SCHIZOPHRENIA: SOCIAL CAUSES AND STIGMA

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Submitted By
Prasha Maharjan
TU.Regd No.: 6-2-0710-0207-2011
Roll no: '1' Section: 'A

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FACULTY OF HUMANITIES AND SOCIAL SCIENCES
CENTRAL DEPARTMENT OF SOCIOLOGY
KIRTIPUR, KATHMANDU, NEPAL

LETTER OF RECOMMENDATION

This is certified that Miss.Prasha Maharjan has completed her dissertation entitled "**SCHIZOPHERENIA: SOCIAL CAUSES AND STIGMA**" as a partial fulfillment of Master's Degree in Sociology under my guidance and supervision. I, therefore, recommend this dissertation for final approval and acceptance.

…………………………
Dr. Guman Singh Khattri
Central Department of Sociology
Kirtipur, Kathmandu

Date …………….............

DECLARATION

I hereby declare that dissertation entitled″ **SCHIZOPHERENIA: SOCIAL CAUSES AND STIGMA,** submitted by me to the Central Department of Sociology, Tribhuvan University, Nepal is an entirely original work prepared under the supervision and guidance of Dr. Guman Singh khatri I have made due to acknowledgements to all idea and information borrowed from different sources in the course of writing this thesis. The result presented or submitted anywhere else for the award of any degree or for any other purpose. No part of the content of this thesis has ever been published in the form or part of any book. I am solely responsible if any evidence is found against my declaration.

Prasha Maharjan

Jan 2019

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FACULTY OF HUMANITIES AND SOCIAL SCIENCES
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KIRTIPUR, KATHMANDU, NEPAL

LETTER OF ACCEPTANCE

The dissertation entitled "SCHIZOPHERENIA: SOCIAL CAUSES AND STIGMA" submitted by Miss. Prasha Maharjan has been accepted as the partial fulfillment of the requirements for the degree of Masters of Arts in Sociology.

Evaluation Committee:

Supervisor …..……………………….
Dr. Guman Singh Khattri

External Examiner …..……………………….
Prof. Sudeep Nakarmi

Head of the Department …..……………………….
Dr. Tulsi Ram Pandey

Date:

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ABSTRACT

Schizophrenia is a debilitating mental illness that strikes approximately 1 in 100 people in the population during their lifetimes. It is an illness that can have a severe impact on the sense of self of people affected. It is the purpose of this thesis to examine the processes by which such a sense of self is disrupted, rebuilt and maintained in people diagnosed with schizophrenia. Twelve people diagnosed with schizophrenia were interviewed with regards to the ongoing impact of their illness. In particular, interviews focused on processes relevant to their sense of identity before, during and after the diagnosis of schizophrenia. The thesis also thematises issues of power and social structure surrounding the person diagnosed with schizophrenia.

It was found that, after medication, a number of social processes were important to rebuilding a sense of identity. These included the development of illness narratives, interaction with family and friends, illness management, life management, the setting of life goals. Identity was typically maintained through processes of stigma concealment and passing. The influence of psychiatrists, psycho pharmaceutical companies and a deinstitutionalised environment in which severe mental illness is treated all emerged as significant factors in the process of rebuilding a sense of identity.

The thesis seeks to make contributions to the sociology of schizophrenia. It also seeks to revise the perspectives of symbolic interactionism to better understand the emotive and embodied nature of identity processes in schizophrenia. Beyond this, the thesis explores the relationship between power, prestige, property and mental illness and its significance in shaping the experience of the patient diagnosed with schizophrenia. Finally, the thesis proposes the concept of prevailing stigma attaching to mental illness.

TABLE OF CONTENTS

DECLARATION 2
LETTER OF RECOMMENDATION 1
LETTER OF ACCEPTANCE iii
ACKNOWLEDGEMENTS 4
TABLE OF CONTENTS 5
ABBREVIATIONS 8
ABSTRACT 5

CHAPTER – ONE: INTRODUCTION 9
1.1 Background of Study 9
1.1.1 Concept of Mental Health and Class 10
1.1.2 Perceptions of Mental Illness 11
1.1.3 Stigma 12
1.1.4 Schizophrenia 15
1.1.5 The Study Context 21
1.2 Statement of the Problem 24
1.3 Research Objectives 25
1.4 Significance of Study 25
1.5 Outline of Study 26
1.6 Limitation of Study 26

CHAPTER - TWO: LITERATURE REVIEW 27
2.1 Theoritical Review 27
2.1.1 Symbolic Interactionism 27
2.1.2 Labeling Theory 28
2.1.3 Foucault, Discourse and Identity 29
2.1.4 Theories of Stigma 33
2.1.5 The Capabilities Approach 36
2.1.6 Functionalist Theory 41
2.2 Empirical Review 43
2.2.1 Downward Drift 44
2.2.2 Environmental Stress 44
2.2.3 Social Class and Stress 46
2.2.4 Geographical Differences 46

2.2.5 Differential Labeling and Differential Treatment 47
2.2.6 Stressful Life Events as a Mediator 49
2.2.7 Social Determinant Factors of Mental Illness 50
2.2.8 Sex and Marital Roles 51
2.2.9 The Stigma of Mental Illness 52
2.2.10 Stigma Research 56
2.2.11 Stigma, Identity and Social Interaction 61
2.2.12 The Impact of Schizophrenia on Identity 75
2.2.13 Scheff; Deviant Behavior 78
2.2.14 Myth of Mental Illness 83

CHAPTER - THREE: RESEARCH METHODOLOGY 86
3.1 Rationale of Site Selection 86
3.3 Nature and Source of Data 88
3.4 Sampling Procedure 88
3.5 Tools of Data Collection 89
3.5.1 Interview 89
3.5.2 Key – Informant Interview 89

CHAPTER - FOUR: INTRODUCTION OF STUDY AREA AND RESPONDENTS 91
5.1 Causes of Schizophrenia 102
5.2 Complications of Schizophrenia 103
5.3 Challenges While Doing Research 104

CHAPTER SIX: PERCEPTION AND SOCIAL STIGMA ATTACHED TO SCHIZOPHRENIA 105

CHAPTER - SEVEN: SUMMARY (RESULTS AND DISCUSSIONS) AND CONCLUSION 108
7.1 Synthesising Results and Discussion 108
7.2 Conclusion 112

REFERENCES
APPENDIX

ABBREVIATIONS

A.C.L	:-	Adult community learning and mental health
C.A	:-	Capabilities Approach
D.S.M	:-	The latest diagnostic statistical manual of mental disorder
ECT	: -	Electroconvulsive Therapy
OCD	:-	Obsessive compulsive disorder
S.I	:-	Symbolic Interactionism
W.E.F	:-	World Economic Forum
W.H.O	:-	World Health Organization

CHAPTER – ONE

INTRODUCTION

1.1 Background of Study

Nepal is a country full of different cultures and traditions.In Nepal, most of the people think that suffering from mental illness is the same as being mad, becoming unfit to remain in society and the family due to loss of control over self, or even being possessed by a holy spirit or a black magic. Individuals with severe mental disorders, as well as their family members, are targets of stigma and discrimination to the point where they hesitate to come forward for appropriate treatment. Even patients with neurotic disorders do not like to consult mental health professionals because of the stigma of mental disease. Although Nepal's constitution regards health as a basic human right, the system′s definition of health and its exclusion of psychological care have led to a faulty understanding of this right, and the Nepali Health Care System neglects this aspect of people′s health care treatments. (Miles,1981)

In terms of financing, less than 1 percent of health care expenditures by the government are directed toward mental health. Although as yet there is no separate mental health legislation, a final draft of mental health legislation has been prepared and under review in the ministry of health. The law in Nepal continues to define mental illness as madness. In the civil code, the legal definition of mental illness is not clarified, but the language of the legislation refers to someone with a broken mind. As noted above, this attitude is reflected in everyday practice.

The number of mental health care professionals in Nepal is low. According to a report by the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS, 2006), the breakdown according to profession is: 32 psychiatrists (0.129 per 100,000 population), 6 psychologists (0.024 per 100,000 populations), 16 other medical doctors, unspecialized in psychiatry (0.0645 per 100,000 population), 68 nurses (0.274 per 100,000 populations), No social workers, No occupational therapists.)

A mental illness is a disease that causes mild to serve disturbances in thought and behavior, resulting in an inability to cope with life's ordinary demands and routines. There are 200 classified forms of mental illness. Some of the more common disorders are depression, bipolar disorder, dementia, schizophrenia and anxiety disorders. This research study explores the causal relationship between social class and mental illness and also stigma related to mental health.

When it comes to illness that concerns the mind, even the young, educated and privileged in the countries most urbane and modern city find it hard to accept, let alone embrace, and so the stigma against mental illness makes a forceful presence even among them. No statistic tool could generate numbers to capture the subjectivity and intensity of the stigma faced by mentally ill patients. Yet the World Health Organisation (WHO) data for the European Union showing that nine out of every 10 mental health patients reported that they faced discrimination shows the deeply pervasive nature of the stigma. Our deeply embedded stigmatising psyche is on display for all to see in Kathmandu, the capital city. In the streets of the Capital, those who are mentally ill roam astray, abandoned by their families. Kathmandu denizens loathe and abuse them, and the government remains apathetic towards their treatment and rehabilitation. (Morgan1975)

For the patients and their families, stigma inflicts devastating consequences. They suffer humiliation and discrimination, their economic opportunities are hindered and social ties severed. For anyone who learns that s/he is mentally ill, retreating to silent suffering becomes a more preferable option than seeking treatment, which further worsens the problems s/he wants to escape from. WHO identifies stigma as one of the biggest challenges in tackling mental health issues (Donrenwend, 1975).

1.1.1 Concept of Mental Health and Class

Mental health is a level of psychological wellbeing or an absence of a mental illness. It is the psychological state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment. Mental health is the successful performance of

mental function, resulting in production activities, fulfilling relationship with other people and providing the ability to adapt to change and cope with adversity. "Mental health is as a state of well-being in which every individual realize their own potential, cope with normal stresses of life, work productivity and fruitfully and are able to make a contribution to her or his community (WHO,1992)

Mental illness can be caused due to physical and genetic factors .Physical factors, for example, a head injury or a condition such as epilepsy can have an impact on behavior and researchers are currently investigating whether there might be a genetic cause of various mental health problems but there is no clear proof yet. Both physical and mental health is the result of a complex interplay between many individual and environmental factors. When the demands placed on someone exceed their resources and coping abilities, their mental health will be negatively affected. Two examples of common demands are: i) working long hours under difficult circumstances, and ii) caring for a chronically ill relative. Economic hardship, unemployment, underemployment and poverty also have the potential to harm mental health.

Class is type of social stratification in which a person's social status depends upon his or her achievement. It is an open group and permits individuals to change his or her status. Boundaries between classes are never rigid. The upward and downward social mobility is much more common in class system. Karl Marx had divided capitalist society into two classes' bourgeois and proletariat whereas some other scholar divided class into three types' Upper class, middleclass and lower class. Social class is a segment of society with a feeling of inferiority to those who stand above and a feeling of superiority to those who are below in a social hierarchy.

1.1.2 Perceptions of Mental Illness

Throughout history, people who are different have been labeled and discriminated against for their mental states. From "moron" and "idiot" to "psycho" and "crazy," people with mental illnesses have been deemed socially undesirable and have therefore been stigmatized (Rose, Pinfold, & Kassam, 2007). Negative stereotypes of the mentally ill enhance the distaste held by "normal" people, leading to avoidance

and intolerance stemming from prejudice. These stereotypes also lead to social stigma, which can result in numerous negative consequences for those diagnosed with mental illness. One main stereotype that intensifies stigma is that people with mental illnesses are seen as dangerous or have a tendency to be impulsive and unpredictable (Lamb 1998; Link and Cullen 1986; Link et al. 1997; Link et al.1999; Penn et al. 1999; Torrey 1994). Studies have shown that this belief above others is what leads people to avoid and want to confine those with mental illness (Link et al., 1999; Phelan et al., 2000; Phelan & Link, 2004).

1.1.3 Stigma

Stigma is a Greek word that in its origins referred to a type of marking. In sociology term Erving Guffman described stigma as an "attribute, behaviour or reputation which is socially discrediting in a particular way". Guffman also defined the meaning of the word "stigma" as a special gap between vital social identity and actual social identity. Goffman's meaning on "vital social identity" relates to the way we represent ourselves with people we don't see and for is take on " actual social identity" he explains it as the way we deal with people in real life (Ashley,2018)

Sociologist Erving Goffman identifies three types of stigma (a) Stigma of character traits, (b) Physical stigma, and (c) Stigma of group identity. Stigma of character traits are "blemishes of individual character perceived as weak will, domineering, or unnatural passions, treacherous and rigid beliefs, and dishonesty, these being inferred from a known record of, for example, mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, and radical political behavior."

Physical stigma refers to physical deformities of the body, while stigma of group identity is a stigma that comes from being of a particular race, nation, religion, etc. These stigmas are transmitted through lineages and contaminate all members of a family.

What all of these types of stigma have in common is that they each have the same sociological features: ″an individual who might have been received easily in normal social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us.″ When Goffman refers to ″us,″ he is referring to the non-stigmatized, which he calls the ″normals.″

Goffman(1959) discusses the role of ″stigma symbols.″ Symbols are a part of information control – they are used to understand others. For example, a wedding ring is a symbol that shows others that someone is married. Stigma symbols are similar. Skin colour is stigma symbol, as is a hearing aid, cane, shaved head, or wheelchair.

Stigmatized people often use symbols as ″disidentifiers″ in order to try to pass as a ″normal.″ For instance, if an illiterate person is wearing ′intellectual′ glasses, they might be trying to pass as a literate person; or, a homosexual person who tells ′queer jokes′ might be trying to pass as a heterosexual person. These covering attempts, however, can also be problematic. If a stigmatized person tries to cover their stigma or pass as a ″normal,″ they have to avoid close relationships, and passing can often lead to self-contempt. They also need to constantly be alert and always checking their houses or bodies for signs of stigmatization. Stigma has been identified as a major concern for people with mental illness and behaviours (Thornicroft, Rose, Kassam, & Sartorius, 2007). It is viewed as a social cognitive process comprising three components: stereotypes, prejudice and discrimination (Corrigan, Watson, & Ottati, 2003). Stereotypes are known structures that help to categorise information. They are shared beliefs about personality traits and behaviours of members of a social group (Hilton & Von Hippel, 1996). Most people have knowledge of a set of stereotypes; however this does not necessarily mean that they all agree with them (Jussim, Nelson, Manus, & Soffin, 1995). For example, many people are able to recall stereotypes about different racial groups but do not agree that the stereotypes are valid. Prejudice

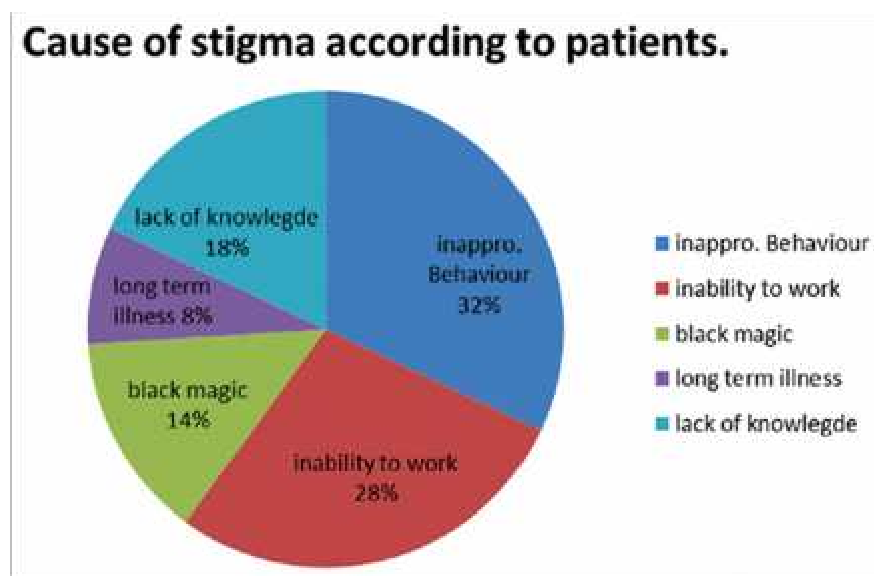
is the endorsement of negative attitudes and stereotypes towards particular social groups (Krueger, 1996) (e.g., "All people with mental illness are violent"). Prejudice leads to discrimination; the behavioural reaction (e.g., employers are less likely to hire people with mental illness). (Crocker, Major, & Steele, 1998).

Stigma associated with mental illness affects different life domains of those afflicted including interpersonal relationships, housing, employment and recovery from mental illness (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). This is because stigma often causes social exclusion and isolation for those afflicted (Gaebel, Baumann, Witte, & Zaeske, 2002). Stigmatising attitudes may also prevent seeking help and increase psychological distress (Link et al., 1997). Thus, an important goal of mental health research is to reveal ways to reduce stigma (Lauber et al., 2004). However, before this can be done it is essential to understand the factors contributing to stigma (Penn, Kohlmaier & Corrigan, 2000).

Pincus (1996) identified three levels of discrimination felt by people with mental illness: institutional, individual and internalised. The current study is interested in individual stigma; the behaviour of individual members of one group intended to have a differential or harmful effect on members of another group (Pincus, 1996). It is most frequently measured by the desire for social distance (Link et al., 2004). This is the

amount of distance that individuals of one group would hypothetically place between themselves and individuals of another group in various contact situations (Bogardus, 1925). Underlying the measure of social distance is the assumption that behaviours symptomatic of mental illness prompt affective reactions such as rejection, acceptance, and ambivalence from members of the public (Crocker et al., 1998).

Link and Cullen (1983) considered that studies based on social distance items merely measure socially desirable attitudes. Individuals overlook more latent and unfavourable views. Link, Cullen, Struening, Shrout, and Dohrenwend (1989) therefore developed the Devaluation-Discrimination measure. This looks at the extent to which individuals' believe that 'most people' will devalue and discriminate against a person with mental illness. It measures both stigmatising attitudes and behaviours towards mental illness. This is the focus of the current research.ess (Dinos, Stevens, Serfaty, Weich, & King, 2004). Stigma refers to problems of knowledgeand attitudes.



1.1.4 Schizophrenia

Schizophrenia is a debilitating mental illness that strikes approximately 1 in 100 people in the population during their lifetimes (Sadock and Sadock, 2007). The illness strikes regardless of class, gender, sexuality or ethnicity. It can seriously affect cognition, emotion and behaviour in the sufferer. Schizophrenia, and accompanying

treatment, can cause significant damage to the sufferer's identity; to his or her capacity to project and maintain a viable self. It is also an illness over which psychiatrists, mental health workers and psychopharmacologists exert significant influence.

The latest Diagnostic and Statistical Manual of Mental Disorders (DSM) released by the American Psychiatric Association suggests diagnostic criteria for the "schizophrenia spectrum" of disorders; that is, disorders involving a schizoid or psychotic element:

Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized motor behaviour (including catatonia), and negative symptoms.

Schizophrenia itself receives more precise diagnostic criteria (APA, 2013, p. 99):

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions.
2. Hallucinations.
3. Disorganized speech (e.g., frequent derailment or incoherence).
4. Grossly disorganized or catatonic behavior.
5. Negative symptoms (i.e., diminished emotional expression or avolition).

Positive Symptoms	**Negative Symptoms**	**Disorganized Symptoms**
Delusions	Affective flattening	Disorganized speech
Hallucinations	Alogia	Thought disorder
Combativeness	Anhedonia	Disorganized behavior
Insomnia	Apathy	Poor attention

Table: Symptoms of Schizophrenia.

Further criteria stipulate that a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset"; that "continuous signs of the disturbance persist for at least six months"; that "schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out"; that "the disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition"; and "If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated)" (APA, 2013, p99).

Current research suggests that some people possess a significant disposition to schizophrenia that may be "triggered" by certain stressful situations. Research also suggests that this disposition may be related to genetic factors. Today the illness is most commonly understood, and researched, on the premise that it is a brain disorder. That is to say, schizophrenia is understood to originate in one or more of the following: faulty brain structure, chemical imbalance in the brain or abnormal brain process. Many explanations for schizophrenia involving the brain have been offered, although none has yet identified with certainty the biochemical process behind the illness. In the meantime, psychiatrists use psychotropic medication as the first tool of treatment, while sufferers generally adopt the language of medication names, of "symptoms" and "side-effects", and the general description of their illness arising from a "chemical imbalance" in their brains.

At this point, we may make a contribution to the understanding of schizophrenia by looking beyond a purely bio-chemical approach. Diagnosis and treatment, usually with medication, is both a biochemical intervention and a social process. The history of diagnoses and treatment (such as that offered by Michel Foucault in Madness and Civilization, 1988) contributes to a sociological understanding not only of madness,

what it is and might be, but also how it is construed and related to larger social structures and historical trends. The language adopted to describe and account for illness may be subject to sociological analysis (McLaughlin, 2009; see, for example, the use of specific terminology to delineate people in the mental health sector Stephens and Belisle, 1993). Various attempts have been made to seek a social or sociological cause for schizophrenia, particularly focusing on inconsistent communication (the "double bind"), or disturbed interpersonal relationships in childhood (Bateson et al., 1956; Sullivan, 1962) , or on the disparity between "true" and social identity (Cooper 1970; 1971) (although many such efforts have been contradicted by more recent developments in the field (Shorter, 1997, p. 176, 240, 244; Sadock and Sadock, 2007, p. 475)). When dealing with the conglomeration of institutions affecting the person diagnosed with schizophrenia. Interaction with friends and family may have a significant effect on illness outcomes. Such processes, vital to recovery, are also amenable to sociological imagining. Furthermore, interactions with members of the public may involve significant experiences of stigma or efforts towards stigma concealment; processes analysed sociologically so well by Erving Goffman (1963) in Stigma. There undoubtedly exists a stigma around major mental illness in Australia, particularly in relation to schizophrenia (Burdekin, 1993) For all these reasons sociology can not only provide an insight into the experience of schizophrenia, but it may also in fact prove indispensable to fully understand the illness.

A sociological approach to schizophrenia may take many tacks. One may attempt a sociological history of the subject. One may interrogate the development of classifications of mental disorders (Black and Boffeli, 1989); develop a political economy of schizophrenia (Warner, 1985); explore differing cultural conceptions of psychiatric disorders (Mercer, 1986); or investigate the relationship between schizophrenia, the law and incarceration (Cockerham, 2006). Whatever perspective we consider, however, most researchers agree that there has been a lack of study from the perspective of the person diagnosed with schizophrenia (Scheper-Hughes and

Lock, 1986). In light of this lacuna, this thesis seeks, via the qualitative sociological method of semi-structured interviews with a limited number of people, to study schizophrenia from the perspective of the person diagnosed. Through these interviews, the thesis aspires to explore the impact schizophrenia, diagnosis and treatment can have on people diagnosed with schizophrenia; to give voice to a group of people who are generally silent.

In drawing out the stories of interviewees, this thesis focuses upon two themes pertaining to the perspective of the person diagnosed with schizophrenia: identity and power. In many ways the theme of identity comes naturally to a sociological approach to schizophrenia. Sociology has classically shown great interest in issues of identity (Leary and Tangney, 2003). Georg Simmel (1958) accounts for society with a picture of interacting subjects and identity emerging in different forms and types of social relation. Stuart Hall (1971) examines the play of power and exclusion in the construction of identity. Anthony Giddens (1990, 1991) contemplates identity in relation to modernity and beyond. Perspectives such as "symbolic interactionism" developed by George Mead and Herbert Blumer (used later in this thesis) focus on issues of identity and social interaction; on the need to understand the rebuilding and maintenance of identity as an ongoing process.

However, this thesis departs from these recognised investigations of identity by focusing on the theme of identity disruption. Schizophrenia is defined first and foremost by the experience of disruption (Dinos 2005). Such disruptions are often expected of chronic illnesses generally; Michael Bury makes this point in his 1982 article, "Chronic Illness as Biographical Disruption". Moving beyond Bury, however, we can observe that schizophrenia is itself an illness whose impact may bring with it a significant interruption to identity. People suffering schizophrenia may suffer delusions and hallucinations that disrupt their sense of self. They may believe, for example, that their body has been replaced by a non-living substance, or that they are an historical figure, or may wish for or attempt suicide (the ultimate negation of identity). They may lose the ability to engage sensibly with those nearest to them.

Indeed, in light of the disruption schizophrenia can cause I suggest the alternative terminology of "biographical crisis" and (as we will see below) "ontological insecurity" as ways of conceptualising experiences of identity breakdown in schizophrenia.

To approach the question of self from the point of view of the schizophrenic subject is to challenge some of the formative premises of sociological theories of identity. These theories typically posit a "functioning" self. Symbolic interactionism, for example, devotes some time to the socialisation of infants but, in adults, assumes an effective and operative identity. However, in the sociological study of schizophrenia – such a disruptive illness – this becomes a significant problem: here we must interrogate how identity malfunctions, and how a broken or disrupted identity is made whole again.

This thesis makes a further contribution by understanding identity as a phenomenon resulting not only from symbolic or discursive processes, but as deeply embodied. Identity must be understood not only as a symbolic process affecting the mind as an abstract system, but also as a phenomenon that is inherently situated in a material and sensorial world. This embodied dimension of identity and its breakdown becomes clear in many of the symptoms a sufferer of schizophrenia may experience. Hallucinations or delusions may occur that may be thought of as breakdowns in the embodied, sensory self. Work by Laing (1990 [1960]) suggests that people with schizophrenia may experience their sense of self as struck by "engulfment", "implosion" or "petrification". Again, however, many traditional accounts of identity formation and maintenance fail to account for these embodied aspects of the self. Symbolic interactionism, for example, focuses on the discursive and semiotic level of language and gesture in the development of viable selves. In light of this issue, this thesis contributes to the relevant literature in two ways. The first is to explore ways we may expand symbolic interactionism to account for embodied experiences. This involves investigating what an "embodied interactionism" or "emotional interactionism" may look like. As we will see, embodied interactionism allows for an

additional, emotive layer of interaction, expressed not only through symbolic language, but also the language of the body ("body language"). Significant gestures and symbolic interaction are provided with context, colour and content by the emotional state of interacting individuals. The second contribution emerges through an analysis of phenomenological accounts of identity and being. Although these accounts vary, they tend to all focus, to some extent, on the disruption of being caused by schizophrenia. Such accounts, in particular that given by Maurice Merleau-Ponty (1962), also establish that the human being is ontologically invested in the world; that he or she is emotionally tied or directed to certain projects and this dedication emerges through an embodied, sensory consciousness. When a breakdown of this relation occurs in schizophrenia, this is necessarily a sensorial or bodily event.

Laing's (1990) concept of "ontological insecurity" speaks to the third area of sociological enquiry in which this thesis seeks to intervene.

1.1.5 The Study Context

In the mid -19 century, William sweetser was the first to coin the term mental hygiene' which can be seen as the precursor to contemporary approaches to work on promoting positive mental health. Dorothea Dix (1802-1887) was an important figure in the development of the mental hygiene movement. Dix was a school teacher who endeavored throughout her life to help people with mental disorders,at the beginning of 20th century ,Clifford beers founded mental health America – national committee for mental hygiene; after publication of his accounts, a mind that found itself, in 1908. A WHO report estimates the global cost of mental illness at nearly $2.5trillion in 2010, with a projected increase to over $6trillion by 2030. One in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide. A 2011 World Economic Forum report estimated the cost of the global burden of mental illness in 2010 was $2.5 trillion. This cost is projected to rise above $6 trillion by

2030, an amount three times greater than overseas development assistance spent by all nations between 1990 and 2010. Around 20% of the world's children and adolescents have mental disorders or problems. About half of mental disorders begin before the age of 14. Similar types of disorders are being reported across cultures. Neuropsychiatric disorders are among the leading causes of worldwide disability in young people. Yet, regions of the world with the highest percentage of population under the age of 19 have the poorest level of mental health resources. Most low- and middle-income countries have only one child psychiatrist for every 1 to 4 million people. Mental and substance use disorders are the leading cause of disability worldwide. About 23% of all years lost because of disability is caused by mental and substance use disorders.

Over 800 000 people die due to suicide every year and suicide is the second leading cause of death in 15-29-year-olds. There are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide. 75% of suicides occur in low- and middle-income countries. Mental disorders and harmful use of alcohol contribute to many suicides around the world. Early identification and effective management are key to ensuring that people receive the care they need. Further, War and disasters have had a large impact on mental health and psychosocial well-being of people worldwide. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are among the main barriers to providing treatment and care in low- and middle-income countries. Low-income countries have 0.05 psychiatrists and 0.42 nurses per 100 000 people. The rate of psychiatrists in high income countries is 170 times greater and for nurses is 70 times greater. Unemployment rates among individuals with mental health disorders can be as high as 90%.Mental illness impacts not only individuals but whole families by increasing the burden of caretakers and reducing the ability of affected individuals to contribute to livelihood, household and community tasks. Available mental health services in South-East Asia tend to be urban-centered and hospital-based, with the result that 80%-90% of populations have no access to treatment. People labelled as mentally ill are the worst victims of social violence; mainstream society still fails to acknowledge

their suffering as a valid human experience that requires attention and support. Once people are labelled as mentally ill, as far as society is concerned, their civil and human rights are suspended for ever. They are exposed to discrimination that results in a non-human identity and damaged personality.

In south Asia, the number of people who commit suicide is higher than the number who dies because of road accidents, terrorism and HIV/Aids. It is among the top three causes of death in the population aged between 15 and 34. Asia is by far the largest continent in the world in terms of area with population exceeding 3.5 billion and has dozens of cultures, religions, languages and ethnic groups. As a result of its highly varied political systems, Asia also spawns a wide variety of health care systems including mental health care systems, often based on historical roots and at times colonial heritages. The people who suffer from mental or neurological disorders in the continent form a vulnerable section of society and often face stigma, discrimination and marginalization in all societies, and this increases the likelihood that their human rights will be violated.

The World Health Organization says that over 90% of suicide cases relate to mental disorder and that more than two-thirds of all suicides are preventable. There is huge scarcity of resources to address the mental health needs of the population in south Asia. The negative social attitudes towards mental health, massive underestimation of the suffering of mentally ill people, lack of political empathy, and the lack of mental health leadership are the real challenges.

Mental health policy exists in Nepal, having been adopted in 1997, but implementation of the policy framework has yet to begin. Day by day mental patients are increasing due to various causes like unemployment, unhealthy family relationship, conflicts etc. Schizophrenia is mysterious and serious mental disorder. Schizophrenia people often hear voices which aren't there and may see the scene which is not real. They may feel other people are trying to hurt them. Actually the word schizophrenia is comprised of two Greek words –'Skhizein' meaning to split and 'phren' meaning mind but schizophrenia isn't considered as spilt personality or multiple personality. The schizophrenic patient also having the problem or multiple personality is rarely noticed which is known as complicated schizophrenia. (Lewis, 2012)

1.2 Statement of the Problem

A considerable number of empirical studies have illustrated the social determinant factors of mental illness like stress, social support, sex and marital roles. Despites these studies, there are some conceptual theoretical and intellectual problems in existing literature on stigma and mental health. Because of diverse perspectives of different disciplines, there is lack of consistency on interpretation or analysis of stigma processes on the distribution of life chances. For instances while psychiatrist believe that a combination of genetics, brain chemistry and environment contributes to development of mental disorder.Sociologists believe that social factors play a role in the development of mental disorder rather than genetics and brain chemistry.

Goffman 1959, observation led to the development of his notions of impression management and the dramaturgical perspective in sociology that views" life as a threatre" and "people as actors on a stage," as well as his concept of stigma as a special gap between vital social identity and actual social identity. Goffman's meaning on vital social identity "relates to the way we represent ourselves with people. We don't see and for is take on" actual social identity" he explain it as the way we deal with people in real life.

Becker1973 notes down that labeling theory held that deviant behavior is not a quality of the act a person commits but rather is a consequence of the definition applied to that act by others Research on stigma is clearly multidisciplinary, including contributions by psychologists, sociologists, anthropologist, political scientist and social geographers. Although there is a great deal of overlap in interests across these disciplines, there are nevertheless some differences in emphasis. Even within disciplines, people approach the stigma concepts from different theoretical orientations that produce somewhat different vision of what should be included in the concept. Thus, different frames of reference have led to different conceptualizations.

Nevertheless, the causes of mental illness and negative effect of stigma in individual life has been ignored by social scientists. As a result stigma process has dramatically infleuencing on careers, earning, social ties, housing, criminal involvement, health of individual. Stigma is life long mark once individual is diagnosis schizophrenia mental

illness. Even after the recovery why victims are facing challenging situation in everyday life.

Mental illness is a commonly abstract concept to most citizens in our nation; everyone knows about this topic; but most don′t comprehensively understand the grand restrictions and everyday difficulties one endures while suffering from a mental illness. All of our perceptions of reality are distorted if abnormalities in our brain are present, thus putting individuals at immense disadvantages to cope with reality and qualities of life. Most mental illness requires some sort of intervention or counseled treatment, especially the more severe disorders that some of our fellow citizens have to work through within their lives Inspite of Goffman fruitful conceptualization the empirical study on causes of mental illness; schizophrenia and prevailing stigma in Nepal has remained unexamined.Therefore i am interested to examined social causes of scizophrenia and prevailing stigma attached to mental illness. in context of nepal. to addresses this problem the present study has proposed the following research questions.

a. What are the social causes and prevailing stigma of Schizophrenia?

b. Does a mentally ill patient’s social position in the status system affect his or her identity?

1.3 Research Objectives

In general, the study is an attempt to gain better understanding of causes of schizophrenia and existing stigma experienced by victims. In order to meet research questions the study is based on the following specific objectives.

a: To explore the social causes of schizophrenia

b: To find out the prevailing stigma attaching to schizophrenia.

1.4 Significance of Study

This study attempted to explores the stigma related to mental illness; mental health is highly overlooked and neglected in Nepal. Despite the fact that mental health problem

is one of the most prevalent health problem in the world. This study also shows the discrimination and social exclusion faced by patients with schizopherenia who belongs to different class status. This research aims to reflect balanced view on social causes of mental illness. This study may be important for policy makers to reduce the stigma related to mental illness.

1.5 Outline of Study

This thesis contains five chapters. The first chapter deals with background introduction, objective of the study and limitations of the study. After the introductory chapter, second chapter begins it contains theoretical and empirical reviews of stigma and mental health. Similarly, third chapter is about methodological section which describes research design, research tools and procedure applied for this dissertation. Third chapter also concentrated on the description of the study area. On the same way, the results and discussion are presented in chapter four. The fifth and the last chapter draw summary and conclusions of the study.

1.6 Limitation of Study

This thesis is based on earlier fieldwork carried out on 2075 jesth 28th, shrawan 24th and mangsir 7th with patients in Patan mental hospital. As a student, this study has certain limitations due to the limited time, study area and financial resources as well as lacked of adequate previous studies.

1. This research focus on social causes of mental illness and stigma related to mental illness and this research try to give accurate findings.
2. This study comprised psychiatrist and mental patients as respondents.
3. This research focused on mental health and illness connecting with social class.
4. This study shows the pain and sufferings of schizophrenic patients however, it does not discuss about other mental illness.
5. This study is basically qualitative in nature.

CHAPTER - TWO

LITERATURE REVIEW

Literature review is an important process of research work, which helps us to bridge the gap between the existing problem and past research work in subject matter. Review of related lecture refers to the study of theories from previously carried out researcher studies etc. In other words the study of related topics that help the desired topic to be effective and more experimental is called literature review. This section includes the previously done researcher report objective, method and finding of these researchers that can help the present researcher to develop new ideas and identify the new aspects of the research problems.

2.1 Theoritical Review

2.1.1 Symbolic Interactionism

Symbolic interactionism is a sociological perspective derived from the American philosophy of pragmatism and is focused on social interaction. From the social interactionist perspective, meaning is produced as a result of social interaction and is thus socially constructed. In the words of Ransome (2010); "there are no social interactions that are not imbued with meaning and similarly this sense of meaning does not exist outside the interactive situation" . Mead (1934) argues that sense-of-self is deeply formed and influenced by the social interaction in the social world. This means that social context and interaction between individuals reform and develop the self or identity of human beings (Ransome, 2010). Thus, from the interactionist view, social action is strongly connected with the context within which it occurs. This action, in context, influences human beings to consider the importance of their experiences and events.

Symbolic interactionism contributed to the development of this area of knowledge, the objective of which has been to gain a better understanding of the meanings that surround health and illness (De Maio, 2010). The main interest of symbolic interactionism in this field, therefore, "understands illness experiences". In the words of Freidson Theoretical Framework (1970), "in its social form, illness is a meaning

assigned to behavior by an actor or those around him, and illness behavior is ordered by that meaning". A further significant contribution of symbolic interactionism to health is the notion that continued social interaction between individuals leads to the construction of social reality (Plummer, 1991). As argued by Mead (1934), the self consists of I and me where "I" is the reaction towards others' attitudes and "me" is a collection of the expected attitudes from others in the society. In relation to the concept of self, the subject is "I", indicating the actions; and the object is "me", referring to the individual's awareness and what is socially expected. In relation to the current research, participants behaved and interacted differently in their environments based on the meanings created from their experiences and social interactions. Symbolic interaction was expressly concerned with understanding the individual's stream of consciousness, internal self-conversations, the development of the individual's self-concept in relation to social experience with other people, self-definitions of social situations, and the merging of individual behavior into collective expression of joint or group activities (Blumer, 1969)

Symbolic interactionism offers an abstract theoretical framework for viewing social realities rather than a definitive explanatory theory that specifies variables and predicts outcomes. Symbolic interactionism committed to an inductive approach to understanding human behavior in which explanations are induced from data with which the investigator has become thoroughly familiar. As blumer (1969) stresses, social interaction forms human conduct instead of being merely a means of expressing or releasing it. Interaction relies on spoken and unspoken shared language, symbols, and meanings. Hence, interaction occurs within social, cultural and historical contexts that shape but do not determine it. In Mead's (1934) view, subjective meaning emerge from grappling with experienced interactions, are given form through language, and change when subjective or collective experience prompt reassessment. Thus, social interaction is dynamic and somewhat open-ended.

2.1.2 Labeling Theory

While the theoretical and empirical origins of the labeling approach have a complex history in sociology (Gibb and Erickson 1975), the central hypotheses as they pertain to mental illness were first specified by Scheff (1966). Scheff saw mental illness

arising from the breaking of the nameless residual rules of social life suchnorm violations, mostly unrecorded and of transitory significance, arise in many ways and are prevelent in society. When a residual rule breaker is publicly labeled as mentally ill, a stereotype of mental illness, learned in early childhood and continuously reinforced, may be applied to the individuals. Labeled deviants are then rewarded for playing a role that conforms to the stereotype and punished if they attempt not to play it. Regarding studies of the discharge of voluntary mental patients, we find Greenley (1972) strongly supporting the labeling perspective. His study shows that the length of stay is heavily influenced by family desires (regardless of symptoms the patient's dangerousness, or the judgement of the psychiatrist. Gove (1970) attacked Scheff's data, methods and analysis. Gove emphasized that studies show that the police and other agencies deny the existence of mental illness unless serve behavior and present and stressed the need for sociologist to deal with the existence and causes of such phenomena. Regarding studies of discharge of voluntary mental patients, Gove and Fain (1975) found that psychiatric symptoms, not family attitudes, were more predictive of length of hospitalization. Further research is needed regarding the interaction between prior behavior, institutional setting, existing social policies and the imposition of unwarranted labeling.

2.1.3 Foucault, Discourse and Identity

The Foucauldian approach to discourse and the subject is a widely influential theoretical framework across the social sciences broadly and organisation studies in particular. Discourse can be understood as linguistic and material practices that 'systematically form the object of which they speak' (Foucault, 1972, p.49). Discourses 'do not identify objects, they constitute them and in the practice of doing so conceal their own invention.'

According to Foucault (1980), it was during the enlightenment, which saw the establishment of sciences as the 'norm' for understanding that systematic State regulation of populations became widespread. Together with the development of

knowledge, new disciplines and new categories (e.g. health and illness) the subsequent taken for granted 'truth' became more commonly and universally determined and widespread. This process of knowledge production and its circulation through the power dynamic of language and other material practices is then referred to in Foucauldian terms as discourse.

Discourses evolve within societies, whereby every culture has its own regimes of 'truth' (Foucault 1980, p.131) which are particular kinds of concepts and structures that divide experiences into what is considered to be the taken for granted/the norm or the 'correct way' as opposed to false/abnormal and 'incorrect' ways of being. This practice of categorisation or classification, or the division into what is acceptable and what is not, by which knowledge is being produced, then suggests that meanings are constructed through a relationship of power and domination. So the State and other legitimised bodies are then engaged in this dividing process and in the creation of the norm which then encourages the rest of the public to think and behave accordingly. This then suggests that discourse and discursive regulation operate at the interface between the social and the individual and that power is productive in a sense that in its operation it produces knowledge, subjects and objects as well as resistance and new meanings (Foucault 1980).

In that sense, power and power relations are embedded within discourse in a subtle way. Power is circulated through discourse in a dynamic relation that produces meanings. As such, power is not an independent unit but is rather created and reinforced through discourse (Foucault, 1980) and in this process it also produces knowledge (Mills, 2003). Thus discourse and power are intertwined in a way that discourse is the tool by which power is created and through which it is circulated but equally discourse is born from power. Thus it is power that places the individual as both its 'vehicle and the effect' of its practice (Foucault 1980, p.98).

Discursive power produces and reproduces discursive categories that tell us what is true and false and this therefore is the way in which we then understand ourselves, the world, our behaviour, desires and so on. Thus, power is everywhere and moves

around within a discursive flow (Foucault, 1977). It is fluid and hidden, not owned by anyone, but is rather based on the dynamics between entities (people, organisations and states). Therefore, power goes beyond economic considerations or the practices of exercising power. The meaning of power thus also transcends the notion that it is repressive, preventive, and bad or negative (Foucault, 1980). It is not understood as a physical entity which controls others but rather is understood as a daily practice which is created, reinforced, exercised and resisted through discourses and individual action. As such, discursive regulation governs individuals as a force that acts upon and through individuals' understandings of themselves on a minute basis (Foucault, 1982) and through this process they gain an understanding of themselves and act upon themselves (Rose, 1989).

Thus, at the individual level, discourses shape the way in which people feel, think, act, behave and understand themselves. Individuals draw meanings from discourses in a way that both enable them to gain a positive identity resource but equally in a way that constrains their actions (Deetz, 1992). In this process of meaning production through and from discourse, individuals engage with that duality of both experiencing and practicing power (Foucault, 1980) in a way that reinforces meanings but also in a way that creates resistance and evolves new meanings (Hardy and Thomas, 2013).

Discursive regulation is created and reinforced through the micro-politics embedded within everyday interaction whereby individuals are expected to behave in a desirable and expected way and according to the subject position within discourse. In this process of discursive regulation 'human beings are made subjects' (Foucault 1982, p.208) in a sense that they are encouraged to think and act according to discursive norms and practices which make them subjects, positioned in discourse. Individuals are thus expected to be, think and behave in a certain way and in accordance to the subject position located within discourse. In this process they gain an understanding of self from a number of subject positions which comprises their identity (Foucault, 1982).

The discourse of mental illness embeds within it the assumption that the 'mentally ill person' is dysfunctional and incapable. An individual who is diagnosed with mental illness incorporates within their understanding of self the 'mentally ill' subject position. While that individual can relate to that subject position in a number of ways (i.e. they can accept it and feel like an incapable person; they can deny or reject it or they can resist and rewrite it), one aspect of their self-understanding would evolve around the notion of 'being mentally ill'. Likewise an employee is expected to behave according to employment discourses and the desired norms of behaviour of being an employee. Thus the meanings which are embedded within discourse are normalising discursive practices which are then internalised into our social and individual identities and self-understanding (e.g. Foucault, 1982; Rose, 2010).

Consequently**,** as discourses can be understood as both resources and constraints within the process of identity construction, individuals construct their identities according to a number of subject positions and the meanings they attribute to them (Foucault, 1977; Musson and Duberley, 2007; Thomas, 2009) each of which contributes a part—and not forming the totality—of identity (Holmer-Nadesan, 1996). Discursive regulation therefore has a direct relationship to the way in which individuals understand and name 'who they are' (e.g. worker or parent) and 'who they are not' (e.g. criminal or pervert). And this process of identity construction takes place through the way in which individuals are evaluated by others and how they evaluate themselves. Thus the understanding of humans as subjects conceptualises individuals as products of historic contexts, situations, relations, discourses and institutions (Foucault, 1977; 1980; 1982).

Overall, within this Foucauldian theoretical framework, the understanding of identity illuminates its context bound nature and so identity is located within discourse and through discursive regulation. Therefore, both discourses and the subject positions resulting from them are not fixed entities but rather something that is dependent upon time and place as well as historical and social context (Foucault, 1977). As such identity can be understood as being fluid and dependent upon discourses and contexts.

This conceptual framework of identity, as regulated within the power dynamics of discourse, represents a long tradition within critical identity studies,

2.1.4 Theories of Stigma

There are two main theoretical frameworks relating to stigma; labelling theories (Link et al., 1987; Scheff, 1966) and attribution theories (Corrigan, 2000; Heider, 1958; Weiner, 1995). Contrasting views exist on the labelling of mental health problems. Labelling of mental health problems refers to how the presenting problem is defined or identified. It is argued from a clinical perspective that labelling provides direction for those afflicted and their relatives by replacing uncertainty and false beliefs with a better understanding of the nature of the problem (Angermeyer & Matschinger, 2003). As a result people will then know who to ask for help and which measures to take to overcome the problem (Rosenfield, 1997). Sociological role theory (Parsons, 1958) points to another positive effect of labelling. This considers most of everyday activity to be the acting out of socially defined roles, each with its own social expectations that individuals are required to fulfil. Parsons' (1958) theory suggests that if an individual's mental health problem is perceived as an illness, the privileges of the patient role will be granted and the patient will not be held responsible for their illness. This should result in a more accepting attitude towards those suffering from mental health problems. By contrast, labelling theory (Scheff, 1966) proposes that psychiatric labelling leads to negative effects. According to Scheff's (1966) theory, through the process of labelling negative stereotypes of the mentally ill are often triggered, leading to increased discrimination. Link et al. (1987) proposed a modified approach to understand the consequences of labelling and extended Scheff's (1966) theory. They suggested that if an individual is labelled with a mental illness this can lead to social rejection. Social rejection triggers responses in the stigmatised individual such as secrecy and withdrawal, which can produce negative consequences such as feelings of shame, lowered self-esteem and reduced earning power. This process may induce a state of vulnerability, increasing the likelihood of repeated episodes of mental illness.

According to attribution theory (Heider, 1958), people begin to understand others by making personal or situational attributions about their behaviour. This has become an important framework for explaining the relationship between stigmatising attitudes and discriminatory behaviour (Weiner, 1995). According to Weiner's (1995) attribution theory, behaviour is determined by a cognitive emotional process by which people make attributions about the causes and controllability of a person's behaviour that lead to inferences about responsibility. These inferences lead to emotional reactions such as anger or pity that affect the likelihood of helping or punishing behaviours. If the causes of a person's behaviour are attributed to factors outside the individual's control, they are less likely to be judged responsible and peoples' emotional reactions and behaviours towards the individual will be less negative. Alternatively, if the causes of a person's behaviour are attributed to factors within the individual's control, the individual is likely to be judged responsible, resulting in negative emotions and behaviours towards them.

Corrigan (2000) adapted Weiner's (1995) theory and applied it specifically to the stigmatisation of mental illness. Corrigan (2000) highlighted the relationship between signalling events (person with mental illness), mediating knowledge structures (attributions), emotional/affective responses and behavioural reactions.

Corrigan (2000) proposed that people who believe that mental illness is under an individual's control (i.e., they are responsible), are likely to respond in anger towards the individual and act towards them in a punishing manner. In comparison, people who consider that mental illness is due to factors outside the individual's control (i.e., they are not responsible) are likely to respond in pity towards the individual, resulting in helping behaviour. According to Corrigan's (2000) model, people who believe that individuals with mental illness are dangerous are likely to react with fear leading to increased social distance. Although Corrigan's (2000) model outlines the different components of stigma towards people with mental illness, and explains how attributions of mental illness lead to discriminatory or helping behaviour, limited

studies have tested the model (e.g., Angermeyer, Matschinger, et al., 2003; Corrigan, Green et al., 2001). Additionally, the model implies a linear relationship between the components and does not consider that other factors may influence the relationship between the separate components (e.g., familiarity with mental illness).

Social identity theory (Tajfel & Turner, 1986) may also help explain intergroup discrimination such as that towards individuals with mental illness. The theory highlights how our sense of identity is closely bound up with our various group memberships, and that we assess our own group's worth by comparing it with other groups. According to Tajfel and Turner (1986), people prefer to have a positive identity rather than a negative one. Since part of our identity is defined in terms of group membership, it follows that there will be a preference to view those in-groups (including oneself) positively and out-groups (different to oneself) negatively. The outcome of these intergroup comparisons is crucial because it contributes to our self-esteem. Therefore when considering the issue of stigma, it is likely that people with mental illness (out-group) are perceived less favourably compared to people without mental illness (in-group) and are therefore more likely to experience discrimination from others.

A detailed social psychological model (Angermeyer & Matschinger, 2003a, 2003b; Angermeyer, Matschinger, & Corrigan, 2003; Corrigan, Edwards, et al., 2001) based on both attribution and labelling theories has also been developed to describe the different components of stigma. This is one of the most widely used models in stigma research conducted in western cultures. It suggests that people hold stigmatising attitudes because of their past experiences and knowledge, and that they react emotionally in response to these attitudes. The emotional reaction leads to a behavioural response (Corrigan et al., 2000). causal pathway model takes into account different experiences (e.g., labelling of mental illness, familiarity with mental illness and demographic variables) and examines how these impact on perceptions of mental illness (e.g., dangerousness, dependency, causal attributions and prognosis). These

perceptions are considered to influence affect (e.g., fear, anger, lack of understanding, pity and desire to help) if confronted with a person with mental illness. The emotional reactions of people finally impact on social distance.

Causal Pathway for social distancing according to the Social Psychological Model (Angermeyer & Matschinger, 2003)

The model has a number of 'paths' from experience to response. 'Perception' and 'Affect' are likely to make up what we understand to be attributions within stigma, while 'Response' is discrimination (Emmerton, 2010). According to the model, there are a number of different factors (experience) aside from attributions that are thought to directly impact on social distance. These include labelling of mental illness, familiarity with mental illness and demographic variables (e.g., age and gender). Numerous studies have been conducted testing the social psychological model in western cultures, using path analysis to examine the relationship between the different components. However, no studies have tested application of the model in non-western cultures.

2.1.5 The Capabilities Approach

The capabilities approach The CA is a human rights-based theory which centres on human development and flourishing as a product of the conditions in which people live (Carpenter, 2009). As set out by Sen (1999, 2010), it is a theory of social justice concerned with the 'substantive freedoms' or choices people have to achieve valued functioning which can include 'elementary ones such as such as being adequately nourished' as well as 'complex activities or personal states' (Sen, 1999, p. 75) such as being knowledgeable, having self-respect and participating in community and political life. The theory focuses on the issue of whether such freedoms – or 'capabilities' – are widely shared in society, whether people have equal opportunities to achieve functionings, or 'valued beings and doings' (Sen, 1999). It is therefore centrally concerned with the cultivation of individual agency – people's ability to

choose and to pursue their own valued goals (Walker, 2005). The CA arose as a challenge to solely economic measures of human de-velopment associated with the tradition of neoclassical economics and neo-liberal ideologies (Carpenter, 2009) and as 'an alternative to utilitarian (resource or income-based) approaches to human welfare' (Hopper, 2007, p. 874). Moving beyond these, Sen proposes broadening the evaluative space to consider the effects of rights, freedoms, policies and social, political and economic arrangements on people's capabilities and lives, on people's 'well-being'. The approach is humanistic, and encapsulates but expands the focus of human capital theory on social provision such as education as a productive resource to focus on the opportunities for human freedom that such provision creates. It also points out that although freedoms are inter-related and can be mutually reinforcing (e.g. social opportunities such as education facilitate economic participation which in turn helps generate public revenue for social facilities), economic growth or consumption does not always expand capabilities and functionings, and valuable functioning (e.g. social activities) exist outside of the market (Carpenter, 2009; Sen, 2010). In addition, Sen argues that we should value the intrinsic importance of freedom and not just the use that is made of it. Sen (1999, 2010) thus highlights both process and outcome elements to freedoms; having capabilities is important in itself in allowing for choice as opposed to constrained lives (substantive freedoms) and because it fosters opportunities to achieve valuable functionings (instrumental freedoms). He argues for consideration of human capabilities in terms of: 'their direct relevance to the well-being and freedom of people' as well as 'their indirect role[s] through influencing social change and . . . economic production' (Sen, 1999, p. 296). Sen also emphasizes how the translation of resources into capabilities – what someone 'can or cannot actually do' (Sen, 2010, p. 261) – is subject to variation according to a person's social characteristics (gender, age, dis-ability etc.) and the social and environmental conditions of any given society, i.e. 'conversion' factors. There is recognition of potential external and internal barriers to converting resources, or commodities, such as education into capabilities for disadvantaged groups. These

barriers include income deprivations as well as 'adaptive attitudes', since people's Capabilities approach, adult community learning and mental health expressed preferences may be conditioned by acceptance of restricted agency due to discrimination or disadvantage. There may also be a 'coup-ling of disadvantages between different sources of deprivation' (Sen, 2010, p. 256). For example, the stigma of a mental illness diagnosis may impede earning a living and also the conversion of income and other resources into capability, into 'good living' (Sen, 2010, p. 258).Within CA, then, evaluation of a public good, such as education, needs to assess the ways in which social inequalities rooted in the cultural or structural context affect people's abilities to use commodities to enhance their 'capability set', or combinations of potential functionings (Walker, 2005), and to achieve functionings. From a capabilities perspective, 'mental health' may be operationalized in terms of 'what you are able to be, do and achieve and how you feel'. This understanding high-lights the inter-related social and emotional elements of 'mental' health in alignment with calls from the mental health service user and survivor movement and other commentators (for example, Williams, 2001). It also accords with the notion of 'mental well-being' which includes 'subjective wellbeing (how we feel about ourselves and our lives), social wellbeing (relationships and connections) and sense of meaning or purpose' (Friedli, 2011a, p. 13). Substantive freedoms, or capabilities, and functionings developed through ACL relevant to mental health include, therefore, social and cultural factors such as social connectivity and friendship; having a sense of purpose and achievement; being knowledgeable (including about 'mental health' itself); and having confidence, self worth, sense of control and optimism, and, in wider terms, a personally and socially valued identity. The ways in which ACL may indirectly impact on mental health through developing capabilities such as enjoying relation-ships and family life, taking part in other collective or community activities, or taking up further education, training or employment also require consideration employing CA entails mapping the interconnections between these different dimensions of people's lives, and between the constituent elements of social life, in order to build a theory, or explanation, of how these are implicated in the production of 'mental

health′ – i.e. a ′social model′ of mental health. The CA can be used to assess the personal and social returns of ACL for mental health according to how the provision may or may not widen possibilities for achievement and flourishing in work and life (Schuller, 2004) situating economic efficiency and social justice as compatible rather than conflicting aims (Salais, 2004). It requires exploration of intrinsic, process and outcome elements across social, economic, cultural and political dimensions, and consideration of how ACL may not only provide ′the means of living′ but also ′the actual opportunities of living′ (Sen, 2010, p. 233). This includes ACL′s symbolic function as a social good for promoting ′human development freedom′ (Walker, 2006, p. 168) as well as its potential empowerment and distributive functions and its impact on tackling a range of capability inequalities. In the context of targeted mental health provision, such opportunities include reshaping identities, which may have been affected by misrecognition, stigmatization or exclusion, as well as creating opportunities to re-engage with society (Brown and Kandirikirira, 2007). The ways in which identified factors and their impact on mental health may vary across social groups also require assessment. This approach provides a corrective to limited, individualized perceptions of the value of ACL merely as a means of achieving educational or occupational progression, or economic benefits of productivity and reduced public dependency. It enables an evaluation framework encompassing these considerations but also highlighting the ways in which the provision directly produces capabilities and functionings that are of value in their own right and which promote ′mental well-being′. Further, countering an overemphasis in recent UK social policy on ′fixing individuals′ (Friedli, 2011), it provides a way of showing how ACL provision generates capabilities and functionings through collective as well as individual means, and of a socio-political and cultural, as well as economic, nature, and thereby how it facilitates people′s wider contributions to their communities and to society. However, any indirect economic benefits from these wider contribu-tions (e.g. a likely reduction in economic losses from illness and in welfare and treatment costs) would also be identified.

A social model of mental health; within the CA, the aim of policy and social provisioning is to expand substantive freedoms (opportunities and choices which are of value in their own right) and it is this that potentially links ACL to a social model of mental health. Resonating with recent expositions of such a model (e.g. Tew, 2005), the CA takes a humanistic and holistic view of the person (Carpenter, 2009) while emphasizing the effects of social conditions on people's lives, and within the approach it is power that mediates the relationship between capability and mental health (Sen, 2010). The approach therefore provides a way of thinking about social inequalities, including gender, class, sexuality, race, ethnicity, age and dis/ability, that is extremely relevant to mental health – in terms of substantive freedoms that are bound up with issues of power. It is compatible with politicized understandings of mental health and distress, as well as service provision, within feminist and survivor perspectives (e.g. Williams, 1996; Tew, 2005), and with the ways in which these have been framed in relation to human rights (Lewis, 2009). From the perspective of the CA, the social and economic disadvantage associated with mental health problems and the stigma arising from contact with mental health services both contribute to capabilities deprivation, impeding valued choice-making and constricting participation in society (Hopper, 2007). The approach therefore has parallels with the social model of disability but as well as identifying barriers provides a more positive, assets-based approach to intervention. Conceptually, it counters the screening out of the social structural factors which affect mental health and, by locating it in the social world, helps to avoid 'splitting off' people experiencing mental health difficulties 'from the rest of humanity' (Pilgrim, 2008, p. 302). Consequently, the CA can usefully inform approaches to 'recovery' within mental health services – a new paradigm originating in the British context in the survivor movement, which focuses on regaining a meaningful life beyond a period mental distress/ illness. It resonates with the 'four pillars' of recovery – regaining competences, social reconnection, identity work and renewing a sense of possibility, but countering currently dominant individualized and depoliticizing approaches, refocuses attention on agency and the redressing of both material and symbolic disadvantage (Hopper, 2007). The notion

within the CA of particular relevance to mental health and learning is that of 'agency freedom', which refers to the capability to act purposefully to advance one's chosen goals and values as an element of a person's effective power (Sen, 2010)In this context, 'mental health' can be viewed as an important human functioning and aspect of freedom related to capabilities and achievements which may stem from Lydia Lewis .It can be understood in terms of self-efficacy and sense of control over one's life, phenomena which arise largely from social conditions and people's positions of advantage or disadvantage within these. Alongside that of 'confidence', these themes recur in adult education evaluative research (e.g. Field, 2009a) and can usefully be encapsulated as agency freedom (Walker, 2010).

2.1.6 Functionalist Theory

Functionalist Theory and Emotion Regulation :

The functionalist theory of emotion provides a foundation for understanding the importance of emotion regulation to adaptive psychosocial functioning. Functionalist theory defines emotions as "bidirectional processes of establishing, maintaining, and/or disrupting significant relationships between an organism and the (external or internal) environment." (Barrett & Campos, 1987, p. 558). Emotions may be experienced as subjective feeling states, physiological arousal, urges, cognitions, or behavioral expressions, and they function to alert the individual and persons in the environment to the occurrence of an important event and to organize goal-directed behavior (Barrett & Campos, 1987). From a functionalist perspective, each emotion is associated with a unique motivational function for the individual and the social environment. For example, sadness functions to signal the self and others that assistance is needed; anger organizes behavior to overcome an obstacle to goal-attainment.

Functionalist theory suggests that emotional experience and expression are influenced by personal characteristics (i.e., biological factors, learning history), the emotion-

eliciting event, and the social context (Barrett & Campos, 1987; Saarni, Mumme, & Campos, 1989). Embedded in the functionalist definition of emotion is an understanding that emotions are reciprocal in nature (Barrett & Campos, 1987). They serve not only to organize individual behavior, but also to motivate the behavior of others in desired ways. In turn, how emotions are received and responded to by the social environment impacts future emotional experience and expression (Barrett & Thompson, 1994) Learning to attend to emotional information and to modify emotional experience and expression is essential to goal attainment and adaptive functioning. According to Thompson (1994), "Emotion regulation consists of the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions… to accomplish one's goals." (Thompson, 1994, pp.27-28). Coping strategies for managing negative affect represent only one facet of emotion regulation, and although emotion regulation is often associated with the diminishing of physiological arousal or the minimizing of emotional expression, effective emotion regulation depends on the context and at times may involve intensifying emotions (Thompson, 1994). Positive emotions (e.g., joy) are also regulated and, the ability to experience and maintain positive affect is considered an essential component of healthy emotion regulation (Cole, Michel, & Teti, 1994). As implied in Thompson's (1994) definition, other aspects of emotion regulation include the ability to attend to and monitor emotional events, to correctly interpret internal and external emotion cues, and to implement effective regulatory strategies for the expression of positive and negative affect.

Finally, I have mentioned different theoretical perspective, among them I choose symbolic interactionism to study stigma and mental health because SI is micro perspective theory and it focused on social interaction as well as concerned with understanding the individual's stream of consciousness, internal self conversation,the development of individual's self concept in relation to social experience with other people, self definition of social situations and the merging of individual behavior into collective expression of joint or group activities.

2.2 Empirical Review

Numerous studies have revealed that there exists a strong association between social class and psychiatric disorder; that the highest rates of the psychiatric disorder are to be found in the lowest social groups. One of the earliest systematic studies in this century by Faris and Dunham (1939) showed that in Chicago the areas having the highest mental hospital admission rates were those with the greatest numbers of people in the lowest socio-economic strata- deteriorated and rootless people from the lowest social classes. Since that time this basic finding of the association between low social class and high mental illness rates, has remained low social class and high mental illness rates has remained remarkably persistent.

The census showed that the association between social class and mental illness was strongest when the psychoses, principally schizophrenia were considered alone. (Hollingshed and Redlich)(1958)

Another significant finding was that the kind of treatment a patient receives varies with his social class position. The most time consuming and expensive treatments were given almost exclusively to patients in social classes I and II. While class V patients were most likely to be accorded custodial care only. With increasingly sophisticated methods, investigators tried to ascertain the reasons for the relationship between high rates of mental illness and low social class and several explanations were put forward. These can be categoriesed under three headings.

1. The ‘downward drift' explanation; people who develop mental illness drift down into the lowest social class;
2. The 'environmental stress'explanation working class environment produces stresses which become causal factors in mental illness.
3. 'The differential labeling and differential treatment' explanation; working class patients are more likely to be labeled mentallyill and less likely to leave the role of mental patients than those from the middle class.

2.2.1 Downward Drift

People who became mentally ill are unable to hold responsible important and well-paid jobs and have to undertake work which is less demanding and less skilled. As the illness develops and increasingly damages the person, these individuals have to find occupations which are increasingly simple less and less demanding and less and less well paid. They 'drift' down the occupational scale. In otherwords, a downward social mobility takes place, as a consequence of mental illness.

This explanation says nothing of what causes the individual's mental illness in the first place: whether it was due to genetic, organic or interpersonal factors or whether it was mainly a result of labeling the argument is that once a person become mentally ill, or is so regarded, downward drift is set in to motion such a person,who had started life in a middle class family and drifted down the social scale, has experienced downward mobility, whatever the causes of his affliction.

Infact, such a middle class individual would experience downward mobility whether his social standing was compared to that of his parents' intergenerational mobility or to his own beginnings (intragenerational mobility). Somewhat different may be the position of those who are born in to working class families and became mentally ill; it has been suggested that in a society with much intergenerational upward mobility. It is quite possible that healthy members of the workingclass move upward leaving behind a 'residue' of less healthy ones. Thus, for those born in to the lowersocial strata, not so much a downward drift, but an experience of being left behind may occur. In certain ways the drift explanation may be peculiarly applicable to schizophrenia. Individuals with this disorder may withdraw from social contacts and seek isolation and undergoing long periods of unemployment. (Aleenan,2013)

2.2.2 Environmental Stress

For hundreds of years, concept of mental illness have stipulated that it is the result of remote and immediate cause or in more modern terms, of predisposing and precipitating causes consists of events and conditions that we now label 'stressful'.

According to the shorter oxford English dictionary, the word stress is probably a shortened form of distress, meaning hardship, straits, adversity, affliction or a force of pressure exercised on a person. In the social sciences, the definition and investigation of stress pose many problems (Dohrenwend, 1974). In this sense a variety of social, personal and physical events can produce stress situations: natural disasters, such as earthquake or floods; war and battle conditions; illness injury, pain, crises of life such as bereavement, loss of employment and many others.

If only experience that can be assumed to be painful for nearly everyone are included in the concept of stress, then the term may embrace very few situations; only the death of a much loved relatives a life- threatening illness, prolonged hunger and other extremities would be included. Moreover, given situation and events are distressing to people whose lives centered around it, whose treasured possessions, full of memories, were in the home and who planned to live there for the rest of their lives, than a similar events would be to people who were not very fond of their house or who regarded it only as a temporary domicile. Thus, ideally stress events should be studied in relation to the personal meaning they have for particular individuals. Life events may cause the mental illness (Dohrenwend, 1974).

A case study cited by brown and harris (1978) had serve to illustrate 'event' Mrs. Ferguson, a married women of 51 with two adult children living at home, was one of the seventy three women admitted as an in -patient. Her husband told her one day that he was having an affair. Before this she said she had no reason to think her marriage was not fine. She said she had suspected nothing. Almost at once she said she felt depressed. She began to cry a great deal and did so every day. She felt life was not worth living and she thought carefully about various methods of committing suicide. She began to feel guilty and in some way responsible for the failure of her marriage. She sweated a good deal and generally felt tense. These symptoms came on within a week or so of the event and for the next five to six months she gradually got worse.(Brown and Harris, 1978)

2.2.3 Social Class and Stress

Several investigators found an association between the number of stressful life events experiencd by psychiatric patients and their social class background. Liem and Liem (1978) Shows that unemployment is a most important source of stress. It is closely connected to loss of self-esteem and deterioration of personal relationships. Loss of work and income give rise to self blame and to estrangments from friends and relatives, thus combining financial and psychological pressures. These stresses apply to the unemployment of all classes; but the risk of unemployment is greater for manual workers than for white color employees and the consequences can be considerably harsher. At the lowest end of the occupational scale unskilled workers have much higher rates of unemployment that skilled manual or non-manual worker. (Rutler and madge,1976)

Working class people are in a weak position in this respect because the stress producing situations they face less alterable by individual action than those most often encountered by middle class individuals. Stress in the working class environment most arises from structural economic factors over which individuals have little control and moreover, they have fewer resources, in money and power, to mitigate the consequence of stressful events.

Kohn (1979) writing about the concentration of schizophrenia at the lower end of the social scale argues that individuals in that class have a characteristics conception of the external world. A fearful and fatalistic belief that one is at the mercy of forces beyond one's control and even understanding.

2.2.4 Geographical Differences

Several studies have found geographical differences in the rates of mental disorder; in general rates are higher in densely populated urban areas of low social status and lower in long-established rural communities. The Faris and Dunham (1939), showed that the majority of psychiatric patients admitted to a state mental hospital had come from the inner city.

A.H Leighton (1959) had researched in a predominantly rural country in Nova Scotia. He found that social cohesiveness, a sense of belonging to a community, is characteristic of the type of environment associated with mental well-being. In well-established communities, there is a lesser incidence of mental disorder than in areas which lack such cohesiveness. It is also argued that urbanization may increase the rate of mental illness because of the social changes associated with it. For women , urban life has meant the loss of traditional functions and importance in earlier times their responsibility for household work, such as cooking marketing and sewing made their contribution to the family far more importance than similar work can be in contemporary urban environment, where readymade articles and 'convenience' foods are available. In rural area like north visit women face fewer such changes and have retained in greater measure the security of traditional roles. For men also, role changes and disruptions of long established patterns are associated with industrialization and urban living .This argument is suggested by Hagnell, whose studies in a predominantly agricultural district of Sweden shows that for both men and women who moved to large city the risk of developing mental illness was greater than for those who stayed in rural areas.(Hagnell, 1966).

2.2.5 Differential Labeling and Differential Treatment

The relationship between rates of mental illness and social class is concerned with the social processes by which people become defined as mentally ill and with the treatment accorded to them after they are so defined. It is argued that people from the lower end of the social scale are the most likely to became defined as mentally ill and encounter most difficulties in returning to normal social roles. It is suggested that the apparent concentration of mental illness among people of the working class is greater than the real prevalence of it would warrant. The patients of different social class treated very differently. A patient from class I and II are given very special expensive treatment by private psychiatrists where as lower class V are given drugs, electric shock or custodial care as mental treatment process according to the class one belongs too.(Dohrenwend1974)

Differences in social and economic resources (education, money, knowledge of the system, etc) play another part in differential treatment and labelling more resources promote prompt and effective action to obtain psychiatric help. Higher social class patients are likely to enter into treatment early, when the disorder is not yet very severe, at a stage when the illness may be treated without the individual becoming defined as a mental patient. By contrast, those with fewer resources, lacking knowledge of the world of psychiatry, may not obtain professional help until the symptoms are severely disruptive. Hollingshed and redlich found that people in classes I and II were considerably more aware of psychological problems than those in classes IV and V. the lower status patient will attribute his troubles to unhappiness, toughluck, laziness, meaness or physical illness rather than factors of psychogenic origin . the worst thing that can happen to a class V person is to be labeled 'bugs', 'crazy' or nuts. Such judgement is often equal to being sentenced for life to the 'bughouse' (hollingshed and Redlich, 1958, p.175).

It has been suggested that lower social class patients stay in hospital longer and have a greater chance of becoming institutionalized. Where as middle class patients would have a greater chance of being discharged from hospital quickly. Studies have demonstrated that working class patients tend to stay in hospital longer than higher class patients with the same condition and this is too influences differential defination of people as mental patients.

The correlation between social class and prevalence of symptoms of psychological disorder is one of the most thoroughly documented relationships in Epidemiological research.

Two kind of explanation are possible in a two variable model that A causes B or that B causes A. In the former instance A, social class, may cause B, psychological disorder, because class membership carries with it life conditions that expose one to whatever it is that produce disorder. Theories such as this have been called social causation theories and have assumed that sociocultural environment

In contrast to the social causation position other theorists have argued that the causal flow between social class and psychological disorder is indeed in one direction but with psychological disorder causing social class placement. People with psychological disorder are said to select themselves (or are selected) in to the lower social- classes.

Additional support for the social selection argument has come from studies of social mobility. If the family of origin is of a higher social class than then maladjusted offspring, then the disorder must have precipitated a decline in social class.

Neither social selection nor social causation aruguments are undisputed nor is it necessary to cling to one or the other set of propositions tenaciously. It is quite likely that future research will show that some disorder are caused by the social environment, while in other cases disorder determines class position and concomitant social environment. In still other cases the relationship is likely to be proven genuinely reciprocal.

2.2.6 Stressful Life Events as a Mediator

Further specification is provided by expanding our discussion to the consideration of three –variable models with stressful life events added to social class and psychological disorder.The most straight forward and best researched of the three-variable models is a simple recursive one which posits an inverse relationship between class position and stressful life events and psychological disorder as shown Social class- stressful life events- psychological disorder

All of the three variable models relating social class, stressful life events and psychological disorder that have been discussed so far have been recursive.

Lower class memberships increases the chances of expose to serve and frequent stressful life events and the risk of psychological disorder, people at top run somewhat less risk of stressful life events and psychological disorder and are more insulted when there conditions do occur.

2.2.7 Social Determinant Factors of Mental Illness

Very little is to know about specific mechanism by which social factors influence the incidence of mental illness. The recent work in this area has focused on the impact of stress, sex and marital status, and social support systems.

Stress:

A decade ago a major literature review in this area (Jaco1970) found that while some association existed, causal evidence was lacking on the proposition that certain social statuses led to an increase in psychopathology or symptoms because of higher level of social stress associated with them. It was possible to use the existing data in support of the hypothesis that stress led to the perception of mental illness and the seeking of help, not to the illness itself; or the mental illness led to the stress. There is no completing accepted definition of stress exists. The question of whether or not stress must be recognized by the victim is still unresolved, as is the question of how to measure it. There is still a need to integrate the physiological, psychological and social dimensions of stress. The Current practice of operationalizing stress as 'life change' is usually traced back to Adolf Meyer.(Holmes and Masunda1974)

Meyer was a psychiatrist; his beliefs about life change were influenced by his familiarity with the work of Dewey, C.H.Cooley, and George Hebert Mead. Whenever an individual is out of touch with the community that has provided symbols, roles to play and positive self-concepts and is coming into contact with new sources of symbolic and social support. Meyer expected to find an increase in stress leading to both physical and mental disorder. Social scientists (Antonovsky 1972, Moss 1973) have moved to specify the social context that leads to a generalized susceptibility to all sorts of disorders including mental illness. Most studies in this area use the 22-item scale as an indicator of mental illness with a variety of modifications; social readjustment rating has been correlated to several indicator of mental illness (schizophrenia, psychiatric hospitalization, depression, anxiety etc)

with moderately positive results. The crucial point is that stress must be seen in a social content in order to understand its relationship to mental illness.

Dooley (1977) found that unemployment had a direct impact on the incidence of depressive symptoms in the population. however, (Spears and Rumos 1978)have found that the relationship between the economy and depressive symptoms was the reverse for poorly educated members of minority groups in the south (Kansas city) both young and old, who perceive structural barrier to a better way of life more acutely during bad.

Again, how events are perceived by those who experience them must be considered along with the events themselves. Such perception arises from social conditions structures and policies.

Similarly, resources for dealing with social stress- eg family support, peer group support community ties are primarily manifestation of social processes and structures. They too are affected by the larger economic forces that create unemployment and other economic dislocations. Thus there is a pressing need to integrate the analysis of social networks and their effect on self- esteem with social class and economic change.

2.2.8 Sex and Marital Roles

Recently, in part due to the influence of the women's movement, sociologists have shown increased interest in how sexual discrimination and demand of the marital role affect mental illness. Reviewing 17 studies conducted between 1690 and 1968, Gove (1972) found that married women showed higher rate of mental illness. Rates for single, widowed, and divorced women were lower than those of males. He reasoned that the female marital role (characterized by restricted freedom, frustration associated with caring for home and children, a lack of structure that leads to brooding and morbid self –obsersion, either a lack of productive work outside of the home or the

double burden of housework and supplementary employment the diffuse and unclear nature of the role expectations explained the differential rates.

Social support:

Much theoretical work indicates the importance of support systems to an individual's self –concept, language system etc. Gore (1978) found that over a two year period the rural unemployed (who had a higher level of social support due to community size and ethnicities) had a significantly lower incidence of symptoms and affective response than a comparable group of urban unemployed. Cohler (1974) found that a high level of social support was associated with a decreased level of mental hospitalization for women after the birth of the first child.

Despite progress in specifying the relevant variables in the social etiology of mental illness, our understanding of the phenomenon is still minuscule. We have seen that the interactionists perspective is capable of synthesizing much of the epidemiological work of the past few years, but such an integration has not yet been achieved as the interactionists have moves closes to a phenomenological view, they have tended to ignore questions of etiology or 'Objective' consequences

2.2.9 The Stigma of Mental Illness

Stigma surrounding mental illness refers to the view that people who are mentally ill are different, have undesirable characteristics, or deserve to be punished because of their mental illness. Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural of each of these categories. Social settings establish the categories of persons likely to be encountered there. The routines of social intercourse in established settings allow us to deal with anticipated others without his special attention or thought. When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his social identity. While the stranger is present before us, evidence can arise of his possessing an attribute that makes him to be, and of a less desirable kind-

in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, it constitutes a special discrepancy between virtual and actual social identity.(Goffman, 1963,P.2). Goffman (1963), as well as Corrigan and Penn (1999), have shown that people who have been diagnosed with a mental illness face many challenges due to public reactions to the stigma that surround mental illness. Many mentally ill people cannot find work or adequate housing because employers and landlords focus mainly on negative stereotypes (Flanagan, & Davidson, 2009; Corrigan, 2004). Stigma can also lead to the criminalization of those with mental illness. More and more people with severe mental illness are being sent to prison, possibly due to lack of resources in public mental health (James & Glaze, 2006). In addition, individuals are more likely to call police responders in the case of a mental health crisis rather than seeking the help of mental health professionals (Corrigan, 2004). Because many police officers are not trained to handle mental health crises, some individuals with mental illness report a low frequency of positive interactions with police officers in which they experience kindness or sympathy (Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002). The fact that people turn to police demonstrates the public distaste for the mentally ill who disturb the peace, thus reinforcing stereotypes of those who are misunderstood. In addition, these stereotypes and police involvement can lead the public to agree with harsh punishments, such as incarcerating those who are mentally ill in either prisons or hospitals. Further, stigma can lead to lower self-esteem and denial of opportunities to participate in the public sphere (Link et al., 1989; Corrigan, 1998; Wahl & Harman, 1989). Several studies conducted by Link and others have also found that expectations of stigma by those with mental illness are associated with higher levels of depression and demoralization (Markowitz, 1998)

The concept of stigma, as Goffman developed it, is helpful to the understanding of the social role of the mentally ill: the traditional image of the mental patient as someone strange in appearance, dangerous and inexplicable, someone to be feared and mistrusted, is deeply discrediting and stigmatizing. A most important feature of

stigma is that it undermines social expectations, a statement which touches the very core of sociological concerns; the explanation of how people interact with each other in specific situations. Of crucial importance for smooth interaction in society is that people have expectations as to how others will behave in given situations. These expectations enable people to orientate their own behavior towards the anticipated action of others. Social expectations are built up slowly and are based on accumulated past experience; without them, routines of daily life in society would not be possible. For example, a man entering a shop has a set of expectation: that the shopkeeper will be willing to sell his goods, that he will accept money in return, etc. and the shopper will have these expectations even if he has never entered that particular shop, nor met that particular shopkeeper. Social expectations form the basis of social roles: persons playing the roles of shopper and shopkeeper are both expected to behave in certain ways.

Possessing a stigma, which in Goffman's term is an undesirable differentness, implies that a person has an attribute which makes him different from others and that the usual social expectations are not applicable. People became unsure of what to expect and this disrupts ordinary interaction in society. If the shopper is uncertain as to what to expect from a particular shopkeeper he will refrain from entering the shop. An individual who is known to be mentally disturbed is thereby thought to be diferent; his other characteristics e.g. that he is middle-aged, male and a town dweller become relatively unimportant as do his social roles as shopkeeper, father and husband. He is now identified as the mentally disturbed man and social expectations as to how he will behave are undermined. When people say that the mentally ill are unpredictable and inexplicable, they typically express their feelings of uncertainty concerning social expectations.

In a sense, all types of illness are stigmatizing. If the term stigma is accepted to mean an 'undesirable differentness', that is, an attribute evaluated as something bad and discrediting, then any physical illness comes in to this category: serious, long-standing and disabling diseases being more undesirable than slight, short-term and

self-limiting conditions. It is helpful to think in terms of a continuum of stigmatizing illnesses, with conditions like backaches, headaches and colds as least stigmatizing and diseases such as multiple sclerosis or paralytic polio as very stigmatizing. Colds and backaches are accepted as something most people get and are therefore part of life, even compatible with overall good health, while disabling diseases such as multiple sclerosis or polio are considered as rare, singling out the sufferers as unfortunates, who are different from everybody else.

Mental illness is at the most stigmatizing end of the continuum; as the studies discussed earlier show, it is consistently ranked by people as more undesirable and fearful than physical illness. It is popularly thought of as a serious condition, with little chance of full recovery, which hits people of not very admirable character. Moreover, the trouble is located in the 'mind' of the sick person and people tend to think that thereby the most essential part of the human being becomes questionable or discredited. As Goffman aptly phrased it, the stigmatized is regarded as less than human. The recovery process of many individuals with mental illness, particularly those with schizophrenia, has been curtailed due to feeling devalued and discriminated against within society because of their mental illness (Phelan & Link, 2004). Cultural stereotypes of patients with schizophrenia include being labeled as crazy, dangerous, incompetent, and not only responsible for their illness but also being unable to recover. Believing these stereotypical labels can produce additional inner psychological distress for the patient (Cavelti, Kvrgic, Beck, Rusch, & Vauth, 2011) Studies indicate that internalized stigma or self-stigma can negatively affect patients with schizophrenia if they embrace stigma as a self-fulfilling prophecy for failure to experience recovery (Berge & Ranney, 2005)

Self-stigmatization can result in a reduction of self-esteem and an ambivalent attitude towards treatment (Cavelti, Beck, Kvrgic, Kossowsky & Vauth, 2012) Ambivalence ultimately affects the process of recovery by reducing self-efficacy (Corrigan & Watson, 2006; Thus reduction in self-efficacy can diminish the client's belief in his or her ability to change, can impede treatment and his or her engagement in the recovery

process (Fung, Tsang & Corrigan, 2008) Patients who experience self-stigma related to mental illness can develop strong beliefs that they are unable to experience recovery. This can result in ambivalence towards change (Cavelti 2011). Ambivalence can reduce self-efficacy and continue to support the client's beliefs that he or she is unable to work towards recovery (Beck &Rector, 2001). The recovery paradigm for patients with mental health illness is a recent development and may be characterized as a process of continual growth towards recovery. The intention is to build self-identity around the ability to discover and pursue personal meaningful goals and aspirations, which will also build a sense of self-efficacy.

This expectation is viewed and promoted as realistic, despite their illness, and stands in sharp contrast to the patients' being disempowered by being externally or self-labeled,solely in reference to the adverse effects of their illness. (Davidson, O'Connell, Tondora, Staeheli & Evans, 2005)

2.2.10 Stigma Research

Numerous researchers have investigated how different factors influence peoples' desire for social distance from people with mental illness (e.g., Angermeyer & Matschinger, 2003a, 2003b; Angermeyer, Beck, et al., 2003; Corrigan, Green, et al., 2001; Lauber et al., 2004; Link et al., 1987). One study that has been particularly influential in the field of stigma research is a large scale representative study (N = 5025) conducted in Germany. Fully structured interviews were conducted with adults who were presented with a vignette containing a diagnostically unlabelled psychiatric case history. The vignette described a case of schizophrenia or major depressive disorder. Both vignettes fulfilled the DSM-III-R criteria for the respective disorder. Participants were asked to complete measures relating to factors of labelling, familiarity with mental illness and causal attributions. Personal attributes of the individual described in the vignette were also generated, which intended to cover two important components of the stereotype of mental illness: dangerousness and dependency. Emotional reactions (e.g., fear, pity and anger) towards the individual

were also assessed. The impact of these factors on desire for social distance was measured. This research has led to many publications (Angermeyer & Matschinger, 2003a, 2003b, 2005; Angermeyer, Beck, et al., 2003; Angermeyer, Matschinger, et al., 2003).

Labeling:

Angermeyer and Matschinger (2003) found that labelling the vignette as mental illness was found to be positively correlated with the belief that the individual described was dangerous. This was shown to lead directly, as well as indirectly through an increase of fear, to a preference for greater social distance. Additionally, perceived dangerousness was found to result in an increase in social distance through an inverse relationship with pity. In contrast, labelling was found to have no effect on these attitudinal responses with major depression. This is further supported by Angermeyer and Matschinger (2003) who examined the similarities and differences of the publics' conceptions of schizophrenia and major depression. They reported that in the case of schizophrenia, labelling as mental illness primarily affects respondents' emotional reactions negatively, whereas in the case of major depression a positive effect prevails. People with schizophrenia are, by far, more frequently considered dangerous and unpredictable. They evoke more fear, whilst people with major depression evoke more pro-social reactions. The study highlights the importance of investigating stigma processes for different mental illnesses.

Link (1987) conducted a postal questionnaire study using a vignette experiment which manipulated labelling status (former mental hospital patient versus hospitalised for a back problem). They found that when the person described in the vignette was not labelled 'a former mental patient', beliefs about the dangerousness of people with mental illness were irrelevant and social distance was reduced. In contrast, when the vignette was labelled as 'a mental patient' respondents who perceived patients as dangerous showed higher levels of social distance. Prior to the study, the authors conducted a pilot study to examine whether participants were able to guess the nature

of the experiment, due to the ordering of questionnaires. Results showed that only two individuals indicated that they were able to guess the hypothesis. Participants for the study were recruited via a random sampling technique. The measures used within the study were shown to have good reliability (Social Distance Scale = .92 and Perceived Dangerousness Scale = .85) and multiple regression analyses were conducted, which were considered to be appropriate.

Consistent with the findings of Link (1987), Lauber (2004) reported that participants in Switzerland who correctly recognized the person described in the vignette as having a mental illness desired greater social distance from the individual. Strengths of the study include its large representative sample and the use of telephone interviews in an attempt to overcome social desirability. The study also examined the influence of a range of demographic, psychological and sociological variables on social distance (Lauber 2004). However, participants were forced to choose between 'illness' and 'crisis' when presented with the vignette, rather than being asked if they considered that anything was wrong with the person, thus limiting their responses and suggesting a problem. Additionally, the authors did not attempt to explain the processes involved in stigma formation, and how labeling leads to an increase in social distance.

The studies conducted by Angermeyer and Matschinger (1987) fit the social psychological model but different reactions and responses were found. In the studies conducted by Angermeyer and Matschinger labelling the person in the vignette as having a mental illness (experience) led to beliefs that the person was dangerous (perception). This led to increased fear of the person with mental illness (affect), which resulted in a desire for greater social distance (response). This was also found by Angermeyer and Matschinger (2003) for schizophrenia. However for depression, labelling the person in the vignette as having a mental illness (experience) led to beliefs that the person was needy or dependent (perception). This led to a desire to help the person with mental illness (affect), which resulted in less desire for social

distance (response). The studies show that labelling influences desire for social distance from people with mental illness in western cultures.

Familiarity

Corrigan, Green, (2001) tested the social psychological model with a sample of community college students. Participants were asked to complete measures relating to each of these factors. Findings were shown to support the model. As expected, the more familiar a person was with mental illness (experience), the less dangerous they believed individuals′ with mental illness to be (perceptions). Weaker perceptions of dangerousness were seen to correspond with less fear of individuals with mental illness (affect), which in turn was associated with less social distance (response). Limitations of the study include that a small student sample was used. This limits the ability to generalise findings to adult and non-western populations. Additionally, the study investigated attitudes towards people with mental illness in general. Therefore it is unclear as to whether the model applies in a similar manner with different disorders.

Link and Cullen (1986) also examined the relationship between familiarity and perceptions of dangerousness. Consistent with the findings of Corrigan, Green, et al. (2001), they found that increased contact with people with mental illness was associated with reduced fear among participants. However, the behavioural reactions towards people with mental illness were not examined in the study.

Angermeyer, Matschinger, (2003) replicated the study conducted by Corrigan, Green, (2001) using data collected from the representative survey conducted in Germany. Results also showed a relationship in the predicted direction between familiarity and the three attitudinal domains of perceived dangerousness, fear and social distance, for both schizophrenia and depression, providing further support for the social psychological model.

The findings indicate that familiarity with mental illness influences desire for social distance from people with mental illness in western cultures. The more familiar individuals′ are with mental illness, the less desire for social distance.

Causal attributions

Angermeyer and Matschinger (2005) investigated participants′ attributions of the cause of schizophrenia described in a vignette. The impact on social distance was also assessed. Results were compared with similar data collected in 1990 in what was then the Federal Republic of Germany, using an identical methodology. It was hypothesised that individuals who indicated greater endorsement of biological causes for schizophrenia would desire lower levels of social distance, in line with attribution theories (e.g., Corrigan, 2000; Weiner, 1995). However, no such relationship was observed in the study. An increase was seen in the endorsement of biological causes compared to the data collected in 1990. Findings demonstrated that both biological attributions and social distance were positively related with each other. Detailed analyses showed that the more participants′ endorsed biological factors (e.g., brain disease) as a cause, the more unpredictable, dangerous and lacking in self control they perceived individuals′ with schizophrenia to be. This in turn was associated with a higher degree of fear, resulting in an increased desire for social distance (Dietrich, Matschinger, & Angermeyer, 2006). Results reported by Angermeyer, Beck, (2003) mirrored these findings. This is not surprising given that both studies used data from the same study. Similar findings were also reported by Read and Law (1999) and Read and Harre (2001) in their studies with undergraduates in New Zealand. These findings can be explained by the social psychological model; attributing biological causes to mental illness/schizophrenia (experience) led participants to infer that the person was unpredictable and dangerous (perception). This evoked fear of the person with mental illness (affect), which resulted in a greater desire for social distance (response).

The findings suggest that perceived causal attributions influence desire for social distance from people with mental illness in western cultures. The endorsement of biological factors as perceived causes of mental illness has been shown to result in an increased desire for social distance. These findings do not support Weiner's (1995) or Corrigan's (2000) attribution theories, and highlight the importance of understanding the process of stigma formation.

2.2.11 Stigma, Identity and Social Interaction

How can the tools of sociology help us understand the relationship between illness, identity and schizophrenia? Perhaps the best place to begin is with Erving Goffman's sociology of stigma, which seeks to understand how people with discredited or unwanted identities, such as suffering a mental illness, must "conceal" their stigma or "pass for normal", and often divide their social world into those who know and don't know about their condition. While rich in detail and nuance, however, Goffman's work does not provide a general theory of identity. This thesis finds such a theory in Symbolic Interactionism, which offers a wider account of the nature of identity, of identity formation and of identity maintenance. The symbolic interactionist emphasis on identity as "process", meaning generated through interaction, and the importance of absorbing the perspective of the general other are all significant and useful insights. These insights provide a useful framework for analysising the specific process whereby a sense of identity is disrupted, rebuilt and maintained in people diagnosed with schizophrenia. Finally, the area of applied interactionism dealing with "reconstructing identities" – in particular, the literature regarding "illness narratives" – helps give insight into how people with schizophrenia deal with the disruption of their condition, and provides tools to unpack the interviews given by respondents

Goffman and Stigma

This section focuses on the work of Erving Goffman to illustrate a fundamental process affecting identity – stigma. Although Goffman's work on this topic occurred after much of the material regarding symbolic interactionism was released (indeed,

symbolic interactionism influenced Goffman deeply), it will better suit the unfolding terrain of theory in this thesis to consider Goffman first. We may start by acknowledging that self-presentation of a stigmatised sense of identity is a vital part of identity maintenance. We consider here Erving Goffman's work (1963) *Stigma*: *Notes on the Management of Spoiled Identity6* and, to a lesser extent, his work (1959) *The Presentation of Self in Everyday Life*. The first work explores how people with identities or conditions such as mental illness that are considered deviant, or "stigmatised', manage their interactions with non-stigmatised people in order to protect their self and reputation – that is to say, how they engage in a process of identity maintenance

Stigma arises through the reaction of broader society to a condition the stigmatised person may have. "By definition… we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances" (Goffman, 1963, p. 5). Stigma is itself defined pithily: "The term stigma… will be used to refer to an attribute that is deeply discrediting" (Goffman, 1963, p. 3). Clearly schizophrenia is a stigmatised condition, and the diagnosis of schizophrenia a violent introduction into this stigmatised condition. Indeed, schizophrenia is frequently understood by members of the public as referring to dissociative personality disorder ("multiple personalities") and as having a strong relationship to the propensity for violence (Grohol, 2016)The awareness of inferiority means that one is unable to keep out of consciousness the formulation of some chronic feeling of the worst sort of insecurity, and this means that one suffers anxiety and perhaps even something worse, if jealousy is really worse than anxiety.

Goffman also recognises that stigma can "spread" to those in close relationship to the stigmatized:

The tendency for a stigma to spread from the stigmatized individual to his close connections provides a reason why such relations tend either to be avoided or to be terminated (1963, p. 30).

The bulk of Goffman's text, however, is constituted by an analysis of the management of the stigmatized condition through various social techniques, typically limiting wider knowledge of the stigmatised person's condition (1963, p. 21). Thus the very anticipation of social contacts can of course lead normals and the stigmatized to arrange life to avoid them" And further: "during mixed contacts, the stigmatized individual is likely to feel that he is "on', having to be self-conscious and calculating about the impression he is making, to a degree and in areas of conduct which he assumes others are not" Being "self-conscious and calculating" about the impression one is making – this form of "management" – is a good example of identity maintenance. This approach echoes the concept of "impression management" discussed in Goffman (1959, p. 208) as a vital element of the self in social interaction. Such management takes place in a number of ways.

In an essay entitled "Information Control and Personal Identity", Goffman discusses a number of techniques, including "passing" and "concealing stigma symbols". The overall approach is titled "stigma management" and will become relevant to the research of identity maintenance in this thesis. Goffman observes that the first set of sympathetic others is of course those who share [the] stigma" (Goffman, 1986) Goffman further comments that people with stigma may seek out others sharing the said stigma; perhaps by joining clubs or support groups. Such behaviour is seen in the person with schizophrenia seeking out groups of people that share schizophrenia; as we will see, a number of research interviewees spend time at an institution for those with mental illness called the Leisure Club. However, the stigmatized person cannot control his or her circumstances at all times, and must either retreat into isolation or confront dealing with members of the public. Here, Goffman emphasizes "visibility" of the stigma. In *The Presentation of Self*, Goffman refers to the unwanted visibility of such hidden conditions as "discrepancy" in social presentation, or "performance

disruption." It may be noted here that schizophrenia is not a strictly visible illness; however, symptoms and drug side-effects such as tremors, flat affect and misreading social cues can soon become visible. In this case, the stigmatized person will make a division between "the knowing" who know of his or her stigmatized status, and the "unknowing". Often a stigmatized person will handle the risks of his or her stigma by "dividing the world into a large group to whom he tells nothing, and a small group to whom he tells all and upon whose help he relies" (Goffman, 1986, p. 95). When confronted with the large group of the unknowing, techniques of identity management include "passing" for normal by hiding one's stigmatized condition. Such a technique may be easier when the stigma is not clearly visible, as is sometimes the case with schizophrenia. A mental patient may attempt the "concealment of stigma symbols" by compensating for such symptoms and drug side-effects as flattened affect, tremors, inability to perceive emotional cues and paranoia. Such passing or compensation may be understood as a form of what Goffman (1953) calls "impression management" – the dramatised presentation of a socially acceptable self in social interaction. In many situations the stigmatized person may need to participate in society in a way that feels inauthentic or difficult in order to present a socially acceptable self (Goffman, 1986, p. 121). Goffman also describes the work a stigmatized person may do to hide his or her stigma:

The stigmatized individual can attempt to correct his condition indirectly by devoting much private effort to the mastery of areas of activity ordinarily felt to be closed on incidental and physical grounds to one with his shortcoming (1963, p. 10). Thus a person with schizophrenia may attempt through psychological training to better perceive emotional cues. Furthermore: The phenomenon of passing has always raised issues regarding the psychic state of the passer it is assumed that he must pay a great psychological price, a very high level of anxiety, in living a life that can be collapsed at any moment (1963, p. 87).

Goffman's discussions of stigma management techniques can offer us an insight into the personal state of mental patients, as well as the use of such techniques to hide their

diagnosis and maintain their "normal" identity. Furthermore, we may borrow from Goffman an emphasis on pathological processes of the self that may be deficient in earlier work in symbolic interactionism, as we shall see below. Goffman also provides a dramaturgical reading of the self – self as "presentation" or "performance" – that may help us understand the ways people with schizophrenia maintain their identities through performance with other people. Finally, the various activities a person may engage in to hide their pathological state offer a clear example of identity maintenance.

What are the limitations of Goffman's work? Goffman's work can be criticised for offering an external account of identity formation – the stigmatized identity is imposed from the outside. Although stigmatized subjects may practice passing or concealment of stigma symbols, they do not necessarily internalise this view of their identity and, if they do, we do not learn from Goffman how this might take place. We are left with the external performance, while internal experiences and compulsion are neglected. Furthermore, Goffman's work does not explore the macro features of society that provide the context for individual relations of stigma. Although this problem is addressed to some extent in his work *Asylums* (1961), the deinstitutionalization movement has reduced the power of asylums, clinics and hospitals to impose binding identities on patients.

Some of the limitations we find in Goffman's work are addressed by the model of symbolic interaction developed by George Mead and Herbert Blumer.

Symbolic interactionism encompasses a range of approaches that emphasise meaningful interaction between social agents as the source of such phenomena as the mind, meaning and, significantly, the self. It also offers a wider approach to questions of identity than presented by Goffman; in particular, proposing a view of the internal self communicating with an external world and allowing for the process of people internalising identity.

Symbolic interactionism draws heavily on the work of George Herbert Mead. This section presents his analysis of the creation of self. Before doing so, however, we should acknowledge Doubt's analysis of the relationship between Mead's theory of the self and the breakdown of self in schizophrenia:

What… is the situation with schizophrenia? What is painful about watching schizophrenics struggle with their illness is that we watch how the illness constitutes a serious invasion of the self. What is uniquely tragic about schizophrenia is that it directly confronts the character of the human self and so the ability of the human self to be itself (Doubt, 1992, p. 310).

We should also recognise that symbolic interactionism may move some way towards engaging with the personal narratives of people suffering schizophrenia. At this point we may begin the analysis of Mead's work. This analysis begins with an account of "meaning". Mead argues that when one person attempts to communicate with another – when they attempt to express meaning – that person actually considers the impact of the expressed term within him or herself. Thus Mead states:

The gesture is that phase of the individual act to which adjustment takes place on the part of other individuals in the social process of behavior. The vocal gesture becomes a significant symbol… when it has the same effect on the individual making it that it has on the individual to whom it is addressed or who explicitly responds to it, and thus involves a reference to the self of the individual making it. (1967, p. 46).

It is important to clarify the point being made here. For Mead, the meaning of a term is that which gives rise to a response both in the person making the meaningful statement and the person receiving the statement during an interaction involving significant symbols. The process is intrinsically social. This is also true of the development of the self: "The self… is essentially a social structure, and it arises in social experience… it is impossible to conceive of a self arising outside of social experience" (Mead, 1967, p. 140) or put differently: "When we reach a self we reach a certain sort of conduct, a certain type of social process which involves the interaction

of different individuals and yet implies individuals engaged in some sort of cooperative activity. In that process a self, as such, can arise" (Mead, 1967, p. 165). It is important to note that this social process is just that –a process rather than an end-point in personal development: "The self is not so much a substance as a process" (Mead, 1967, p. 178).

Mead offers an account of how the structure of the self is developed and realised through social interaction it develops in the given individual as a result of his relations to [the process of social experience and activity] as a whole and to other individuals within that process" (Mead, 1967, p. 135). The essence of achieving self-hood is for a person to experience his or herself as an object through the eyes of another person (C.f. Tice and Wallace, 2003). The self, as the heart of human subjectivity and the result of identity formation, requires external perception in order to develop. The person thus becomes an object to itself, seeing itself through "individual members of the same social group, or from the generalized standpoint of the social group to which he belongs" (Burke, 2003) "The organized community or social group which gives to the individual his unity of self may be called the 'generalized other'. The attitude of the generalized other is the attitude of the whole community" (Mead, 1967, p. 154). Furthermore, only in so far as he takes the attitudes of the organized social group to which he belongs toward the organized, co-operative social activity… in which that group as such is engaged, does he develop a complete self (Mead, 1967, p. 155).

This point is vital to the task at hand as it outlines a process against which we may judge the degree to which respondents have recovered from the biographical disruption of schizophrenia; indeed, it might be the failure to see oneself from the perspective of the other which is itself at risk or lacking in the schizophrenic experience. An argument along these lines is made by Rosenberg (1984) Rosenberg draws upon symbolic interactionism, and the work of Mead (amongst others), to contend that "insanity" is defined by a failure in the ability to role-take during social interaction. More will be said below of Rosenberg's work. In a similar vein to

Rosenberg, the following quote makes the point that "taking the attitude of the other" is vital to experiencing oneself *as a self*:

When the response of the other becomes an essential part in the experience or conduct of the individual; when taking the attitude of the other becomes an essential part in his behaviour – then the individual appears in his own experience as a self, and until this happens he does not appear as a self (Mead, 1967, p. 195).

Taking the attitude of the other inevitably involves the person with the rules and structures of his or her community; in some sense, the communal life is prior to the individual self (Mead 1967, p. 162), although Mead does recognise that people can change, that each self has "its own peculiar individuality" (Mead, 1967, p. 201) and people can effect change in their communities. It is also important to note that this "becoming an object to itself" takes place through the medium of language: "…the language process is essential for the development of the self" (Mead, 1967, p. 135).

Doubt points out; the person diagnosed with schizophrenia may not be able to take the role of the other: In taking the role of the other, we are controlled by society, but, more importantly, we control our relation to society as well as society's relation to us. Insofar as schizophrenics seem unable to take the role of the other, whether due to their illness or to others' view of them, it becomes difficult for them to control their relation to society as well as society's relation to them (Doubt, 1992, p. 313).

Nevertheless, despite this difficulty, Doubt emphasizes that, to understand the identity of the person with schizophrenia, it is necessary to recognize how people with schizophrenia do engage in role-taking, calling it role-taking success. Mead also traces the development of the social self in children. He emphasises two aspects of development: "play" and "game". In the play period, the child is presented with a particular set of stimuli aligned with a common social role. The child learns to respond to these stimuli correctly, building a social self; the child "utilizes his own responses to … stimuli which he makes use of in building a self" (Mead, 1967, p. 150). The game is somewhat more sophisticated. It involves a set of rules governing

interactions that are agreed upon, usually tacitly, by others in the game. The developing child must be able to understand the game and it′s rules from the perspective of the other children, and must be willing to take any role in the game taken by any other person.

Interestingly, Mead acknowledges that there may be different parts of the self that emerge in different circumstances: A good deal of the self does not need to get expression. We carry on a whole series of different relationships to different people. We are one thing to one man and another thing to another. There are parts of the self which exist only for the self in relationship to itself (Mead, 1967, p. 142).

This is a view that dovetails nicely with Goffman′s concept of the dramaturgical self. Mead′s picture of different selves being presented to different people helps us to understand the diverse situations of respondents in for a perspective on social behaviour as a ″performance″(Joas, 1987). Indeed, this multiplicity of the self may help explain the particular self-experiences of people diagnosed with schizophrenia, although there are some limits to Mead′s approach, as explored below.

One of the more complicated elements of Mead′s approach to the self is his definition and distinction between the ″I″ and the ″Me″. The ″I″ is the response of the person to the attitudes of others, whilst the ″me″ is the set of attitudes of others that the person assumes. ″The attitudes of the others constitute the organised ″me′, and then one reacts that as an ″I′″ (Mead, 1967, p. 175). To rephrase, the ″me″ is the repository of socialisation, the absorber of social attitudes, whilst the ″I″ is the active agent that acts upon the basis of information from the ″me″. Here we can see that Mead offers a much more nuanced account of the self than we find in Goffman′s theory of stigma: the ″me″ is ″the set of attitudes of others″ but it is also assumed by the person and is thus never a mere imposition while the ″I″ emerges when the person actively responds to the attitudes of others. Mead elaborates:

The "me" and the "I" lie in the process of thinking and they indicate the give-and-take, which characterizes it. There would not be an "I" in the sense in which we use that term if there were not a "me"; there would not be a "me" without a response in the form of the "I". These two as they appear in our experience, constitute the personality. We are individuals born into a certain nationality, located at a certain spot geographically, with such and such family relations, and such and such political relations. All of these represent a certain situation, which constitutes the "me"; but this necessarily involves a continued action of the organism toward the "me" in the process within which that lies. The self is not something that exists first and then enters into relationship with others, but it is, so to speak, an eddy in the social current and so still a part of the current (Mead, 1967, p. 182).

Furthermore, "The "I" reacts to the self which arises through the taking of the attitude of others. Through taking those attitudes we have introduced the "me" and we react to it as an "I"" (Mead, 1967, p. 174). It is possible to use the "I"/"me" distinction as a means to account for emotional experience in the self – that is to say, we may see the "I" as the emotional or affective side of the self, and the "me" as the cognitive side. However, such a contention is not strongly thematised by mead and it is arguable that we need to move beyond Mead to find a more comprehensive way of understanding emotional or affective self-experiences, including in schizophrenia.

The last sentence in the quote above is also interesting. Mead compares the self to an "eddy" swept along by the superior force of the "social current". Perhaps we may regard the diagnostic process and hospitalisation as an eddy in the social current of the diagnosed person's life. However, this comparison is somewhat deterministic; a limitation that is considered below, but one which is recognised by Mead in his analysis of the relation between self and society (Mead, 1967, p. 192).

Mead offers a strong theoretical and philosophical position from which we can attempt the analysis of rebuilding a sense of identity after the diagnosis of schizophrenia. Using Mead's insights we can suggest that rebuilding identity is an

intrinsically symbolic process, involving symbolic interchange of gestures and a deep engagement with the external views of individual people or the "generalised other".

However, there are a number of aspects of his work that are under-theorised, or to which Mead does not advert that limit the usefulness of his thesis as a basis for the study at hand. Mead offers a picture of identity forming in an essentially healthy and normal manner. He does not discuss the emergence of "pathological" self-states such as schizophrenia, nor the possibility that deviant groups or subcultures may emerge within society. Mead is unclear on the relationship between self and society; that is to say, he does not state to what extent self affects society and society affects self and, through this, identity formation. Mead's position may also encounter difficulties in making sense of all experiences of schizophrenia; for example, Mead's generally ideational position may falter when faced with emotional or embodied experiences of schizophrenia (accepting the criticism made here of using the "I"/"me" distinction as a way to include the emotional or affective in Mead's schema).

Many of these issues are considered in the later work of Herbert Blumer on symbolic interaction.

In his most well-known work, Symbolic Interaction: Perspective and Method (1986), Herbert Blumer offers a re-statement of the principles of Mead's symbolic interactionism in terms of the larger social world and sociological methodology which is of help here (Blumer, 1986, p. 21). Blumer draws on Mead to emphasise the way meaning and the social origins of the self in a symbolic interactionist account are constituted by symbolic social processes (1986, p. 4, 12). He argues that symbolic interactionism rests on three premises:

The first premise is that human beings act toward things on the basis of the meanings that the things have for them… The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise is that these meanings are handled in, and modified through, an

interpretive process used by the person in dealing with the things he encounters (1986, p. 2).

Blumer also emphasises the located interaction of humans, "The actor selects, checks, suspends, regroups and transforms… meanings in the light of the situation in which he is placed and the direction of his action" (1986, p. 5). In everyday interaction, this situation may involve other people, of whom the actor takes account: human beings in interacting with one another have to take account of what each other is doing or is about to do; they are forced to direct their own conduct or handle their situations in terms of what they take into account (1986, p. 8).

It is important to note here the social interactions necessary in the production of meaningful "self-objects." Identity formation arises out of symbolic interaction – "The human being is seen as "social" in a… profound sense" (1986, p. 14). The next relevant aspect of Blumer's approach is his portrayal of the broader society from a symbolic interactionist perspective. In beginning this portrayal, Blumer offers a sophisticated portrait of the work he inherited from Mead, and, within this work, the lack of a convincing macro-picture of society (1986, p. 61). Blumer sets out to map such a theoretical scheme of human society (Lyman and Vidich, 1988). He uses the phrase "joint action" to refer to collective acts of symbolic interactions, including social actors in various social positions (1986)

The life of any human society consists necessarily of an ongoing process of fitting together the activities of its members. It is this complex of ongoing activity that establishes and portrays structure or organization (1986, p. 7). According to his analysis, from joint action emerges social structure: "A society is seen as people meeting the varieties of situations that are thrust on them by their conditions of life" Blumer also offers a better picture of the relationship between self and society than Mead; as noted, he attempts to theorise the role of society in relation to the self. This aspect of Blumer's work can help provide a social context for understanding the processes of diagnosis, rebuilding a sense of identity and identity maintenance.

There still remain a number of issues to be treated. Blumer fails, like Mead, to provide an analysis of the emergence of pathological selves, subcultures and deviant groups. At this point we may stop to observe that Rosenberg (1984,) does draw on a symbolic interactionist perspective to account for the definition of pathological ("insane") selves as defined by a failure to take roles in social interaction. For Rosenberg, schizophrenia would be defined by a failure to role-take in thoughts, emotions and behavior In light of Rosenberg's work, we must acknowledge that symbolic interactionism may be developed to provide an analysis of dysfunctional selves. However, Rosenberg's work does not account for the full range of behaviours outlined by symbolic interactionism that may be compromised by serious mental illness..

Tied to the problem of pathological selves, although Blumer discusses the role of society in self-formation, he fails to provide a thorough picture of the impact of power and hierarchy in the processes being studied. Nor does his work focus on the social context of meanings relevant to a symbolic interaction; he fails to account for how the institutions and structures of social context take on a causative and ontological life of their own. Such is admitted by Dennis and Martin (2005, p. 210) who describe symbolic interactionism's approach to conceptualising sociology at the macro level:

Symbolic interactionism rests on a principled refusal to deal in the supposedly universal, objective and metaphysical categories and concepts which have produced little more than confusion in philosophy and sociology.

It is the purpose of this thesis to provide an analysis of how power suffuses the relationship between the patient and the psychiatric apparatus; this task is approached below.

So far, we have considered symbolic interactionism from the relatively theoretical perspectives of Mead and Blumer. It is worthwhile at this point to consider a perspective on mental illness that has absorbed the interactionist focus of symbolic interaction, namely Thomas Scheff's *Being Mentally Ill: A Sociological Theory*

(1984). This text does seek to offer an interactionist account of dysfunctional selves. Here, Scheff proposes that the existence of mental illnesses, like schizophrenia, arises out of processes of deviancy and labelling. More specifically, Scheff argues that the career of the so-called mentally ill arises out of a process of "residual rule-breaking" and subsequent labelling by the psychiatric apparatus and society generally (Cf. also Lemert, 1962, who argues that paranoid psychosis is reinforced through exclusionary dynamics in social institutions). Scheff observes that "insane" behaviours are in fact learnt and absorbed by children from an early age, and that the mental patient exhibits these behaviours as a result of interaction with psychiatrists, mental health professionals and other authority figures. Scheff's argument is interesting and mildly persuasive. He certainly possesses insight into the sociological nature of mental illness,that is how the social impacts upon the definition and classification of behaviours as mentally ill and the power played by sources of authority. However, his argument suffers from several flaws. The suggestion that mental illness is an expression of behaviour learnt as a child, rather than derivative of some biochemical process, is weak. One may criticise the text on the grounds that there appears to be (growing) evidence that mental illnesses such as schizophrenia are caused at some level by neurochemical brain processes (Gove 1980, 1984). Furthermore, his position is essentially externalist. It offers a theory of mental illness from the outside, from the point of view of socially imposed norms and expectations, and does not engage with the subjective experience of the mentally ill person. As such, the argument that symbolic interactionism does not offer a sufficient analysis of pathological selves still stands.

Having dealt with Scheff's theory of labelling, there also exists a relevant literature of writers using symbolic interactionist principles to address expressions of chronic illness, overcoming the key problem that pure symbolic interactionist accounts do not refer sufficiently to deviant or pathological identity states. This literature provides us with concepts for understanding the experience of schizophrenia as a chronic illness, and one where identity is particularly under threat. In particular, this material provides

the tools to understand narratives regarding illness developed by people diagnosed with schizophrenia.

2.2.12 The Impact of Schizophrenia on Identity

It has been observed that schizophrenia has perennially been an object of interest for psychiatry (Woods, 2011), if not in broader culture. It comes as no surprise then that there exist a number of strong accounts of the impact of schizophrenia on identity.

Ronald Laing′s seminal work *The Divided Self* (1990) offers a complex portrait of the effect of schizophrenia on the self. In his text, Laing attempts to offer an ″interior″ account of schizophrenia – a view ″from the inside″′. For Laing, schizophrenia (particularly in the pro-dromal stage) typically leads to a division of the self (1990, p. 39). Laing deloys the concept of ″ontological security″ to illustrate what breaks down in the divided self. ″Ontological security″ may be thought of as a sense of wholeness or fullness in a person′s being. The person is not divided; he or she is not lacking a vital element of self-esteem or self-fulfilment. In contrast to this, ″ontological insecurity″ arises where there is some lack or division within a person′s identity. This can be a sense that one is not whole, that one′s mind or self is fragmented, that one is lacking a crucial element of self-hood or self-fulfilment. The person suffering identity breakdown in schizophrenia is a classic example of someone lacking ontological security, and the concept is used in this thesis to explore the experience of biographical disruption and biographical crisis.

Laing divides ontological insecurity of the person with schizophrenia into three, overlapping categories that will prove useful for the analysis of research .The first is ″engulfment″ – experienced as a loss of identity, or the threat thereof: ″to be enclosed, swallowed up, drowned, eaten up, smothered, stifled″ The second is ″implosion″, which occurs when one experiences the external world as impinging dangerously on the inner world: ″the full terror of experience of the world as liable at any moment to crash in and obliterate all identity as a gas will rush in and obliterate a vacuum″ The

third is ″petrification″ or ″depersonalisation″. To feel petrified or depersonalised is to fear that one′s identity will become nullified or exterminated: ″…the possibility of turning, or being turned, from a live person into a dead thing, into a stone, into a robot, an automaton, without personal autonomy of action, an *it* without subjectivity″ To experience one of these situations sounds horrific, and may go some way toward explaining the intense fear and misunderstanding associated with schizophrenia by some members of the public(Laing,1990).

Lysaker and Lysaker also contribute to an understanding of the impact of schizophrenia upon the self. In their 2008 book, *Schizophrenia and the Fate of the Self*, they outline the impact of schizophrenia on identity through the concept of ″self as dialogue′. This concept posits that people hold ″self-positions″ and express these through dialogue .Such dialogue can contribute to ″life histories″ that help the subject make sense of his or her life experience, and illness experience. The text that seeks to outline how these self-positions, and the dialogue that expresses them, can be compromised by schizophrenia. Such compromise typically emerges in a ″diminished sense of self expressed in apparently disordered or interrupted dialogue and can lead to a case where subjects ″find themselves engulfed and overwhelmed by their illness″ (lysaker2008) One can discern a clear proximity here with Laing′s concept of ontological insecurity.

Lysaker and Lysaker outline three forms of ″self-experience″ that may emerge in schizophrenia as they have conceptualised it. First they identify *the monological self,* where: a significant decrease in the interanimating play of self-positions due to the inflexible dominance of one or two self-positions. In such cases a rigidly unchanging hierarchy emerges in which self-world interactions are consistently ordered in a singular manner, and intra- and interpersonal dialogue is replaced by a monologue (Laing, 2008). *The barren self*, where subjects express themselves: in ways that lack even the singular focus… of monological self-presentations. Instead, it is as if they are ciphers through which disjointed remarks and actions flow they are empty,

disjointed. *The cacophonous self*, where: certain people suffering schizophrenia find themselves in a swirl of self-positions that seem to proceed without any order at all.

Davidson and Strauss (1992) offer an even-handed account of the effect of severe mental illness on the person suffering the illness. They describe a ″distortion in sense of self″ as an essential characteristic of schizophrenia (1992) Davidson and Strauss also advert to the process of recovering from biographical disruption in severe mental illness. They suggest that: the process of rediscovering and reconstructing an enduring sense of self as an active and responsible agent provides an important, and perhaps crucial, source of improvement. This process of becoming aware of a more functional sense of self and building upon it in the midst of persisting psychotic symptoms and dysfunction is alluded to over and over again by persons suffering from these disorders.

Article by Sue Estroff (1989), ″Self, Identity, and Subjective Experiences of Schizophrenia: In Search of the Subject″, Estroff echoes the point made above that ″Schizophrenia is an *I am* illness − one that may overtake and redefine the identity of the person″ (1989, p. 189; emphasis included). She argues that social science may have valuable input into understanding this redefinition − a position endorsed by this thesis. This redefinition is again one that will generally not occur in chronic illness or non-psychotic mental illness, largely because they do not carry the stigma or the nature of comprehensively subsuming identity present in schizophrenia.

Finally, we may refer to Doubt, who also considers the fate of the self in schizophrenia. In his 1992 article titled ″Mead′s Theory of Self and Schizophrenia″ (Doubt 1992) he argues that What is painful about watching schizophrenics struggle with their illness is that we watch how the illness constitutes a serious invasion of the self. What is uniquely tragic about schizophrenia is that it directly confronts the character of the human self and so the ability of the human self to be itself.

While this literature paints a frankly horrifying picture of identity in schizophrenia, we must be careful not to assume that all cases will involve the kind of failures or

breakdowns described in this literature. The experience of people diagnosed with schizophrenia may actually range from less to more intense symptoms; those with fewer symptoms may not experience the horror of engulfment, implosion or petrification. This thesis seeks to be open to such divergence. It is also unclear if the categories presented, such as the petrified self or the monological self apply to the whole spectrum of schizoid disorders. It appears that the categories may not apply to schizoaffective disorder or schizoid personality disorder, for example, where a grave threat to the self is not present.

This chapter has charted the literature concerning the impact of schizophrenia upon identity. A picture of a highly compromised self, in many cases, has emerged. However, processes affecting the identity of the person with schizophrenia are not limited to the illness itself; the social context in the form of diagnosis may also impact the self.

2.2.13 Scheff; Deviant Behavior

From a sociological point of view, therefore, the question is not whether mental illness is illness, in the positivistic sense of referring to an inherent disorder or disease, but why it is that certain forms of social deviance are treated as symptoms of illness and explained as a form of disease. This question has nothing to do with the nosology of diseases, or the psychopathology of everyday life, rather it concerns the normative and epistemological character of judgments of illness and how, in particular, the ascription of mental illness is to be explained as social facts.(Morgan, 1975)

Not all episodes of deviant behavior, of course, are perceived as symptoms of mental disorder. On the other hand, it would be misleading to suppose that in the absence of consistent diagnostic criteria, imputations of insanity are necessarily arbitrary. Though psychiatric judgments may be difficult to justify in clinical terms, a preoccupation with the inadequacies of medical procedures tends obscure the tacit, taken-for-granted assumptions which structure ascriptions of insanity in common sense terms. The first question then is to consider how we socially discriminate

between actions identify and respond to as deviance, and those acts of deviance interpret as illness. In the case of manifestly visible signs of bodily disorder which impair socially competent conduct, such as fever injury, this question has little theoretical significance; however, ascriptions of insanity are involved, the relationship between infraction of social norms and imputations of illness presents altogether more complex and difficult problem. Some help is offered in this direction by the inventive and influential account of mental illness proposed by Scheff. Scheff argues that every society has a vocabulary for categorizing violations of norms—sin, crime, perversion, bad manners are common examples. Each of these categories refers to the type of norm that is broken the kind of behaviour involved. However, after exhausting all these categories, he claims there is always a residue of the most diverse kinds of violations for which the culture provides no explicit label. For the convenience of society these violations may be lumped together into a residual category: witchcraft, spirit possession, or, our own society, mental illness. Here, Scheff argues that just as 'crime' refers to specific, legally defined acts of deviance, so label "mental illness" corresponds to a set of circumscribed, "unnamable and unthinkable" acts of behavior that violate what he calls 'residual' rules. Accordingly, Scheff assumes that "mental illness" refers to a particular form of deviant behavior which, though subject to specialized medical control, is accountable in the same theoretical terms as other kinds of social offence. In effect, he claims that those behaviors commonly taken to be symptoms of mental disorder are commonplace and usually transitory deviations from taken-for-granted residual rules, the violation of which leads to the offender being labelled "mentally ill" and treated as if he were insane.(Morgan,1975)

This perspective presupposes a close analogy between insanity and kinds of deviant behavior in terms of the type of rule that and the behavior that this involves. This initially plausible is, however, theoretically misleading and difficult to maintain. Some critics point out; there is a lack of empirical evidence support of Scheff's theoretical description of a category of unspecified rules. His examples of residual deviance, include communicative incompetence and looking distracted, that what is more accurately referred to here are evaluative for monitoring someone's behavior, no

matter what they are —as, for example, when a person is sanctioned for acting 'carelessly', or 'inattentively' or 'without thinking'. In short, Scheff's examples tend to confuse normative rules with the evaluation of an actor's performance in relation to those rules. However, this suggests a second and more important point. Unlike accusations of crime, ascriptions of insanity do not appear to be limited to the violation of a specific category of rules. We commonly find imputations of insanity contested in criminal law, or invoked as excuses for deviant behavior when the rules violated are in no sense 'residual', but often central to the structure of social life. For instance, pleas of "not guilty by reason of insanity" do not dispute that a legally defined rule has been broken, but refer to the "nature and quality of the act"; in particular, they contend that the accused was not conscious of what he was doing, and cannot assume "mental responsibility" for his acts. This suggests an important difference between mental illness and other forms of deviant behaviour; for it appears that what is significant about the ascription of insanity is not the category of rule that is broken, or the kind of behavior involved, but how the cognitive and moral relationship of a person to their acts is socially perceived and explained. Thus, although Scheff's description of mental illness as "residual deviance" draws attention to the normative features of 'symptomatic' behavior in relation to other categories of social offence, there seems little to be gained from attempting to account for these features in the same conceptual terms that are applied to other forms of deviant response. (Morgan, 1975)

Deviancy and social exclusion: the stigmatized subject position

Apart from providing medical advice, the discourse of mental illness has a socio-political aspect to it whereby, as a profession, psychiatry is understood as a means through which authorities and communities are enabled to control and regulate excluded groups. This in turn implies that the understanding of madness as an illness in modern societies is socially constructed. It also implies that the classification of the normal and the non-normal/insane (Foucault, 1971; 1980; 1982) has embedded within it a form of social exclusion (Gordon, 1986).

This pejorative classification arises because the diagnosis of mental illness under the medical model requires the linguistic processes of naming, categorising and classifying someone as 'insane', ('mad' or mentally ill). This very process degrades those so classified, asserting that they cannot be considered as 'normal' or 'un-ill' (Foucault, 1971). As such, the discourse of mental illness illustrates how psychiatry and the medical model are incorporated within the social structure (Durkheim, 1964[1895]) in a way which ensures that a diagnosis of illness legitimises the social exclusion surrounding it. This procedure has long been used to enforce and legitimise the management of deviancy (Scull, 1979) in previous centuries and to establish particular meanings around psychiatry and mental illness which prevail to this day (Porter, 1987; Doerner, 1981; Bracken and Thomas, 2005).

Foucault illustrates how this process takes place when he evaluates the segregating of individuals in the asylums and names it 'The Great Confinement' (Foucault 1971). According to Foucault, the economic considerations of the state were the initial reason for shifting populations into the asylums as a form of labour market regulation (Foucault, 1971; Doerner, 1981). When cured or rehabilitated, individuals were expected to return into the labour market (Rogers and Pilgrim, 1996). This division between those who could and wanted to work and those who could not (Rose, 1985) constituted the class of the unemployable in previous centuries (Donnelly, 1983), and illuminates how the categorisation of the mentally ill was linked to a reduced social role and unemployment (Rose, 1989).

Thus the notion of being 'mad' was associated with being unproductive, 'discreditable' (Szasz, 1961) and socially ineffective (Peterson, 1982; Porter, 1987; Foucault, 1971). Scholars critical of the status quo therefore argued that psychiatry is a means of 'isolating', 'treating', 'correcting,' or 'punishing' individuals (Schur, 1971). Consequently, society perceives the mentally ill as lacking a social or economic role and, therefore, as weakening the social system (Parson, 1951).

The social construction of mental illness as a pejorative and stigmatised identity is also linked to a lack of public education and ignorance as well as to a sense of

secrecy. The segregation and the isolation within the asylums system, and the domination of medical professionals over the discourse relating to mental illness, has also been seen as restricting the distribution of mental health knowledge to 72 the public as well as to other professionals, leaving them ignorant of the nature of mental health conditions. This process of obscuring uncomfortable realities also promotes fear, which in turn reinforces social exclusion (Bracken and Thomas, 2005). This sense that we should fear those diagnosed with mental illness illuminates further how, in addition to their reduced social and economic role, the mentally ill is also being viewed as hopeless, dangerous (Cohen and Struening, 1962) violent unpredictable and a potential threat to the community (Peterson, 1982; Porter, 1987).

This constitution of mental illness and the mentally ill remains a pejorative and discriminative discourse and subject position until this day. This discrimination can take place on interpersonal levels (Lloyd, 2010) and also on wider institutional levels by excluding people with MHCs from participation in legal, economic, social and other institutional activities (Link and Phelan, 2001) such as gaining employment (Corrigan, Kerr and Knudsen, 2005) and living independently (Wahl, 1999).

Although the emotive term 'madness' is not officially used today, mental illness is still associated with continued experiences of stigma and prejudice (Rivers, 2005). Still, today it seems that the effects of stigma on a person receiving a psychiatric diagnosis can act as a mark of shame (Byrne, 1999; Blackman, 2001). This exclusion is also manifested through marginalisation and various forms of discrimination (Clinard and Meier, 1992; Dovidio, Major and Crocker, 2000), social inequality (Williams, 1999; Marmot Review, 2010) and other inequalities in rights and responsibilities such as reduced citizenship and marginalisation (Bracken and Thomas, 2005), isolation (Huxley and Thornicroft, 2003) and poverty (McCrone and Thornicroft, 1997). The ongoing stigma of people with MHCs in organisations (Goffman, 1961; 1968; Hunt, 1966; Campling, 1981) and in employment supports the view that mental illness is still regarded as a shameful condition which restricts social mobility (Bracken and

Thomas, 2005) and causes despair, dislocation and oppression (Williams, 1999) for these individuals.

This legacy of stigmatisation impacts upon the identity construction of someone who is diagnosed with mental illness. Constructing a positive sense of self for people with MHCs is therefore highly problematic given this association with social rejection, a restricted social network, isolation, unemployment and low income (Perlick, 2001)

Consequently, people with MHCs can be prone to 'self-stigma' (Goffman, 1968), an internal feeling of suppression, inferiority, guilt, shame, a sense of uselessness and dependence reduced self-esteem and self-efficacy (Link, 1987; Markowitz, 1998), a wish for secrecy (Goffman, 1968), as well as a reduced sense of self, impaired coping mechanisms, confidence and ontological uncertainty (Thomas, 2007). As stigma is an integral part of the construction of the pejorative mentally ill subject position, a detailed discussion on the concept of stigma and of living with a stigmatised identity as studied through the work of Goffman (1961; 1968) is outlined below.

2.2.14 Myth of Mental Illness

Myth1: Mental health problems do not affect children or youth. Any problems they have are just part of growing up. Reality: One in five children and youth struggle with their mental health. 70% of adult mental illness begins during childhood or adolescence, including: depression, eating disorders, obsessive compulsive disorder and anxiety disorders. However, 79% of youth who receive help improve significantly with treatment, which lasts less than 12 sessions for 66% of them.

Myth #2: It is the parents' fault if children suffer from mental health problems. Reality: Mental health disorders in children are caused by biology, environment, or a combination of both. They can be caused by genetics or biological factors such as a chemical imbalance or prenatal exposure to alcohol or drugs. They can also be the result of abusive or neglectful treatment or stressful events.

Myth #3: People with a mental illness are 'psycho', mad and dangerous, and should be locked away.Reality: Most people who have a mental illness struggle with depression and anxiety. They have normal lives, but their feelings and behaviours negatively affect their day-to-day activities. Conduct disorders or acting out behaviours are consistently the primary reason for referral to a children's mental health agency.

Myth # 4: All people with Schizophrenia are violent. Reality: Very little violence in society is caused by people who are mentally ill (violence and mental illness). Unfortunately, Hollywood often portrays mentally ill people as dangerous. People with a major mental illness are more likely to be victims of violence than perpetrators.

Myth #5: Depression is a character flaw and people should just 'snap out of it'.Reality: Research shows that depression has nothing to do with being lazy or weak. It results from changes in brain chemistry or brain function. Therapy and/or medication help people to recover.

Myth #6: Addiction is a lifestyle choice and shows a lack of willpower. Reality: Addictions involve complex factors including genetics the environment, and sometimes other underlying psychiatric conditions such as depression. When people who become addicted have these underlying vulnerabilities it's harder for them to simply kick the habit.

Myth #7: Electroconvulsive therapy (ECT), also known as shock therapy, is painful and barbaric. Reality: ECT is one of the most effective treatments for people whose depression is so severe that antidepressant medications just don't do the job and who are debilitated by the depression.

Myth #8: People with a mental illness lack intelligence. Reality: Intelligence has nothing to do with mental illnesses or brain disorders. On one hand, many people with mental disorders are brilliant, creative, productive people. On the other hand, some people with mental disorders are not brilliant or creative. Certain mental illnesses may

make it difficult for people to remember facts or get along with other people, making it seem like they are cognitively challenged. Overall, the level of intelligence among people with mental illness likely parallels the patterns seen in any healthy population.

Myth #9: People with a mental illness shouldn't work because they'll just drag down the rest of the staff.Reality: People with mental illness can and do function well in the workplace. They are unlikely to miss any more workdays because of their condition than people with a chronic physical condition such as diabetes or heart disease. The real problem is the prejudice against hiring people with mental illness (how will disclosing my mental illness affect work/school). The resulting unemployment leaves them isolated, a situation that can add to their stress, and make it more difficult to recover from the illness.

Myth #10: Mental illness is a single, rare disorder. Reality: Anxiety disorders, mood disorders, personality disorders, addiction disorders and impulse control disorders are all different categories of very different mental illnesses- each with its own features and underlying causes (common mental illnesses). Each mental illness is a variation on the theme of brain chemistry gone awry, affecting things like mood and perception and each has its own specific causes, features and approaches to treatment.

Myth #11: People with a mental illness never get better. Reality: Treatments for mental illnesses are more numerous and more sophisticated than ever and researchers continue to discover new treatments. Because of these advances, many people can and do recover from mental illness. (Patrick,2011)

CHAPTER - THREE
RESEARCH METHODOLOGY

3.1 Rationale of Site Selection

In this research, questions like what are the prevailing stigma of schizophrenia and what are the social causes of schizophrenia are included. Mental patients who are suffering from schizophrenia has been research respondent.(where) I choose Patan community based rehabilitation organization for doing research because this is the renowned mental hospital Where different type of mental patients are admitted from different class group. This hospital is in lalitpur district and I also belong to same district which makes me convenient to do research. I collected the qualitative data from the field using various research tools and techniques. I conducted 12 cases of mental ill patients who were diagnosed patients of schizophrenia and I used in depth interview with well known mental doctors of Nepal. As per the question created in this research, I choose in-depth interview to collect the qualitative data.

What is the best method to study issues of identity, power and schizophrenia? While a large quantitative study might present valuable data on such issues, this thesis proceeds from the assumption that a close, qualitative approach offers deeper, more detailed and more expressive material. As such, this thesis is based upon data drawn from the interpretive study of twelve people diagnosed with schizophrenia. Such a study, by its nature, offers depth rather than breadth of insight; highly individualized perspectives, rather than general "truths". This focus on depth of understanding is reinforced by the researcher's own status as a person diagnosed with schizophrenia; a point that will be explored below. Interviews themselves were semi-structured, allowing greater flexibility to draw out salient details of interviewees' accounts, and focused on questions of identity disruption, stigma and mental illness.

3.2 Research Design

The present research project is based on descriptive and explorative research design in which causes of schizophrenia and prevailing stigma has been described on the basis precise perceptions, narratives and effects of stigma on individuls before and after recovery.

By using exploratory research design' I tried to explore how individual are stigmatized by people before and after recovery. In this study, stigma negatively effect on individuals identity. When people are labeled, setapart and linked to undesirable characteristics a rationale is construced for devaluing, rejecting and excluding them.the patient and out patient from patan mental hospital is taken as a unit of analysis.

Tentative outline for this research design has been drawn on the chart following components of them are explained later.

Data collection

- Interview of 12 patient diagnosed with schizophrenia
- Key informant interview with 2 doctors
- Observation
- Secondary sources

Data Analysis

- Transcription of tape recorded material (Nepali to English)
- Organize the data
- Refinement of them exploring the relationship and find out the prevailing stigma attaching to mental health.
- Interpretation / analyze the result

Indicator of social class

- Occupation, income, social standing

- Place of residence
- Education level, clothing, life style.

Mental health

- The people suffering from mental illness schizophrenia.
- Struggles and stigma they face.
- Patan mental hospital patient who are diagnosed of schizophrenia.

Brief introduction of site:

The research was conducted in Patan mental hospital, lagankhel which is the oldest neuropsychiatric hospital in Nepal. It is the government hospital with commitment to serve the humanity. It has got 50 beds at present. Mental health is highly overlooked and neglected in Nepal.

3.3 Nature and Source of Data

To illustrate the effects of stigma on individual life, both primary and secondary information are ascertained from different sources. The secondary information related to causes of schizophrenia and prevailing stigma is obtained from previous publication, books articles, journals and reports published by different scholars and organizations. Since secondary information was not enough, I made a field trip to generate first hand information about causes of schizophrenia and prevailing stigma and its effect on individual's daily life.

3.4 Sampling Procedure

Any research requires a sample selection because the model is selected when there is a lot of population and also due to lack of money and time. i used homogeneous purposive sampling to select the respondent because the main goal of purposive sampling is to focus on particular characteristics of a population that are of interest, which will best enable me to answer my research questions. The objective of my research is to find out the social causes and prevailing stigma of schizophrenia. All

the respondents are schizophrenic patients of patan mental hospital. So, I think purposive sampling is appropriate for my research. Purposive sample is a non-probability sample that is selected based on characteristics of a population and the objective of the study. Purposive sampling is also known as judgmental, selective, or subjective sampling.

3.5 Tools of Data Collection

Different qualitative research tool will be used to obtaining the required data. They are described as follow:

3.5.1 Interview

Qualitative research tool interview was conducted with selected respondent who are diagnosis as schizophrenic. Interview was started after introducing the purpose of research.taking consent with the head of hospital.interview was taken in nepali and later transcribed to English for data analysis. respondents.

The study of life story of patients and their suffering was based on unstructured interviews. Corresponding with several formal and informal interviews, general information, family background, place of residence, economic background, education status, work profile, problem treatment and relationship with family and community were focal point of the interviews. While doing interaction with respondents, they seemed fearful and doubtful and hesitate to share their life history which makes me harder to collect data. Eventhough I did not give up and continue my research project taking help from hospital staff docter and family member of patients. The causes and stigma of schizophrenia can be found in life story respondents, it supported researcher to meet research objectives.

3.5.2 Key - Informant Interview

In this study,I interacted with Docters, staffs and family members of patient in order to gain better understanding of causes and stigma experienced. The key informant helped me to generate the information which was not obtain from the mental patients. Similarly, it supported me to explore the effect of stigma and stigma in the

relationship of interrelated components like attributes and stereotype. In addition key informant interviews helped me to cross check and verify the data ascribed from respondents.

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CHAPTER - FOUR
INTRODUCTION OF STUDY AREA AND RESPONDENTS

The present study was undertaken in Patan mental hospital in lalitpur districts in central development region of Nepal. The relevancy of selection of this hospital as study area was because it is one of the oldest neuropsychiatric hospital in Nepal. It is the government hospital where different socioeconomic background people visit to check their mental state. This hospital is in lalitpur district and I also belong to same district which makes me convenient to do research. Therefore present study has been a representative one to comprehend the cause of mental illness and prevailing stigma in Nepal.

From my childhood days, i am much more curious about mental health, when one of my close relative suffer from mental illness; I realized the condition of mental health service is not good in Nepal. In other to explore the sufferings and life experience of mental patient and also aware people about mental health I decided to research in mental illness hoping that person who reads my thesis will change his or her perception of mental illness, accepts the victim of mental patients who they are and help them to seek the treatment for better living.

In this study, 12 mental patient (6 male, 6 female) respondents were taken purposively. Among them I choose 4 out patients who are already recover from schizophrenia because their perception, experience and narrratives would be more reliable information to meet research objectives. The name and age of respondents are noted here; Ketan35, Kamala31, Tarapati45, Shyam40, Balkumari34, Seti43, Shanti35, Nibesh 27, Rabina29, Rajeev31, Padam49, Premshova46.

Schizophrenia and Identity Disruption:

The content of the twelve interviews undertaken for this thesis varied widely. some spoke of optimism and hope for the future; other spoke of lost dream of crippling lonliness and ongoing symptoms.

This chapter presents materials relevant to schizophrenia and identity disruption. it begins with an account of the disruption caused by the illness itself and variety of

symptoms of schizophrenia. Social isolation is misunderstanding of the condition by friends and relatives. It is found in many,perhaps most cases the experience of schizophrenia is so disruptive that it could take on the quality of an existential. Similarly shared experience of diagnosis often carried a significant emerged too as disruptive, finally, relapse occured in some cares as a reminder of the severity and significance of the illness often a prompt to keep on taking medication.

Introduing the Respondents:

Twelve people diagnosed with schizophrenia were interviewed for this study. Their ages and location varied as did the symptoms. This sections gives an introduction to the respondents.

ketan dulal was a wellspoken 35 years old who was diagnosed with schizophrenia in 2016 and lived with his family in kathmandu. Kamala was a 31 years old lady who lived in rented room in kathmandu. her home is in sarlahi and who was diahnosed with schizophrenia in 2015.Tarapati was a slow spoken man of 45years who was diagnosed in 2015, lived in luvu and in particular caged him by family. Shyam was seemingly happy individual of 40 years who was native of Dolakha diagnosed in 2015,and abandon by his wife. Balkumari Thapa was a well dressed women of 34 years from chapagaun who was diagnosed with schizophrenia in 2016. Seti Baral was 43 years old women from pokhara and now living in rent in baneswor,who was diagnosed with schizophrenia in 2010. Nibesh was a seemingly aggresive young guy of 27 years who was diagnosed with schizophrenia in 2018. He lived in Patan. Shanti Shrestha was unemployment women of 35 years who was diagnosed with schizophrenia in 2018 and left her in hospital by husband.Rabina maharjan was a beautiful young beautician of 29 years who was divorced and diagnosed in 2017. Rajeev kunwar was 31 years old guy who lives in kapan with his grand mother n mother and who was diagnosed in 2017. padam chhetri was 49 years who appeared to have come to an acceptance of his illness and life position who lived in samakhusi and diagnosed in 2015. finally, Premshova was a women of 46 year who lived in Balkhu

The Impact of Schizophrenia:

Chapter 4 of this thesis has suggested that people with schizophrenia generally experience some kind of instability or breakdown in their sense of identity. This may constitute a phenomenological breakdown. This suggestion is borne out to some extent. However, a number of different themes relating to identity and schizophrenia also emerge.

We begin with circumstances where the research subject's identity or personality was changed by their illness. As Bury suggests, schizophrenia is a chronic illness and, as such, often brings "biographical disruption". Ketan, who was diagnosed with schizophrenia, makes the observation that his personality changed both with, and after schizophrenia:

Ketan: I think that's, that's interesting that the illness has affected my personality, I think it's true. It has, so I am a new person. I was a person until I was in my late adolescence and then I was a different person during psychosis and I've come out the other end, a combination of the two.

This can clearly be seen as a form of biographical disruption. Indeed, Ketan describes a complete change in his identity or personhood. The illness has rebuilt his personality. This echoes themes of ontological insecurity described in the Theory Chapters, as well as descriptions of schizophrenia as an "I am" illness, rather than an "I have" illness. Interestingly, such a change occurred as a *process*, as predicted by symbolic interactionism. With that said, symbolic interactionism has some trouble accounting for specific symptoms that people such as ketan experienced (described below), other than as a compromised interaction. Another significant point to make is that this change seemed to come as a result of the illness itself, not by the social situation that ketan found himself in. ketan links his "biographical disruption" to delusions and convictions:

Ketan: It took years, to get me to have to have understanding and acceptance of my condition.

PM: Why did it take you so long?

Ketan: Because of the nature of the condition. Because, um... um um because it was hard to have insight at the very beginning because of my convictions and my delusions, my convictions and my delusions were so prominent in my perspective of life.

Although symbolic interactionism may have some difficulty in making sense of such convictions and delusions, we may turn to phenomenology for a better description. In particular, we find that ketan symptoms suggest Binswanger's "breakdown in the consistency of natural experience", or a breakdown of the body-in-the-world from Merleau-Ponty's point of view. Unlike many people afflicted with schizophrenia, ketan also has the insight to see that his illness has caused him to lose life opportunities, in a sense shrinking the possibilities of identity development, but also opening opportunities for successful medication and treatment. Insight has a particular psychiatric definition: it involves "the patient's awareness of mental disorder, awareness of the social consequences of disorder, awareness of the need for treatment, awareness of symptoms and attribution of symptoms to disorder" (Mintz et al, 2003, p. 75) and is often seen by psychiatrists as a significant step in overcoming psychosis. Ketan further talks of lost opportunities due to his illness:

Ketan: I definitely have missed out on life's opportunities.

PM: Can you tell me a bit about that.

Ketan: Yeah OK, um, I mean getting ill the first time and having time off uni, getting ill the second time and lost a girlfriend, um, we broke up. Being responsible, earning money, doing normal things, like getting married and having a family, having a mortgage, you know, having a social circle of friends, you just lose all that. Not to have that is a big part of your life. That's certainly something that I've lost.

These lost opportunities would certainly interfere with his ability to develop a more viable self through the process of social interaction with others, particularly inhibiting his ability to internalise the views of the general other.

Nibesh Adhikari, who was diagnosed with schizophrenia 2 years before the time of interview, emphasises that schizophrenia changed his personality by making him paranoid, so much so that he would close all the doors to his house to prevent neighbours from listening to him:

Nibesh: Um, well you tend to have um, quite a paranoid personality when you got schizophrenia, but the illness has, say from when I was young, it's changed my personality to the extent that I'm exceptionally careful and um whatever um, for instance, ah you know I made sure I closed the door so that the neighbours couldn't hear and this sort of thing. You tend to ... ah ... be a bit paranoid but at the same time ah you're aware of what's happening around you.

As an illustration of Nibesh ongoing symptoms, Nibesh closed his house doors during the interview to prevent neighbours from "listening in". As Peter points out, this paranoia has changed his personality, and perhaps echoes Minkowski's "loss of vital contact with reality". It also suggests the concept of biographical disruption; indeed, the disruption may be so severe as to pass beyond the purview of the concept of biographical disruption. Perhaps we require a more developed conceptualisation of disruption in people diagnosed with schizophrenia. We must also again be aware that the paranoia Nibesh felt and feels probably comes as a product of his disease, not his social context. There was in all probability no real conspiracy of neighbours listening in. This is also a paranoia that Nibesh has carried with him since first developing schizophrenia, through diagnosis and treatment. Amongst the respondents Nibesh was far from alone in continuing to experience identity-threatening symptoms through diagnosis and treatment. Again, symbolic interactionism may prove somewhat limited in accounting for a dysfunctional self as expressed through paranoia, and we may have to develop a concept of "compromised" gesture or interaction, as well as looking to the contribution of phenomenology.

Tarapati who was diagnosed with schizophrenia 4 years before the time of interview, related similar feelings of paranoia and persecution by a neighbour. Again, symbolic interactionism may prove of limited use in accounting precisely for such symptoms: Tarapati, 45 age was a diligent officer serving in the Armed Police Force (APF), when during the internal insurgency, he was captured by the Maoist rebels and subjected to months of torture. When he was released he was also dismissed from his duties.

Subsequently, his mental health deteriorated and he began displaying aggressive behavior. He showed no signs of improvement so his family locked him in a cage for over a year in 2016. He was badly behaved by friends and relatives. He was treated like danger animal. He was totally discriminated and stigmatized. Due to lack of mental health knowledge in our society Tarapati had to spend his life like an animal. Later after one year kosish mental organization provided him with emergency psychosocial support in a short-term residential home. Five months later, he made a full recovery and he was reintegrated back with his family.

Seti, who was diagnosed with schizophrenia 3 years before the time of interview, describes ambivalence about adopting her diagnosis, an understandable reaction given that schizophrenia is such a heavily stigmatised illness and can present such a serious break in the sufferer's ontology. Perhaps seti was experiencing negative feelings about being "labelled" as a "schizophrenic". Note also how Seti associates accepting the diagnosis with taking the correct medication, perhaps implying a link between the psychiatric apparatus that diagnoses and the psychopharmaceutical complex that medicates. This link will be explored further below:

Seti: I was hearing voices, yeah, yeah, that was the main thing. And I'd get messages from the TV and the radio and I'd get very depressed and I'd isolate myself and yeah but um, I had severe depression and I went to a psychiatrist here about 5 year ago and he said "well you've got schizophrenia" after talking to him.

PM: And how did you feel about that?

Seti: Oh well, it took a while to accept but now everything is you know, I accept it and I am taking the right medication and that.

Seti has clearly come to the point of accepting her condition and the disruption it entails. She repeats her story of accepting the diagnosis, responding to the idea that she was "labelled":

PM: How did it feel like getting diagnosed?

Seti: Um I was a bit shocked, yeah.

PM: Did you feel like you were being labelled?

Seti: Yeah, sort of yeah. You know um but now you know, I just accept it, you

know, it's just one of those things.

Subsequently, Seti offers a non-committal response about her identity as a person with schizophrenia, again pointing to the stigma of the condition, although she still experienced hearing negative voices that would form a breakdown of the regular body-in-the-world, and met with a carer regularly. We may also understand seti's non-committal response as a form of resistance against the psychiatric apparatus and a society that stigmatises schizophrenia.

PM: So, do you see yourself as a schizophrenic?

Seti: (pause) I don't know, that's a hard question. You know (pause) yeah. A very

hard question. You don't like to be labelled do you. No. (pause) I don't think I can answer that one.

In 2015, over 8,800 people lost their lives and 22,304 were left injured when the country was struck by a devastating earthquake).Government of Nepal Statistic.(This incident had a large impact on human lives .It caused unimaginable trauma resulting in an increase in cases of mental health problems. The large segments of the population faced major social and emotional challenges in coping with the events and with an uncertain future. KOSHISH has been providing its services to protect and enhance psychosocial well-being and/or work to prevent and treat severe mental disorders.

Forty-year-old Shyam Thapa, a native of Dolakha, had been suffering from Schizophrenia for the past 18 years .Because of his condition, his wife abandoned him .After the earthquake, his condition worsened as he began to display aggressive behavior and set the neighboring cowsheds on fire .To rein in his aggressive behavior, his family imprisoned him inside a cage His case was brought to koshish 's notice after it was published in a national daily .Subsequently, the team of koshish freed him on February 16, 2016 .In the care home, proper medication and psychosocial

counseling, Shyam showed drastic improvement and had a quick recovery .Shyam was reintegrated to his family and helps them with the agricultural work.

PM: how has Schizophrenia changed your life?

Shyam: Well, um, I lack motivation, um ...pause..., I'm not working at the moment, ah, and I've worked on and off ever since, different jobs, um, ...pause..., it's just been a real negative in my life.

The emphasis on work here is interesting. The importance of employment for identity formation emerges, particularly in a society where the work ethic is closely related to recognised forms of identity. Shyam also again picks up on the theme of motivation and being a "real negative". His story is incredibly sad and is a testament to the power of external stigma to be internalised by the sufferer of schizophrenia:

Shyam: I just don't think I'm worth much and, um, I lack a lot of confidence now, yeah, it's like I've been cut down to size. Yeah.

Shanti Shrestha is 35-years old women suffering from schizophrenia. She lives in buddhanilkantha She was abandoned by her husband at Patan mental hospital, lagankhel. He promised to care for her during her hospital stay but disappreared after a few days. Shanti is not only one mentally ill people are dumped on streets, or simply abandoned by relatives who can't deal with the stigma and burden of taking care of patients. Now shanti's daughter and cousin are taking care of her.

Rabina Maharjan is beautiful 29years old divorced lady. Her education qualification is intermediate level. She is beautician, earn 7ooo in a month. Because of violent behavior of her mother in law and sister in law, she run out from the hell and divorced his man who was in abroad now with new wife. Due to lack of support caring and loving, she became mentally ill. She doesnot have any support and living lonely life. She laughs and cries without any reason and always doing self talk. She stops doing job in parlour. Every one hates her calling baulahi mad and crazy women.

The Impact of Hospitalisation

Upon hospitalisation many respondents accepted that there was "something wrong" with them – typically a form of biographical disruption – and they were going to the "right place". The progress of schizophrenia-diagnosis-hospitalisation can be understood as a common "illness trajectory" and may confirm for many patients that there is something significantly wrong with them. Some patients came to accept, if not appreciate, the hospital as a place where they could find peace and could exist without major stress for a period of time. The hospital in this sense is clearly a fundamental, if sometimes brief, aspect of the illness trajectory of the person diagnosed with schizophrenia, as well as being for a time the key social structure that surrounds the diagnosed person. With that said, it is not surprising that respondents who had been scheduled or otherwise forced into hospitalisation generally reacted negatively to this experience. The issues surrounding power and forced hospitalisation are treated more extensively later in this thesis.

Padam Chhetri is 49 years old man who is wage laborer illiterate man. Due to poverty, neither he could provide nutrients food nor quality education for her two sons and a daughter .Due to over stress in life; he suffered from schizophrenia 10 years ago. He was somehow recovered after taking medicine. Then his daughter who lives in US called him and now his whole family is in US. His family was discriminated by society 10 years before due to his low economic status and madness. He was badly stigmatized by society earlier but now the condition has been changed. There is good relationship and interaction with relatives. It clearly shows that stigma related to mental illness is diretly and indirectly affected by patient's social position of status system.

He was originally hospitalised for a weight condition that gradually formed a psychotic episode. Such a career, or trajectory, is not exclusive amongst respondents. Typically, a patient may forget to take medication or, once medicated, "feel better" and decide the medicine was un-necessary. Such patterns of behaviour typically resulted in re-hospitalisation; having a psychotic episode seemed to be the common denominator amongst people admitted to hospitals, clinics or psychiatric wards. Such a pattern emerges in the quote from Padam regarding hospitalisation. Later in the interview continues with the observation that he was re-hospitalised after suffering

relapse due to “going off” his medication. Such an experience is again common among people who were hospitalised multiple times. What is the relevance of this? It confirms the primacy of medical intervention, even whilst clinics or wards may play a shortened role in a deinstitutionalised environment. The shift towards deinstitutionalisation draws on critiques of the asylum or mental hospital such as those given by Goffman, as well as being premised by the belief that people with mental illness are best treated within the community. It is a sad reality, however, that many people with serious mental illness do not currently receive adequate community support and may live isolated, if not fragmented and peripheral, lives:

Padam: I was in the hospital initially, for about two months and after that, I was returned home, medicated and it wasn’t until another year or two down the track that I had the symptoms again after going off the medication.

Padam’s description here of returning home, medicated, exemplifies the point made above that the psychiatric apparatus has exercised a productive power over Prescott’s self, whilst also shedding a more positive light on the deinstitutionalisation process.

Rajeev Kunwar is 31 year’s old unmarried guy who lives in kapan with his grand mother and mother. His father had extra marital affair. Due to unhealthy relationship with husband, Rajeev’s mother falls in mental illness. Rajeev is only child of his family no siblings. At age of 25 he went to India to study aruvedic medicine. For five years he stays in India then return back to Nepal with mental illness. From childhood day he did not get love and affection from his father. Father always beat him and his mother badly. His father was heavy drunkard businessman. He had grown up in conflict environment which ultimately result schizophrenia at age thirty. Rajeev expands in the interview, expressing his unease at the possibility of an ambulance coming to take her to hospital, or even the police. We may also understand Rajeev expression of unease as a form of resistance to the psychiatric apparatus, if not to the neoliberal state more broadly:

Rajeev: Yeah. I wonder whether the injections, um, I wonder whether that’s doing any good. When you been on injection for a long period of time, your body gets immune to the medication and it doesn’t work, so I’d rather be off that but they put me on a community treatment order because I wouldn’t go and have it.

PM: What's a community treatment order?

Rajeev: When you're forced ... If you don't want your injection, you're forced to have it.

PM: And who made that decision?

Rajeev: Um, my case manager.

PM: And you weren't happy with that?

Rajeev: No.

PM: Why were you not happy?

Rajeev: Because I didn't want the community treatment or whatever, force me to do something if I don't want to do it. Like, they ring an ambulance if you don't go in and get your injection. And you have to go with them because they will schedule you and if he decides he can ring the police and tell the police to take you to hospital and get your injection.

Although only a few of the respondents were scheduled or otherwise forced into treatment, the experience is certainly one of theoretical, and humanistic, interest. It is of theoretical interest because it confirms the power of the psychiatric apparatus over the sick individual,. It is of humanistic interest because it is the meeting point of individual rights to self-determination and the interest of society to control and limit that which is perceived as bizarre or a threat.

CHAPTER FIVE
CAUSES OF SCHIZOPHRENIA

5.1 Causes of Schizophrenia

The causes of schizophrenia are complex. There's a great deal of ongoing debate and research about them. Most experts agree on what is known as the bio-psycho-social model: schizophrenia is the result of a combination of genetic, personal and socio-environmental factors.

1. **Family History**

A person is more likely to develop schizophrenia if there is a family history of the illness, and biological relatives have also suffered from it. This is known as having a genetic pre-disposition. For example, Case 10: Rajeev kunwar who is 31 years of age suffer from schizophrenia and his mum is also victim of schizophrenia.

2. **Unhealthy relationship**

Unhealthy relationship with family member may also causes schizophrenia. Continue dispute between husband and wife also lead child to suffer from schizophrenia. For example Case 9: respondent Rabina Maharjan who is 29 years old beautician suffer from schizophrenia due to un healthy relationship with his husband. Her husband has extra marital affair and doesnot care and support her.even sister in law and mother in law always misbehave her. It became the reason how she became victim of mental illness.

3. Death of closed one

Lose of someone close individual or beloved increases stress level which ultimately leads to schizophrenia. For example, Case 6: Seti Baral who is 43 years of age experienced extreme mental disorder schizophrenia after the death of her husband. She left her home and live 3 month in street.

4. Sexually absued

It is also one of the social cause of schizophrenia. Sexual assault can have a variety of short- and long-term effects on a victim's mental health. Many survivors report flashbacks of their assault, and feelings of shame, isolation, shock, confusion, and guilt. People who were victims of rape or sexual assault are at an increased risk for developing: depression, eating disorder, anxiety. For example, Case 5: Balkumari Thapa who is 34 years old was manipulated and sexually abused by a man in young teenage. She was raped several times and deliver a baby girl. She left home and lives in street in worse mental condition.

5. Higher expectation

Expectations of conformity may come from family, friends, peers, media or other larger cultural forces and may cause depression. For example, some women may feel an intense pressure to get married and have children and may never stop to consider whether such a path is really what they want. A woman who is trying to meet cultural expectations at the expense of her own internal desires may fall prey to an insidious depression, which would then provide her with an opportunity to reflect on her own needs. For example, Case 1, ketan dulal a phd candidate of prince Edward isaland in Canada Suffer from schizophrenia because he could not earn money as much as he thought. His expection in life was too high whch lead him o experience extrema menta illness schizophrenia.

5.2 Complications of Schizophrenia

Left untreated, schizophrenia can result in severe problems that affect every area of life. Complications that schizophrenia may cause or be associated with include:

1. Suicide, suicide attempts and thoughts of suicide
2. Self-injury
3. Anxiety disorders and obsessive-compulsive disorder (OCD)
4. Depression
5. Abuse of alcohol or other drugs, including tobacco
6. Inability to work or attend school

7. Legal and financial problems and homelessness
8. Social isolation
9. Health and medical problems
10. Being victimized
11. Aggressive behavior, although it's uncommon

5.3 Challenges While Doing Research

Doing research on mental illness is quite complex job. Mostly in context of nepal people try to hide their mental illness. They did not have courage to speakout their experience. They are very much fearful of illness which might take away their power prestige and property. 90 percent of total population believe on myth of mental illness. Rather then going hospital for counselling or medication they prefer to meet shamans for traditional healing therapy. Each and every individuals believes that something supernatural or evil thing affect their body and soul. Patients see every other people suspiciously which make me difficult to collect data. Patients are less sociolized they have less memory and could not talk propely due to side effect of heavy dose medicine. Next biggest challenge is when i submit recommendation letter in Patan mental hospital, they asked me for proposal. After a months i went to submit proposal again they asked me for money but i didnot gave them .so truly speaking i didnot get reports of patients. Most of research is based on formal interview with female Dr. Deepti kafley and closely obervation of patients with dr. Kafley and in formal interview with family members of patients in patan mental hospital and also secondary sources like published journal, articles and newpaper help me to find the answers of research questions.

CHAPTER SIX
PERCEPTION AND SOCIAL STIGMA ATTACHED TO SCHIZOPHRENIA

Stigma is a mark of disgrace, stereotyping or rejection (eg. A social distance). Erving Goffman (1963) Stigma as the co- occurrence of its components. Labeling, stereotyping, sepration, status loss, and discrimination and further indicate that for stigmatization to occur.power must be exercised.

In the extreme, the stigmatized person is thought to be so different from “US” as to be not really human. And again, in the extreme, all manner of horrific treatment of “THEM” becomes possible. Evidence of efforts to separate us from them are sometimes directly available in the vary nature of the labels conferred. Incumbents are thought to be the things they are labeled (Estroff 1989). For example, epileptics or schizophrenics rather than describing them as having epilepsy or schizophrenia. This practice is revealing regarding this component of stigma because it is different for other disease or the flu-such a person is one of “US” a person who just happens to be beset by a serious illness. But a person is schizophrenic. (Bruce G .Link and JO.C. phelan, 2001).

The labeled person experiences status loss and discrimination. When people are labeled, set apart and linked to undesirable characteristics a rationale is constructed for devaluing rejecting and excluding them.

An almost immediate consequence of successful negative labeling and stereotyping is a general downward placement of a person in a status hierarchy.

Still in 21st century people believe in myth. They believe in something supernatural power or bad evils which is hampering in their health. Rathet than going to mental hospital they prefer to go to visit shamans (dhami jhakri). Here in research even the phd candidate ketal dulal believe in myth and visit several times in shamans home for traditional healing therapy. Other than that next respondent Tarapati KC who was diligent officer serving in the armed police force when during the internal insurgency, he was captured by the maoist rebels and subjected to months of torture.when he was released he was also dismissed from his duties. Subsequently, his mental health

deteriorated and he began displaing aggressive behavior. He showed sign of schizophrenia so his family locked him in a cage for over a year (365 days) can u believe it? Due to lack of mental health knowledge in our society individuals like Tarapati kc a army police officer who was living prestigious life became compelled to spend like an animal in cage for years. Society takes patients of schizophrenia as Monster, criminals threating and dangerous people who is unsuitable to participate in social activities.

Furthermore, next respondent Shanti Shrestha a victim of schizophrenia who was abandoned by her husband in Patan mental hospital lagankhel, people believe that once individual suffer from schizophrenia they will never recover from illness. But it's a totally wrong perception that society is carrying ahead. Shanti is not only a single person for whom his life partner or soulmate abandon her. Hundreds of women who suffer from this illness are abandoned in mental hospital by their family members and relatives because they have no courage to deal with stigma and burden of taking care of schizophrenic family member. We should continue to love and support our friends, neighborhood, and family even after diagnosed and accept them as who they are to live in more diverse world.

Stigma is entirely dependent on social, economic, and political power – it takes power to stigmatize. For instance Case 11: Padam Chhetri who is 49 years old wage laborer illiterate man who was highly discriminated by society after mental disorder. Their relative does not call him in any religious occasion. Later, when he recovered from illness his married daughter called him in U.S.A. Now his status is upgraded. His son Sanjay Chhetri also graduated in psychology from Chicago University. Now they have good relationship with relatives. Padam chhetri was badly treated earlier but now the condition has been drastically changed it is all because of his recent status.

There is myth that people with mental illness lack intelligence. According to the modified labeling theory (link ,1982) about the effects of stigma on people with mental illnesses. People develop conceptions of mental illnesses early in life as part of socialization in to our culture. People from expection as to whether most people will reject an individuals with mental illness as friend, employee, neighbor, or intimate partner whether most people will devalue a person with mental illness as less trustworthy, intelligent and competent. If one believe that others will devalue and

reject people with mental illnesses, one must now fear that this rejection applies personally. Expecting and fearing rejection, people who have been hospitalized for mental illnesses may act less confidently and more defensively or they simply avoid a potentaially threatening contact. The result may be strained and uncomfortable social interactions with potential stigmatizers more constricted social networks,a compromised quality of life, low self-esteem depressive symptoms, unemployment and income loss.(Pine 1999)

Steele and Aronsons (1995) concept of "stereotype threat". According to this idea, people know about the stereotypes that might apply to them. Mostly I found that out-patient respondent have stigma consciousness and stereotype threat.

African American knows they are tagged withattributes of violence and intellectual inferiority, and people with mental illnesses know that they are believed to be unpredictable and dangerous. The insight that Steele and Aronson provide is that the stereotype becomes a threat or challenge either because one might be evaluated in a accordance with the stereotype or because one might confirm the stereotype through one's behavior. For example Case 7 Nibesh Adhikari: who is 27 years of age diagnosed schizophrenia. He is student of civil engineering.After one month of hospitalization, he feels that he is recovered now but his parents are not willing to take in home. There was a great quareel between Nibesh and his father. Decision concerning discharge is only in the hand of parents or Docter. After illness nibesh was treated like illiterate person who doesnot know nothing about his health. He was shouting that please don't give me high dose medicine I am becaming weeker day by day. Eventhough docter give him injection and suggest Nibesh father to mix medicine in daal and feed him. My findings shows that lower social class patients like Nibesh stay in hospital and have a greater chance of becoming institutionalized. Weak social status patients are more likely to victimized and labeled.

CHAPTER - SEVEN

SUMMARY (RESULTS AND DISCUSSIONS) AND CONCLUSION

This thesis has sought to answer the question of what are the causes of schizophrenia. and prevailing stigma. The thesis engaged in a qualitative case study of twelve people with schizophrenia, using semi-structured interviews as the primary research method. This method has provided rich data in response to the research question. The values of this thesis lie in showing how people with schizophrenia can actively re-buiild a shattered self, and maintain that self under difficult circumstances. This thesis also seeks to re-think and revise some of the available conceptual tools for understanding the self and other, and to make sense of processes of identity disruption, rebuilding and maintenance in people diagnosed with schizophrenia. The thesis intervenes in the sociology of chronic illness, proposing the concept of biographical crisis; contributes to symbolic interactionism, with the concepts of compromised gesture and emotional interactionism; finally, the thesis contributes to the theorisation of power relations in serious mental illness, with the concept of negotiated power networks and an analysis of the role of power and prevailing stigma.

7.1 Synthesising Results and Discussion

The data uncovered by this research is deep and resonant. Interviewees shared significant, personal stories. These stories provided fertile material with which to address the research question. Stories of identity disruption, prevailing stigma, rebuilding and maintenance could be found within the pages of data collected. Vital experiences of mental illness, of isolation, of stigma and of power emerged.

Interviewees generally faced grave disruption to their lives and biographies through their experience with schizophrenia. Encounters with the illness itself, as well as with diagnosis, hospitalisation, the psychiatric apparatus and the psychopharmaceutical complex all contributed to the disruptive nature of the schizophrenic experience. Typically, interviewees experienced a significant breakdown in their "self", as theorised in Mead and Blumer's work in the symbolic interactionist literature. The

symbolic interactionist literature was also extended to account for the disruptive, or dysfunctional, experience of self-breakdown. The concepts of compromised gesture and compromised interaction helped make sense of the breakdown of the self in schizophrenia, and contributed to a richer reading of symbolic interactionist theory. Such was the intensity of the disruption of schizophrenia that many cases came to constitute a biographical crisis; an ontological breakdown of the very being of the interviewee. The issue of isolation-as-disruption also emerged for a number of interviewees who lived alone or rarely socialised. The power of the psychiatric apparatus also began to become clear, insofar as diagnosis with a psychiatrist and hospitalisation contributed to these processes of identity disruption.

Rebuilding a sense of identity was revealed to be a complex, subtle process involving a number of factors. The primary role of medication cannot be underestimated. Medication, in many cases, dampened symptoms of schizophrenia sufficiently for the person diagnosed to engage in everyday processes of symbolic interaction. Typically, meaningful interaction with others, making meaningful gestures and the internalising of the view of the general "other", as predicted by symbolic interactionist theory, was a vital aspect of the process of rebuilding identity for interviewees. Such interactions included relations with family and friends, mental health professionals, other sufferers and religious communities. Processes of rebuilding identity involved the sufferers in a course of active behaviours aimed at ameliorating the impact of their illness. Typically this included negotiating prescriptions of medication, as well as illness and practical life management. Such agent-driven attempts at self-management were described collectively as identity work; a concept that may hold broader significance outside the field of rebuilding a sense of identity in schizophrenia. The ontological nature of the breach-in-self that interviewees sought to fill led the researcher to inquire into phenomenological readings of schizophrenic symptoms. In particular, the thesis makes the suggestion of re-establishing the body-in-the-world, or ontological renovation, as concepts to guide our understanding of processes of rebuilding identity. The use of language provided a revealing lens with which to understand efforts towards rebuilding identity in people diagnosed with schizophrenia. Typically

interviewees would adopt psychiatric discourse to describe their situations and experiences of rebuilding a sense of identity, involving again the influence of the psychiatric apparatus. However, language use proved significant for other reasons. In particular, the use of the term ″consumer″ by interviewees using psychiatric medication brought with it a complex relationship to the mental health market and the psychopharmaceutical complex. The use of illness narratives involved interviewees in a personal re-telling, or re-framing, of their experiences; a re-framing often involving themselves as an active agent who sought help, negotiated medications, searched for work, and so forth. The issue of agency was one which emerged in the theorisation of power exercised by the psychiatric apparatus in a context of psychopharmaceutical interventions and deinstitutionalisation of psychiatric service provision. The term ″negotiated power network″ captured the relationship of the interviewee who often lived alone, but regularly took psychiatric medication and was visited by mental health workers, or visited a psychiatrist.

Finally, interviewees engaged in a number of behaviours to maintain their identities. Strictly speaking, such identity maintenance involved a number of the same processes as rebuilding a sense of identity; managing medication and doctor′s appointments, for example, contributed both to interviewees re-establishing a sense of self as well as maintaining such a self once established. Identity maintenance also involved distinct processes of stigma management. Interviewees managed the considerable stigma of having schizophrenia by dividing their social world into people who knew and did not know, by passing for normal, and by concealing the more noticeable aspects of the illness, such as paranoid thinking or misjudging affect. Again, the opportunity to practice these skills was important to many interviewees, and issues of isolation sometimes mitigated the processes of identity maintenance they could take part in the lower class patients tended to stay in hospital continuously or if released were more likely subsequently to be readmitted than were the higher class patients. People who develop mental illness drift down into the lowest social class. They are fired from office or workplace .then they depend with family members for survival. In literate family, patients seem to get sound emotional as well as financial support where as in

illiterate family patients get hardly a good support. In case of supporting patients are more likely to abandon and excluded from home.

My finding showed large class difference schizophrenia was much more common among lower class than among middle class. Stigmas related to mental illness are quite different among different classes. Lower class people experience higher level of discrimination and totally excluded from the family trend and relatives. In similar way, middle class also experience some discrimination but very low in comparison to lower class. They are not excluded from family, friends and relatives but they experience vast difference in behavior of society towards them. Upper-class is not discriminated in society. Even if they became mentally ill, they are cured in very short span of time. They are also given very special treatment.

My finding shows that lower social class patients stay in hospital longer and have a greater chance of becoming institutionalized. Decision concerning discharge may also be influenced by the hospital staff′s expectations regarding the patient′s medicine taking behavior. My findings show that stigmatizing labels is most likely to be applied to those who are powerless to resist it. Weak social status patients are more likely to victimize.

Upper class patients take very expensive and time consuming therapy whereas lower social class patients take treatment by drugs and electric shock.

Psychiatrists also tend to choose higher class, well educated people for special treatment. Next surprisingly, this treatment carries far less stigma than a stay in a mental hospital and drug treatment. Those who are able to afford it will understandably obtain the more pleasant and less stigmatizing treatment and thus will not appear in the records of mental hospital and mental health clinics. There are lots of challenges on mental health among them, Lack of adequate mental health professionals and treatment facilities major one. There is only one mental health hospital in the country, and mental health services are not easily available in rural and remote areas. Mental health infrastructure is poor and human resources are not

sufficient to meet the need. At present, most psychiatric wards are staffed and run by general nursing staff without specialized training in mental health or disorder. Governmental structures to address mental health are not yet in place. Although legislation is planned, there is presently no division for mental health under the Ministry of Health, and there is not an adequate budget for mental health services. There is no consumer or professional organizations that advocate for mental health issues.As we know that disabled persons may be limited in their ability to work not so much because of their inherent limitations but because they are exposed to what Hahn(1983) calls “a disabling environment” created by the barriers to participation that reside in architecture we humans have constructed. the same kind of structural discrimination is of course present in mental illness like schizophrenia.. This illness is highly stigmatized and less funding is dedicated to research about it than for other illnesses and less money is allocated to adequate care and management. Because of historical process influenced by stigma, treatment facilities tend to be either isolated in settings away from other people or confined to some of the most disadvantaged neighborhoods in urban settings in communities that donot have enough power to exclude this stigmatized group from their area. at the same time, the most successful and accomplished mental health personnel tend to accure more status and money by treating less serious illnesses in private offices in affluent areas, leaving the care of people with schizophrenia to a generally less accomplished group. Thus there is a structural discrimination in context of Nepal. Finally , the standard way of conceptualizing the connection between labelling stereotyping and discrimination in the stigma literature follows a relatively simplistic formulation. in this approach, the importance of attitudes and beliefs are thought to lie in whether person A’s labeling and stereotyping of person B leads persons A to engage in some obvoius forms of overt discrimination directed at person B, such as rejecting a job application, refusing to rent an appartment and so on.

7.2 Conclusion

This study demonstrated an ongoing need for advocacy for individual's schizophrenia, as well as a need for continued, raised awareness about the social stigma these individuals encounter. Stigma is Symbol that the way first categorized people into different categorize people in to different categorizes to understand and view them in

certain way. Stigma has complex roots in society and is life long mark. Stigma complicates the process of recovery for patients for many reasons and it also interferes with people′s willingness to seek professional help due to a fear of being labeled. If such individuals seek help and encounter treatment providers who do not embrace the belief that individuals can change, grow and recover hopelessness will permeate the tone of the session.

Therefore, it is imperative for therapists to be aware of their own attitudes toward recovery for individuals with schizophrenia. It is also important that the therapist remain cognizant of his or her client′s experience of stigma. As a local clinical scientist, psychologist should maintain an awareness of how stigma affects not only the patient′s belief of his or her own recovery process but also how societal views of mental health and illness play a major role in the recovery cycle. Psychologists are encouraged to support and promote efforts to reduce stigma and endorse recovery for people with severe mental illnesses. Promoting the recovery paradigm begins with assessing therapists′ own attitudes towards mental health and belief in recovery.

Therefore, as true patient advocates, therapists should understand that they are not immune from holding attitudes based on social stereotypes. Therapists need to be encouraged to use self-reflection to examine their attitudes toward patients with schizophrenia, including their professional dedication to the model of recovery. Advocating for people with mental health disorders encourages providers to become more hopeful about their clients′ opportunities for recovery. Research and effective treatment that promotes recovery principles for individuals with serious mental illnesses will provide the best evidence to alter core beliefs about mental illness and reduce the barriers of stigma.

In addition most of the respondent of my research belongs from small family type. I found that both literate and illiterate., rich and poor, male and female suffer from schizophrenia .only difference is the causes of illness and the way they perceive illness and treatment process. for example ketan dulal who is phd candidate suffer from illness due to exccesive desire and expectation where as Seti Baral an illiterate

housewife suffer from illness due to untimely demise of her husband who worked as an agent for foreign companies. these two respondent are from upper and middle class background respectively.i found that upper and middle class patients get suppoet from their family members so they recover soon in camparision to pauper classs or poor lower class.

For instance, ketan family members became so panic and terrfied after diagnosed schizophrenia to his son. for more than years they compell their son to follow the rules and regulation like taking bath regularly at early morning and eating a rice grain which is given by shaman traditional healer. Even in literate family , there is myth behind mental illness in Nepal. They believe that some bad evil make them so to act deviant behaviour like laughing and crying without reason and communicating with imaginary person and so on.

In order to seti's story she leave home after death of husband due to mental stress. her son try to search every places but could not found her until 3 month. Seti live in street for 3 months. My quest is why government is not taking action in field of mental health ? why government doesnot allocate the adequete budget in the field of mental health for the management and treatment facilities. Seti is just an example there are lots of Seti who are struggling with their life in the street of kathmandu. eventhough nepal health government remaining silence for schizophrenia. we can see campaign, health camp, walk for cancer these days but have u ever ever seen a walk for schizophrenia. NO! not at all. have you ever walk on event depression anxiety sucide to raise awareness of mental illness? Probably NO. Mental health condition is quite miserable in Nepal due to Individual and Structural discrimination. So, now its time to raise voice against stigma barrier and talk mental illness openly in public sphere. Thus,There is No Health Without Mental Health.

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APPENDIX I
THE RESEARCH SCENARIO

Case I: Here is the description of a 35 years old man ketan Dulal a PhD canditates at the University of Prince Edward Island in Canada. Who hide his illness for decad

Case II: Kamala, who is 31 years old lady who was sold to women traffickers in Rs 30,000 when she was 4 years of age. She was in Kathmandu central jail for 10 years, and then suffers from schizophrenia.

Case III: Tarapati K.C, 45 age was a diligent officer serving in the Armed Police Force (APF), when during the internal insurgency, he was captured by the Maoist rebels and subjected to months of torture. When he was released he was also dismissed from his duties. Subsequently, his mental health deteriorated and he began displaying aggressive behavior. He showed no signs of improvement so his family locked him in a cage for over a year in 2016. He was badly behaved by friends and relatives. He was treated like danger animal. He was totally discriminated and stigmatized.

Case IV: Forty-year-old Shyam Thapa, a native of Dolakha, had been suffering from Schizophrenia for the past 18 years .Because of his condition, his wife abandoned him .After the earthquake, his condition worsened as he began to display aggressive behavior and set the neighboring cowsheds on fire .To rein in his aggressive behavior, his family imprisoned him inside a cage.

Case V: Balkumari Thapa, who is 34years old was manipulated and sexually abused by a man as a young teenager .She became pregnant while the man was already married and settled with his family .After having two children from this man, she became a victim of severe domestic violence .As a result, she left home and was living in the streets .Even in this critical time, severely mentally and physically traumatized, she was raped again and delivered a baby girl in the stree

Case VI: Seti is a 43-year-old woman who lives in the western part of Nepal .Three years ago, her husband —who worked as an agent for foreign companies seeking employees —passed away, and Seti entered a prolonged period of mental disorder .

She traveled to Kathmandu, stayed at the Pashupatinath temple, and then began living out on the streets .Her family tried to find her in every possible way, but they failed . Seti lived in the street for three months .She had no knowledge of herself or her family .People called her Boulahi, meaning "insane woman, "and Seti faced an overwhelming amount of cruel behavior from even the most respected people who saw her.

:Case VII Nibesh Adhikari is 27 years old aggressive danger looking guy who was student of Civil engineering.and his home town is Kathmandu .He himself thinks he is normal but he was diagnosis schizophrenia in Patan hospital. While I was doing conversation with Dr. Deepti Kafley, we heard a quarreling sound .That was Nibesh and his father got fight in topic of taking medicine .Father was forcing his son to take medicine but he refuse to take it.

Case VIII: Shanti Shrestha is 35-years old women suffering from schizophrenia. She lives in buddhanilkantha She was abandoned by her husband at Patan mental hospital, lagankhel. He promised to care for her during her hospital stay but disappreared after a few days. Shanti is not only one mentally ill people are dumped on streets, or simply abandoned by relatives who can't deal with the stigma and burden of taking care of patients. Now shanti's daughter and cousin are taking care of her.

Case IX: Rabina Maharjan is beautiful 29years old divorced lady. Her education qualification is intermediate level. She is beautician, earn 7ooo in a month. Because of violent behavior of her mother in law and sister in law, she run out from the hell and divorced his man who was in abroad now with new wife. Due to lack of support caring and loving, she became mentally ill. She doesnot have any support and living lonely life.

Case X: Rajeev Kunwar is 31 year's old unmarried guy who lives in kapan with his grand mother and mother. His father had extra marital affair. Due to unhealthy relationship with husband, Rajeev's mother falls in mental illness. Rajeev is only child of his family no siblings. At age of 25 he went to India to study aruvedic medicine. For five years he stay in india then return back to Nepal with mental illness. From childhood day he did not get love and affection from his father. Father always

beat him and his mother badly. His father was heavy drunkard businessman. He had grown up in conflict environment which ultimately result schizophrenia at age thirty.

Case XI: Padam Chhetri is 49 years old man who is wage laborer illiterate man. Due to poverty, neither he could provide nutrients food nor quality education for her two sons and a daughter .Due to over stress in life; he suffered from schizophrenia 10 years ago. He was somehow recovered after taking medicine. Then his daughter who lives in US called him and now his whole family is in US. His family was discriminated by society 10 years before due to his low economic status and madness. He was badly stigmatized by society earlier but now the condition has been changed. There is good relationship and interaction with relatives.

Case XII: Premshova Shrestha is a well-spoken 46 year old married women with two children. She has study grade 9. Due to family problem she could not give final exam of grade nine. Her father lost the eye sight when she was in teen age. With the loss of his father's eyesight, she lost his dream of study. From early teen age she had to experience problems and hindrance. After marriage, when she was working on German project office where she earn 5000in a month, suddenly the fire alarm ring. All workers run outside office. She fell down on ladder and broken her right leg. It takes one year to recovery. Then after she did not get job. Then her health condition became bad. She thought that all bad things that happen in her life due to evil spirit which enter in her body. She started to enter in external world and later she was diagnosis as mental patient of schizophrenia. She even skips her meal with a suspiousness that someone has poisoned her food.