s deviant behaviour can be separated from ‘original’ norm deviation or primary deviation/deviance and secondary deviance.
As per this perspective, primary deviance is comprised of those attributes, behaviours which are different from the accepted social norms yet are not singled out by significant others or the society at large. Usually these behaviours are short term and do not incite people’s responses. On the other hand, secondary deviance refers to those behaviours which arise from one’s belief that he/she is deviant, a belief that is based on people’s perception of deviance and his/her major role and identity then starts revolving around this belief (Lemert 1973).

The primary/secondary deviance notion can be used in another sense, especially in case of physical disabilities wherein the primary deviance (i.e., the disability) is a long lasting one, the person having it gets assigned a stigmatized role, and the secondary deviance involves other behaviours like engaging in day to day activities, emotional state of affairs etc. (Lemert 1973). In short, this perspective is a twofold approach which doesn’t talk about the causal relationship of deviance but rather development of deviant behaviour that is identity, as a result of defining persons as deviant and attempting to treat, punish and otherwise control them (Petrunik 1980).

**Labelling theory and mental illness.** By far the most explicit theory of viewing mental illness from a labelling perspective is studied by Thomas Scheff (1966). According to Scheff society has perceptions about people with mental illness. He maintains that everyone in society learns the stereotyped imagery of mental disorder through ordinary social interaction. From childhood, people learn to use terms like, ‘crazy,’ ‘looney,’ ‘nuts’ and associate them with disturbed behaviours. The media also contributes to this bias against mentally ill people by associating them with violent crimes. Scheff (1966) believes that mental illness is a label given to a person who has behaviour which is away from the social norms and behaviours and so is treated as deviant. The symptoms and deviant behaviours associated with mental illness are actually deviation from the social norms rather than just psychopathology.
Once a person is given the label of ‘mental illness’, he/she receives a set of uniform responses from the society, which are generally negative in nature. These responses from the society compel the person to take on the role of ‘mentally ill’ as he/she starts internalizing the same. When the individual takes on this role of being mentally ill as his/her central identity, he/she becomes a case of a stable mentally ill person. Chronic mental illness is thus a social role and the societal reaction is the most important determinant of one’s entry into this role of chronic mentally ill (Scheff 1966).

According to Scheff (1966) hospitalisation of a mentally ill person further reinforces this social role and forces him/her to take this role as part of his/her self perception. Once the person is institutionalized for a mental disorder, he/she has been publicly labelled ‘crazy’ and forced to become a member of a deviant social group. It then becomes difficult for the deviant to return to his/her former level of functioning as the status of ‘patient’ causes unfavourable evaluations by self and by others.

Other Labelling theorists like Becker (1963: 33-34) believe that the status of deviant is a ‘master status’ which overrides all other statuses in determining how others will behave towards one. Once a person is stigmatized by being labelled as deviant, a self-insight develops based on the perceptions of others ‘perceiving and responding as deviant’.

Furthermore, once a person goes through the social process of degradation, which often happens in three phases namely he/she becomes the member of deviant group. This process of degradation involves social confrontation between the suspected deviant and representative member of the society, a psychiatric consultation followed by an official announcement of a judgment of deviance like a diagnosis of mental illness and finally performing an act of social exclusion like hospitalisation or institutionalisation that puts him/her as a member of deviant group. This social process of degradation is irreversible; the person has not only acquired a status which is inferior
but which has a deviant world view wherein people share similar knowledge, skills and deviant self image.

According to Becker (1963) such groups have one thing in common: their deviance; they share a similar fate, face similar problems, and have the same deviant sub culture. This subculture is comprised of a similar world view. ‘Membership in such a group solidifies their deviant identity’, (Becker 1963: 38). According to Labelling theorists, once a person is stigmatized by labelling it is very difficult to break that label.

While attempting to explore what makes some people deviant and others not, the Labelling theorists emphasize the four following societal attributes as determining factors for labelling one as deviant (Scheff 1966).

i. **Power and Resources** - The more the power and resources of the person the less likely that he/she will be labelled deviant (i.e., the higher the social status, the lesser probability that he/she will be labelled as deviant).

ii. **Tolerance level towards deviance** - Similarly, the lower the tolerance levels of the community towards deviant behaviour, the higher the chances that one will be labelled as deviant. According to the Labelling theorists, communities are usually low tolerant to deviant behaviour of people who belong to marginal sections of the society than those who are well integrated into society.

iii. **Social distance** - The Labelling theorists put explicit stress on the fact that if the labellee belongs to the marginal sections of the community and the social distance between the labeller and the labellee is more, then he/she has more chances of being labelled; rather if the social distance between the two is less then, the labellee can avoid labelling.
iv. *Visibility of the deviant behaviour* - It is also stressed that if the deviant behaviour is very visible, then there are more chances that the person will be labelled.

Scheff (1966) states the following proposition covering five important areas of a deviant person’s life:

i. *Hospitalized patients tend to support unfavourable attitudes toward mental illness* – Scheff (1966) believes that unfavourable attitudes toward mental illness are evident among people with mental illness right from the commitment as they tend to claim that they are not ‘crazy.’ In fact according to him, patients become angry when they are forced into a mental hospital or treatment. They try to oppose that by articulating negative attitude towards hospitalization.

ii. *Patient’s attitude toward mental illness becomes more unfavourable during course of hospitalization* – Scheff’s (1966) proposition about societal reaction maintains that psychiatric treatment or hospitalization reinforces the thought among patients that they are sick and there is a considerable amount of pressure on them to take on the role of mentally ill as part of their self concept. The stigma attached to this role is so strong that the person’s self perception worsens and it gets into a vicious circle leading to intensifying his/her deviant behaviour. Hospitalization further exposes their private lives, displacing them from the normal social activities, worsening their self esteem.

iii. *Patients have less favourable attitude towards mental illness than non patients* – According to the Labelling theory, non patients are those who have not deviated from social norms. It is presumed that the personal experience of loss of freedom and deprivation caused due to hospitalization makes patients tend to evaluate the social situation of the mentally ill more harshly than non patients.
iv. *Ex-patients tend to express unfavourable attitudes toward stigma of mental hospitalization* - Scheff (1966) views that the societal reaction process systematically blocks the person with mental illness from returning to non deviant roles. The person after discharge from hospitals also faces discrimination at work, marital life and status loss which prohibits him/her from getting into non deviant roles.

v. *Ex-patients’ attitude toward stigma of mental hospitalization will be more unfavourable as compared to their pre-discharge* – Societal reaction is the most important ‘carrier’ of deviance. Ex-patients experience greater rejection and discrimination depending upon their stay at hospitals; the longer they are in hospitals, the greater the rejection. The stigma attached to hospitalization would become more negative over time because the deviant role has become more strong and an integral part of his self worth and conception which is why many people after discharge fear rejection at the community level and fail to get back to their non deviant roles and activities (Scheff 1966: 92 -93).

Miller’s (1967) study among 1045 state mental hospital patients released on leave of absence in California very clearly confirmed these above stated propositions by Scheff. The study established that ex-mental patient differed markedly in their family roles from ‘normal’ adult population (Miller 1967: 138). The study showed variation with regard to re hospitalizations in terms of gender where it was seen that wives who failed in their respective role performance were more likely to be re-hospitalized than the husbands who failed in role performance. In general, wives were re-hospitalized more often than the husbands. Wives who exhibited psychiatric symptoms which upset the general integration of the family were more likely to be expelled from the family and would be re-hospitalized. Similarly, sons who failed in their role performance were less likely to be re-hospitalized than the daughters. This is particularly related to the status of headship in the family, wherein men who generally are considered the head of the family have more power than wives to avoid re-hospitalizations.
Those who were employed were less likely to be re-hospitalized than those who weren’t and those with adequate financial income and were self supporting were less likely to be re-hospitalized. Often parents who rejected the ex-patients who resided with them, but could not ‘throw him out’ (Miller 1967: 139), and sought re-hospitalization as the only alternative. In nutshell, this study indicated that family role position was an important construct to view post hospital patients’ community careers. The findings of the study are very similar to the propositions made by Labelling theorists like Scheff (1966) which states the various reasons of why it becomes difficult for people to get into a non-deviant role after hospitalization

The Labelling theory emphasizes that labelling process plays an important role in the causation of severe mental illness thereby creating the illness. Sari et al. (2005), with a purpose to examine the influence of Labelling, conducted a study with 129 first year medical trainee students in Turkey. The results showed strong support for the influence of Labelling on certain attitudes. Psychiatric label of severe mental disorder, like schizophrenia, resulted in greater social distance, less social acceptance, and higher perception of need for treatment. This finding provides support for the fundamental Labelling theory proposition; namely, that a mental illness label results in negative attitudes irrespective of a person’s behaviour.

**Labelling Theory VS Psychiatric Model.** The Labelling theory has been strongly debated and criticized by other theorists like Gove, Fain among many who strongly supported of the psychiatric (medical) perspective to mental illness. Perhaps, the most controversial issue in the sociology of mental illness is that involving the difference between the proponents of the psychiatric (medical) and Labelling (Societal Reaction) models of mental illness (Krohn and Akers 1977). Basically psychiatric perspective views deviant behaviour as symptomatic of an underlying psychic pathology. Deviant acts, socially defined as insane, are seen as symptoms of the sickness, just like any other symptoms of a physical illness. The psychiatric diagnosis of that illness and decision of whether and/or how long to treat are considered scientific judgments unaffected by any variables external to the type, severity and progress of the mental disease (Gove 1975).
According to them, the Labelling theory puts people as passive recipients of the mental illness; the critics to this theory hereby argue that the process of Labelling and subsequent stigmatization is a dynamic process wherein a person is not just a passive recipient. According to critics (Schneider and Conrad 1981), a person takes on the role of mentally ill only when he/she recognizes him/herself with the societal perception of how society thinks about a person with mental illness and accepts that role.

Gove (1975) cites a number of research studies which negate the postulation of the Labelling theory. Citing several studies (Bentz and Edgerton 1971; Bord 1971; Kirk 1974; Swanson and Spitzer, 1970), Gove has attempted to explain how the societal attributes that Labelling theorists stress do not hold true in many cases. In all these studies’ label of mental illness were not associated with rejection. In fact these findings led to the conclusion that the societal reaction theory needs to be modified if not rejected altogether (Kirk 1974)

According to Gove, Labelling is primarily concerned with two questions. In the first place, “Why is someone labelled deviant?” - labelling as a dependent variable and the second question he puts is, “What are the consequences for the individual of being labelled deviant?” – labelling as an independent variable. Based on evidence, Gove argues and concludes that it is the behaviour that is a critical factor in causing labelling and labelling is not the major cause of deviant behaviour (Gove 1975). He strongly argues that negative societal reactions are the result rather than the cause of mental illness.

Weinstein (1983), in his review of 35 patient (with mental illness) attitude studies, stressed that Labelling theory has apparently misjudged patients’ and ex-patients’ reactions to labelling. His review revealed patients’ beliefs in stereotypes and negativity towards mental illness are heightened by the Labelling theorists. He also negates the fact that ex-patients generally tend to move away from social deviance, as a majority of the studies he reviewed revealed that, months
after discharge, ex-patients found that ‘treatment was helpful; shame and embarrassment were not a problem’, and settling back in communities was easier (80).

There is nothing in the Labelling theory that considers the possibility that labelled deviants may deny the wrongfulness of their social and personal situation or the appropriateness of community evaluation of them; however, there is growing evidence that mental patients are not affected by the Labelling process as much as stated by the Labelling theorists. Contrary to the Labelling theorists, ‘societal reactions to disturbed behaviour and mental hospitalizations are understood, but not internalized by the patients’ (Weinstein 1983: 81).

Furthermore, Weinstein (1983) points out that the theoretical and methodological biases associated with Labelling theory are the root cause for this presumption that patients and ex-patients tend to be more negative than they actually are. According to him, Labelling theorists have studied the labelling process based on the account of the pseudo patients who have acted as participant observers in mental hospitals. As they are not mentally ill, there is a tendency for pseudo patients to experience the discomfort more keenly without taking into account the element of alleviation of psychic pain that the hospitalization offers. He states that such methodological techniques are biased and so is the Labelling theory.

It needs to be understood here that both the perspectives (medical and Labelling respectively) are based on strikingly different paradigms. The Labelling perspective is based on an interpretive sociological paradigm which gives importance (a) to the processual details as opposed to the structural elements of social life (b) the individual and collective ‘construction’ and ‘reconstruction’ of the reality through the attribution of meaning and (c) the relativity of social standards with time and place (Petrunik 1980: 216). Gove’s criticism is based on the causal relationship that he derives from the writings of Becker (1963) which reflect the assumptions of a positivist paradigm (Petrunik 1980).
Petrunik (1980) also argues that critiques like Gove and others have failed to look into the Labelling theory and deviance in greater details and hence their criticism stands on a superficial note. Moreover, as Petrunik (1980) states, the root of conflict between the Labelling theory and the psychiatric model is primarily because they both stand on different paradigms and hence the contradictions.

**Modified labelling theory (1989).** Following these arguments and contra-arguments by the Labelling theorists and the proponents of the psychiatric model, Link et al. (1989) propose the modified Labelling theory wherein they depend heavily on Scheff’s (1966) Labelling theory. According to the modified theory, societal conceptions comprise two prime components – ‘devaluation’ and ‘discrimination,’ i.e., a person with mental illness will be devalued and will be discriminated against (402). This sort of response of devaluation and discrimination sets in a label that becomes relevant to the person with mental illness. To overcome this, the person uses various strategies, namely – secrecy (wherein he/she tries to conceal his/her status of mental illness), withdrawal (restricting his/her social interaction and mingling with people who either know his/her status of mental illness or with those who empathize with him/her; these are the people whom Goffman terms as *own and wise* (1963:19) and educating others or ‘preventive telling’ wherein he/she tries to enlighten others to ward off the stigma attached to mental illness (Link et al. 1989: 403).

The label of mental illness leads to stigmatizing conditions for people with mental illness having several negative outcomes which may arise directly from one’s belief about societal attitude towards the status of mental patients or from one’s attempt to conceal his/her illness from others by ‘maintaining secrecy’ and ‘withdrawal’ (Link et al. 1989: 403). Responses like secrecy and withdrawal will limit his/her scope for social interaction and better employment opportunities. When this process continues it gives rise to low self-esteem and a poor and weak social support
system; this can increase the risk of psychopathology and there is likelihood that for some people these can be precipitating factors for relapse of the illness.

Empirical studies using Modified Labelling Theory (1989)

Link and colleagues (1989) attempted to assess the predictions of the modified Labelling theory with five groups who differed in their experience of psychopathology and Labelling in the city of New York. The total sample of community residents was four hundred and twenty nine (N=429), while the patient sample of one hundred and sixty four (N=164) patients suffering from either major depression or schizophrenia were drawn from outpatient services in the city. These patients (N=164) were then placed in four groups as first episode psychotic, first episode major depression, and repeated psychotic and repeated depression. The study findings significantly confirmed the modified Labelling theory. The study highlighted that mental patients were devalued and discriminated against. It was clear that most people expect that mental patients are to be devalued and discriminated (Link et al. 1989: 413).

The possible effects of Labelling can be conceptualized in three following domains: (a) the emergence of the deviant behaviour, (b) the stabilization or maintenance of the deviant behaviour, and (c) the consequences of the label in various areas in a person’s life like work and social network. Link (1982) argues that while the critics of the Labelling theory have overstressed the first domain (creation of the deviant behaviour) the other two are almost overlooked and, in his attempt to understand the same, he revealed that the psychiatric label has a strong negative effect on work related aspects (income, work) in an individual’s life.

This particular study finding thus transcends and broadens the scope of the Labelling theory, wherein Link (1982) argues that a psychiatric label not only leaves negative impact on a person’s various other domains of life, but also leads to stabilization of the disorder; the negative label induces a series of conditions which are more likely to increase the stress such as job loss,
rejection by employer or would be life partners, and restricted access to social networks, all of which weaken the coping means of the person thereby engendering increased risk of mental illness. In this way Labelling plays a partial role in stabilizing the mental disorder and gradual by compounding it into chronic mental disorder.

Phillips (1964: 679), in her pre-doctoral study on rejection, tried to understand the ‘behaviour and sex’ of four categories of mental illness namely paranoid schizophrenia, depressive neurotic, simple schizophrenia and phobic compulsive to ascertain the relative importance of each in determining attitudes of the public towards mental illness. Her findings showed that it is not the label of mental illness per se but the behaviour that a person with mental illness exhibits which is deviant from his/her expected role that leads to rejection and social distancing behaviour by others. The study revealed that more rejection was related to more visibly disturbing behaviour, rather than the pathology of the illness. Interestingly, the findings ascertained that men who sought help for mental illness were more rejected than women, because in contemporary American society, women were perceived as constitutionally ‘sick’ and hence their seeking help from an external source was nothing unexpected; while men were expected to be more masculine, so their seeking help for mental illness was perceived as deviant. The study clearly established that it was the deviant behaviour and not the label that was the root cause of rejection.

In an attempt to critically challenge this school of thought, Link et al. (1987) in their quasi experimental study with one fifty one community people in Ohio using vignette of a fictitious person named ‘Jim Johnson’ through the mail, clearly showed that Labelling does play a role in the process of stigmatization, rejection and social distance. The study illustrates some twenty other study details which have proved that it is the deviant behaviour of the person with mental illness and not the label that leads to social distance and rejection.
However when Link and colleagues attempted to measure perceived dangerousness of mental patients, there emerges a strong Labelling effect, wherein past hospitalization led to strong rejection among those who perceived mental illness as dangerous and vice versa. This suggests that Labelling plays a role on how the public perceives mental illness. The study concludes emphatically that Labelling theory cannot be discarded and should keep playing a vital role in understanding various social facets of mental illness.

Wright et al (2000), in their study to understand the experiences of social rejection and self esteem among eighty eight former mentally ill patients who have been discharged from institutions, found that stigma played a long lasting and powerful force in the lives of the discharged patients. The results indicated that after discharge, subsequent experiences of social rejection increase and crystallize patients' self-deprecating feelings. The impact of these new experiences of rejection appears to persist over time and, indirectly, contribute to a decrease in some clients' feelings of mastery and control. The findings of the study strongly supported the Modified Labelling theory and the results demonstrated convincingly that exposure to stigmatizing experiences represents a potentially serious source of chronic or recurrent mental illness.

Socal and Holtgraves (1992) examined the beliefs and attitudes of common people (N=206) regarding persons with mental illness. The study used case vignettes wherein mental illness severity was manipulated with physical illness (anxiety/food allergy vignette, schizophrenia/brain tumour vignette, and depression/medication side effect vignette). The findings highlighted that the label of mental illness led to rejection among the respondents irrespective of the behaviour. This finding restated that Labelling has an effect on rejection independent of that accounted for by illness severity. Consistent with this, the study also revealed that individuals labelled as mentally ill are believed to be less hopeful than those having identical physical illness of similar severity, thereby emphasizing that rejection are at times due to beliefs which are negative in nature.
The Modified Labelling Theory as propounded by Link et al. (1989) seems more progressive than Scheff’s Labelling theory (1966) in the following ways: first, while Scheff stresses that community attitude towards mental illness is strongly negative, the former believes that community attitude can be vilifying as well as temperate. Second, while Scheff perceives mentally ill people as silent recipients of the label, the modified Labelling theorists argue that people with mental illness do react and respond to the label in various ways. Third, while Scheff believes that a label of mental illness pushes the person to take on a role of a serious mentally ill person, Link et al. state that ‘Labelling and stigma could be possible causes of negative outcomes that may place mental patients at risk for the recurrence or prolongation of disorders that resulted from other causes’ (Link et al. 1989: 404).

However, the Labelling theory over-emphasizes the societal perception of what it is to be a mental patient and people’s responses based on their belief about societal attitude. The theory completely overlooks the component of people’s felt stigma and there is an over-emphasis on enacted stigma alone. While developing theoretical frameworks it is significant to look into the actual experiences of the stigma faced by people due to their illness rather than their belief of what society perceives about their illness.

**Further refinements of the concept of stigma.** There are others, like Crocker et al (1998); Jones (1984); Link and Phelan (2001) and Stafford and Scott (1986), who have attempted to study the consequences of stigma on the lives of the stigmatized and have further refined the concepts of stigma and discrimination. According to Stafford and Scott (1986: 80), ‘stigma is a characteristic of persons that is contrary to a norm of social unit, where norm is defined as shared belief that a person ought to behave in a certain way at a certain time.’ Jones et al. (1984) use Goffman’s (1963: 4) observation (stigma as a relationship between attribute and a stereotype) and conceptualize the definition of stigma as a mark (attribute) that links a person with undesirable characteristics (stereotypes).
Markowitz (1998), in his attempt to examine the stigma process, described that stigma affects social outcomes through its effects on the individual’s self concept and that has an impact on the psychological well-being and life satisfaction among persons with mental illness. He indicated that rejection was more due to discriminatory behaviour, and this affected the person’s overall life satisfaction.

**Explanation of the concept of discrimination.** According to Link and Phelan (2001), the stigma or mark is something in the person rather than a tag or a designation that others affix to the person. In this respect it brings attention to a different term, like discrimination – that produces rejection and exclusion.

Perhaps the best definition of stigma and discrimination and its linkages have been clearly stated by Link and Phelan (2001: 365) who, like Goffman (1963), use a set of relationships to conceptualize stigma and expand the nexus of relationships to a fuller context. In their conceptualization, stigma exists when people distinguish and label human differences, and dominant cultural beliefs link labelled people to undesirable characteristics – to negative stereotypes. This process leads to placing of people in distinct categories so to accomplish some degree of separation between ‘US’ and ‘THEM’, wherein stigmatized individuals are seen to “be” and are referred to by their label (e.g., “a manic-depressive” or “a schizophrenic”). Thus, labelled persons experience status loss and discrimination that leads to unequal outcomes.

According to Link and Phelan (2001) without reference to power, the concept of stigma becomes overly broad. ‘Stigma is entirely dependent on social, economic and political power – it takes power to stigmatize’ (Link and Phelan 2001: 367). As they emphasize, this relationship of power and stigma is also culturally defined; when people who have power confer stigma on others, it insures that the human differences that are labelled different are culturally relevant, recognized and acknowledged as ‘different’ (Link and Phelan 2001).
This framework clearly highlights the fact that stigma and discrimination are all together different concepts. According to Link and Phelan (2001: 368) discrimination, which may occur at regular intervals in the life of a person living with mental illness, can be of two types namely, direct discrimination and structural discrimination. Direct discrimination is where the attitude and belief of a person lead to labelling and stereotyping another person as ‘different’ and thereby engaging in some discriminatory act like rejecting a job, refusing a tenancy etc. Structural discrimination lies definitely at a much larger level, wherein low budgetary allocation for mental health care services and poor medical infrastructure for people with mental illness are all counted as examples of structural discrimination which in a way prohibits the latter from access to better treatment and care (Link and Phelan 2001).

The conceptualization of stigma and its linkages with discrimination was also made by other theorists. Corrigan and Kleinlein (2005) discussed that stigma can be of two kinds: public stigma and self stigma. As Corrigan and Kleinlein (2005: 17) put forth, there are three components that constitute stigma – stereotypes, prejudice and discrimination. While stereotype is essentially a knowledge structure that is learnt by many within a society, it is ‘social’ in nature because many people can collectively identify with the stereotype and in this case people generally tend to have a negative stereotype against people with mental illness. Prejudice, on the other hand, is the agreement that the general population endorses towards those negative beliefs against people with mental illness. Prejudice which is essentially evaluative in nature is a cognitive and affective response which leads to discrimination.

So while public stigma is characterized by the reaction that the general population has for people with mental illness, self stigma is marked by internalization of those negative public reactions by the person with mental illness and his/her response to those feelings, which means that public stigma has its ramifications more in the public life of the individual like access to rightful life opportunities, access to health system (Corrigan and Kleinlein 2005) whereas self stigma impacts the person’s self in terms of self esteem and confidence. Gallo (1994), who coined the term self
*stigma* emphasized that self stigma has long lasting and dampening effects on one’s self esteem. This explanation definitely borrows a lot from Goffman’s (1963) understanding of stigma.

**Conceptual Framework for the study**

The theoretical explanations of stigma and discrimination described above have provided a body of knowledge that has strengthened the understanding of the primary concepts of this study. Social interactionist theory gives the explicit premise that stigma is a public mark which raises a sense of inferiority in the person and his/her acceptance thus becomes questionable (Goffman 1963). The basic postulation of labelling theory is that people become deviant because certain labels are attached to their behaviour by common people and authorities in society. Based on these theoretical frameworks along with the existing research done in the field of mental illness stigma initial conceptual foundation and map has been diagrammatically represented below.
Figure 2.1

Conceptual Map, as evolved prior to the study based on existing theories
The conceptual map was developed based on the literature review. The conceptual map presented below shows a tentative set of relationships from which the study objectives were informed.

To begin with stigma as a prime domain of the study included sub domains like - self-esteem, societal perception, role fulfilment, nature of social acceptance, identity of the person, which was expected to have a two way influence on the researched’s illness profile including nature of illness, severity of the illness, duration of the illness and nature of treatment. Illness profile and experiences of stigma may or may not have influenced by the personal profile of the researched; like education, work profile, marital status. The domain of stigma may have a two way relationship with the family’s response to the same; again family’s response, whether positively, (as termed by Goffman, 1963, as own and wise) or negatively to the person’s illness may have an influence on the researched’s identity and his/her illness profile as such.

Based on labelling theory (Scheff 1966; Link et al 1989) it was thought that the perception of the family members about mental illness may have an impact on response to the researched. This may or may not lead to discriminatory acts within family domains. If there were discriminatory acts produced against the researched, the latter may also exhibit some response to the same. This sort of discrimination may have an impact on the illness as well as the nature of rights exercised.

Similar patterns may be noticed in community setting wherein community’s perception about mental illness may lead to stigmatization and their response to the researched, to which the latter may respond in various patterns and make some attempt to cope up with the same. Similar, trend may be noticed in health settings as well wherein perceptions about mental illness of the mental health professionals might initiate a process of stigmatization. In all these settings there may be absence or presence of discrimination which may influence the nature and variation in which rights may be actualized or denied in these settings.
These theoretical explanations will be revisited again as the study findings unfold and emerging conceptual map evolves based on study findings and ground reality of people living with mental illness. In the last chapter (Chapter – IX) researcher will make an attempt to compare the tentative set of relationships (represented above) with the emerging web of hypothesis.